Acronym Glossary of Health Information Technology Terms
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This Acronym Glossary was created by the Medicaid EHR Team (MeT) on behalf of and approved by the CMS Medicaid HITECH Team. The MeT is contracted by CMS to provide technical assistance to states on their implementation and administration of the Promoting Interoperability Program, formerly called the Medicaid Electronic Health Record Incentive Program.

A-B

Acronym	Definition
AAC	**Average Allowable Cost** • As it relates to CEHRT, an eligible provider's AAC for the first year of payment under the Medicaid EHR Incentive Program is the average cost for purchasing and implementing or upgrading the technology, including training necessary for its adoption and initial operation. In subsequent years of the provider's payment, AAC is the average cost above those incurred in the first year of operating, maintaining and using the technology. • An Eligible Professional's net average allowable cost (NAAC) for the first year of payment may not exceed $25,000, or a lesser amount determined by the Secretary of HHS. In subsequent years, the NAAC per year may not exceed $10,000. • This term is described in more detail at 42 USC § 1396b(t).
AATS	**Affordable Care Act Assurance Testing System** • AATS refers to both the IRS process and system used to test software and electronic transmissions prior to accepting forms from software developers, transmitters and issuers into the IRS Production AIR System. Software developers are required to pass IRS AATS annual test scenarios for the forms and tax years that the software package will support. Transmitters and issuers are required to pass a one-time communication test for the forms they will file.
ACA	**Affordable Care Act** • ACA is the shortened term for the Patient Protection and Affordable Care Act of 2010.
ACI	**Advancing Care Information** • This term refers to the Medicare Merit-based Incentive Payment System (MIPS) performance category focused on use of electronic health records. It replaces the meaningful use program for Medicare physicians.
ACO	**Accountable Care Organization** • ACOs are groups of physicians, hospitals, and other health care providers that work together to coordinate high quality care for their patients. In some instances, ACO providers contract with payers to accept risk for not meeting goals or to be rewarded for exceeding goals.
ADP	**Automated Data Processing** • ADP refers to the creation and implementation of technology that automatically processes data. It includes computers and other communication electronics that gather, store, manipulate, prepare, and distribute data.
ADT	**Admissions, Discharges, Transfers** • An ADT system sends automatic notifications or alerts from hospitals to primary care practices and/or care managers when a patient has an admission, discharge, or transfer. Its intent is to improve the timely flow of information needed when a patient is transitioning to care in another setting or in the community.
AHRQ	**Agency for Health Care Research and Technology** • The AHRQ is an organizational unit within HHS charged with improving the safety and quality of America's health care system through the production of evidence on making health care safer, of higher quality, more accessible, equitable, and affordable, and to work with others to make sure the evidence is understood and used.
AIR	**Affordable Care Act Information Return System** • The ACA requires insurance companies, self-insured companies, large businesses, and businesses that provide health insurance to their employees to report information on this health insurance coverage electronically to the IRS through the AIR system.

Acronym	Definition
AIU	**Adopt, Implement, Upgrade** • AIU is an initial step toward meaningful use (MU) of electronic health record technology. • Eligible professionals (EPs) and eligible hospitals (EHs) received funding through the Medicaid EHR Incentive Program when they attested to adopting, implementing, or upgrading (AIU) certified EHR technology (CEHRT). • The last year an EP or EH could attest to AIU for the Medicaid EHR Incentive Program was program year 2016.
ANSI	**American National Standards Institute** • A private, non-profit organization, ANSI oversees the creation, promulgation and use of thousands of norms and guidelines that impact businesses in many sectors, including information technology.
APCD	**All Payer Claims Database** • An APCD is a database that collects health insurance claims information from a wide variety of health care payers into a statewide information repository and is designed to inform cost containment and quality improvement efforts. Payers may include commercial insurers, publicly funded programs, and specialty payers such as prescription drug plans and vision or dental insurers.
APD	**Advance Planning Document** • An APD refers to an advance automated data processing (ADP) planning document that provides a recorded plan of action by a state or territory to request federal funding approval for a project that will require the use of ADP services or equipment, including the use of shared or purchased services in lieu of state acquired stand-alone resources. • An approved APD is required for a state or territory to receive federal funding for certain programs or investments, including the administration of its Medicaid EHR Incentive Program.
API	**Application Programming Interface** • In computer programming and as it relates to electronic health records, an API is a set of programming protocols established for multiple purposes and related to meaningful use measures associated with Stage 3 Electronic Access and Coordination of Care through Patient Engagement. It is a technology that allows one software program to access the services provided by another software program. • APIs may be enabled by a provider or provider organization to provide the patient with electronic access to their health information through a third-party application with more flexibility than is often found in other “patient portals.”
APM	**Alternative Payment Model** • In health care, an APM is a payment approach that rewards providers for delivering high-quality and cost-efficient care. • Advanced APMs are a subset that let practices earn more for taking on some risk related to their patients’ health care outcomes.
ARRA	**American Recovery and Reinvestment Act of 2009** • The ARRA was an economic stimulus package that included authorization and funding for the Medicare and Medicaid EHR Incentive Programs. The Health Information Technology for Economic and Clinical Health (HITECH) Act was a part of the ARRA.
ASPE	**Assistant Secretary for Planning and Evaluation** • The ASPE is the principal advisor to the Secretary of HHS on policy development and is responsible for major activities in policy coordination, legislation development, strategic planning, policy research, evaluation, and economic analysis.
ASPR	**Assistant Secretary for Preparedness and Response** • The ASPR reports to the Secretary of HHS and leads the nation’s medical and public health preparedness for, response to, and recovery from disasters and public health emergencies.

Acronym	Definition
ASTHO	**Association of State and Territorial Health Officials** • The ASTHO represents the public health agencies of the US states, territories, and the Freely Associated States of Micronesia, the Marshall Islands, and Palau. ASTHO's members, who are the chief health officials in each of these jurisdictions, formulate and influence public health policy and work to protect and promote good health in the populations they serve.
ASTM	**American Society for Testing and Materials** • The ASTM is a non-profit organization that develops and publishes technical standards covering the procedures for testing and classification of a wide range of materials, products, systems, and services.
ATC	**Authority to Connect** • An ATC is required from CMS to activate a system-to-system connection to the Data Services Hub. The CMS Chief Information Officer grants the ATC upon review of security and privacy compliance artifacts.
ATCB	**Authorized Testing and Certification Body** • The ATCB is an organization authorized by the Office of the National Coordinator for Health IT (ONC) to perform complete electronic health record (EHR) and/or EHR module testing and certification. There are six authorized organizations and together they approve the Certified Health IT Product List (CHPL) used by providers.
BA	**Business Associate** • As it relates to health care, this term generally refers to a person who assists in the performance of a function or activity involving use or disclosure of individually identifiable health information, including claims processing or administration, data analysis, or other administrative activities that require use of the health information. • The term is defined at 45 CFR 160.103.
BAA	**Business Associate Agreement** • This agreement, sometimes called a contract, describes the permitted and required uses of protected health information shared between a covered entity, such as a health plan or health care provider, and a business associate, as defined at 42 CFR 160.103. • The required elements in the agreement are specified at 45 CFR 164.504(e).
BI	**Business Intelligence** • This term refers to strategies and technologies used by enterprises for the data analysis of business information to transform raw data into meaningful and useful information for effective strategic, tactical, and operational insights and decision-making.
BOS	**Business Operations Staff** • As it relates to health care, this term may reference general administrative staff, information technology staff, general and patient accounting staff and managed care administrative staff with needed expertise to help strategically align business and clinical functions to meet initiatives and have long-term success and sustainability.
BPR	**Business Process Re-Engineering, or Redesign** • This term refers to a business management strategy focused on the analysis and design of workflows and business practices in an organization, to help the organization rethink how to make improvements. • The term is relevant to clinical workflow redesign to meet meaningful use requirements as well.

C

Acronym	Definition
C&S	**Conditions and Standards** • This term refers to the seven conditions and standards set by CMS that states must meet for Medicaid technology investments to be eligible for enhanced federal matching funds: modularity, MITA, industry standards, leverage, business results, reporting, and interoperability.
CAH	**Critical Access Hospital** • CAH is a designation given by CMS to certain rural hospitals that meet specified criteria related to availability of emergency services, bed size, average length of stay, and location from any other hospital. The designation entitles the hospitals to certain levels or types of payment and exempts them from Medicare Prospective Payment System requirements.
CAHPS	**Consumer Assessment of Healthcare Providers and Systems** • A family of survey instruments, each is designed to ask consumers and patients to report on and evaluate their experiences with health care. The surveys focus on aspects of quality that consumers are best qualified to assess, such as the communication skills of providers and ease of access to health care services. • The acronym "CAHPS" is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ), an organizational unit with HHS.
CALiPHR	**CQM Aligned Population Health Reporting** • CALiPHR is a technology designed to calculate electronic clinical quality measures (eCQMs) at a provider, practice, payment arrangement, and community level to support incentive and value-based payment programs.
CBES	**State Children's Health Insurance Budget and Expenditure System** • This system is a web-based application used by CMS and implemented nationwide that allows states to report budgeted and actual expenditures for their Children's Health Insurance Program (CHIP). • States use this application to submit both their CMS-37 anticipated quarterly budgeted cost reports and their CMS-64 actual quarterly expense reports, which also include both incentives paid and administrative costs associated with the Medicaid EHR Incentive program.
CBT	**Computer-Based Training** • CBT refers to any course of instruction whose primary means of delivery is a computer. The CBT may be delivered via a software product installed on a single computer, through a corporate or educational intranet, or over the Internet as Web-based training.
CCD	**Continuity of Care Document** • Built using HL7 Clinical Document Architecture elements, the document contains data defined by the ASTM Continuity of Care Record and is used to share summary information about a patient within the broader context of the personal health record.
CCHIT	**Certification Commission for Health Information Technology** • The CCHIT is an independent, non-profit group focused on advancing health information technology It is approved by the Office of the National Coordinator for Health Information Technology (ONC) as an authorized testing and certification body.
CCIIO	**Center for Consumer Information and Insurance Oversight** • The CCIIO is an organizational unit within HHS/CMS charged with helping implement reforms included in the Affordable Care Act, with a focus on Health Insurance Marketplaces in the states.
CCN	**CMS Certification Number** • The CCN is a unique identifying number CMS assigns to participating providers in the Medicare program. It is also called the Medicare Provider Number.

Acronym	Definition
CCR	**Continuity of Care Record** • The CCR is a published, open, extensible markup language-based standard, developed by ASTM to exchange relevant current and past patient history information between clinical applications. It offers practitioners the background information required to deliver quality care.
C-CDA	**Consolidated Clinical Document Architecture** • The HL7 C-CDA standard is used in the context of EHR certification and Meaningful Use. It contains a library of CDA template standards and represents a unified implementation guide for nine common electronic clinical documents.
CDA	**Clinical Document Architecture** • The CDA is a flexible markup standard that defines the structure of certain medical records, such as discharge summaries and progress notes, to better exchange information between providers and patients.
CDC	**Centers for Disease Control and Prevention** • The CDC is an organizational unit with HHS responsible for detecting and responding to new and emerging health threats, and promoting healthy and safe behaviors, communities and the environment.
CDR	**Clinical Data Repository** • A CDR is a real-time database that consolidates data from a variety of clinical sources, such as an electronic medical record or a laboratory system, to present a full picture of care a patient has received.
CDS	**Clinical Decision Support** • A key functionality of health information technology, a CDS provides timely information to a practitioner at the point of care to help inform decision making. It can increase quality of care, enhance health outcomes, help to avoid errors and adverse events, improve efficiency, reduce costs, and boost provider and patient satisfaction. • It is also called Computerized Decision Support.
CDT	**Code on Dental Procedures and Nomenclature** • The CDT is a series of alpha-numeric codes used to document dental treatment on claims for payment. It is the HIPAA standard code set for dental services and is maintained by the American Dental Association.
CE	**Covered Entity** • In health care, this is a health plan, health care clearinghouse, or a health care provider that transmits personal health information electronically to carry out financial or administrative activities. • The term is defined at 45 CFR 160.103.
CEHRT	**Certified Electronic Health Record Technology** • This term refers to electronic health record (EHR) technology that has been certified specifically for the Medicare and Medicaid EHR Incentive Programs. Its certification gives providers assurance that the EHR system or module offers the necessary technological capability, functionality, and security to help them meet meaningful use criteria. • This term is described in more detail at 42 USC § 1396b(t).
CFR	**Code of Federal Regulations** • The CFR is a codification of general and permanent rules published in the Federal Register by the departments and agencies of the federal government.

Acronym	Definition
CGD	**Certification Guidance Document** • The CGD explains the factors used by the Office of the National Coordinator for Health Information Technology (ONC) to determine whether to recommend to the Secretary of HHS an organization for ‘‘recognized certification body’’ status. The CGD serves as a guide for ONC to evaluate applications and provides the information an organization needs to apply for and obtain such status.
CHAMPS	**Community Health Automated Medicaid Processing System** • This term refers to Michigan’s Medicaid Management Information System (MMIS).
CHIP	**Children’s Health Insurance Program** • Established by Public Law 105-33, the Balanced Budget Act of 1997, and contained in Title XXI of the Social Security Act, the program provides federal matching funds to states for health coverage for uninsured children in families with modest income but too high to qualify for Medicaid. • It was initially called the State Children’s Health Insurance Program (SCHIP).
CHIPRA	**Children’s Health Insurance Program Reauthorization Act of 2009** • This law made changes to the CHIP as originally created in 1997 and authorized a continuation of program funding.
CHPL	**Certified Health Information Technology Products List** • The CHPL is the authoritative, comprehensive listing of health information technology products tested and certified under the Health IT Certification Program administered by the Office of the National Coordinator for Health IT (ONC).
CMA	**Computer Matching Agreement** • In health care, this term refers to a written agreement between two government agencies, state or federal, directly or through contractors, that identifies the purpose and parameters for matching electronic files containing information about individuals. The CMA also identifies procedural safeguards to protect the privacy of individuals identified in the files. • Agreements involving federal agencies must comply with the Computer Matching and Privacy Protection Act of 1988 (also abbreviated as CMA).
CMCS	**Center for Medicaid and CHIP Services** • The CMCS is an organizational unit within HHS/CMS that serves as the focal point for all national program policies and operations related to Medicaid, the Children's Health Insurance Program (CHIP), and the Basic Health Program (BHP).
CMS	**Centers for Medicare and Medicaid Services** • The CMS is an organizational unit within HHS and is responsible for administering the Medicare, Medicaid, and Children’s Health Insurance Programs, as well as the Health Insurance Marketplace.
CMS-zONE	**CMS Opportunity to Network and Engage** • This term refers to a collaborative online platform for state-based marketplace exchanges, insurance agents, and business and technology teams to connect, communicate and share information.
CNM	**Certified Nurse Midwife** • A CNM is an advance practice nurse trained and licensed in midwifery.
CO	**Central Office** • As it relates to CMS, this term generally refers to locations (and staff) in the Baltimore, MD or Washington, DC area.

Acronym	Definition
ConOps	**Concept of Operations** • In data processing, this is a document that describes the characteristics of a proposed system from a user's perspective. It also describes the user organization, mission, and objectives, from an integrated systems view, and communicates the quantitative and qualitative characteristics to all stakeholders.
CoP	**Community of Practice** • This term is used to describe a group of people who share a craft or profession for something they do, and learn how to do it better as they interact regularly. • A CoP may be used by state or federal agency staff to bring stakeholders together around a particular subject for information sharing and learning. • With the support of CMS, the Medicaid EHR Team (MeT) conducts CoPs for states implementing and administering the Medicaid EHR Incentive Program
COTS	**Commercial Off The Shelf** • In data processing, COTS refers to software and services built and delivered from a third-party vendor that can be purchased, leased or even licensed to the general public rather than designed for a single unique application.
CPC+	**Comprehensive Primary Care Plus** • This term refers to an advanced primary care medical home model that rewards value and quality by offering an innovative payment structure to support primary care practices to improve quality, access, and efficiency. • As the term relates to either the EHR Incentive Programs, states are encouraged to consider aligning their clinical quality measurement (CQM) initiatives with CPC+.
CPOE	**Computerized Physician Order Entry** • This term refers to the process used by a medical professional to enter medication orders or other instructions electronically rather than on paper charts.
CPT	**Current Procedural Terminology** • The CPT is a series of alpha-numeric codes used to document medical treatment on claims for payment. It is the HIPAA standard code set for medical, surgical, and diagnostic services and is maintained by the American Medical Association.
CQM	**Clinical Quality Measure** • A CQM is a tool that helps measure and track the quality of health care services provided to ensure effective, safe, efficient, patient-centered, equitable, and timely care. Aspects of patient care measured include patient and family engagement, patient safety, care coordination, population/public health, efficient use of health care resources, and clinical process/effectiveness.
CRISP	**Chesapeake Regional Information System for our Patients** • The CRISP is a non-profit regional health information exchange serving Maryland and the District of Columbia.
CSD	**Clinical Services Discovery** • This term refers to a HIE profile that searches for care or clinical services by proximity and availability. • The CSD can respond to queries regarding when combinations of people and/or services will be available, where they will be provided, and their proximity to a specific geographic location, and it leverages the use of a Provider Directory.
CY	**Calendar Year** • This term refers to the 12-month period from January through December.

D-E

Acronym	Definition
DDI	**Design, Develop, Implement** • This term refers to a team-based approach to learning design with technology as a lever. It is activity based, iterative, forward-looking, and grounded in everyday educational practices.
DEL	**Data Element Library** • The DEL is a centralized resource for CMS long-term and post-acute care assessment instrument data elements and their associated health information standards. It promotes interoperable health information exchange. • This resource is available at https://del.cms.gov
DICOM	**Digital Imaging and Communications in Medicine** • DICOM is the international standard for transmitting, storing, retrieving, printing, processing, and displaying medical imaging information.
DO	**Doctor of Osteopathic Medicine** • Also called a Doctor of Osteopathy, this is a professional doctoral degree for physicians and surgeons offered by US medical schools. The osteopathic philosophy may be more holistic than allopathic medicine with a heavier focus on musculoskeletal training and physical manipulation of the body.
DSM	**Direct Secure Messaging** • DSM is a standard to facilitate secure electronic communication of patient-related data between health care providers and health care information technology systems.
DSTU	**Draft Standard for Trial Use** • An HL7 standard, a DSTU is used to provide timely compliance with regulatory or other governmental mandate and/or timely response to industry or market demand. Not suitable for a document considered informative, a DSTU is expected, after a suitable period, to be incorporated into an accredited version of the standard.
DUA	**Data User Agreement** • In health care, a DUA is a legal document executed between a requestor and holder of data containing protected health information and/or personally identifiable information. Its purpose is to ensure that the requestor adheres to legal requirements associated with privacy and security of the information shared.
E&E	**Eligibility & Enrollment** • An E&E system is used to determine beneficiary eligibility for Medicaid and other human services programs. • States are moving away from their legacy computer systems and enhancing/modernizing them to have more integration between agencies and programs eligible for Federal Financial Participation (FFP).
EC	**Eligible Clinician** • As the term relates to the Quality Payment Program (QPP), this is a health care professional that meets federal and state requirements to participate in the QPP via one of two tracks: Alternative Payment Models (APM)S or Merit Based Incentive Payments System (MIPS).
eCQI	**Electronic Clinical Quality Improvement** • This term most commonly refers to the eCQI Resource Center, a website managed by CMS and ONC that provides the latest version of CQMs, eCQM tools, standards, and relative educational materials.

Acronym	Definition
eCQM	**Electronic Clinical Quality Measure** • An eCQM uses data from electronic health records (EHRs) and/or health information technology systems to measure health care quality. They are considered an improvement over traditional quality measures because the work to gather the data from medical charts is very resource intensive and subject to human error. • Quality measures may be used to determine if a provider is making meaningful use (MU) of an EHR system.
eCQMR	**Electronic Clinical Quality Measures Repository** • This is a generic term for where some states are storing their eCQMs.
EDI	**Electronic Data Interchange** • EDI refers to the computer-to-computer exchange of business documents in a standard electronic format between business partners.
EH	**Eligible Hospital** • As the term relates to either the Medicare or Medicaid EHR Payment Incentive Programs, this is a hospital approved to participate and receive incentive payments. For Medicare, a hospital must be paid under the Inpatient Prospective Payment System, be a Critical Access Hospital, or be affiliated with a Medicare Advantage Plan. For Medicaid, a hospital must have at least a 10 percent Medicaid patient volume, except that Children's Hospitals have no volume requirements. • As it relates to Medicare, this term is described in more detail at 42 USC § 1395ww. As it relates to Medicaid, this term is described in more detail at 42 USC § 1396b(t).
EHR	**Electronic Health Record** • An EHR is an electronic version of a patient's medical history, maintained by a provider over time. It includes key administrative clinical data relevant to a patient's care, such as demographics, past medical history, progress notes, problems, medications, vital signs, laboratory data and radiology reports. Its purpose is to automate access to information to streamline a clinician's workflow and support other care-related activities through various interfaces. • This term is often used interchangeably with EMR – Electronic Medical Record.
EIDM	**Enterprise Identity Management** • This term refers to a system, managed by CMS, which was established to provide the agency's various business partners a means to apply for and receive a single User ID they can use to access many CMS applications.
ELC	**Enterprise Life Cycle Model** • In enterprise architecture and engineering, the life cycle is the iterative process of changing an enterprise over time by incorporating new business processes, technology, and capabilities, as well as maintenance, disposition, and disposal of existing elements of the enterprise. • A Medicaid enterprise system that supports those business processes would follow this lifecycle.
ELR	**Electronic Laboratory Reporting** • This term refers to electronic transmission from laboratories to public health entities of laboratory reports identifying reportable conditions. It is included as a meaningful use objective in both the Medicare and Medicaid EHR Incentive Programs as a catalyst to accelerate adoption by eligible professionals and hospitals, including critical access hospitals.
eMAR	**Electronic Medication Administration Record** • This term refers to technology that automatically documents the administration of medication into certified EHR technology using electronic tracking sensors, such as radio frequency identification or electronically readable tagging such as bar coding.

Acronym	Definition
emPOWER	**emPOWER** • This term is not an acronym but a program to help community partners better anticipate, plan for, and respond to the needs of electricity dependent populations in each community. HHS' Office of the Assistant Secretary for Preparedness and Response (ASPR) and Centers for Medicare & Medicaid Services (CMS) launched the program and maintain a map that provides monthly de-identified data for Medicare beneficiaries at the zip code level for reference by community organizations during times of natural disasters. • The emPOWER Medicaid pilot helps states to provide de-identified Medicaid data sets to their state preparedness departments to supplement the Medicare data.
EMR	**Electronic Medical Record** • An EMR is an electronic version of a patient's medical history, maintained by a provider over time. It includes key administrative clinical data relevant to a patient's care, such as demographics, past medical history, progress notes, problems, medications, vital signs, laboratory data and radiology reports. Its purpose is to automate access to information to streamline a clinician's workflow and support other care-related activities through various interfaces. • This term is often used interchangeably with EHR – Electronic Health Record.
EP	**Eligible Professional** • As the term relates to either the Medicare or Medicaid EHR Payment Incentive Programs, this is a health care professional that meets federal and state requirements to participate and receive incentive payments. Several provider types are eligible for both programs, including physicians, dentists, podiatrists, optometrists, and chiropractors. Nurse practitioners, nurse midwives, and physician assistants providing services in Federally Qualified Health Centers are also eligible for the Medicaid incentive program. Medicaid patient volume requirements vary by type of provider and location of practice. • This term is described in more detail at 42 USC § 1396b(t).
ePHI	**Electronic Protected Health Information** • This term refers to any protected health information covered under the Health Insurance Portability and Accountability Act (HIPAA) of 1996 security regulations that is produced, saved, transferred, or received in an electronic form.
EPO	**Exclusive Provider Organization** • An EPO health insurance plan requires an enrollee to use only the organization's network providers. Out-of-network benefits are not available.
e-prescribing	**Electronic Prescribing** • This refers to a certified electronic health record technology framework that allows physicians and other medical practitioners to write and send prescriptions to a participating pharmacy electronically rather than using a handwritten or faxed note or calling in a prescription. • See also eRx.
EPLC	**Enterprise Performance Life Cycle** • The EPLC framework applies to all HHS information technology investments and projects. It encompasses 10 phases associated with the planning, development, implementation, and maintenance of projects.
eRx	**Electronic Prescribing** • This refers to a certified electronic health record technology framework that allows physicians and other medical practitioners to write and send prescriptions to a participating pharmacy electronically rather than using a handwritten or faxed note or calling in a prescription. • See also e-prescribing.

Acronym	Definition
ESB	**Enterprise Service Bus** • This term refers to a standardized software integration platform that combines messaging, web services, data transformation, and intelligent routing, to reliably connect and coordinate the interaction of a significant number of heterogeneous applications with transactional integrity.
EUA	**End User Application** • The EUA is computer software that provides specific functions for an individual or small group and is not part of processing corporate information. Software is either commercially available, such as Microsoft Office, or a custom application.
EUA	**Enterprise User Administration** • This term refers to a system that manages User IDs for access to information systems under the control of the Centers for Medicare & Medicaid Services (CMS).

F

Acronym	Definition
FACA	**Federal Advisory Committee Act 0f 1972** • This federal law established the legal foundation for and defined how federal advisory committees operate. • Committees such as the Health Information Technology Advisory Committee (HITAC) must operate under provisions of this law.
FAQ(s)	**Frequently Asked Question(s)** • An FAQ document provides, in question and answer format, information that addresses issues associated with a topic.
FCC	**Federal Communications Commission** • The FCC is an independent US government agency overseen by Congress that regulates interstate and international communications by radio, television, wire, satellite, and cable in all 50 states, the District of Columbia and the US territories. • The FCC has some authority over the transmittal of electronic health record information when broadband, mobile health, or other health care devices are employed for that purpose.
FDSH	**Federal Data Services Hub** • The FDSH is a software tool used in the eligibility verification process for enrollment in qualified health plans and insurance affordability programs created through enactment of the Patient Protection and Affordable Care Act of 2010.
FedRAMP	**Federal Risk and Authorization Management Program** • This term refers to a government-wide program that provides a standardized approach to security assessment, authorization, and continuous monitoring for cloud products and services. It was established within the US General Services Administration (GSA), and the governing body includes chief information officers from the GSA as well as from the Departments of Defense and Homeland Security.
FERPA	**Family Educational Rights and Privacy Act of 1974** • This term refers to a federal privacy law that gives parents certain protections regarding their children's education records, such as report cards, transcripts, disciplinary records, contact and family information, and class schedules.

Acronym	Definition
FFP	**Federal Financial Participation** • FFP refers to the federal government's contribution toward state expenditures associated with certain social services and health care programs, such as Medicaid and the Children's Health Insurance Program. • See also FMAP.
FFS	**Fee-for-Service** • In health care, this is a payment model where services performed are unbundled and separately reimbursed.
FFY	**Federal Fiscal Year** • This term refers to the 12-month period for which the federal government bases its budget, October through September.
FHA	**Federal Health Architecture** • The FHA is a federal Office of Management and Budget E-Government Line of Business initiative designed to bring together decision makers in federal health IT for inter-agency collaboration. • It addresses efficient and secure health information exchange, enhanced interoperability among federal health IT systems, and efficient coordination of shared services to support federal agency adoption of nationally-recognized standards and policies.
FHIR	**Fast Healthcare Interoperability Resources** • FHIR is an interoperability standard for electronic exchange of health care information developed by HL7. It provides software development resources and tools for administrative concepts such as patients, providers, organizations and devices, as well as a variety of clinical concepts including problems, medications, diagnostics, care plans and financial issues, among others. • See also HL7.
FIPS	**Federal Information Processing Standards** • FIPS are a set of standards that describe document processing, encryption algorithms, and other information technology standards for use within non-military government agencies and by government contractors and vendors who work with the agencies.
FISMA	**Federal Information Security Management Act** • The FISMA was signed into law as part of the Electronic Government Act of 2002 and defines a comprehensive framework to protect government information, operations, and assets against natural or man-made threats.
FMAP	**Federal Medical Assistance Percentage** • This term refers to the percentage of federal matching funds for state expenditures associated with certain social services and health care programs, such as Medicaid and the Children's Health Insurance Program (CHIP). Percentages for program health services vary based on state per capita income, with a floor of 50 percent and a ceiling of 83 percent for Medicaid, and an enhanced matching rate is available for CHIP and for certain Medicaid covered services. Matching rates for state administrative expenditures, including those associated with the Medicaid EHR incentive program, vary depending on the activity. • This term is described in more detail at 42 USC § 1301(a)(8) and 42 USC § 1396d(b).
FMG-CMS	**Financial Management Group Change Management System** • This system is associated with the business practices and required for internal control of changes to official US Office of Personnel Management financial systems. It includes data related to change requests, justifications, costs, acquisitions, and criteria or factors to be considered when making a decision.
FOA	**Funding Opportunity Announcement** • A FOA is a notice published on the Grants.gov Web site of a federal grant funding opportunity.

Acronym	Definition
FPL	**Federal Poverty Level** • This term refers to a measure of income issued annually by HHS. The FPL income values are used to calculate eligibility for many social services and health care programs, including Medicaid and CHIP.
FQHC	**Federally Qualified Health Center** • A FQHC is a community-based health care provider that receives funds from the federal Health Resources & Services Administration within HHS to provide primary care services in underserved areas. It may be a community health center, migrant health center, health care program for the homeless or health center for residents of public housing and must meet stringent requirements, including providing care on a sliding fee scale based on ability to pay. • Eligible Professionals working in FQHCs qualify for Medicare and Medicaid EHR Incentive Program payments if they meet "needy encounters" criteria. • Defining legislation appears in 42 USC § 1396d (l)(2)(B).
FTE	**Full Time Equivalent** • This term refers to the hours worked by an employee on a full-time basis. The concept is used to convert the hours worked by several part-time employees into the hours work by full-time employees. • The acronym is also used to refer to a Full-Time Employee.
FTP	**File Transfer Protocol** • This term refers to a standard network protocol used for the transfer of computer files between a client and server on a computer network. The protocol is built on a client-server model architecture and uses separate control and data connections between the client and the server.
FY	**Fiscal Year** • This term refers to the 12-month period for which an entity bases its budget for fiscal purposes.

G-H

Acronym	Definition
GPRO	**Group Practice Reporting Option** • The GPRO was related to the PQRS, but focused on physician group practices, and was part of the quality reporting program that encouraged the physician group practices to report information on quality of care to Medicare. The program ended in 2016 and was transitioned to the Merit-based Incentive Payment System (MIPS).
HCBS	**Home and Community-Based Services** • This term relates to opportunities for Medicaid beneficiaries to receive services in their own home or community rather than institutions or other isolated settings. With federal state plan or waiver approval, HCBS programs serve a variety of targeted populations, such as people with intellectual or developmental disabilities, the elderly and those with physical disabilities, and persons with mental illness.
HcDir	**Healthcare Directory Initiative** • An initiative of the Office of the National Coordinator for Health Information Technology (ONC) and the Federal Health Architecture (FHA) that began in 2016, this project sought to define the architecture of a proposed national resource of validated health dare directory data and develop an HL7 Fast Heathcare Interoperability Resources (FHIR) Based Implementation Guide describing the exchange of information between a national resource of validated health care directory data and local environments, such as provider organizations, payers, and HIEs.

Acronym	Definition
HCPCS	**Healthcare Common Procedure Coding System** • HCPCS is a set of health care procedure codes based on the American Medical Association's Current Procedural Terminology (CPT) with two levels, the first being the CPT codes. The second level of codes is used to bill for other medical and health services, including those rendered by non-physician practitioners and a wide range of other providers.
HEDIS	**Healthcare Effectiveness Data and Information Set** • HEDIS is a tool used by more than 90 percent of America's health plans to measure performance on important dimensions of care and service. Entrusted to the NCQA, the measurement development process has expanded in size and scope to include measures for physicians, preferred provider organizations, and other entities.
HHS	**Health and Human Services** • The HHS is a federal cabinet agency in the US charged with enhancing and protecting the health and well-being of all Americans. HHS has 11 operating divisions, including 8 agencies in the US Public Health Service and 3 human services agencies. • Some states also have departments with this name.
HIE	**Health Information Exchange** • An HIE allows doctors, nurses, pharmacists, other health care providers and patients to appropriately access and securely share a patient's vital medical information electronically to improve the speed, quality, safety and cost of health care. • There are three key forms: direct exchange of information between providers, query-based exchange so providers can find or request information about a patient from another provider, and consumer-mediated exchange so patients can aggregate and control the use of their health information among providers.
HIO	**Health Information Organization** • This term refers to government-led non-profit health organizations that provide information about the American Recovery and Reinvestment Act of 2009 as it pertains to electronic health record (EHRs) development for incentive payments. They assist providers in the interoperability of EHRs for meaningful use information exchanges.
HIPAA	**Health Insurance Portability and Accountability Act of 1996** • Public Law 104-191 provides, among other things, data privacy and security provisions for safeguarding medical information.
HIS	**Health Information System** • This term refers to any system that captures, stores, manages, or transmits information related to the health of individuals or the activities of organizations that work within the health sector.
HIS	**Hospital Information System** • This term refers to an element of health informatics that focuses mainly on the administrative needs of a hospital. Such a system provides a central and comprehensive repository of patient information for access by providers and other hospital personnel when managing a hospital's operations associated with medical, administrative, financial, and legal issues as well as the corresponding processing of invoices for services.
HIT	**Health Information Technology** • This term refers to health information management across computerized systems and the secure exchange of health information between consumers, providers, payers, and quality monitors.
HITAC	**Health Information Technology Advisory Committee** • This committee was established in the 21st Century Cures Act of 2016. The HITAC reports to the Office of the National Coordinator for Health Information Technology (ONC) and recommends policies, standards, implementation specifications, and certification criteria, relating to the implementation of a health information technology infrastructure, nationally and locally, that advances the electronic access, exchange, and use of health information.

Acronym	Definition
HITECH	**Health Information Technology for Economic and Clinical Health Act of 2009** • This law was enacted as part of the American Recovery and Reinvestment Act to promote the adoption and meaningful use of health information technology.
HITECH TA	**Health Information Technology for Economic and Clinical Health Technical Assistance** • This term refers to supports CMS provides to state Medicaid agencies in their activities associated with the Medicaid EHR Incentive Program and includes staff education and training, resolution of issues and questions, and assistance with program analytics.
HITPC	**Health Information Technology Policy Committee** • Also called the HIT Policy Committee, this group reported to the National Coordinator for Health Information Technology and was replaced by the Health Information Technology Advisory Committee (HITAC) following passage of the 21st Century Cures Act of 2016.
HITRC	**Health Information Technology Research Center** • This term refers to the national extension program that established and offered technical assistance, guidance, and information of best practices to Regional Extension Centers (RECs) to help them support and accelerate health care providers' efforts to become meaningful users of electronic health records.
HITSC	**Health Information Technology Standards Committee** • Also called the HIT Standards Committee, this diverse group of stakeholders is charged with making recommendations to the Office of the National Coordinator for Health Information Technology (ONC) on standards, implementation specifications, and certification criteria for the electronic exchange and use of health information.
HITSP	**Heath Information Technology Standards Panel** • The HITSP is a cooperative partnership between the public and private sectors to achieve a widely accepted and useful set of standards that will enable and support widespread interoperability among health care software applications. Its primary objective is to harmonize relevant standards in the health care industry to enable and advance interoperability of health care applications, and the interchange of health care data, to assure accurate use, access, privacy and security, both for supporting the delivery of care and public health.
HIX	**Health Insurance Exchange** • A HIX is an entity, sometimes called a marketplace, through which people can purchase health insurance that complies with the Patient Protection and Affordable Care Act of 2010. A HIX offers a range of government-regulated and standardized health care plans, with some entities operated by the states and others by the federal government.
HL7	**Health Level Seven International** • This term refers to the non-profit, American National Standards Institute (ANSI)- accredited standards developing organization dedicated to providing a comprehensive framework and related standards for the exchange, integration, sharing, and retrieval of electronic health information that supports clinical practice and the management, delivery and evaluation of health services.
HMO	**Health Maintenance Organization** • An HMO is a type of health insurance plan, often paid on a risk-based per member per month basis, that usually limits coverage to care from doctors who work for or contract with the HMO and generally will not cover out-of-network care except in an emergency.
HOQR	**Hospital Outpatient Quality Reporting Program** • This program was established by CMS to promote higher quality and more efficient health care for Medicare beneficiaries through measurement. The program provides a unique opportunity for hospitals to report outpatient quality data as a means to improve quality of care and performance.

Acronym	Definition
HOS	**Health Outcomes Survey** • The HOS is the first patient-reported outcomes measure used in Medicare managed care. Its goal to gather valid, reliable, and clinically meaningful health status data from the Medicare Advantage (MA) program to use in quality improvement activities, pay for performance, program oversight, public reporting, and to improve health. All managed care organizations with Medicare contracts must participate. • The HOS is administered annually to a random sample of Medicare beneficiaries drawn from each participating MA plan.
HPD	**Healthcare Provider Directory** • This term refers to a searchable directory of individual and organizational health care providers with selected demographics including direct email addresses. It permits secure electronic messaging between providers of patient health care information instead of faxing and paper-based sharing of information.
HPSA	**Health Professional Shortage Area** • A HPSA is an area within a state where there is a shortage of health care providers in primary care, dental health, or mental health. The shortage area may be geographic-, population-, or facility-based, and the federal designation is given by the Health Resources and Services Administration when a threshold ratio for population to provider need is met.
HPSD	**Health Professional Shortage Designation** • The HPSD is a numeric score assigned to an area within a state by the federal Health Resources and Services Administration because there is a shortage of health care providers in primary care, dental health, or mental health. • See also HPSA.
HQMF	**Health Quality Measurements Format** • The HQMF is a standards-based representation of quality measures as electronic documents developed by HL7. • See also HL7.
HRSA	**Health Resources and Services Administration** • The HRSA is an organizational division within the HHS and is the primary federal agency charged with improving health care for people who are geographically isolated or economically or medically vulnerable. HRSA's programs are designed to help those in need of primary health care, people living with HIV/AIDS, pregnant women, and mothers, and to supports training of health professionals and distribution of providers to areas where they are needed most.
HTML	**HyperText Markup Language** • HTML is a computer language devised to allow website creation and the means to move around the World Wide Web. It is the standard protocol for formatting and displaying documents on the Web.
HTTP	**Hypertext Transfer Protocol** • HTTP is an application protocol for distributed, collaborative, and hypermedia information systems. It is the foundation of data communication for the World Wide Web. Hypertext is structured text that uses logical links (hyperlinks) between nodes containing text.

I-L

Acronym	Definition
IAPD	**Implementation Advance Planning Document** • An IAPD refers to a written plan of action states and territories use to request federal funding approval for a portion of the costs of designing, developing, and implementing an automated data processing (ADP) system.
IAPD-U	**Implementation Advance Planning Document-Update** • This term refers to the routine reporting by a state or territory to the federal government on the status of an automated data processing (ADP) project for which federal funding has been authorized.
ICD-9-CM	**International Statistical Classification of Diseases and Related Health Problems, Ninth Revision, Clinical Modification** • ICD-9-CM is a medical classification list developed by the World Health Organization that contains codes for diseases, signs and symptoms, abnormal findings, complaints, social circumstances, and external causes of injury or disease. It was superseded by the Tenth Revision.
ICD-10-CM	**International Statistical Classification of Diseases and Related Health Problems, Tenth Revision, Clinical Modification** • ICD-10-CM is a medical classification list developed by the World Health Organization that contains codes for diseases, signs and symptoms, abnormal findings, complaints, social circumstances, and external causes of injury or disease. It replaced the Ninth Revision.
ICD-10-PCS	**International Statistical Classification of Diseases and Related Health Problems, Tenth Revision, Procedure Coding System** • ICD-10-PCS is a cataloging system for procedure codes that track health interventions by medical professionals and is used for facility reporting of inpatient procedures.
ICM	**Integrated Care Model** • An ICM is generally a model of health care service delivery that systematically coordinates mental health, substance use disorder, and physical health care services, and with providers potentially choosing to accept risk for not meeting goals or to be rewarded for exceeding goals.
ICR	**Information Collection Requirement** • This term refers to the process federal departments and agencies must follow when they seek to collect information from the public and was established through the Paperwork Reduction Act of 1995.
ID	**Identifier** • This term generally means a numeric or other sequence of characters used to identify or refer to a person, program, or thing.
IHE	**Integrating the Healthcare Enterprise** • The IHE is an initiative by health care professionals and the industry to improve the way computer systems share health care information electronically. It promotes the coordinated use of established standards to address specific clinical needs in support of optimal patient care.
IHS	**Indian Health Service** • The IHS is an organizational unit within HHS responsible for providing and advocating for federal health care services to American Indians and Alaska Natives.

Acronym	Definition
IIS	**Immunization Information System** • An IIS is a confidential, population-based, computerized database that records all immunization doses administered by participating providers to persons residing within a given geographical area. • It is also called an Immunization Registry (IR).
IOM	**Institute of Medicine** • The IOM is the former name for the National Academy of Medicine (NAM), which is an American non-profit, non-governmental organization that is a part of the National Academies of Sciences, Engineering and Medicine. The organization works outside the framework of government to provide evidence-based research and recommendations for public health and science.
IPA	**Independent Practice Association** • This term refers physician-led and organized associations designed to negotiate physician reimbursement with insurance companies on behalf of contracted physicians. • These groups may also be called Independent Physician Associations.
IPP	**Initial Patient Population** • As it relates to clinical quality measures, the IPP is the group of patients that a performance measure is designed to address.
IPPS	**Inpatient Prospective Payment System** • This term refers to the system of payment for operating costs of acute care hospital inpatient stays under Medicare Part A based on prospectively set rates. • This term is described in more detail at 42 USC § 1395ww(d).
IQR	**Inpatient Quality Reporting** • Originally mandated in 2003 but since modified, the IQR program authorizes CMS to collect quality data from hospitals, reduce Medicare payments to hospitals that do not successfully report designated quality measures, and to publish reported data to drive quality improvement and help consumers make informed decisions about their health care.
IR	**Immunization Registry** • An IR is a confidential, population-based, computerized database that records all immunization doses administered by participating providers to persons residing within a given geographical area. • It is also called an Immunization Information System (IIS).
IRS	**Internal Revenue Service** • The IRS is an organizational unit within the US Department of the Treasury and is the nation's tax collection agency responsible for administering the Internal Revenue Code enacted by Congress.
ISA	**Interconnection Security Agreement** • This agreement documents and formalizes the technical and security requirements for establishing, operating and maintaining an interconnection, or direct connection, between two or more information technology systems for the purpose of sharing data and other information resources.
ISA	**Interoperability Standards Advisory** • This term refers to the model by which the Office of the National Coordinator for Health Information Technology (ONC) will coordinate the identification, assessment, and public awareness of interoperability standards and implementation specifications that can be used by the health care industry to address specific interoperability needs including, but not limited to, interoperability for clinical, public health, and research purposes.
IT	**Information Technology** • This term refers to the application of computers to store, study, retrieve, transmit, and manipulate data, or information, often in the context of a business or other enterprise.

Acronym	Definition
IV&V	**Independent Verification & Validation** • This term refers to independent procedures used together for checking that a product, service, or system meets requirements and specifications and that it fulfills its intended purpose. • This evaluation is often completed by an independent organization with no affiliation to the government agency operating the program or information system.
LEP	**Limited English Proficiency** • This term is generally applied to individuals for whom English is not their primary language and who have difficulty communicating effectively in English. • The term is relevant to HITECH as it relates to patient engagement and education efforts around use of health care data.
LOINC	**Logical Observation Identifiers, Names and Codes** • The LOINC is a database and universal standard for identifying health measurements and medical laboratory observations. It applies universal code names and identifiers to medical terminology related to electronic health records to assist in electronic exchange and gathering of clinical results. • It was created in 1994 and is maintained by the Regenstrief Institute, a US non-profit medical research organization.
LTC	**Long-Term Care** • This term refers to a range of services and supports in an institutional or community-based setting that help meet the medical and non-medical needs of people with a chronic illness or disability who cannot care for themselves for long periods. • It is also called Long-Term Services and Supports (LTSS).
LTSS	**Long-Term Services and Supports** • This term refers to a range of services and supports in an institutional or community-based setting that help meet the medical and non-medical needs of people with a chronic illness or disability who cannot care for themselves for long periods. • It is also called Long-Term Care (LTC).

M

Acronym	Definition
M&O	**Maintenance & Operations** • As it relates to information technology, this term impacts the shift of systems and resources from the Design, Development and Implementation (DDI) phase to one related to ongoing operations. • It also has relevance from a level of federal Medicaid funding perspective.
MA	**Medicare Advantage** • Medicare Advantage (MA) is a type of health insurance that provides coverage within Part C of Medicare in the US. MA Plans combine coverage for hospital care (Part A) with doctor visits and other medical services (Part B), and in some cases also include prescription drugs (Part D).
MAC	**Medicaid and Children's Health Insurance Program (CHIP)** • This acronym is sometimes used to refer to these two health care programs collectively.
MAC	**Medicare Administrative Contractor** • A MAC is a private health care insurer that has been awarded a geographic jurisdiction to process Medicare Part A and Part B (A/B) medical claims or Durable Medical Equipment claims for Medicare beneficiaries receiving their benefits on a fee-for-service basis.

Acronym	Definition
MACBIS	**Medicaid and CHIP Business Information and Solutions** • MACBIS is a CMS enterprise-wide initiative to ensure the Medicaid and CHIP data infrastructure and technology are commensurate to the programs' role in supporting program monitoring, technical assistance and oversight. MACBIS data sets include T-MSIS, MACPro, pharmacy and financial data.
MACPro	**Medicaid and CHIP Program System** • MACPro is a state-facing system within CMS' MACBIS that captures state and territory submissions of State Plan Amendments, Waiver documents, Quality Measures, Advance Planning Documents, and more.
MACRA	**Medicare Access and CHIP Reauthorization Act of 2015** • This law authorized implementation of Alternative Payment Models (APMs) and the Merit Based Incentive Payments System (MIPS).
MAP	**Medicare Advantage Plan** • An MAP provides coverage within Part C of Medicare in the US. MAPs combine coverage for hospital care (Part A) with doctor visits and other medical services (Part B), and in some cases also include prescription drugs (Part D). • Also called a Medicare Advantage Organization (MAO).
MAPIR	**Medical Assistance Provider Incentive Repository** • The MAPIR was developed by a collaborative of 13 states to allow providers to more easily apply for electronic health record (EHR) incentive payments made available through passage of the HITECH Act of 2009. It uses open source technology and is integrated with currently existing state Medicaid Management Information Systems to leverage state and federal investments.
MARS-E	**Minimum Acceptable Risk Standards for Exchanges** • This term refers to a document suite of guidance, requirements, and templates developed by CMS in accordance with the agency's Information Security and Privacy programs. • The guidance in the MARS-E document suite addresses the mandates of the Patient Protection and Affordable Care Act of 2010, and HHS' ACA Regulations (45 CFR §§155.260 and 155.280), and applies to all ACA Administering Entities.
MBES	**Medicaid Budget and Expenditure System** • The MBES is a web-based application used by CMS and implemented nationwide that allows states and territories to report budgeted and actual expenditures for their Medicaid Program. States use this application to submit both their CMS-37 anticipated quarterly budgeted costs report and their CMS-64 actual quarterly expense reports.
Mbps	**Megabits per Second** • This is a unit of measurement for bandwidth and throughput, or data transfer speed, on a network. Equal to one million bits or 1,000 kilobits, a megabit is roughly one eighth the size of a megabyte.
MCO	**Managed Care Organization** • A MCO is an entity that has, or is seeking to qualify for, a comprehensive risk contract and is a federally qualified health maintenance organization that meets advance directive requirements in law, or is a public or private entity that meets the advance directive requirements and agrees to make services as accessible (in terms of timeliness, amount, duration, and scope) as they would be for other Medicaid beneficiaries in the same service area and meets solvency standards in law. • MCOs are encouraged to work with their network providers and support states with clinical quality measure (CQM) collection, EHR usage, and health information sharing. • Federal requirements are explained in 42 CFR Part 438.

Acronym	Definition
MD	**Medical Doctor** • Also called a Doctor of Allopathic Medicine, this is a professional doctoral degree for physicians and surgeons awarded upon initial graduation from medical school.
MDBT	**MMIS Detailed Budget Template** • This template is a required component in Advance Planning Documents submitted to CMS to request federal funding approval for projects that use automated data processing services or equipment. The template breaks out the funding request by federal fiscal year, federal financial participation rate, and Medicaid Budget and Expenditures System line item.
MECL	**Medicaid Enterprise Certification Life Cycle** • A cornerstone of the Medicaid Enterprise Certification Toolkit (MECT), the MECL includes milestone reviews throughout the Medicaid Management Information Systems (MMIS) life cycle so states receive early feedback about issues that may impede federal certification. • It is flexible to fit various state approaches and its checklists ensure alignment with Medicaid Information Technology and Architecture (MITA) and the standards and conditions for Medicaid IT.
MECT	**Medicaid Enterprise Certification Toolkit** • CMS developed the MECT to assist states as they plan, develop, test, and implement their Medicaid Management Information Systems (MMIS). The toolkit accommodates modular and agile development, includes refined certification criteria, and provides templates and tools to assist states and their contractors in the certification process.
MEELC	**Medicaid Eligibility and Enrollment Life Cycle** • A cornerstone of the Medicaid Eligibility and Enrollment Toolkit (MEET), the MEELC is flexible, fitting various state approaches and system development life cycles to ensure alignment with the latest federal regulations and guidance. Its checklists ensure alignment with Medicaid Information Technology and Architecture (MITA) and the standards and conditions for Medicaid IT.
MEET	**Medicaid Eligibility and Enrollment Toolkit** • CMS developed the MEET to assist states as they work to streamline and modernize their Eligibility and Enrollment (E&E) systems and to help them reduce project delays and costs.
MeT	**Medicaid EHR Team** • The MeT is a team of five organizations working together under contract to and with CMS to provide analysis, training, and technical assistance to state Medicaid agencies and territories for the Medicaid EHR Incentive Program.
MFCU	**Medicaid Fraud Control Unit** • A MFCU is an organizational unit separate and distinct from a state Medicaid agency that investigates and prosecutes Medicaid provider fraud as well as patient abuse or neglect in health care facilities and board and care facilities. They employ teams of investigators, attorneys, and auditors, are constituted as single, identifiable entities, and generally are part of a state/territory's Attorney General's office.
MiHIN	**Michigan Health Information Network Shared Services** • MiHIN is a non-profit entity created in Michigan to coordinate and build bridges between health care providers and organizations. It offers technology and resources needed by health care providers to securely share patient information.
MIME	**Multipurpose Internet Mail Extensions** • A MIME is an extension of the original Internet e-mail protocol that allows exchange of different kinds of data files on the Internet, such as audio, video, images, application programs as well as ASCII text.

Acronym	Definition
MIPS	**Merit Based Incentive Payments System** • The MIPS is a Quality Payment Program authorized by the Medicare Access and CHIP Reauthorization Act of 2015. Participating Medicare Part B providers are eligible for a performance-based payment adjustment based on evidence-based and practice-specific quality data.
MITA	**Medicaid Information Technology Architecture** • MITA is a CMS initiative intended to foster integrated business and information technology transformation across the Medicaid enterprise to improve program administration. Its goals include development of seamless and integrated systems that communicate effectively through interoperability and common standards.
MLTSS	**Managed Long-Term Services and Supports** • This term refers to a range of services and supports in an institutional or community-based setting, provided or arranged by a managed care organization, that help meet the medical and non-medical needs of people with a chronic illness or disability who cannot care for themselves for long periods.
MMIS	**Medicaid Management Information System** • An MMIS is an integrated group of procedures and computer processing operations, or sub-systems, developed at the general design level to meet principal objectives, including Medicaid program control and administrative costs; services to beneficiaries, providers, and inquiries; operation of claims control and computer capabilities; and management reporting for planning and control. • Defining legislation appears in 42 USC § 1396b (a)(3) and in federal regulations at 42 CFR 433.11.
MMS	**Measures Management System** • This term refers to a standardized system, managed by CMS, that includes a core set of business processes and decision criteria used when developing, implementing, and maintaining quality measures.
MPD	**Master Provider Directory** • A MPD is designed to include and manage health care provider and practice information and is structured to meet local informational needs of consumers and analytical needs of payers. • It is similar to a Healthcare Directory or Provider Registry.
MPI	**Master Patient Index** • A MPI is a patient database used by health care organizations to maintain accurate medical data across various departments. • The database contains records for all patients served, with select demographics and unique identifiers for each patient
MSA	**Medical Savings Account** • In the US, a medical savings account refers to a program, generally associated with self-employed individuals, in which tax-deferred deposits can be made for medical expenses. Withdrawals from the MSA are tax-free if used to pay for qualified medical expenses. • Medicare offers a consumer-directed Medicare Advantage Plan, called a Medicare MSA Plan, combining a high-deductible insurance plan with a medical savings account.
MSIS	**Medicaid Statistical Information System** • MSIS has long been CMS' data system with information from all states and territories about Medicaid and CHIP beneficiary and provider eligibility and enrollment, claims, managed care encounters, and third-party liability data, but it has been improved and transformed into a new system, called T-MSIS, with states and territories gradually transitioning their data submission from MSIS to T-MSIS.

Acronym	Definition
MU	**Meaningful Use** • MU refers to the use of certified EHR technology to improve quality, safety, and efficiency; reduce health disparities; engage patients and family; improve care coordination as well as population and public health; and maintain privacy and security of patient health information. • MU sets specific objectives that Eligible Hospitals and Eligible Professionals must achieve to qualify for federal Incentive Programs and to receive EHR Incentive payments. • Since implementation of the Medicare and Medicaid EHR Incentive Programs, there have been three different stages of MU.

N-O

Acronym	Definition
NAM	**National Academy of Medicine** • Formerly called the Institute of Medicine (IOM), this is an American non-profit, non-governmental organization that is a part of the National Academies of Sciences, Engineering and Medicine. The organization works outside the framework of government to provide evidence-based research and recommendations for public health and science.
NAMD	**National Association of Medicaid Directors** • The NAMD is an independent, bipartisan, non-profit, professional organization that represents members who oversee Medicaid programs in US states and territories.
NCHS	**National Center for Health Statistics** • NCHS is an organizational unit within HHS' Centers for Disease Control and Prevention, charged with compiling health statistical information to guide actions and policies to improve the health of the US populace.
NCPDP	**National Council for Prescription Drug Programs** • The NCPCP is a non-profit, ANSI-accredited, standards development organization that represents most sectors of the pharmacy services industry.
NCQA	**National Committee for Quality Assurance** • NCQA is an independent non-profit organization in the US that works to improve health care quality through the administration of evidence-based standards, measures, programs, and accreditation.
NCVHS	**National Committee on Vital and Health Statistics** • The NCVHS is the statutory public advisory body to the Secretary of HHS on health information policy, providing advice and assistance on key health data issues related to community and population health, standards, privacy and confidentiality, quality, and data access and use.
NDC	**National Drug Code** • The NDC is a 10-digit, 3-segment number that identifies the labeler, product, and trade package size of a drug. The labeler code is assigned by the federal Food and Drug Administration to any firm that manufactures or distributes a drug.
NGA	**National Governors Association** • The NGA is a bipartisan organization of the nation's governors that promotes visionary state leadership, shares best practices and speaks with a collective voice on national policy.

Acronym	Definition
NHIN	**Nationwide Health Information Network** • This term refers to a web-based set of standards, services, and policies that enable the secure exchange of health information over the Internet. It was developed through HHS but is managed by a non-profit industry coalition called Sequoia Project, and the acronym is now outdated. • It is also known as the eHealth Exchange and may also be abbreviated as NwHIN.
NIH	**National Institutes of Health** • The NIH is one of the world's foremost medical research centers. An agency in HHS, the NIH is the federal focal point for health and medical research.
NIST	**National Institute of Standards and Technology** • The NIST is a measurement standards laboratory, and a non-regulatory agency of the US Department of Commerce.
NLM	**National Library of Medicine** • A part of the National Institutes of Health in HHS, NLM is the world's largest medical library and was the developer of electronic information services that delivers data to millions of scientists, health professionals and members of the public daily.
NLR	**National Level Repository (CMS Registration and Attestation Module)** • The NLR is a federal database designed to track incentive payments to health care providers that adopt electronic health records and modernize their computer systems.
NP	**Nurse Practitioner** • A nurse practitioner is an advanced practice registered nurse that manages acute and chronic medical conditions, both physical and mental, through history and physical exam and the ordering of diagnostic tests and medical treatments. Depending on state licensing laws, a NP may be able to practice without physician supervision.
NPI	**National Provider Identifier** • The NPI is a unique 10-digit identifier issued to health care providers in the US and is required for Medicare and Medicaid as well as for many other payers. The NPI is used with electronic transactions identified in HIPAA.
NPPES	**National Plan and Provider Enumeration System** • The NPPES is a federal system, under the purview of CMS, that assigns and maintains information concerning National Provider identifiers assigned to health care providers in the US.
NPRM	**Notice of Proposed Rule Making** • A NPRM is a public notice issued by law, that is published in the Federal Register, when one of the independent agencies of the US government wishes to add, remove, or change a rule or regulation as part of the rulemaking process.
NQF	**National Quality Forum** • The NQF is a non-profit, non-partisan, membership-based organization that works to catalyze national collaboration and improvements in health care. The forum reviews and endorses standards to measure and report on the quality and efficiency of health care in the US.
NQS	**National Quality Strategy** • A requirement in the Patient Protection and Affordable Care Act of 2010 and charged to the Secretary of HHS, the NQS sets national goals to improve the quality of health care and standards and regulations to measure the quality of health care and its impact on public health.
NTP	**Notice to Proceed** • This term refers to a notification letter from a responsible party to a contractor stating the date the contractor may commence work on a project.

Acronym	Definition
NVLAP	**National Voluntary Laboratory Accreditation Program** • The NVLAP is a federal program run by the National Institute of Standards and Technology (NIST) that provides third-party accreditation to laboratories in the US.
NwHIN	**Nationwide Health Information Network** • This term refers to a web-based set of standards, services, and policies that enable the secure exchange of health information over the Internet. It was developed through HHS but is managed by a non-profit industry coalition called Sequoia Project, and the acronym is now outdated. • It is also known as the eHealth Exchange and may also be abbreviated as NHIN.
OAPD	**Operational Advance Planning Document** • An OAPD is a record of no more than two pages to be submitted to CMS annually by state programs whose system is not in development, and it provides a short summary of activities, method of acquisition, and annual budget for operations and software maintenance.
OCR	**Office of Civil Rights** • In HHS, the OCR is charged with enforcing federal laws that protect against nondiscrimination, conscience, religious freedom, and health information privacy. • There are Offices of Civil Rights in other federal agencies as well, where charges related to other issues, and state governments also have Offices of Civil Rights.
OIG	**Office of the Inspector General** • In HHS, the OIG is a staff division in the Office of the Secretary, charged with combating fraud, waste, and abuse, improving the efficiency of HHS programs, and ensuring that funds disbursed or managed by HHS agencies, such as CMS, are utilized effectively. As major recipients of federal funds, the OIG focuses heavily on the Medicare and Medicaid programs. • There are also OIG divisions in other cabinet level agencies of the federal government and in state governments as well.
OMB	**Office of Management and Budget** • The OMB is the largest office within the Executive Office of the US President and is charged with overseeing the performance of federal agencies, and producing the President's federal budget.
ONC	**Office of the National Coordinator for Health IT** • In HHS, the ONC is a staff division in the Office of the Secretary, charged with coordination of nationwide efforts to implement and use the most advanced health information technology and the electronic exchange of health information.
ONC-PCP	**Permanent Certification Program** • This PCP is administered by the Office of the National Coordinator for Health Information Technology (ONC) and provides a process by which an organization may become an ONC–Authorized Certification Body to perform the certification of Complete Electronic Health Records (EHRs) and/or EHR Modules.

P

Acronym	Definition
PA	**Physician Assistant** • A PA is a health care professional that practices medicine as part of a health care team with collaborating physicians and other providers. Through passage of the Patient Protection and Affordable Care Act of 2010, a PA is now recognized as a primary care provider, along with physicians and advance practice nurse practitioners. If certified by the appropriate national accrediting body, this health care professional may be called a Physician Assistant-Certified, or PA-C.
PAHP	**Prepaid Ambulatory Health Plan** • A PAHP is a noncomprehensive prepaid health plan that provides only certain outpatient services, such as dental services or outpatient behavioral health care. PAHPs provide no inpatient services and are paid on an at-risk or capitated basis.
PAPD	**Planning Advance Planning Document** • A PAPD refers to a written plan of action developed by a state or territory to determine the need for, feasibility of, and projected costs and benefits of an automated data processing (ADP) equipment or services acquisition.
PC	**Primary Care** • This term refers to the day-to-day health care, including preventive medicine, given by a physician or other qualified health care professional who is generally the first contact and principal point of continuing care for patients in a health care system.
PCCM	**Primary Care Case Management** • This term refers to a form of managed care where a contracted entity furnishes case management, monitoring of primary health care services, and coordination with providers of specialty services, behavioral health, and long-term services and supports.
PCMH	**Patient Centered Medical Home** • This term refers to a care delivery model whereby patient treatment is coordinated through a primary care provider to ensure that all necessary care is given when and where needed and in a manner understood by the patient. NCQA established a recognition program for qualified provider practices that many payers have recognized through financial incentives or coaching.
PCP	**Primary Care Provider** • This term refers to a physician, nurse practitioner, clinical nurse specialist, or physician assistant, as allowed under state law, who provides, coordinates or helps a patient access a range of health care services.
PCPM	**Primary Care Payment Model** • This term generically refers to a primary care delivery system that rewards value and quality by offering an innovative payment structure to support primary care practices to improve quality, access, and efficiency. • As the term relates to either the EHR Incentive Programs, states are encouraged to consider aligning their clinical quality measurement (CQM) initiatives with such initiatives.
PDMP	**Prescription Drug Monitoring Program** • A PDMP is an electronic database that tracks controlled substance prescriptions in a state. It provides health authorities timely information about prescribing and patient behaviors to assist medical, pharmacy, and public health professionals in the identification and prevention of prescription drug abuse.

Acronym	Definition
PECOS	**Provider Enrollment, Chain, Ownership System** • This system supports the Medicare provider and supplier enrollment process by allowing registered users to securely and electronically submit and manage Medicare enrollment information.
PFFS	**Private Fee-for-Service** • A Medicare PFFS Plan is a type of Medicare Advantage Plan (Part C) offered by a private insurance company. The plan determines how much it will pay doctors, other health care providers, and hospitals, and how much its enrollees must pay when accessing care.
PHA	**Public Health Agency** • This is a generic term for a government organization at the federal, state, or local level whose mission is to protect the health, safety, and security of the population represented.
PHI	**Protected Health Information** • Under US law, this term refers to any information about the health status, provision of health care, or payment for health care that is created or collected by a covered entity, is transmitted by or maintained in electronic media or other form or medium, and can be linked to a specific individual. • The term is defined at 45 CFR 160.103.
PHO	**Physician Hospital Organization** • A PHO is a legal, or perhaps informal, entity formed by a hospital and a group of physicians to further mutual interests and achieve market objectives, and they are frequently developed for the purpose of obtaining payer contracts.
PHR	**Personal Health Record** • A PHR is an electronic application, or tool, used and controlled by an individual to maintain and manage health information in a private, secure, and confidential environment. It permits improved communication with and allows information to be shared with caregivers, family members, and providers.
PHS	**Public Health Service** • Overseen by the Surgeon General and the Assistant Secretary of Health in HHS, members of the US PHS Commissioned Corps hold positions throughout HHS and certain non-HHS federal agencies and programs where they are involved in disease control and prevention; biomedical research; regulation of food, drugs, and medical devices; mental health and drug abuse; and health care delivery.
PHSA	**Public Health Service Act** • Enacted in 1944, and amended many times since, the full act appears in 42 USC, Chapter 6A.
PI Programs	**Promoting Interoperability Programs** • This is the new name of the former Medicare and Medicaid Electronic Health Record (EHR) Incentive programs and reflects CMS' priority for interoperability and improved patient access to health information as well as a strong emphasis on measures that require exchange of health information between providers and patients.
PIHP	**Prepaid Inpatient Health Plan** • A PIHP is an entity that provides, arranges for, or otherwise has responsibility for the provision of inpatient hospital or institutional services for its enrollees and is paid on a capitated basis but does not have a comprehensive risk contract. Generally, PIHPs are responsible for services associated with behavioral health care.
PMS	**Payment Management System** • Managed by the Program Support Center (PSC) in HHS, the PMS is a centralized payment and cash management system that handles all payment-related activities from the time of a grant award through closeout.

Acronym	Definition
POA&M	**Plan of Action and Milestones** • This term refers to a remedial action plan that helps an agency identify and assess information system security and privacy weaknesses, set priorities, and monitor progress toward mitigating the weaknesses. • As it relates to CMS, the term is further explained in the agency's Risk Management Handbook, Volume III, Standard 6.2., Plan of Action and Milestones Process Guide, November 5, 2015.
POS	**Place of Service** • In health care, this is the setting in which a service is provided, such as a physician office or inpatient hospital, and is a required data element on claims submitted for payment by most publicly funded and commercial insurers. • It is also called Point of Service.
PP	**Practicing Predominantly** • As the term relates to the Medicaid EHR Payment Incentive Program, an Eligible Professional who cannot meet Medicaid patient volume (PV) thresholds may be able to meet needy individual PV thresholds if they practice predominantly in a Federally Qualified Health Center or a Rural Health Clinic because the calculation process considers low-income patients without Medicaid eligibility as well.
PPACA	**Patient Protection and Affordable Care Act of 2010** • A health care reform law with provisions associated tied to making affordable health insurance more widely available, expanding the Medicaid program, and supporting innovative medical care delivery methods designed to lower health care costs. • The PPACA is often referenced in an abbreviated manner as the Affordable Care Act, or ACA.
PPO	**Preferred Provider Organization** • A PPO is a type of health plan that contracts with medical providers, such as hospitals and physicians, to provide services to enrollees at reduced payment rates, with the PPOs charging an access fee to insurers for the use of their provider network. • It is also called a Participating Provider Organization or a Preferred Provider Option.
PQRS	**Physician Quality Reporting System** • This is a system the Medicare program encourages its individual Eligible Professionals and group practices to use to report information on quality of care. The PQRS gives the professionals and practices an opportunity to assess quality of care provided to their patients and, by reporting on quality measures, also quantify how well they are meeting particular quality metrics, with satisfactory scores preventing negative payment adjustments. • 2016 was the last program year for PQRS; it has transitioned to the Merit Based Incentive Payments System (MIPS) under the Quality Payment Program (QPP).
PROM	**Patient Reported Outcome Measure** • The PROM is a tool/instrument used to measure a patient's functional status, health-related quality of life, symptom and symptom burden, personal experience with care, and health-related behaviors such as anxiety and depression. The tool is often completed by the patient.
PSC	**Program Support Center** • Overseen by the Assistant Secretary for Administration in HHS, the PSC is a shared services organization that supports services and products in four different portfolios: administrative operations, financial management and procurement, occupational health, and real estate and logistics.
PSO	**Provider Sponsored Organization** • A PSO is a type of managed care plan operated by a group of doctors and hospitals that formed a network within which enrollees must stay to receive coverage for care. Where geographically available, it is an option for Medicare enrollees.

Acronym	Definition
PV	**Patient Volume** • As the term relates to the Medicaid EHR Incentive Program, this is a percentage of an Eligible Professional's total patient load that is covered by the Medicaid program. The percentages vary by type of professional and practice setting, and Medicaid Eligible Hospitals have patient volume requirements as well.

Q-R

Acronym	Definition
QA	**Quality Assurance** • As it relates to health care, this term means maintaining a high quality of care by constantly measuring the effectiveness of the providers and organizations providing it.
QDM	**Quality Data Model** • A QDM is an information model that defines relationships between patients and clinical concepts in a standardized format to enable electronic quality performance measurement.
QMS	**Quality Management System** • As it relates to health care, this term refers to a collection of patient-centric business processes focused on consistently meeting patient health care needs and enhancing their satisfaction. It is aligned with an organization's purpose and strategic direction.
QNet	**QualityNet Secure Portal** • The QNet is a secure Web portal used by Eligible Hospitals to submit meaningful use and quality attestations for the EHR Incentive Programs. The portal is also used by hospitals for their clinical quality measure (CQM) reporting.
QPP	**Quality Payment Program** • This term refers to the Medicare Part B program, authorized by MACRA to provide physicians with tools and resources to improve health care quality and to potentially earn a performance-based payment adjustment. Alternative Payment Models (APMs) and the Merit-based Incentive Payment System (MIPS) are a part of the QPP.
QRDA-I	**Quality Reporting Document Architecture-Category I** • This term refers to an HL7 Clinical Document Architecture-based standard and is an individual-patient-level report that contains quality data for one patient for one or more eCQMs.
QRDA-III	**Quality Reporting Document Architecture-Category III** • This term refers to an HL7 Clinical Document Architecture-based standard and is an aggregate quality report containing quality data for a set of patients for one or more eCQMs, advancing care information measure, and/or improvement activities.
QRUR	**Quality and Resource User Report** • This report shows how a physician's payments under Medicare Part B fee-for-service will be adjusted based on performance on quality and cost of care measures delivered to patients. It is a part of CMS's effort to move physician payment toward a system that rewards value over volume.
R&A	**Registration and Attestation** • As it relates to the EHR Incentive Programs, this is the required process professionals and hospitals must follow to determine if they are eligible to receive incentive payments from the Medicare and/or Medicaid programs for adopting, implementing, upgrading, and meaningfully using certified electronic health record technology.

Acronym	Definition
R&S UI	**Research & Support User Interface** • This term refers to an application accessed via the CMS Enterprise User Administration (EUA) portal that provides states the ability to view detailed individual provider registration, attestation, and payment information from the National Level Repository (NLR). • See also RNSGUI.
RBRVS	**Resource Based Relative Value Scale** • This term refers to a schema used to determine how much physicians and similar medical providers should be paid. It is based on the principle that payments for services should vary with the resource costs for providing them.
REC	**Regional Extension Center** • A REC is an organization that assists health care providers in their selection and implementation of electronic health record technology.
REST	**Representational State Transfer** • REST is an architectural style for developing Web services and is based on a set of principles that describe how networked resources are defined and addressed.
RFA	**Regulatory Flexibility Act of 1980** • The RFA requires federal agencies to review regulations for their impact on small businesses and to consider less burdensome alternatives.
RFI	**Request for Information** • A RFI is a standard business process whose purpose is to collect written information so to decide on next steps related to an issue and/or about the capabilities of various suppliers of goods or services.
RFID	**Radio-Frequency Identification** • This term refers to an electronic tracking sensor used in certified EHR technology, whose purpose is to document administration of medication.
RFP	**Request for Proposal** • A RFP is a document released by an entity seeking to procure a commodity, service, or other valuable asset from a qualified supplier. It solicits proposals from interested bidders, often on a competitive basis.
RHC	**Rural Health Clinic (Center)** • An RHC is a clinic located in a rural area designated by HRSA as a shortage area. It is not a Federally Qualified Health Center, rehabilitation agency or a facility primarily delivering behavioral health services, and it must employ non-physician practitioners such as physician assistants and nurse practitioners in rural areas. • Defining legislation appears at 42 USC § 1395x(aa)(1).
RHQDAPU	**Reporting Hospital Quality Data for Annual Payment Update** • A requirement dating back to 2004 but modified with passage of the Deficit Reduction Act of 2005, hospitals are required to annually submit data for specific quality measures associated with health conditions common among Medicare beneficiaries or face a reduction in payment.
RLS	**Record Locator Service** • This term refers to computerized functionality that provides the ability to identify where records are located based upon criteria such as a Person ID and/or record data type. It also provides functionality for the ongoing maintenance of the location information.

Acronym	Definition
RNSGUI	**(HITECH's) Research & Support User Interface** • This term refers to an application accessed via the CMS Enterprise User Administration (EUA) portal that provides states the ability to view detailed individual provider registration, attestation, and payment information from the National Level Repository (NLR). • See also R&S UI.
RO	**Regional Office** • As it relates CMS, this term refers to the 10 regional locations (and staff) responsible for representing and delivering key messages on behalf of the department to stakeholders in the states/territories within their purview, including state agencies responsible for administering health care programs.
RPPO	**Regional Preferred Provider Organization** • A RPPO is a PPO whose network of preferred providers is not limited to one state but crosses state boundaries within a specific region. • See also PPO.

S-T

Acronym	Definition
S&CC	**Standards and Certification Criteria** • This term refers to the required capabilities and related standards and implementation specifications that certified EHR technology must include to, at a minimum, support the achievement of Meaningful Use (MU) by Eligible Professionals and Eligible Hospitals under the Medicare and Medicaid EHR Incentive Programs. • There have been multiple stages of S&CC, which complemented the stages of MU in the incentive programs.
SaaS	**Software as a Service** • SaaS is a software licensing and delivery model in which software is licensed on a subscription basis and is centrally hosted. It is sometimes referred to as "on-demand software" and has been incorporated into the strategy of nearly all leading enterprise software companies.
SAMHSA	**Substance Abuse and Mental Health Services Administration** • The SAMHSA is the organizational unit within HHS responsible for leading public health efforts to advance the behavioral health of the nation by reducing the impact of substance abuse and mental illness on America's communities.
SDE/SDHIE	**State Designated Entity/ State Designated Health Information Technology Entity** • As it relates to health information, this term refers to a state organizational unit charged with fostering effective and efficient exchange of health information that leverages existing regional and state efforts and is based on federal HHS-adopted standards and certification criteria.
SDLC	**Systems Development Life Cycle** • This term is used in systems engineering, information systems and software engineering to describe a process for planning, creating, testing, and deploying an information system. The concept applies to a range of hardware and software configurations and may also be called an Application Development Life Cycle.

Acronym	Definition
SERCH	**Southeast Regional HIT-HIE Collaboration** • Initiated in 2010, this was a collaborative effort across six southern states (Alabama, Arkansas, Florida, Georgia, Louisiana, and Texas) that came together with the common goal of developing a strategic plan for sharing health information data among the states following a declared natural disaster. • SERCH is no longer an active collaborative.
SFY	**State Fiscal Year** • This term refers to the 12-month period for which a state government bases its budget. Dates vary by state.
SHARP	**Strategic Health IT Advanced Research Projects** • This term refers to innovative research to address well-documented problems that impede the adoption of health information technology (IT). Knowledge generated and innovations created accelerate progress toward the meaningful use of health IT and a high-performing, adaptive, nationwide health care system that will be translated into patient-centered health IT products and services. • Supported by the federal Office of the National Coordinator for Health Information Technology in HHS/CMS, the program is led by major collaborative efforts of select universities and hospitals.
SIM	**State Innovation Model** • SIM is a federal initiative through which CMS has partnered with states to advance multi-payer health care payment and delivery system reform models.
SLR	**State Level Repository** • This term refers to a state-based platform and process through which Eligible Professionals and Eligible Hospitals attest to meeting requirements of the Medicaid EHR Incentive Program.
SMA	**State Medicaid Agency** • This term refers to the state agency charged with administering the Medicaid program in that state and is generally headed by the state Medicaid Director.
SMDL	**State Medicaid Director's Letter** • This numbered correspondence is from the CMS Administrator or a designee and addressed to state agency officials responsible for administering the Medicaid program in each state and territory to convey federal guidance and instructions.
SMHP	**State Medicaid HIT Plan** • The SMHP is a document completed by a state Medicaid agency and submitted to CMS that explains how the state agency will make EHR incentive payments to providers, how the agency will monitor the program, and how the agency plans to coordinate activities with other statewide HIE initiatives and regional extension centers.
SNOMED CT	**Systemized Nomenclature of Medicine-Clinical Terms** • This term refers to a standardized, multi-lingual vocabulary of clinical terminology used by physicians and other health care providers for the electronic exchange of clinical health information. The nomenclature is owned and maintained by SNOMED International, a non-profit association.
SOA	**Service Oriented Architecture** • This term refers to a style of software design where services are provided to other components by application components, through a communication protocol over a network. Its basic principles are independent of vendors, products and technologies.
SOAP	**Simple Object Access Protocol** • SOAP is a messaging protocol that allows programs running on disparate operating systems to communicate with HTTP and XML.

Acronym	Definition
SOTA	**State Operations and Technical Assistance** • SOTA is an initiative of the Center for Medicaid and CHIP Services (CMCS) within HHS/CMS. To help provide a smooth and efficient experience for state agencies managing the Medicaid and CHIP programs, SOTA coordinates the resolution of issues across CMCS components and other parts of CMS.
SPA	**State Plan Amendment** • A state plan for Medical Assistance is a contract between a state or territory and the federal government describing how the state/territory administers its Medicaid program. Any amendment to the plan must be submitted to and approved by HHS/CMS.
SSA	**Social Security Act** • The SSA is a federal law enacted by President Franklin D. Roosevelt in 1935 and amended many times since. It is the primary legal authority for the Medicare, Medicaid, and CHIP health care programs.
SSO	**Single Sign-On** • This term refers to a session and user authentication service that permits a user to use one set of login credentials (e.g., name and password) to access multiple applications. It authenticates the end user for all applications the user has been given rights to and eliminates further prompts when the user switches applications during the same session.
SSP	**System Security Plan** • A SSP provides an overview of the security requirements of an information system and describes the controls in place or planned, responsibilities and expected behaviors of all individuals accessing the system and should be viewed as documentation of the structured process for planning adequate, cost-effective security protection for a major application or general support system.
TA	**Technical Assistance** • Generically, this term refers to the provision of skills training, working knowledge or consulting services to assist individuals and organizations in their implementation, staffing, or management of a program or other activity. Effective TA is designed to achieve specific learning objectives, resolve problems, and foster collaborative discussion of innovative practices.
TCP/IP	**Transmission Control Protocol/Internet Protocol** • This term refers to a suite of communication protocols used to interconnect network devices on the Internet and similar computer networks. It is essentially the agreed-upon set of procedures and rules that permit computers to understand each other and exchange information.
TIN	**Tax Identification Number** • The TIN is a number used to identify a business entity (or estates and trusts with income) for tax purposes in the US. The number may be assigned by the Social Security Administration or the Internal Revenue Service. • It is also known as the Federal Taxpayer Identification Number.
TJC	**The Joint Commission** • An independent, non-profit organization, the Commission accredits and certifies US health care organizations and programs and its approval is recognized nationwide as a symbol of quality that reflects an organization's commitment to meeting certain performance standards.
T-MSIS	**Transformed Medicaid Statistical Information System** • A critical data and systems component of CMS' MACBIS, the T-MSIS data set contains enhanced information about beneficiary eligibility, beneficiary and provider enrollment, service utilization, claims and managed care data, and expenditure data for both Medicaid and CHIP. States and territories have been transitioning their data submission from MSIS to T-MSIS since 2012.

Acronym	Definition
TOC	**Transition of Care** • This term refers to the movement of a patient from one setting of care, such as a hospital or nursing facility, to another setting, such as a patient's home or another community setting. It is a measure in the Eligible Professional Meaningful Use Menu Set of Measures associated with the EHR Incentive Programs.
TRA	**Technical Reference Architecture** • A reference architecture in the field of software or enterprise architecture provides a template solution for a particular domain and a common vocabulary with which to discuss implementations, often with the aim to stress commonality and best practices.

U-Z

Acronym	Definition
UAT	**User Acceptance Testing** • This term refers to the last phase of the software testing process during which actual users test the software to make sure it can handle required tasks in real-world scenarios, according to specifications.
UCUM	**Unified Code for Units of Measure** • UCUM is a code system intended to include all units of measures being contemporarily used in international science, engineering, and business to facilitate unambiguous electronic communication of quantities together with their units. A typical application of The UCUM are electronic data interchange (EDI) protocols.
UDDI	**Universal Description, Discovery, and Integration** • First developed by UDDI.org and then transferred to OASIS, this term refers to a set of services supporting the description and discovery of businesses, organizations and other Web services providers; the Web services they make available; and the technical interfaces used to access those services. • It is based on a common set of industry standards, including HTTP, XML, XML Schema, and SOAP.
UDS	**Uniform Data System** • Maintained by HHS/HRSA, the UDS is a standardized reporting system that provides consistent information about health centers and look-alikes based on their annual reports on performance using measures defined in the system.
UMLS	**Unified Medical Language System** • The UMLS integrates and distributes key terminology, classification and coding standards, and associated resources to promote creation of more effective and interoperable biomedical information systems and services, including electronic health records.
URL	**Uniform Resource Locator** • A URL, colloquially termed a web address, is a reference to a web resource that specifies its location on a computer network and a mechanism for retrieving it.
VBP	**Value Based Payment** • In health care, this term refers to a payment approach that rewards providers for delivering high-quality and cost-efficient care, with programs intended to achieve better care for individuals, better health for populations, and lower the total cost of care provided. • The acronym is also used to refer to Value Based Purchasing and Value Based Programs.

Acronym	Definition
VFC	**Vaccines for Children** • The VFC is a federally-funded program that provides vaccines at no cost to children who otherwise might not be vaccinated because of inability to pay. • The HHS/CDC buys vaccines at a discount and distributes them to grantees, including state health departments and certain other public health agencies, that in turn distribute them to health care providers for administration to qualified children.
VLP	**Verification of Lawful Presence** • As it applies to participation in Medicaid or CHIP, this term refers to the steps taken during eligibility determination to assess whether an applicant is lawfully present in the US. Some applicants who do not meet Medicaid or CHIP requirements may still be eligible to enroll in a Qualified Health Plan and receive advance payments of the premium tax credit and cost-sharing reductions.
VPN	**Virtual Private Network** • A VPN is a technology that creates a safe and encrypted connection over a less secure network, such as the Internet, and enables users to securely send and receive data across shared or public networks.
XDS	**Cross-Enterprise Document Sharing** • This term refers to an interoperability profile that facilitates the registration, distribution, and access across health enterprises of patient electronic health records.
XML	**Extensible Markup Language** • This term refers to a universal mark-up language that defines a set of rules for encoding documents in a format that is both human-readable and machine-readable. It is maintained by the World Wide Web Consortium (W3C), an international group that works together to develop Web standards.
XSD	**XML Schema Definition** • This term refers to the shape or structure of an XML document, along with rules for data content and semantics such as what fields an element can contain, which sub-elements it can contain, and how many items can be present.