Frequently Used Terms

Patient Protection and Affordable Care Act (PPACA) & Health Care and Education Reconciliation Act of 2010

Benzos and Barbs - Benzodiazepines and Barbiturates – depressant drugs used therapeutically to induce sleep, relieve anxiety and muscle spasms, and to prevent seizures. These drugs can become addictive.

Congressional Budget Office (CBO) - Primary congressional agency charged with reviewing congressional budgets and other legislative initiatives with budgetary implications.

Centers for Disease Control and Prevention (CDC) - US federal agency works to protect public health and safety by providing information to enhance health decisions.

Children's Health Insurance Program (CHIP) - CHIP is a program that offers coverage to uninsured children. Tennessee's CHIP program is called "CoverKids." This program is funded with both state and federal dollars and was formerly known as SCHIP.

Centers for Medicare and Medicaid Services (CMS) - US federal agency which administers Medicare, Medicaid, and the Children's Health Insurance Program (CHIP).

Currently Eligible but Not Enrolled - Individuals who would have previously qualified for Medicaid under the eligibility requirements in place prior to March 23, 2010, but were not enrolled in the program.

Drug Rebates - Payments received from pharmaceutical manufacturers for drugs that were sold by the Medicaid agency. The rebates for drugs function similarly to other retail rebates - you purchase a product, and submit a rebate request to the company to receive funds back from the company for purchasing their product.

Dual eligible - A person who is eligible for both Medicare and Medicaid,. Most duals receive most of their services from Medicare, but also get the services TennCare covers that Medicare does not cover. Other duals arePartial Benefit Dual Eligible. They are a Medicare beneficiary who does not qualify for TennCare, but who qualifies for TennCare to pay some or all of his Medicare cost-sharing expenses.

Federal Medical Assistance Percentage (FMAP) - The term for the federal Medicaid matching rate.— Medicaid programs share the cost of the program between the federal government and the state government.

Federal Poverty Level (FPL) - The poverty level is one way the federal government measures poverty. Poverty levels are used in determining eligibility for TennCare. For 2008, the HHS poverty guideline for a family of four was $21,200.

Full benefits - Medical assistance for all services covered under the State plan that is not less in amount, duration, or scope, or is determined by CMS to be substantially equivalent to the medical assistance available to a Medicaid eligible individual.

Health and Human Services (HHS) - The Department of Health and Human Services (HHS) is the United States government's agency for protecting the health of all Americans and providing essential human services.

Health Information Technology (HIT) - Systems and technologies that enable health care organizations and providers to gather, store, and share information electronically.

Health Insurance Exchange/Connector - A purchasing arrangement through which insurers offer health insurance. Smaller employers and individuals can then purchase health insurance through the Exchange. State, regional, or national exchanges will be established to set standards for what benefits would be covered, how much insurers could charge, and the rules insurers must follow in order to participate in the insurance market. Individuals and small employers could select their coverage within this organized arrangement.

Health Maintenance Organization (HMO) - An entity licensed by the Tennessee Department of Commerce and Insurance (TDCI) that provides managed care for its members.

High-Risk Pool - State programs designed to provide health insurance to residents who are considered medically uninsurable due to pre-existing conditions and are unable to buy coverage in the individual market.

Household Income – The combined gross income (meaning before taxes) of all persons living in one household. This is the modified adjusted gross income (MAGI) of the individual plus the MAGI of other individual s in the household who are required to file a tax return.

Managed Care Organization (MCO) - An appropriately licensed Health Maintenance Organization (HMO) approved by the Bureau of TennCare as capable of providing medical services to enrollees in the TennCare program.

Maintenance of Effort/ Eligibility - Not having in effect eligibility standards, methodologies or procedures under the State plan or a waiver that are more restrictive than the eligibility standards, methodologies or procedures under the plan or waiver that were in effect on March 23,2010.

Medicaid - The program for medical assistance provided under Title XIX of the Social Security Act for certain persons with low incomes and special circumstances. Medicaid programs are administered jointly by the State and the Federal government. The parameters under which the Bureau of TennCare operates its Medicaid program are found in the Medicaid State Plan.

Medicaid-eligible - People who are eligible under the Tennessee Medicaid State Plan (otherwise known as "TennCare Medicaid"). Eligibility for TennCare Medicaid is determined by either the Social Security Administration or the Department of Human Services (DHS).

Medical Home - A health care setting where patients receive comprehensive primary care services; have an ongoing relationship with a primary care provider who directs and coordinates their care; have

enhanced access to non-emergent primary, secondary, and tertiary care; and have access to linguistically and culturally appropriate care.

Medicare - The program for medical assistance provided under Title XVIII of the Social Security Act for elderly and certain disabled individuals. The Medicare program is administered solely by the federal government.

Minimum Creditable Coverage (MCC) -The minimum level of benefits that must be included in a health insurance plan in order for an individual to be considered insured.

Newly Eligible - Individuals who did not previously qualify for Medicaid under the eligibility requirements in place prior to March 23, 2010.

Percent of Medicare - 100% of Medicare reimbursement equals the total amount Medicare pays for a particular service. Medicaid agencies use this as a base-line for determining what percent of Medicare they will reimburse providers.

Portability of Coverage - Rules allowing people to obtain coverage as they move from job to job or in and out of employment. Individuals changing jobs are guaranteed coverage with the new employer without a waiting period. In addition, insurers must waive any pre-existing condition exclusions for individuals who were previously covered within a specified time period. Portable coverage can also be health coverage that is not connected to an employer, allowing individuals to keep their coverage when they have a change in employment.

Pre-existing Condition Exclusions - An illness or medical condition for which prevents a person from qualifying for commercial health insurance. Health care providers can exclude benefits for a defined period of time for the treatment of medical conditions that they determine to have existed within a specific period prior to the beginning of coverage.

Primary Care Provider - A provider, usually a physician specializing in internal medicine, family practice, or pediatrics (but can also be a nurse practitioner, physician assistant or even a health care clinic), who is responsible for providing primary care and coordinating other necessary health care services for patients.

Uncovered individuals - Individuals with no health insurance coverage at any time during the year (as determined by CMS based on the most recent data available).