Law and Healthcare Policy

Healthcare Financing and Legislation,

Affordable Care Act (ACA) – A federal statute enacted in 2010 that expands health insurance coverage, regulates insurers, and establishes health insurance marketplaces. Related terms: Marketplace, Essential Health Benefits. The ACA mandates that most individuals obtain coverage or face a penalty (repealed in 2019 for most taxpayers) and provides subsidies based on income. Challenges include political opposition, state-level implementation variations, and ongoing litigation concerning its constitutionality.

Accountable Care Organization (ACO) – A network of physicians, hospitals, and other providers that voluntarily coordinate care to improve quality and reduce costs for Medicare beneficiaries. Related terms: Shared Savings, Population Health. ACOs receive financial incentives when they meet predetermined quality metrics and achieve cost savings relative to a benchmark. Difficulties involve aligning incentives across diverse providers and managing data sharing while protecting patient privacy.

Adverse Selection – A market phenomenon where individuals with higher health risk are more likely to purchase insurance, while healthier individuals may forgo coverage, leading to premium increases. Related terms: Moral Hazard, Risk Pooling. Insurance markets attempt to mitigate adverse selection through mandates, underwriting restrictions, and risk adjustment mechanisms. Persistent adverse selection can destabilize insurance markets and raise costs for all participants.

Affordable Care Act Individual Mandate – A provision requiring most U.S. Residents to maintain minimum essential health coverage or pay a penalty, designed to reduce adverse selection. Related terms: Coverage Gap. Though the penalty was reduced to zero at the federal level in 2019, many states have retained their own mandates. Enforcement and public perception remain contentious.

Bundled Payments – A reimbursement method where providers receive a single, predetermined payment for all services related to a treatment episode, rather than separate fee-for-service claims. Related terms: Episode of Care, Value-Based Purchasing. Bundled payments aim to encourage efficiency and coordination, but providers must manage cost variability and ensure quality standards are met.

Capitation – A payment arrangement where providers receive a fixed amount per patient per period, regardless of services rendered. Related terms: Risk Adjustment, Primary Care. Capitation incentivizes preventive care and cost containment but poses financial risk if patient needs exceed the capitated amount, requiring robust risk management strategies.

Certificate of Need (CON) – A state-level regulatory process requiring health care providers to obtain approval before constructing new facilities or purchasing major equipment. Related terms: Health Care Market Entry. CON programs aim to control health care costs and prevent unnecessary duplication of services, yet critics argue they can limit competition and hinder innovation.

Centers for Medicare & Medicaid Services (CMS) – The federal agency within the Department of Health and

Human Services that administers Medicare, Medicaid, and the Children's Health Insurance Program (CHIP). Related terms: Regulatory Oversight. CMS develops payment policies, sets quality standards, and enforces compliance, influencing the financial landscape of U.S. Health care.

Charitable Immunity – A legal doctrine protecting nonprofit health care entities from certain liability claims, encouraging the provision of uncompensated care. Related terms: Nonprofit Hospital. While charitable immunity can reduce litigation costs, it may also limit accountability for patient safety lapses, prompting debates over its scope.

CHIP (Children's Health Insurance Program) – A jointly funded federal-state program that provides low-cost health coverage to children in families that earn too much to qualify for Medicaid but cannot afford private insurance. Related terms: Medicaid Expansion. CHIP enrollment varies by state, and funding fluctuations can affect program stability and service availability.

Co-Pay – A fixed amount a patient pays out-of-pocket at the point of service, with the insurer covering the remaining cost. Related terms: Deductible, Coinsurance. Co-pays are used to share cost responsibility and discourage overutilization, yet high co-pay amounts may deter necessary care, especially among low-income populations.

Coinsurance – A cost-sharing arrangement where the patient pays a specified percentage of the allowed charge after meeting any deductible, while the insurer pays the remainder. Related terms: Out-of-Pocket Maximum. Coinsurance balances risk between insurer and enrollee, but can lead to unpredictable expenses for patients with high utilization.

Community Health Center (CHC) – A nonprofit, federally funded health care facility that provides comprehensive primary care services to medically underserved populations, regardless of ability to pay. Related terms: Federally Qualified Health Center (FQHC). CHCs receive enhanced reimbursement rates and grant funding, yet face challenges in staffing, funding continuity, and meeting growing demand.

Cost-Sharing – The portion of health care expenses that patients are required to pay, including deductibles, co-pays, and coinsurance. Related terms: Risk Adjustment. Cost-sharing aims to curb unnecessary utilization, but excessive cost-sharing may create barriers to care, particularly for chronic disease management.

Cost-Effectiveness Analysis (CEA) – An economic evaluation comparing the relative costs and health outcomes of two or more interventions, expressed as cost per quality-adjusted life year (QALY) or similar metric. Related terms: Health Technology Assessment. CEA informs coverage decisions and price negotiations, yet ethical concerns arise when assigning monetary value to human life.

Deductible – The amount a patient must pay for covered services before the insurer begins to pay its share. Higher deductibles lower premiums but increase financial risk for enrollees, influencing plan selection and utilization behavior.

Diagnostic Related Group (DRG) – A classification system that groups hospital cases with similar clinical characteristics and resource usage for Medicare inpatient reimbursement. Related terms: Prospective

Payment System. DRGs incentivize hospitals to control costs, yet may encourage premature discharge or under-service if not balanced with quality metrics.

Disproportionate Share Hospital (DSH) Payments – Federal subsidies to hospitals that serve a large number of low-income patients, intended to offset uncompensated care costs. Related terms: Medicaid Shortfall. DSH payments are calculated based on Medicaid and uninsured patient volumes, but reductions in Medicaid expansion have raised concerns about hospital financial stability.

Electronic Health Record (EHR) Incentive Program – A federal initiative, also known as "Meaningful Use," that provides payments to eligible professionals and hospitals for adopting certified EHR technology and meeting specific usage criteria. Related terms: Health Information Technology for Economic and Clinical Health (HITECH) Act. While EHR adoption improved data accessibility, providers cite workflow disruption and reporting burdens.

Fee-for-Service (FFS) – A traditional reimbursement model where providers are paid separately for each service rendered. Related terms: Volume-Based Compensation. FFS can drive overutilization and higher costs, prompting a shift toward value-based payment structures that reward outcomes rather than volume.

Fiscal Intermediary – An organization that processes claims, distributes payments, and provides administrative services for Medicaid or other public programs on behalf of a state. Related terms: Managed Care Organization (MCO). Fiscal intermediaries improve efficiency but require robust oversight to prevent fraud and ensure compliance with federal regulations.

Health Care Reform – Legislative and policy efforts aimed at improving access, quality, and affordability of health care. Related terms: Universal Coverage, Policy Innovation. Major reforms include the ACA, Medicaid expansion, and various state-level initiatives, each confronting political, economic, and logistical challenges.

Health Care Savings Account (HCSA) – A tax-advantaged account that individuals can use to pay for qualified medical expenses, similar to a Health Savings Account but often linked to high-deductible plans. Related terms: Pre-Tax Contributions. HCSAs encourage consumer-direct spending decisions, yet may not be accessible to low-income workers lacking high-deductible coverage.

Health Maintenance Organization (HMO) – A type of managed care plan that provides a defined network of providers and requires members to obtain care primarily from that network, often requiring referrals for specialists. Related terms: Gatekeeper. HMOs aim to lower costs through care coordination, but restrictions can limit patient choice and create administrative hurdles.

Health Technology Assessment (HTA) – A multidisciplinary process that evaluates the clinical effectiveness, cost-effectiveness, and broader impact of health technologies, such as drugs, devices, or procedures. Related terms: Cost-Effectiveness Analysis. HTA informs reimbursement decisions and formulary placement, yet may be contested by manufacturers and patient advocacy groups.

Health-Care Fraud – Deliberate deception for financial gain, including billing for services not rendered, upcoding, and kickbacks. Related terms: False Claims Act. Fraud undermines program integrity and increases costs; enforcement agencies employ audits, data analytics, and whistleblower provisions to detect

and deter misconduct.

Health-Care Provider – An individual or organization that delivers medical services, ranging from physicians and nurses to hospitals and ambulatory surgery centers. Related terms: Credentialing. Provider status determines reimbursement eligibility, participation in networks, and compliance obligations under federal and state law.

Health-Care Quality Measures – Standardized metrics used to assess the performance of health-care services, including clinical outcomes, patient experience, and safety indicators. Related terms: Pay-for-Performance. Quality measures drive value-based reimbursement but require robust data collection and risk adjustment to ensure fairness.

Health-Care Reform Act – A generic term for legislative proposals intended to overhaul the health-care system; notable examples include the ACA and various state statutes. Related terms: Legislative Process. Reform bills often contain provisions on insurance markets, Medicaid eligibility, and cost-containment strategies, sparking extensive stakeholder debate.

Health-Care Tax Credits – Financial incentives that reduce the tax liability of individuals or businesses purchasing health insurance, typically based on income level. Related terms: Premium Subsidy. Tax credits improve affordability but can be complex to calculate, and policy changes may affect eligibility thresholds.

Health-Care Transparency – Policies and practices that make information about prices, quality, and provider performance publicly available. Related terms: Price Disclosure. Transparency aims to empower consumers and stimulate competition, yet data standardization and privacy concerns pose implementation challenges.

Health-Care Utilization Review – The systematic assessment of the appropriateness, medical necessity, and efficiency of health-care services. Related terms: Prior Authorization. Utilization review helps control costs but may be perceived as a barrier to timely care, leading to provider resistance.

Health-Insurance Exchange – An online marketplace where individuals and small businesses can compare and purchase qualified health-insurance plans, established under the ACA. Related terms: Marketplace Subsidies. Exchanges increase competition and consumer choice, yet technical glitches and limited plan availability in some regions have hindered enrollment.

Health-Insurance Portability and Accountability Act (HIPAA) – A 1996 federal law that protects the privacy and security of individuals' health information and ensures continuity of coverage when changing jobs. Related terms: Protected Health Information (PHI). HIPAA compliance requires robust administrative, technical, and physical safeguards, and violations can result in substantial penalties.

Health-Insurance Premium – The periodic payment made by an individual or employer to maintain health-insurance coverage. Related terms: Subsidy. Premium levels reflect risk pooling, benefit design, and regulatory requirements; rising premiums can strain household budgets and affect enrollment decisions.

Health-Insurance Subsidy – Financial assistance, often in the form of tax credits or cost-sharing reductions, that lowers the out-of-pocket cost of purchasing coverage on an exchange. Related terms: Affordable Care

Act. Subsidies are calibrated to household income relative to the federal poverty level, but policy changes can alter eligibility and benefit amounts.

Health-Insurance Risk Adjustment – A methodology that transfers funds among insurers to account for differences in the health status of enrollees, thereby discouraging selection based on risk. Related terms: Medicaid Risk Adjustment. Accurate risk adjustment relies on comprehensive diagnostic coding and robust data validation.

Health-Insurance Marketplace – See Health-Insurance Exchange.

Health-Policy Analyst – A professional who examines health-care data, legislation, and market trends to inform policy development and evaluation. Related terms: Stakeholder Engagement. Analysts must balance evidence-based recommendations with political feasibility and equity considerations.

Health-Savings Account (HSA) – A tax-advantaged account paired with a high-deductible health plan, allowing individuals to contribute pre-tax dollars for qualified medical expenses. Related terms: Triple Tax Advantage. HSAs encourage consumer-direct spending decisions, yet high deductibles may deter necessary care for low-income participants.

Health-Technology Innovation Act – A legislative proposal aimed at accelerating the development and adoption of medical technologies through streamlined regulatory pathways and reimbursement reforms. Related terms: Food and Drug Administration (FDA). While fostering innovation, the act must balance safety, efficacy, and cost-effectiveness concerns.

Hospital Readmission Reduction Program (HRRP) – A Medicare value-based initiative that penalizes hospitals with higher than expected 30-day readmission rates for certain conditions. Related terms: Quality Metrics. HRRP incentivizes care coordination and discharge planning but may lead to unintended coding practices to avoid penalties.

Hospital Uncompensated Care – Services rendered by a hospital for which no payment is received, including charity care and bad-debt losses. Related terms: Disproportionate Share Hospital Payments. Uncompensated care imposes financial strain on hospitals, especially safety-net institutions, prompting calls for policy reforms to address funding gaps.

Inpatient Prospective Payment System (IPPS) – A Medicare reimbursement framework that pays hospitals a predetermined amount for each inpatient stay, based on DRG classification. Related terms: DRG. IPPS encourages cost control but requires accurate documentation to avoid underpayment or compliance violations.

Individual Health Insurance Policy – A contract that provides health coverage to a single enrollee or family, purchased directly from insurers or through an exchange. Related terms: Group Health Plan. Individual policies may have higher premiums than group plans due to smaller risk pools, and underwriting rules vary by state.

Insurance Broker – An intermediary who assists individuals or employers in selecting and purchasing

health-insurance coverage, typically receiving commissions from insurers. Related terms: Agency Model. Brokers provide market expertise but must disclose potential conflicts of interest and comply with licensing requirements.

Insurance Premium Tax – A tax levied on health-insurance premiums, collected by state or federal authorities. Related terms: Cost Pass-Through. Premium taxes increase the overall cost of coverage, influencing insurer pricing strategies and potentially affecting enrollment rates.

Insurance Risk Pool – A collective of individuals whose health-care costs are aggregated to spread financial risk among participants. Related terms: Adverse Selection. Larger, more diverse risk pools tend to stabilize premiums, while narrow pools can lead to volatility and higher costs.

Interstate Health-Insurance Compact – An agreement among states to allow insurers to sell policies across state lines, aiming to increase competition and lower premiums. Related terms: Regulatory Harmonization. Critics argue that differing state regulations and consumer protections may be compromised, creating a "race to the bottom."

International Classification of Diseases (ICD) – A standardized coding system for diagnoses and health conditions, maintained by the World Health Organization. Related terms: Diagnostic Coding. ICD codes are essential for billing, epidemiology, and risk adjustment; transitions between versions (e.G., ICD-9 to ICD-10) require extensive provider training.

Job-Based Health Insurance – Coverage offered by an employer to its employees, often subsidized and administered through group plans. Related terms: Employer-Sponsored Insurance. Job-based insurance provides economies of scale, but job loss or changes can disrupt continuity of coverage, raising concerns about portability.

Joint Commission Accreditation – A nationally recognized certification process that evaluates health-care organizations against performance standards for quality and safety. Related terms: Hospital Accreditation. Accreditation can affect reimbursement eligibility and public reputation, yet the process can be costly and time-intensive.

Laboratory Services Reimbursement – The payment mechanisms for clinical laboratory tests, including the Clinical Laboratory Fee Schedule (CLFS) under Medicare. Related terms: Medicare Part B. Reimbursement rates influence lab test utilization and the adoption of new diagnostic technologies.

Legal Liability in Health Care – The responsibility of health-care providers and institutions to compensate patients for harms caused by negligence, malpractice, or breach of duty. Related terms: Medical Malpractice. Liability risk drives defensive medicine practices and contributes to higher health-care costs.

Medicaid – A joint federal-state program that provides health coverage to low-income individuals, families, seniors, and persons with disabilities. Related terms: Medicaid Expansion, Eligibility Threshold. Medicaid reimbursement rates are typically lower than Medicare, affecting provider participation and access to care.

Medicaid Expansion – The extension of Medicaid eligibility to adults with incomes up to 138% of the federal

poverty level, as authorized by the ACA. Expansion has increased insurance coverage in participating states, yet non-expansion states experience higher uninsured rates.

Medicare – A federal health-insurance program for individuals aged 65 and older, certain younger people with disabilities, and those with end-stage renal disease. Related terms: Part A, Part B, Part D. Medicare financing relies on payroll taxes, premiums, and general revenues, and it faces solvency challenges due to an aging population.

Medicare Advantage (Part C) – A private-insurance alternative to traditional Medicare that offers additional benefits and may include prescription drug coverage. Related terms: Risk-Adjusted Capitation. Medicare Advantage plans receive a fixed per-member payment and are incentivized to manage costs, yet they can vary widely in network restrictions and out-of-pocket costs.

Medicare Part A – The portion of Medicare that covers inpatient hospital stays, skilled nursing facility care, hospice, and some home health services. Related terms: Hospital Inpatient Prospective Payment System. Part A is primarily funded through payroll taxes, and beneficiaries typically do not pay a premium for this coverage.

Medicare Part B – The portion of Medicare that covers outpatient services, physician services, preventive care, and medical supplies. Related terms: Premium Tax Credit. Part B requires a monthly premium based on income, and cost-sharing includes an annual deductible and 20 % coinsurance for most services.

Medicare Part D – The prescription-drug benefit added to Medicare in 2006, administered through private plans that negotiate drug prices and coverage. Related terms: Formulary. Part D involves a monthly premium, annual deductible, and a coverage gap (“donut hole”) that has been gradually closed by legislation.

Medicare Prescription Drug Discount Card – A program that offers reduced medication costs for Medicare beneficiaries who are not enrolled in Part D. Related terms: Out-of-Pocket Savings. The card aims to improve medication adherence among low-income seniors but may be limited by pharmacy participation.

Medicare Sustainable Growth Rate (SGR) – A former formula used to control Medicare physician payments by linking them to economic growth; repealed in 2015 and replaced by the Medicare Access and CHIP Reauthorization Act (MACRA). Related terms: Physician Fee Schedule. The SGR’s instability prompted frequent congressional “doc fixes,” highlighting the need for a more predictable payment system.

Medicare Access and CHIP Reauthorization Act (MACRA) – A 2015 law that reformed Medicare physician payment, introducing the Quality Payment Program, which includes the Merit-Based Incentive Payment System (MIPS) and Advanced APMs. Related terms: Value-Based Purchasing. MACRA aims to shift incentives toward quality and cost efficiency while providing greater payment stability.

Medical Loss Ratio (MLR) – The percentage of premium dollars that health-insurance companies must spend on clinical services and quality improvement, as mandated by the ACA (≥80 % for individual and small group markets, ≥85 % for large groups). Related terms: Premium Refunds. Failure to meet MLR requirements results in rebate payments to policyholders, promoting consumer protection.

Medical Malpractice – A legal claim alleging that a health-care provider's negligence caused injury or death to a patient. Related terms: Tort Reform. Malpractice litigation can lead to large settlements, influence practice patterns, and contribute to the phenomenon of defensive medicine.

Medical Necessity – A criterion used by insurers to determine whether a service, procedure, or medication is appropriate for diagnosis or treatment based on clinical evidence. Determinations of medical necessity affect coverage decisions and reimbursement levels.

Medicare Value-Based Purchasing (VBP) Program – An initiative that adjusts hospital payments based on performance on quality and efficiency measures. Related terms: Hospital Readmission Reduction Program. VBP incentivizes hospitals to improve outcomes, yet metric selection and data accuracy remain critical challenges.

Minimum Essential Coverage (MEC) – The type of health-insurance coverage that satisfies the ACA's individual mandate requirement. Related terms: Essential Health Benefits. MEC includes employer-sponsored plans, government programs, and individual market policies that meet defined benefit standards.

National Health Service (NHS) – The publicly funded health-care system of the United Kingdom, providing comprehensive services primarily free at the point of use. Related terms: Single-Payer System. While not a U.S. Model, the NHS is frequently referenced in comparative health-policy analyses.

National Provider Identifier (NPI) – A unique 10-digit identification number assigned to health-care providers in the United States, required for electronic transactions. Related terms: HIPAA. The NPI simplifies billing and data exchange but requires providers to maintain up-to-date information to avoid claim denials.

Netherlands Health-Care System – A regulated competitive insurance model where private insurers are mandated to offer a standardized benefits package, and individuals are required to purchase coverage. The system balances universal coverage with market competition, offering insights for U.S. Policy debates.

Non-Profit Hospital – A health-care organization that operates without profit distribution to shareholders, often qualifying for charitable tax status and receiving DSH payments. Related terms: Charitable Immunity. Non-profit status imposes community benefit obligations, yet measuring and reporting those benefits can be complex.

Obamacare – A colloquial term for the Affordable Care Act and its associated reforms. Related terms: ACA. The nickname reflects public discourse and political framing, and it is often used in media and policy debates.

Out-of-Network Billing – Charges incurred when a patient receives services from a provider not contracted with their insurance plan, often resulting in higher cost-sharing or balance-billing. Related terms: Balance Billing. Out-of-network billing can create surprise medical bills, prompting legislative actions to protect consumers.

Out-of-Pocket Maximum – The maximum amount a patient must pay for covered services in a benefit year,

after which the insurer pays 100 % of allowed costs. Related terms: Cost-Sharing. The limit provides financial protection but varies across plans, influencing patient cost exposure.

Patient Protection and Affordable Care Act (PPACA) – The formal title of the ACA, emphasizing its goals of expanding coverage and protecting patients. The PPACA introduced numerous provisions, including insurance marketplaces, Medicaid expansion, and preventive-service mandates.

Patient Safety Organization (PSO) – A federally designated entity that collects and analyzes data on medical errors to improve safety, granting participating providers confidentiality protections. Related terms: Quality Improvement. PSOs facilitate learning from adverse events while encouraging voluntary reporting.

Pay-for-Performance (P4P) – A reimbursement strategy that ties provider payments to the achievement of specific quality or efficiency metrics. P4P aims to align financial incentives with better outcomes but may inadvertently reward providers serving healthier populations.

Pharmacy Benefit Manager (PBM) – An intermediary that administers prescription drug benefits on behalf of insurers, negotiating rebates, formularies, and pricing with manufacturers. Related terms: Drug Rebates. PBMs can lower drug costs but have faced scrutiny over transparency and potential conflicts of interest.

Population Health Management – A set of strategies that aim to improve the health outcomes of a defined group by addressing preventive care, chronic disease management, and social determinants. Related terms: Risk Stratification. Effective population health management can reduce costs and improve quality, yet requires robust data integration and coordinated care pathways.

Premium Subsidy – See Health-Insurance Subsidy.

Provider Network – The group of physicians, hospitals, and other health-care entities that have contracted with an insurer to deliver services to plan members. Related terms: In-Network. Network adequacy standards seek to ensure sufficient access, but narrow networks can limit patient choice and lead to dissatisfaction.

Quality Adjusted Life Year (QALY) – A metric that combines length of life with health-related quality of life, used in cost-effectiveness analysis. QALYs help policymakers assess the value of interventions, though ethical debates arise over assigning numeric values to health states.

Risk Adjustment – A statistical process that modifies payments to health plans based on the health status and demographic characteristics of enrollees, intended to level the playing field among insurers. Related terms: Medicare Advantage. Accurate risk adjustment depends on comprehensive coding and data integrity.

Risk Pooling – The aggregation of health-care expenses across a group of individuals to spread financial risk. Related terms: Insurance Premium. Larger risk pools tend to yield more stable premiums, while small or homogenous pools can experience volatility.

Rubber-Stamp Legislation – Lawmaking that passes without substantive debate or amendment, often used to expedite health-policy reforms. While efficient, such legislation may overlook stakeholder concerns and result in unintended consequences.

Self-Insured Employer – An employer that assumes the financial risk of providing health benefits to employees, paying claims directly rather than purchasing traditional insurance. Related terms: Stop-Loss Insurance. Self-insurance can lower costs for large firms but requires sophisticated claims administration and risk management.

Social Determinants of Health (SDOH) – Non-medical factors such as income, education, housing, and environment that influence health outcomes. Related terms: Population Health Management. Addressing SDOH is increasingly recognized as essential for reducing health disparities and controlling costs.

Stop-Loss Insurance – Coverage purchased by self-insured employers to protect against catastrophic claim amounts exceeding a predetermined threshold. Related terms: Self-Insured Employer. Stop-loss limits financial exposure but may involve high premiums for low-frequency, high-severity events.

Supply-Side Reform – Policy initiatives that focus on increasing the availability and efficiency of health-care resources, such as expanding provider workforce or improving infrastructure. Related terms: Demand-Side Reform. Supply-side reforms aim to reduce access barriers but can be costly and require long-term planning.

Telemedicine – The remote delivery of clinical services via telecommunications technology, including video visits, remote monitoring, and e-consults. Related terms: Health-Information Technology. Telemedicine expands access, especially in rural areas, yet reimbursement policies, licensure, and privacy concerns present ongoing challenges.

Third-Party Administrator (TPA) – An organization that processes insurance claims and administers benefits on behalf of self-insured entities or insurers. Related terms: Fiscal Intermediary. TPAs improve operational efficiency but must maintain compliance with regulations and data security standards.

Triple Aim – A framework developed by the Institute for Healthcare Improvement that seeks to improve the patient experience, improve population health, and reduce per-capita health-care costs. Related terms: Value-Based Care. Achieving the Triple Aim requires coordinated efforts across payment, delivery, and public-health systems.

Universal Health Coverage (UHC) – The goal of providing all individuals with access to needed health services without financial hardship. UHC is a global health priority, and various financing models (tax-based, insurance-mandated, mixed) aim to achieve it.

Value-Based Purchasing (VBP) – A strategy that links provider payments to performance on quality, efficiency, and patient-experience metrics. VBP encourages clinicians to focus on outcomes rather than volume, yet accurate measurement and risk adjustment are essential to fairness.

Veterans Health Administration (VHA) – The U.S. Department of Veterans Affairs' health-care system, providing comprehensive services to eligible veterans. Related terms: Federal Health System. VHA operates as a large integrated delivery network, facing challenges related to funding, access, and quality improvement.

Waiver Authority (Section 1115 Waiver) – The power granted to the Secretary of HHS to test innovative health-care delivery or financing models that deviate from statutory requirements. Related terms: Medicaid Demonstration. Waivers enable states to implement Medicaid expansion alternatives, but they require rigorous evaluation and congressional approval.

Whole-Person Care – An integrated approach that addresses physical, mental, and social health needs of individuals, often coordinated across multiple providers and community resources. Related terms: Patient-Centered Medical Home. Whole-person care aims to improve outcomes and reduce costs, yet it demands robust data sharing and cross-sector collaboration.