Advanced Certificate in Healthcare Case Management

Healthcare System and Policy Frameworks

A

Accountable Care Organization (ACO) – A network of doctors, hospitals, and other health care providers that voluntarily comes together to provide coordinated, high-quality care to a specific patient population. Related terms: value-based care, shared savings. Example: An ACO may share in any cost savings it achieves for Medicare beneficiaries while meeting quality benchmarks. Challenge: Aligning incentives across diverse provider types.

Adverse Selection – A situation in which individuals with higher health risks are more likely to enroll in a health plan, potentially leading to higher premiums. Related terms: risk pooling, premium pricing. Example: A marketplace that does not mandate enrollment may see healthier individuals opt out, leaving a sicker risk pool.

Affordability Gap – The difference between the cost of needed health services and what patients can reasonably pay. Related terms: out-of-pocket maximum, cost-sharing. Example: A patient may forgo medication because the co-pay exceeds their monthly budget, illustrating an affordability gap.

Alternative Payment Model (APM) – Any payment approach that provides added incentives to deliver high-quality and cost-efficient care, moving away from fee-for-service. Related terms: bundled payment, capitation. Example: The Medicare Shared Savings Program is an APM that rewards providers for lowering spending while meeting quality standards.

American Health Care Act (AHCA) – A 2017 legislative proposal aiming to repeal and replace the Affordable Care Act. Related terms: ACA, health reform. Example: Although the AHCA did not become law, its provisions sparked debate over market-based insurance reforms.

American Medical Association (AMA) Code of Medical Ethics – A set of principles guiding physicians' professional conduct. Related terms: professional standards, clinical ethics. Example: The AMA code addresses conflicts of interest in physician-industry relationships, influencing policy on transparency.

American Rescue Plan Act (ARPA) – A 2021 federal law that expanded health insurance subsidies and provided funding for public health. Related terms: premium tax credit, state Medicaid expansion. Example: ARPA increased the subsidy ceiling, making marketplace plans more affordable for middle-income families.

Antitrust Law – Regulations designed to promote competition and prevent monopolistic practices in health care markets. Related terms: herd-law, price-fixing. Example: The DOJ may challenge a hospital merger that would substantially reduce competition in a region.

Appeals Process (Insurance) – The procedural steps a patient or provider follows to contest a denied claim. Related terms: utilization review, grievance. Example: An ACO's case manager may initiate an appeal for a denied specialty service, providing additional clinical documentation.

Application Programming Interface (API) – A set of protocols that allows different health IT systems to exchange data securely. Related terms: interoperability, FHIR. Example: An EHR vendor may expose an API that lets a pharmacy management system retrieve a patient's medication list in real time.

Area Health Education Center (AHEC) – Regional programs that support health professional education and improve access to care in underserved areas. Related terms: rural health initiatives, pipeline programs. Example: An AHEC may partner with community colleges to train nurse practitioners for local clinics.

Artificial Intelligence (AI) in Health Care – Computer systems that perform tasks requiring human intelligence, such as diagnosis assistance or predictive analytics. Related terms: machine learning, clinical decision support. Example: AI algorithms can flag patients at high risk for readmission, enabling proactive case management.

Assistive Technology – Devices or software that help individuals with disabilities perform daily activities. Related terms: universal design, rehabilitation engineering. Example: Speech-generating devices support communication for patients with severe aphasia.

Audit Trail – A chronological log that records system activity, essential for compliance and security. Related terms: HIPAA Security Rule, data integrity. Example: An audit trail can reveal who accessed a patient's chart and when, supporting investigations of unauthorized access.

Beneficiary – An individual who receives health benefits under a public or private program. Related terms: enrollee, member. Example: Medicare beneficiaries may be eligible for supplemental coverage through Medigap policies.

Beneficiary Identification System (BIS) – The system used by Medicare to assign unique identification numbers to beneficiaries. Related terms: Medicare Beneficiary Identifier (MBI), patient matching. Example: The MBI replaces the Social Security Number on Medicare cards to enhance privacy.

Benefit Design – The structure of health plan coverage, including deductibles, co-pays, and covered services. Related terms: cost-sharing, formularies. Example: A high-deductible health plan (HDHP) paired with a health savings account (HSA) is a benefit design that encourages consumer cost awareness.

Bundled Payment – A single, pre-determined payment for all services related to a treatment episode. Related terms: episode-based payment, global budgeting. Example: A bundled payment for a total knee replacement may cover surgeon fees, hospital stay, and post-acute rehab.

Capitation – A payment model where providers receive a fixed amount per patient per period, regardless of services rendered. Related terms: risk-adjusted capitation, per-member per-month (PMPM). Example: A primary care practice may be paid $30 PMPM to manage the health of its enrolled members.

Case Management – A collaborative process that assesses, plans, implements, coordinates, and monitors health care services to meet an individual's needs. Related terms: utilization management, care coordination. Example: A case manager may arrange home health services for a post-surgical patient to reduce readmission risk.

Case Mix Index (CMI) – A relative value that reflects the diversity and clinical complexity of patients treated in a facility. Related terms: DRG weight, resource intensity. Example: A hospital with a high CMI typically treats more complex cases and may receive higher reimbursement under DRG-based payments.

CCHP (Community-Based Chronic Care Model) – A framework that integrates community resources with health system services to improve chronic disease outcomes. Related terms: patient-centered medical home, population health. Example: The model encourages community health workers to conduct home visits for diabetes education.

Certificate of Need (CON) – A state regulatory process that requires health care providers to obtain approval before expanding services or building facilities. Related terms: health care licensing, capacity planning. Example: A hospital must secure a CON before adding a new cardiac surgery unit, ensuring that the service is needed in the region.

CHIP (Children's Health Insurance Program) – A federal-state partnership 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, public insurance. Example: CHIP enrollment often includes preventive dental services, supporting early oral health.

CHRA (Community Health Resource Allocation) – A systematic method for distributing funds to community health initiatives based on identified needs. Related terms: needs assessment, grantmaking. Example: A health department may use CHRA data to allocate funds for mobile clinics in underserved neighborhoods.

Clinical Decision Support (CDS) – Health IT tools that provide clinicians with knowledge and patient-specific information to enhance decision making. Related terms: evidence-based practice, order sets. Example: A CDS alert may warn a prescriber of a potential drug-drug interaction before finalizing an order.

Clinical Governance – The framework through which health organizations are accountable for continuously improving service quality and safeguarding high standards of care. Related terms: quality assurance, risk management. Example: Clinical governance committees review adverse event reports and develop corrective action plans.

Clinical Pathway – A multidisciplinary plan that outlines the optimal sequence and timing of interventions for a specific clinical condition. Related terms: care protocol, evidence-based pathway. Example: A pathway for sepsis may specify early fluid resuscitation, antibiotic timing, and lactate monitoring.

Co-Pay – A fixed amount a patient pays for a covered health service at the time of care. Related terms: cost-sharing, out-of-pocket expense. Example: A $20 co-pay for an office visit may be waived for patients meeting income-based exemptions.

Co-Insurance – The percentage of costs a patient pays after meeting the deductible. Related terms: deductible, benefit design. Example: After a $1,000 deductible, a patient may be responsible for 20% of subsequent inpatient charges.

Collective Bargaining (Health Care) – Negotiations between employer groups (often health plans) and labor

unions regarding wages, benefits, and working conditions for health-care staff. Related terms: union contracts, labor relations. Example: A hospital may negotiate staffing ratios in a collective bargaining agreement, influencing patient safety.

Community Health Assessment (CHA) – A systematic process for identifying health needs and resources within a defined population. Related terms: needs assessment, public health surveillance. Example: A CHA may reveal high rates of asthma in a locality, prompting targeted air-quality interventions.

Community Health Needs Assessment (CHNA) – A federally mandated evaluation for non-profit hospitals to identify community health priorities and develop implementation strategies. Related terms: IRS Form 990, hospital community benefit. Example: A hospital's CHNA may prioritize mental-health services, leading to new outpatient clinics.

Comparative Effectiveness Research (CER) – Studies that compare the benefits and harms of alternative health interventions to inform decision making. Related terms: evidence synthesis, outcome measurement. Example: CER may compare the efficacy of tele-rehab versus in-person physiotherapy for stroke survivors.

Comprehensive Care Management (CCM) – A Medicare benefit for patients with two or more chronic conditions that require coordinated care. Related terms: care coordination, chronic disease management. Example: A CCM plan includes monthly virtual check-ins, medication reconciliation, and personalized care plans.

Consolidated Omnibus Budget Reconciliation Act (COBRA) – Federal law that allows employees to continue group health coverage after job loss or other qualifying events. Related terms: continuation coverage, benefit eligibility. Example: An employee who resigns may elect COBRA coverage for up to 18 months, paying the full premium plus a surcharge.

Consumer-Driven Health Plans (CDHPs) – High-deductible health plans paired with tax-advantaged accounts (HSA or HRA) that give members greater control over spending. Related terms: high-deductible health plan, patient cost awareness. Example: A CDHP may incentivize members to shop for lower-cost generic medications.

Continuity of Care – The degree to which a patient experiences coherent and linked care over time and across settings. Related terms: care transition, medical home. Example: Discharge summaries that promptly reach primary care providers support continuity.

Coordinated Care Organization (CCO) – A Medicaid-managed care model used in Oregon that integrates physical, mental, and dental health services. Related terms: integrated delivery system, population health. Example: A CCO may align incentives to reduce avoidable emergency department use among high-needs patients.

Cost-Benefit Analysis (CBA) – An economic evaluation that compares the total expected costs of an intervention with its benefits, expressed in monetary terms. Related terms: return on investment, economic evaluation. Example: A CBA might assess whether investing in a community fitness program yields net savings from reduced chronic disease treatment.

Cost-Effectiveness Analysis (CEA) – An evaluation that compares the relative costs and outcomes (often in quality-adjusted life years) of two or more interventions. Related terms: incremental cost-effectiveness ratio, health economics. Example: CEA may show that a vaccination program averts more disease per dollar spent than a screening program.

Cost-Sharing – The portion of health care expenses that patients pay out of pocket, including deductibles, co-pays, and co-insurance. Related terms: benefit design, financial risk. Example: High cost-sharing can deter low-income patients from seeking necessary care, a phenomenon known as “financial toxicity.”

Covered Entity (HIPAA) – A health-care provider, health plan, or health-care clearinghouse that must comply with HIPAA privacy and security rules. Related terms: business associate, protected health information. Example: A hospital’s billing department is a covered entity that must safeguard patient data.

Cross-Sector Collaboration – Partnerships between health care, social services, education, and other sectors to address determinants of health. Related terms: social determinants of health, community partnerships. Example: A health system may work with housing agencies to reduce homelessness among chronically ill patients.

CMS (Centers for Medicare & Medicaid Services) – Federal agency that administers Medicare, Medicaid, and the Children’s Health Insurance Program, and oversees health-care quality initiatives. Related terms: federal health programs, regulatory oversight. Example: CMS issues the Hospital Readmissions Reduction Program (HRRP) penalties for excess readmissions.

CMS Innovation Center (CMMI) – The Center for Medicare & Medicaid Innovation, tasked with testing new payment and service delivery models. Related terms: alternative payment models, pilot projects. Example: CMMI launched the Comprehensive Primary Care (CPC) initiative to support primary-care transformation.

Coordinated Care – The deliberate organization of patient care activities among multiple providers to ensure that patients receive appropriate, timely services. Related terms: care pathways, interprofessional collaboration. Example: A coordinated care team may include a physician, pharmacist, and social worker managing a heart-failure patient.

Corporate Social Responsibility (CSR) in Health Care – Voluntary actions by health-care organizations to address societal concerns, such as environmental sustainability or community health. Related terms: social impact, ethical stewardship. Example: A hospital may implement a green-building program to reduce its carbon footprint.

Cost-Shifting – The practice of charging higher prices to one payer group to compensate for lower reimbursement from another. Related terms: price discrimination, reimbursement mix. Example: Hospitals may increase commercial insurer rates to offset reduced Medicare payments.

Critical Access Hospital (CAH) – A designation for rural hospitals that meet specific criteria, allowing them to receive cost-based reimbursement from Medicare. Related terms: rural health policy, hospital classification. Example: A CAH can maintain 25 inpatient beds and must be more than 35 miles from another acute-care hospital.

Cross-walk (Coding) – A mapping tool that translates codes from one classification system to another (e.G., ICD-10-CM to SNOMED CT). Related terms: clinical terminology, interoperability. Example: A cross-walk enables claims data to be used in population-health analytics that rely on SNOMED concepts.

Data Governance – Policies, procedures, and standards that ensure data quality, security, and appropriate use across an organization. Related terms: data stewardship, information governance. Example: A data-governance board may approve data-sharing agreements with external research partners.

Data Interoperability – The ability of disparate health-IT systems to exchange, interpret, and use data cohesively. Related terms: FHIR, semantic interoperability. Example: Interoperability allows a primary-care EHR to send medication lists directly to a pharmacy dispensing system.

Diagnostic Related Group (DRG) – A classification system that groups inpatient stays with similar clinical characteristics and resource use for payment purposes. Related terms: case-mix index, prospective payment. Example: DRG 470 (major joint replacement) determines the fixed reimbursement amount for that admission.

Digital Health – The use of digital technologies, such as mobile apps, wearables, and telehealth, to improve health outcomes. Related terms: e-health, telemedicine. Example: A diabetes management app that syncs glucose readings to the patient's EHR exemplifies digital health.

Direct Primary Care (DPC) – A membership-based primary-care model where patients pay a flat monthly fee for a defined set of services, bypassing traditional insurance billing. Related terms: concierge medicine, fee-for-service. Example: DPC practices often offer same-day appointments and longer visit times.

Disparities in Health Care – Differences in health outcomes and access to care that are closely linked with social, economic, or environmental disadvantage. Related terms: health equity, social determinants of health. Example: Higher infant mortality rates among certain racial groups illustrate persistent disparities.

Discharge Planning – The process of preparing a patient for transition from hospital to home or another care setting, ensuring continuity and safety. Related terms: care transition, post-acute care coordination. Example: A discharge planner may arrange home health nursing and schedule follow-up appointments before the patient leaves.

DRG-Based Payment – A prospective payment system that reimburses hospitals a fixed amount per case based on the assigned DRG. Related terms: prospective payment system, case-mix index. Example: Under DRG-based payment, a hospital receives the same amount for all uncomplicated coronary artery bypass surgeries, regardless of actual cost.

Dual Eligible – Individuals who qualify for both Medicare and Medicaid benefits. Related terms: Medicare-Medicaid coordination, benefit integration. Example: Dual-eligible beneficiaries often have complex health needs and higher utilization rates.

Durable Medical Equipment (DME) – Medical devices that are ordered by a health-care provider for long-term use at home. Related terms: home health, reimbursement coding. Example: A wheelchair

prescribed for a patient with spinal cord injury is considered DME.

E-Prescribing (Electronic Prescribing) – The electronic generation and transmission of a prescription from a prescriber to a pharmacy. Related terms: health IT, clinical decision support. Example: E-prescribing reduces transcription errors and can trigger drug-interaction alerts.

Electronic Health Record (EHR) – A digital version of a patient's paper chart that contains comprehensive health information accessible to authorized users. Related terms: interoperability, clinical documentation. Example: EHRs enable real-time access to lab results, improving diagnostic speed.

Electronic Medical Record (EMR) – A digital version of the chart used within a single practice, focusing primarily on clinical documentation. Related terms: EHR, health information technology. Example: An EMR may lack the ability to exchange data across organizations, unlike a full EHR system.

Employer-Sponsored Insurance (ESI) – Health coverage provided by an employer to its employees, often through group health plans. Related terms: benefit design, premium contribution. Example: ESI plans may offer wellness incentives such as gym membership discounts.

Encounter-Based Billing – A reimbursement method where providers bill for each patient encounter, regardless of diagnosis or procedure. Related terms: fee-for-service, service-based payment. Example: A primary-care visit is billed as a single encounter code.

Enrollee – An individual who is officially registered in a health-insurance plan. Related terms: member, beneficiary. Example: An enrollee may receive a welcome packet outlining coverage details and cost-sharing responsibilities.

Enterprise Resource Planning (ERP) in Health Care – Integrated software that manages core business processes such as finance, supply chain, and human resources. Related terms: operational efficiency, system integration. Example: An ERP can track inventory levels of surgical supplies, reducing stockouts.

Evidence-Based Medicine (EBM) – The conscientious use of current best evidence in making decisions about the care of individual patients. Related terms: clinical guidelines, systematic review. Example: EBM guides clinicians to prescribe statins for patients with a calculated 10-year cardiovascular risk above a certain threshold.

Exhibit A (HIPAA) – The list of identifiers that must be removed to de-identify protected health information. Related terms: de-identification, privacy rule. Example: Removing names, geographic subdivisions smaller than a state, and all dates except year is required under Exhibit A.

Facility-Based Care – Health services delivered in a physical location such as a hospital, clinic, or nursing home. Related terms: inpatient care, outpatient services. Example: Surgical procedures performed in an operating-room constitute facility-based care.

Fee-For-Service (FFS) – A payment model where providers are paid separately for each service rendered. Related terms: volume-based reimbursement, service line billing. Example: Each lab test, imaging study, and office visit generates a distinct claim under FFS.

Financial Toxicity – The distress or hardship experienced by patients due to high out-of-pocket costs for medical care. Related terms: cost-sharing, patient financial counseling. Example: A cancer patient may skip supportive medications because of prohibitive co-pay amounts, illustrating financial toxicity.

Formulary – A list of prescription drugs covered by a health-insurance plan, often tiered by cost. Related terms: pharmacy benefit management, preferred drug list. Example: A tier-1 formulary drug typically has the lowest co-pay, encouraging its use.

Four-Pillars of Health Care Quality – Safety, effectiveness, patient-centeredness, and timeliness; a framework for evaluating quality. Related terms: IOM quality domains, quality metrics. Example: Reducing medication errors addresses the safety pillar.

Full-Risk Contract – An arrangement where a provider assumes both financial upside and downside for the health outcomes of a defined population. Related terms: global budget, risk-adjusted capitation. Example: A health system may accept a full-risk contract to manage all Medicare beneficiaries in a county.

Functional Status – A measure of a patient's ability to perform activities of daily living. Related terms: activities of daily living (ADLs), quality of life. Example: Functional-status assessments help determine eligibility for home-health services.

GAP Analysis (Health Policy) – The process of comparing current performance with desired outcomes to identify deficiencies. Related terms: needs assessment, strategic planning. Example: A GAP analysis may reveal that a state's Medicaid program lacks sufficient dental coverage.

Global Budget – A fixed total expenditure set for a health-care organization or system for a defined period. Related terms: population-based payment, cost containment. Example: A hospital system operating under a global budget must allocate resources efficiently to stay within the cap.

Group Health Plan – An insurance arrangement that provides coverage to a defined group, typically employees of an organization. Related terms: employer-sponsored insurance, benefit administration. Example: A union-negotiated group health plan may include extended mental-health benefits.

Health Equity – The pursuit of the highest possible standard of health for all people, valuing fairness and justice. Related terms: disparities, social determinants of health. Example: Policies that expand Medicaid eligibility aim to promote health equity.

Health Information Exchange (HIE) – The electronic movement of health-care information among organizations according to nationally recognized standards. Related terms: interoperability, clinical data sharing. Example: An HIE enables an emergency department to view a patient's medication list from their primary-care EHR.

Health Literacy – The degree to which individuals can obtain, process, and understand basic health information to make appropriate decisions. Related terms: patient education, communication barriers. Example: Simplified discharge instructions improve adherence among patients with limited health literacy.

Health Maintenance Organization (HMO) – A managed-care organization that provides health services

through a network of providers for a fixed prepaid fee. Related terms: managed care, gatekeeper. Example: HMO members typically need a primary-care physician referral to see a specialist.

Health Outcome Measures – Quantitative indicators that reflect the impact of health-care services on patients (e.G., Mortality, readmission rates). Related terms: quality metrics, performance indicators. Example: 30-Day readmission rate for heart failure is a common outcome measure.

Health Policy – Decisions, plans, and actions undertaken to achieve specific health care goals within a society. Related terms: legislation, regulatory framework. Example: A state's policy to expand Medicaid eligibility influences insurance coverage rates.

Health Savings Account (HSA) – A tax-advantaged account that individuals with high-deductible health plans can use to pay qualified medical expenses. Related terms: CDHP, tax benefits. Example: Contributions to an HSA are tax-deductible, and unused funds roll over year to year.

Health System – The organization of people, institutions, and resources delivering health-care services to meet the health needs of a population. Related terms: integrated delivery network, public health infrastructure. Example: A regional health system may include acute hospitals, primary-care clinics, and a health-plan subsidiary.

Health Technology Assessment (HTA) – Systematic evaluation of the properties, effects, and impacts of health technology, informing policy and reimbursement. Related terms: evidence synthesis, cost-effectiveness. Example: HTA may determine whether a new oncology drug provides sufficient benefit to justify its price.

Health-Care Quality Improvement (QI) – Systematic, data-driven activities designed to improve the safety, effectiveness, and patient experience of care. Related terms: continuous quality improvement, plan-do-study-act (PDSA). Example: Reducing central-line associated bloodstream infections through a QI bundle.

HIPAA (Health Insurance Portability and Accountability Act) – Federal law governing the privacy and security of protected health information, and establishing standards for electronic health transactions. Related terms: privacy rule, security rule. Example: Organizations must conduct a risk analysis to comply with HIPAA's security requirements.

Hospital Acquired Condition (HAC) – An undesirable condition that develops during a hospital stay, such as pressure ulcers or catheter-associated infections. Related terms: patient safety, quality metrics. Example: Medicare reduces payments for hospitals with high rates of HACs.

Hospital Readmissions Reduction Program (HRRP) – A Medicare value-based program that penalizes hospitals with excess 30-day readmissions for certain conditions. Related terms: quality incentives, performance penalties. Example: Reducing readmissions for heart failure can improve a hospital's reimbursement.

Hospital Service Area (HSA) – A geographic region defined by the Medicare program based on where

patients receive inpatient services. Related terms: service market, geographic analysis. Example: HSA data help planners assess hospital capacity needs.

Hospital-Based Outpatient Department (HOPD) – Services provided in a hospital setting but billed under outpatient claims. Related terms: outpatient services, facility fees. Example: An HOPD may deliver same-day surgery without admission.

Human Capital – The economic value of a workforce's skill, knowledge, and health. Related terms: workforce development, productivity. Example: Investing in staff training enhances human capital and can improve patient outcomes.

ICD-10-CM (International Classification of Diseases, 10th Revision, Clinical Modification) – The U.S. Diagnostic coding system used for morbidity reporting and billing. Related terms: coding compliance, DRG. Example: Accurate ICD-10-CM coding is essential for appropriate reimbursement.

ICD-10-PCS (Procedure Coding System) – The U.S. System for coding inpatient procedures. Related terms: procedure coding, billing. Example: A coronary artery bypass graft is represented by a specific ICD-10-PCS code.

Informed Consent – A process whereby a patient voluntarily agrees to a proposed medical intervention after receiving adequate information. Related terms: patient autonomy, ethical disclosure. Example: Consent forms must explain risks, benefits, and alternatives.

Integrated Delivery Network (IDN) – A system of health-care facilities and providers that offers a continuum of services under a unified management structure. Related terms: vertical integration, network alignment. Example: An IDN may own hospitals, physician groups, and a health-plan subsidiary.

Interoperability – The ability of different information technology systems and software applications to communicate, exchange data, and use the information that has been exchanged. Related terms: FHIR, standardized vocabularies. Example: Interoperability enables a primary-care EHR to pull lab results from an external reference laboratory.

International Classification of Functioning, Disability and Health (ICF) – A WHO framework for describing health and health-related states, focusing on functioning and disability. Related terms: functional status, rehabilitation outcomes. Example: ICF codes can be used to document a patient's mobility limitations.

International Health Regulations (IHR) – Legally binding framework for global public-health security, requiring countries to detect, assess, and report public-health events. Related terms: pandemic preparedness, WHO. Example: IHR guided the international response to the COVID-19 outbreak.

Investment in Population Health – Allocation of resources toward preventive, community-based, and chronic-disease management initiatives that improve health outcomes across a defined group. Related terms: value-based care, risk-adjusted contracts. Example: Funding a community walking program can reduce hypertension prevalence, lowering overall health-care costs.

Joint Commission Accreditation – A national accreditation body that evaluates health-care organizations for

compliance with performance standards. Related terms: quality standards, survey. Example: Maintaining Joint Commission accreditation is often required for Medicare reimbursement.

Key Performance Indicator (KPI) – A measurable value that demonstrates how effectively an organization is achieving key objectives. Related terms: metrics, benchmarking. Example: Average length of stay is a KPI for hospital operational efficiency.

Kaiser Family Foundation (KFF) – A non-partisan organization that provides health-policy analysis, polling, and data. Related terms: research institute, policy briefs. Example: KFF's reports on Medicaid enrollment trends inform state policy decisions.

Laboratory Developed Test (LDT) – An in-house diagnostic test designed, manufactured, and used within a single laboratory. Related terms: regulatory oversight, CLIA. Example: Some genetic panels are offered as LDTs pending FDA clearance.

Learning Health System – A system that continuously and systematically captures data from routine care to generate knowledge that informs practice improvement. Related terms: real-world evidence, feedback loops. Example: A learning health system may use EHR data to identify best practices for sepsis management.

Levy (Health Care) – A tax imposed by a government to fund health-care programs, such as a payroll tax for Medicaid. Related terms: financing mechanism, public funding. Example: Some states levy a health-care surcharge on tobacco sales to fund tobacco-cessation programs.

Life-Cycle Costing – An economic analysis that considers all costs associated with a health-care asset or intervention over its entire lifespan. Related terms: total cost of ownership, budget impact. Example: Life-cycle costing of an MRI machine includes purchase price, maintenance, staffing, and depreciation.

Limited-Purpose Health Plan – A plan that provides coverage for a narrow set of services, often used for specific populations like students. Related terms: student health insurance, benefit carve-out. Example: A university may offer a limited-purpose plan that covers only on-campus urgent care.

Managed Care Organization (MCO) – An entity that provides or arranges for the provision of health services and seeks to control costs through contracts with providers. Related terms: HMO, PPO. Example: An MCO may negotiate bundled rates with hospitals for joint replacement episodes.

Medicaid – A joint federal-state program that provides health coverage to low-income individuals and families. Related terms: means-tested eligibility, state plan. Example: Medicaid expansion under the ACA extended eligibility to adults earning up to 138 % of the federal poverty level.

Medicaid Waiver – A state-requested deviation from standard Medicaid rules to test innovative delivery or financing models. Related terms: Section 1115, demonstration project.