TAKACS MCGINNIS
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Long-Term Care Glossary

The long-term care system can seem like an alphabet soup of programs. This article provides definitions for some of the terms, concepts and programs that an older American and his or her caregivers are likely to encounter.

CHOICES is TennCare's program for long-term care services for the elderly (65 years of age and older) or disabled (21 years of age and older). Long-term care includes help with everyday activities such as bathing, dressing, getting around the home, preparing meals, or doing household chores. Long-term care services include care in a nursing home as well as certain services to help a person remain at home or in the community. These are called Home and Community Based Services or HCBS.

Dual-Eligible Beneficiaries are people who are jointly enrolled in Medicare and Medicaid and who are eligible to receive benefits from both programs.

Extra Help refers to a subsidy for Medicare Part D members who meet low income and resources qualifications or who are dual eligible. It helps pay the costs of Medicare prescription drug coverage.

Long-Term Services and Supports (LTSS) is a category that encompasses a variety of supportive services provided to people who have limits on their ability to perform daily activities, such as bathing or dressing.

Managed Care Organizations (MCOs)
Like HMOs, these companies agree to provide most Medicaid benefits to people in exchange for a monthly payment from the state.

Managed Care Plans are a type of health insurance. They have contracts with health care providers and medical facilities to provide care for members at reduced costs. These providers

make up the plan's network. Plans that restrict your choices usually cost you less. There are 3 types:

1. Health Maintenance Organizations (HMO) usually only pay for care within the network. You choose a primary care doctor who coordinates most of your care.
2. Preferred Provider Organizations (PPO) usually pay more if you get care within the network. They still pay part of the cost if you go outside the network.
3. Point of Service (POS) plans let you choose between an HMO or a PPO each time you need care.

Medicaid is a health insurance program for low-income individuals and families who cannot afford health care costs. Medicaid serves low-income parents, children, seniors and people with disabilities.

Medicare is the federal health insurance program for people who are 65 and older, certain younger people with disabilities, and people with end-stage regal disease.

Medicare Advantage Plan is a type of Medicare Managed Care Plan offered by a private company that contracts with Medicare to provide Part A and Part B (and sometimes Part D) benefits. On Medicare's web site, it is referred to as a Medicare Health Plan.

Medicare Parts A, B, C, and D: The Medicare program has three components: Hospital Insurance (Part A), Medical Insurance (Part B), and prescription drug coverage (Part D). Medicare Part C (known as Medicare Advantage) specifies the rules under which private health care plans can assume responsibility for, and be compensated for, providing benefits covered under Parts A, B, and D.

Qualified Medicare Beneficiary (QMB) is a level of help available under the Medicare Savings Program for low income Medicare beneficiaries. It covers Medicare cost-sharing requirements such as premium, deductibles and 20% co-insurance. Medicaid applicants are automatically screened for QMB.

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TennCare is Tennessee's Medicaid program. TennCare services are offered through managed care entities. Medical, behavioral and Long-Term Services and Supports (LTSS) are covered by "at risk" managed care organizations (MCO) in each region of the state.