DEFINITIONS

1. Capitalized terms used in the MUCA and not otherwise defined, shall have the meaning given them in the Terms. The Parties may set forth additional defined terms within each Exhibit.

2. **Acknowledgment (AK or ACK)** means "acknowledged" and is used to positively acknowledge a previously received Message Content.

3. **ACR Type** means the type of Active Care Relationship based on how it was created or its status. ACR Types include, but are not limited to, the following:

   a) **DECLARED ACR** means an ACR that has been sent to Network from a person, Caregiver, Health Professional or entity defined within the ACR. A DECLARED ACR is considered a very trustworthy and accurate type of ACR.

   b) **ASSIGNED ACR** means an ACR that has been provided to Network by a third party. For example, a Health Plan or government program may indicate they have assigned a specific individual or organization to help in managing or coordinating the care for a "member." As further elaboration, ASSIGNED ACRs are common when a primary care physician has been assigned by a Health Maintenance Organization (HMO), but increasingly for payment and performance assessment under alternate payment programs.

   c) **REPORTED ACR** means an ACR that has been created by Network for an organization based on Message Content passing through Network. For example, when an ADT is received by Network, Network will create a REPORTED ACR for that patient with the organization that sent the ADT Message from a Source System.

   d) **DERIVED ACR** means an ACR created using statistical analysis or via mathematical modeling of data integrated from multiple sources and provided to Network. For example, a DERIVED ACR may come through traditional attribution analysis conducted on claims data by a Health Plan to determine which Health Professional is linked to a patient.

   e) **CONTESTED ACR** means an ACR that has been called into question. Patients, Health Providers, TDSOs, or Network may all contest an ACR by communicating to the Network that the ACR is contested using the means for communicating as specified in the UCIG.

   f) **CONFIRMED ACR** means an ACR that was a **CONTESTED ACR** and the issue was resolved and the former **CONTESTED ACR** will remain in ACRS with its ACR Type changed to **CONFIRMED ACR**.

   g) **EXPIRED ACR** means an ACR that has been terminated. This occurs either when a **CONTESTED ACR** does not become a **CONFIRMED ACR** within the time limit, or when an ACR is no longer **DECLARED, ASSIGNED, REPORTED, DERIVED**, or other ACR Type introduced by an Exhibit.

4. **Active Care Relationship (ACR)** means (a) for Health Providers, a patient who has been seen by a provider within the past 24 months, or is considered part of the Health Providers'

active patient population they are responsible for managing, unless notice of termination of that treatment relationship has been provided to Network; (b) for payers, an eligible member of a Health Plan; (c) an active relationship between a patient and a Health Provider for the purpose of Treatment, Payment and/or Healthcare Operations consistent with the requirements set forth in HIPAA; (d) a relationship with a Health Provider asserted by a consumer and approved by such Health Provider; or (e) any person or TDSO authorized to receive Message Content under an Exhibit which specifies that an ACR may be generated by sending or receiving Message Content under that Exhibit. ACR records are stored by Network in the ACRS.

5. **Active Care Relationship Service (ACRS)** means the Network Infrastructure Service that contains records for those TDSOs, their Authorized Users or any Health Providers who have an Active Care Relationship with a patient.

6. **Active Care Team** means the list of persons or organizations having an Active Care Relationship for a single given patient.

7. **Admission, Discharge, Transfer (ADT)** means an event that occurs when a patient is admitted to, discharged from or transferred from one care setting to another care setting or to the patient's home. For example, an ADT event occurs when a patient is discharged from a hospital. An ADT event also occurs when a patient arrives in a care setting such as a health clinic or hospital.

8. **ADT Message** means a type of HL7 message generated by healthcare systems based upon ADT events and the HL7 "Electronic Data Exchange in Healthcare" standard. The HL7 ADT message type is used to send and receive patient demographic and healthcare encounter information, generated by Source System(s). The ADT Messages contain patient demographic, visit, insurance and diagnosis information.

9. **ADT Notification** means an electronic notification that a given patient has undergone an ADT event. An ADT Notification is not a complete ADT Message.

10. **Advance Directive (ADs)** means a document in which consumers specify what type of medical care they want in the future, or who should make medical decisions if they become unable to make decisions for themselves.

11. **Affiliation** means the relationship between a Person Record and an Organization Record or between two Organization Records.

12. **Affiliation Type** means the type of relationship or Affiliation between a Person Record and an Organization Record or between two Organization Records. For example employed by, admitting privileges, and others as may be specified in an Exhibit or UCIG.

13. **Applicable Laws and Standards** means, in addition to the definition set forth in the Agreement, the federal Confidentiality of Alcohol and Drug Abuse Patient Records statute,

section 543 of the Public Health Service Act, 42 U.S.C. 290dd-2, and its implementing regulation, 42 CFR Part 2;[relevant state Mental Health Code]; and [relevant state Public Health Code].

14. **Assertion** means a package of information exchanged about an identity. The outer structure of an Assertion is generic, providing information that is common to all of the statements within the package. Within an Assertion, a series of inner elements describe the authentication, attribute, authorization decision, or user-defined statements containing the specifics.

15. **Attribution** means a connection between a consumer and a healthcare provider. One definition of attribution is: Assigning a provider or providers, who will be held accountable for a consumer based on an analysis of that consumer's claim data.

16. **Authorized User** means a person or entity exchanging healthcare information via the Participant with the Services, and possibly with other TDSOs as specified in an Exhibit.

17. **Caregiver** means an individual such as a Health Professional or social worker who assists in the identification, prevention or treatment of an illness or disability.

18. **Clinical Quality Measures (CQMs)** means tools that help measure or quantify healthcare processes, outcomes, patient perceptions, and organizational structure and/or systems that are associated with the ability to provide high-quality healthcare and/or that relate to one or more quality goals for healthcare.

19. **Common Gateway** means the method by which data is sent and received by Network using various national standard protocols (e.g., NwHIN SOAP, IHE XCA, IHE XDS.b).

20. **Common Key Service (CKS)** means a Network Infrastructure Service that communicates with a Master Person Index (MPI) to match patients and to assign and retrieve Network Common Keys that are linked to unique patients.

21. **Comprehensive Primary Care Plus (CPC+)** means a national advanced primary care medical home model that aims to strengthen primary care through a regionally-based multi-payer payment reform and care delivery transformation and has identified core performance measures for quality, forming its own quality measure set.

22. **Conforming Message** means Message Content that is in a standard format that strictly adheres to the Implementation Guide for its applicable Use Case.

23. **Consumer-Facing Application** means a personal health record, online health portal, mobile application or any tool that allows consumers to access, manage and store (e.g., View Download Transmit) their Health Information.

24. **Core Quality Measure Collaborative (CQMC)** means an effort led by the America's Health Insurance Plans (AHIP) and its member plans' Chief Medical Officers, leaders from CMS and the National Quality Forum (NQF), as well as national physician organizations,

employers and consumers, that reached consensus on core performance measures for quality, forming the CQMC's own quality measure set.

25. **Critical Access Hospital (CAH)** means a Critical Access Hospital as defined under the Medicaid EHR Incentive Program.

26. **Data Sharing Agreement** means any data sharing organization agreement agreed to by both Network and Participant. Data sharing organization agreements include but are not limited to: Qualified Data Sharing Organization Agreement, Virtual Qualified Data Sharing Organization Agreement, Consumer Qualified Data Sharing Agreement, Sponsored Shared Organization Agreement, State Sponsored Sharing Organization Agreement, Direct Data Sharing Organization Agreement, Simple Data Sharing Organization Agreement, Terms of Service, or other data sharing organization agreements developed by Network.

27. **Departmental Health Information Exchange ([Name of Department] HIE)** means the [Name of department] Health Information Exchange that is used as part of the Network's network-of-networks.

28. **Digital Credentials** means a digital certificate, including server certificates, issued to Participant by Network, its designee or trusted anchor. The Digital Credentials will be presented electronically by Participant to prove identity and the right to access Message Content through the Services.

29. **Durable Power of Attorney for Healthcare** also known as a healthcare proxy or patient advocate designation, is a document in which another individual is appointed to make medical treatment and related personal care decisions for a patient when he/she can no longer make them for her/himself.

30. **eCQM Analytic Solution** means a system or service focused on a statewide measures analytics system, including electronic clinical quality measures (eCQM) and other quality analytics, in support of healthcare quality improvement activities and value-based purchasing models.

Commented [SN1]: Jurisdictions may wish to customize this definition

31. **eHealth Exchange** – see the definition for Sequoia Project.

32. **Electronic Address** means a string that identifies the transport protocol and end point address for communicating electronically with a recipient. A recipient may be a person, organization or other entity that has designated the Electronic Address as the point at which it will receive electronic messages. Examples of an Electronic Address include a secure email address (Direct via secure SMTP) or secure URL (SOAP / XDR / REST / FHIR). Communication with an Electronic Address may require a digital certificate or participation in a trust bundle.

33. **Electronic CQM (eCQM)** means CQMs that are specified in a standard electronic format and are designed to use data from Health IT systems for measurement.

34. **Electronic Medical Record or Electronic Health Record (EMR/EHR)** means a digital version of a patient's paper medical chart.

35. **Electronic Service Information (ESI)** means all information reasonably necessary to define an electronic destination's ability to receive and use a specific type of information (e.g., discharge summary, patient summary, laboratory report, query for patient/provider/healthcare data). ESI may include the type of information (e.g., patient summary or query), the destination's Electronic Address, the messaging framework supported (e.g., SMTP, HTTP/SOAP, XDR, REST, FHIR), security information supported or required (e.g., digital certificate) and specific payload definitions (e.g., CCD C32 V2.5). In addition, ESI may include labels that help identify the type of recipient (e.g., medical records department).

34. **Eligible Hospital (EH)** means an Eligible Hospital as defined under the Medicare and Medicaid EHR Incentive Programs.

35. **Eligible Professional (EP)** means an Eligible Professional as defined under the Medicare and Medicaid EHR Incentive Programs.

36. **End Point** means an instance of an Electronic Address or ESI.

37. **Exhibit** means, collectively, a Use Case Exhibit or a Pilot Activity Exhibit.

38. **Facility/Hospital** means an organization that operates a facility, which is required by a State to be licensed, registered, or similarly recognized as a hospital.

39. **Fast Healthcare Interoperability Resources (FHIR)** is a standard describing data formats and elements and an Application Programming Interface (API) for exchanging Electronic Health Records.

40. **Federal Programs** means "Meaningful Use" criteria as specified in the American Recovery and Reinvestment Act of 2009, also as permitted by HIPAA, and the Medicare Access and CHIP Reauthorization Act (MACRA) Quality Payment Program (QPP), including Merit-Based Incentive Payment System (MIPS),) the Medicare Shared Savings Program (MSSP) and Alternative Payment Models (APMs).

41. **Federated Identity** means a trusted form of identification such as username and password or Digital Credential, which can be used to access multiple systems, including those outside the home organization.

42. **Federated Identity Management (FIdM)** means an arrangement among multiple organizations that allows use of the same Federated Identity to access the resources of Federated Organizations, including shared identities and shared services.

43. **Federated Organization** means a TDSO that has entered into an Exhibit that uses Federated Identities and services.

44. **Gaps in Care ("Care Gaps" or "Gaps in Coverage")** means the discrepancy between recommended best practice medical care and the care that is actually provided. Health Plans determine care that is actually provided based on a combination of claims and Quality Information received from Health Providers.

45. **Gaps in Care Report** means quality measure performance data, often listing individual patients and any missing services, designed to be actionable to Health Providers such that they can improve quality scores and patient care.

46. **Health Level 7 (HL7)** means an interface standard and specifications for clinical and administrative healthcare data developed by the Health Level Seven organization and approved by the American National Standards Institute (ANSI). HL7 provides a method for disparate systems to communicate clinical and administrative information in a normalized format with Acknowledgement of receipt.

47. **Health Information** means any information, including genetic information, whether oral or recorded in any form or medium, that (a) is created or received by a Health Provider, public health authority, employer, life insurer, school or university, or healthcare clearinghouse; and (b) relates to the past, present, or future physical or mental health or condition of an individual; the provision of healthcare to an individual; or the past, present, or future payment for the provision of healthcare to an individual.

48. **Health Plan** means an individual or group health plan that provides, or pays the cost of medical care (as "group health plan" and "medical care" are defined in section 2791(a)(2) of the Public Health Service Act, 42 U.S.C. 300gg-91(a)(2)). Health Plan further includes those entities defined as a health plan under HIPAA, 45 C.F.R. 160.103.

49. **Health Professional** means (i) any individual licensed, registered, or certified under applicable Federal or State laws or regulations to provide healthcare services; (ii) any person holding a non-clinical position within or associated with an organization that provides or coordinates healthcare or healthcare related services; and (iii) people who contribute to the gathering, recording, processing, analysis or communication of Health Information. Examples include, but are not limited to, physicians, physician assistants, nurse practitioners, nurses, medical assistants, home health professionals, administrative assistants, care managers, care coordinators, receptionists and clerks.

50. **Health Provider** means Facilities/Hospitals, Health Professionals, Health Plans, Caregivers, Pharmacists/Other Qualified Professionals or any other person or organization involved in providing healthcare.

51. **Health Provider Directory (HPD or "Provider Directory")** means the statewide shared service established by Network that contains contact information on Health Providers, Electronic Addresses, End Points, and ESI, as a resource for authorized users to obtain contact information and to securely exchange Health Information.

52. **Health Provider Information** means information about Health Providers, including name, contact information, organization(s), title(s), position(s), Health Plan network participation, ESI, End Points, Person Records, Organization Records, any related Affiliations, a National Provider Identifier (NPI) and other associated information as appropriate and as required by the HPD or SCD.

53. **Healthcare Effectiveness Data and Information Set (HEDIS)** means a set of standardized performance measures the National Committee for Quality Assurance

(NCQA) developed to allow for comparison across Health Plans based on quality not just cost.

54. **Identity Provider** means a Federated Organization that creates, maintains, and manages identity information and is responsible for (a) providing identifiers for Principals or Service Providers looking to interact with another service; (b) asserting to such a service that an identifier presented is known to the Identity Provider; and (c) possibly providing other Assertions about the Principal or system that is known to the Identity Provider.

55. **Identity Exchange Platform** means the platform operated by Network supporting the exchange of Message Content. The Identity Exchange Platform enables the utilization of identities and services between Identity Providers and Service Providers under this Master Use Case Agreement.

56. **Immunization Information System (IIS)** means a registry that stores immunization records.

57. **Information Source** means any organization that provides information that is added to a Network Infrastructure Service.

58. **Lab Results** means any type of lab results sent electronically whether general lab results from a lab reporting organization, state lab results, cancer pathology and related notifications, reportable labs for Meaningful Use, newborn screening lab results, blood lead results, or any other type of lab test results sent electronically. Lab Results typically are represented electronically in an HL7 Message called an "ORU" message.

59. **Master Person Index (MPI or "Master Patient Index")** means a database used to identify, match, merge, de-duplicate, and cleanse records for individuals, to create a master index of demographic information for each person in a population.

60. **Meaningful Use (MU)** means using certified EHR technology to improve quality, safety and efficiency of healthcare, and to reduce health disparities as further contemplated by Title XIII of the American Recovery and Reinvestment Act of 2009.

61. **Message** means a mechanism for exchanging Message Content between the Participant to the Services, including query and retrieve.

62. **Message Content** means information, as further defined in an Exhibit, which is sent, received, found or used by a Participant to or from the Services. Message Content includes the Message Content Header.

63. **Message Header ("MSH") or Message Content Header** means the MSH segment present in every HL7 message type that defines the Message's source, purpose, destination, and certain syntax specifics such as delimiters (separator characters) and character sets. It is always the first segment in the HL7 message, with the only exception being HL7 batch messages.

66. **MIDIGATE®** means the Medical Information DIrect GATEway, which is an Network Infrastructure Service that receives inbound Direct Secure Messages, processes the payload

based on the Message type, and routes and sends the Message Content to its appropriate destination.

67. **Nationwide Health Information Network (NwHIN)** – see the definition for Sequoia Project.

68. **Negative Acknowledgment (NAK or NACK)** means "not acknowledged" and is used to negatively acknowledge or to reject previously received Message Content or to indicate some kind of error.

69. **Network Common Key** means an alphanumeric key assigned by the Common Key Service and stored by a Master Person Index for purposes of linking patients to their health information across various systems.

70. **Network Infrastructure Service** means certain services that are shared by numerous Use Cases. Network Infrastructure Services include, but are not limited to, Active Care Relationship Service (ACRS), Health Provider Directory (HPD), Statewide Consumer Directory (SCD), and the Medical Information DIrect GATEway (MIDIGATE®).

71. **NIST Levels of Assurance (LOA)** refers to the standards created by the National Institute of Standards, which describe separate identity authentication assurance levels that can be leveraged to grant permissions based on a user's LOA, from 1 through 4. The LOA is further described in NIST 800-63-2, which can be found online at http://dx.doi.org/10.6028/NIST.SP.800-63-2 or as such url may be updated from time to time.

72. **Notice** means a message transmission that is not Message Content and which may include an acknowledgement of receipt or error response, such as an ACK or NACK.

73. **OAuth** means an authentication protocol that allows users to approve an application to act on their behalf without sharing their password.

74. **Organization Record** means any record that primarily relates to a company or other organization (i.e., not a person).

75. **Patient Data** means any data about a patient or a consumer that is electronically filed in a Participant or Authorized User's systems or repositories. The data may contain Protected Health Information (PHI), Personal Credit Information (PCI) or Personally Identifiable Information (PII).

76. **Person Record** means any record in a Network Infrastructure Service that primarily relates to a person.

77. **Pharmacist/Other Qualified Professional** means an individual authorized under Applicable Laws and Standards to administer prescriptions.

78. **Physician Quality Reporting System (PQRS)** means a quality reporting program that encourages individual Eligible Professionals and group practices to report information on the quality of care to CMS.

79. **Pilot Activity** means the activities set forth in the applicable Exhibit and typically includes sharing Message Content through early trials of a new use case that is still being defined and is still under development and which may include Participant feedback to Network to assist in finalizing a Use Case and Use Case Exhibit upon conclusion of the Pilot Activity.

80. **Prepaid Inpatient Health Plan** means an organization that manages the Medicaid specialty services under the 1915(b)(c) Waiver Program, consistent with the requirements of 42 C.F.R. Part 401. This benefit plan covers mental health and substance use services for people eligible for Medicaid who have a need for behavioral health, intellectual/developmental disabilities services and support, or substance use services.

81. **Prescription Drug Monitoring Program** means the state-run programs that collect and distribute data about the prescription and dispensing of federally controlled substances and other potentially addictive or prescription drugs subject to abuse.

82. **Principal** means a person or a system utilizing a Federated Identity through a Federated Organization.

83. **Privacy Tags** means special machine readable tags placed in Message Content indicating that the Message Content contains Specially Protected Information.

84. **Quality Information** means any of the following: (a) CQMs including those used in connection with government initiatives; (b) claims-based quality data; (c) Supplemental Clinical Data Files used to calculate HEDIS measures; (d) HEDIS measures; or (e) quality measures and the data used to calculate them for any quality measure set.

85. **Quality Reporting Document Architecture (QRDA)** is a standard document format for the exchange of eCQM data. QRDA reports contain data extracted from EHRs and other information technology systems. The reports are used for the exchange of eCQM data between systems for quality measurement and reporting initiatives.

86. **QRDA CAT 1 Report** means a QRDA Category 1 (or "CAT 1") file is based on an XML standard designed for communicating patient-level clinical data that is used to calculate CQMs. Examples include preventative care and screening for cholesterol or use as appropriate medications for asthma. These individual patient-level reports are used to calculate aggregate level QRDA Category 3 Reports. Quality reports contribute the quality data necessary to calculate population measure metrics.

87. **QRDA CAT 3 Report** means a QRDA Category 3 (or "CAT 3") file which contains aggregate quality results and does not contain PHI.

89. **Relying Party** means a Service Provider that uses an Identity Provider to authenticate a Principal who wants to access an application or service controlled by that Service Provider.

90. **Repository** means a central location in which data is stored and managed.

91. **Requesting Party** means the Principal that initiates a session to a Service Provider.

92. **REST** means REpresentational State Transfer, which is an architectural style, and an approach to communications that is often used in the development of Web services.

93. **Send / Receive / Find / Use (SRFU)** means sending, receiving, finding, or using Message Content. Sending involves the transport of Message Content. Receiving involves accepting and possibly consuming or storing Message Content. Finding means querying to locate Message Content. Using means any use of the Message Content other than sending, receiving or finding. Examples of use include consuming or integrating into workflow, reporting, storing, or analysis.

94. **Services** means the Network Infrastructure Services and additional services and functionality provided by Network allowing the Participant to send, receive, find, or use information to or from Network as further set forth in an Exhibit.

95. **The Sequoia Project** means an organization that manages the nationwide network formerly known as NwHIN now called eHealth Exchange, which uses a set of standards, services and policies that enable secure Health Information exchange ("HIE") over the Internet.

96. **Service Interruption** means a Party is unable to send, receive or find Message Content for any reason, including the failure of network equipment or software, scheduled or unscheduled maintenance, general Internet outages, and events of force majeure.

97. **Service Provider** means a Federated Organization that requests and obtains an authentication Assertion from the Identity Provider. On the basis of this authentication Assertion, the Service Provider can make an authorization decision – in other words it can decide whether to perform some service (such as for the connected Principal in SAML). Services may include, but are not limited to, application services, network services, or SAML-type services.

98. **Security Assertion Markup Language (SAML)** means an XML standard that allows secure web domains to exchange user authentication and authorization data. Using SAML, an online service provider can contact a separate online identity provider to authenticate users who are trying to access secure content.

99. **Single Sign-On (SSO)** is a property of access control that allows a user to sign on one time and 'share' one identity across multiple networks, web sites or software applications. The alternative to SSO is that a user must login to each system individually.

100. **Source System** means a computer system, such as an electronic health record system, at the Participant, that sends, receives, finds or uses Message Content or Notices.

101. **Specially Protected Information** means Health Information that is protected beyond the scope of HIPAA such as under 42 CFR Part 2, the state mental health code or other state or federal privacy laws.

102. **Statewide Consumer Directory (SCD)** means a Network Infrastructure Service that helps organizations provide tools to consumers, which allow the consumers to manage how their

personal Health Information can be shared and used. The Statewide Consumer Directory is essentially a Software Development Kit (SDK) with a robust set of APIs that can be used by Consumer-Facing Applications that enable consumers to take an active role in viewing and editing their preferences for how their Health Information is shared.

103. **Statewide IIS** means the IIS for the [designated jurisdiction] operated by the [designated public health agency].

104. **Supplemental Clinical Data Files (SCDF)** means information sent to Health Plans for the purpose of calculating HEDIS measures.

105. **Transactional Basis** means the transmission of Message Content or a Notice within a period of time of receiving Message Content or Notice from a sending or receiving party as may be further set forth in a specific Exhibit.

106. **Transitions of Care** means the movement of a patient from one setting of care (e.g., hospital, ambulatory primary care practice, ambulatory specialty care practice, long-term care, rehabilitation facility) to another setting of care and can include transfers within a healthcare organization.

107. **Trusted Data Sharing Organization (TDSO)** means an organization that has entered into any form of agreement with Network for data sharing.

108. **Use Case** means (a) a Use Case Agreement previously executed by Participant; or (b the Use Case Summary, Use Case Exhibit and a Use Case Implementation Guide that Participant or TDSO must follow to share specific Message Content with the Network.

109. **Use Case Implementation Guide (UCIG)** means the document providing technical specifications related to Message Content and transport of Message Content between Participant, Network, and other TDSOs. Use Case Implementation Guides are made available via URLs in Exhibits.

110. **Use Case Summary** means the document providing the executive summary, business justification and value proposition of a Use Case. Use Case Summaries are provided by Network upon request and via the Network website at www.velatura.org.

111. **View Download Transmit (VDT)** means a requirement for Meaningful Use with the objective to provide patients with the ability to view online, download and transmit their Health Information within a certain period of the information being available to an Eligible Professional.

112. **XCA** means the IHE (Integrating the Healthcare Enterprise®) standard for Cross-Community Access which provides specifications to query and retrieve patient relevant Health Information held by other communities.

112. **XDS.b** means the IHE (Integrating the Healthcare Enterprise®) standard for Cross-Enterprise Document Sharing revision b, which provides specifications to query and retrieve patient relevant healthcare data held within a community.