



I - Acronyms

AIU: Adopt, Implement, or Upgrade to a certified EHR system/module

CHERT: Certified Electronic Health Record Technology

CHPL: Certified Health IT Product List (from ONC)

CMS: Centers for Medicare & Medicaid Services

CMS R&A (or RNA): CMS Registration & Attestation System web site

CY: Calendar Year

DBM: Dental Benefits Manager

EH: Eligible Hospital

EHR: Electronic Health Record

EP: Eligible Professional

FEIN: Federal Employer Identification Number

FFY: Federal Fiscal Year

FQHC: Federally-Qualified Hospital or Clinic

FY: Fiscal Year

HIE: Health Information Exchange

HIT: Health Information Technology

HITECH ACT: The Health Information Technology for Economic and Clinical Health Act

MCC: Managed Care Contractor, includes the Managed Care Organizations (MCOs), Dental Benefits Manager (DBM), and the Pharmacy Benefits Manager (PBM)

MCO: Managed Care Organization

MU: Meaningful Use

ONC: Office of the National Coordinator (for Health Information Technology)

PBM: Pharmacy Benefits Manager

PIPP: [TennCare Medicaid] EHR Provider Incentive Payment Program

PV: Patient Volume

RHC: Rural Health Clinic

SRA: Security Risk Analysis

II – Glossary

Adopt / Implement / or Upgrade (AIU) to a Certified EHR System / Module:

- **Adopt** – Acquire, purchase, or secure access to CEHRT capable of meeting MU requirements
- **Implement** – Install or commence utilization of CEHRT capable of meeting MU requirements
- **Upgrade** – Expand the availability of CEHRT capable of meeting MU requirements at the practice site, including staffing, maintenance, and training, or upgrading from existing EHR technology to CEHRT per the ONC EHR certification criteria (42 CFR § 495.302)

Attestation (Attesting): The process whereby an EP or EH submits information and data showing AIU or MU (as applicable) and attests to the accuracy and completeness of the information in an attempt to qualify for an EHR Provider Incentive Payment. An attestation is submitted online through the TennCare Medicaid PIPP portal.

Calendar Year: January 1 – December 31

EHR Incentive Payment: An incentive payment made to qualifying EPs and EHs who have met the requirements of the EHR Incentive Program as established by the HITECH Act of 2009.

- To receive an AIU incentive payment, a provider must adopt, implement, or upgrade to a certified EHR system/module, in addition to meeting other eligibility criteria.
- To receive an MU incentive payment, a provider must also meet the criteria demonstrating meaningful use of his certified EHR system/module.

Eligible Hospital (EH): A hospital described in 42 CFR § 495.304(a) as being eligible to participate in the EHR Provider Incentive Program. EHs are acute care hospitals, Critical Access Hospitals (CAHs), and children’s hospitals.

Eligible Professional (EP): A professional described in 42 CFR § 495.304(b) as being eligible to participate in the EHR Provider Incentive Program. EPs are Physicians (both Medical and Osteopathic), Dentists, Certified Nurse Midwives, Nurse Practitioners, and Physician Assistants (PAs) who practice in a FQHC led by a PA or in a RHC so led by a PA.

Fiscal Year: Often refers to the Federal Fiscal Year (FFY), which is October 1 through September 30 of the following year. Otherwise, a fiscal year can be any 12-month period defined by the entity.

Hospital-based Professional: An EP who provides substantially all of his professional services in a hospital setting. “Substantially all” is defined as 90% or more of the EP’s services being rendered in a hospital setting (inpatient [POS 21] or emergency department [POS 23])

Medicaid Encounter for Eligible Hospitals: For the purposes of calculating hospital patients, the following definitions apply.

Inpatient – A Medicaid encounter occurs when services are rendered to an individual per inpatient discharge when either:

- Medicaid or a Medicaid demonstration project (TennCare) paid for all or part of the service
- Medicaid or a Medicaid demonstration project (TennCare) paid for all or part of the individual's cost sharing
- The individual was enrolled in Medicaid (TennCare or the Medicaid program of another state) at the time the billable service was provided (42 CFR § 495.306(e)(2)) If an individual was enrolled in TennCare Medicaid on the date of service and a billable service was rendered, the encounter may be counted regardless of how it was adjudicated, **except** if the claim was denied because the individual was **not** Medicaid-eligible on the date of service. Both conditions must exist to count this encounter.

Emergency Department – A Medicaid encounter occurs when services rendered in an emergency department on any one day and either:

- Medicaid or a Medicaid demonstration project (TennCare) paid for all or part of the service
- Medicaid or a Medicaid demonstration project (TennCare) paid for all or part of the individual's cost sharing
- The individual was enrolled in Medicaid (TennCare or the Medicaid program of another state) at the time the billable service was provided (42 CFR § 495.306(e)(2)) If an individual was enrolled in TennCare Medicaid on the date of service and a billable service was rendered, the encounter may be counted regardless of how it was adjudicated, **except** if the claim was denied because the individual was **not** Medicaid-eligible on the date of service. Both conditions must exist to count this encounter.

Medicaid Encounter for Eligible Providers: A "Medicaid encounter" refers to services rendered to an individual on any one day where:

- Medicaid or a Medicaid demonstration project (TennCare) paid for part or all of the service
- Medicaid or a Medicaid demonstration project (TennCare) paid all or part of the individual's cost sharing
- The individual was enrolled in a Medicaid program (or a Medicaid demonstration project – TennCare, or the Medicaid program of another state) at the time the billable service was provided. (42 CFR § 495.306(e)(1)) If an individual was enrolled in TennCare Medicaid on the date of service and a billable service was rendered, the encounter may be counted regardless of how it was adjudicated, **except** if the claim was denied because the individual was **not** Medicaid-eligible on the date of service. Both conditions must exist to count this encounter.

All services rendered on a single day to a single individual by a single EP counts as one encounter. If the individual receives services from another EP who is a part of the same group, each EP can count his services provided as a separate encounter.

Needy Individual: An individual who

- Receives assistance from Medicaid or CHIP (CoverKids)
- Is furnished uncompensated care by the provider
- Is furnished care at no cost or at a reduced cost based on a sliding scale determined by the individual's ability to pay

Needy Individual Encounter (applies to services provided in an FQHC or RHC only): A Needy Individual encounter occurs when services are rendered to an individual on any one day and either

- Medicaid (TennCare) or CHIP (CoverKids) paid for part or all of the service
- Medicaid (TennCare) or CHIP paid all or part of the individual's cost sharing
- The individual was enrolled in a Medicaid program (TennCare or the Medicaid program of another state) at the time the billable services were provided
- The services were furnished at no cost consistent with 42 CFR § 495.310(h)
- The services were paid at a reduced rate based on a sliding scale determined by the individual's ability to pay. (42 CFR § 495.306(e)(3)) If an individual was enrolled in TennCare Medicaid on the date of service and a billable service was rendered, the encounter may be counted regardless of how it was adjudicated, **except** if the claim was denied because the individual was **not** Medicaid-eligible on the date of service. Both conditions must exist to count this encounter.

The inclusion of Needy Individuals in the threshold calculation applies **only** to meeting the patient volume requirements for EPs practicing predominately in FQHCs or RHCs. All services rendered on a single day to a single individual by a single EP counts as one encounter. If the individual receives services from another EP practicing in the same FQHC or RHC on the same day, this counts as an encounter for each EP.

Payment/Program Year: The year for which the provider is attesting and receiving payment.

- When attesting for AIU, the Payment/Program Year is Y, while the patient volume data comes from Y-1. (That is, the Payment/Program Year is 2016, but the patient volume data comes from 2015, even if you are attesting in the 2016 grace period, which ends March 31, 2017 for EPs.)
- When attesting for Year 1 – Stage 1 MU, the MU data comes from a 90-day period within the Payment/Program Year for which attesting is done (I.e., if attesting for 2015, the 90-day MU period must fall within 2015; patient encounters come from 2014).
- When attesting for Year 2 and following in which a full year of MU data is required, you will attest in the following calendar year. For example, if attesting for 2016, you would submit your attestation AFTER December 31, 2016.

 **NOTE:** Several times since the inception of the EHR Provider Incentive Payment Program, CMS has changed the MU attestation period from 365 days for providers attesting for their second or later years of MU to only 90 days. Although both CMS and TennCare do our best to make this change

known to providers, if you ever have a question about what the MU attestation period is for any given Program Year, send an email to EHRMeaningfuluse.TennCare@tn.gov and ask.

Practices Predominately at an FQHC/RHC: An EP is considered to practice predominately at an FQHC or RHC when over 50% of his total encounters over a period of six months, in the most recent 12 months prior to the attestation, are provided in an FQHC or RHC.

Reporting Period:

- For **Patient Volume Encounters:** A consecutive 90-day period in the previous calendar year
- For **Meaningful Use:** The first year of MU attestation, the provider is to report on a 90-day period. In the 2nd through 6th years, the reporting period is 1 year.

(Please also see “Payment/Program Year” above)

So Led: An FQHC/RHC is “so led” by a PA when

- A PA is the primary provider in the clinic (for example, when there is a part-time physician and full-time PA, CMS considers the PA as the primary provider)
- A PA is a clinical or medical director at a clinical site of practice (being a director of a department **within** the FQHC/RHC does **not** qualify the PA as being the lead)
- A PA is the owner of the RHC

Unique Patient: The number of unduplicated patients in a given reporting period. If a patient is seen by an EP more than once during the EHR reporting period, then for purposes of meaningful use measurement, that patient is counted once in the denominator for the measure.