

GLOSSARY

A glossary of terms is included below in order to promote a better understanding of the Provider Network Manual and the service delivery processes that will be required. If there are additional terms or definitions that would be helpful, please contact Northern Affiliation.

Adjudication: Processing claims according to contract.

Access Center: Mechanism established to conduct initial screening, eligibility verification and direct consumers to approved providers. The Access Center is the first component of the utilization review function and authorizes the services. The Access Center is the central hub of communication with both consumers and providers.

Admissions per 1,000: Number of people admitted to a particular service per 1,000 members. An indicator calculated by taking the number admissions from a specific group, for a specific period of time, dividing it by the average number of covered members in that group during the same period, and multiplying the result by 1,000.

Any willing provider: Plans to contract with all health care providers that meet established terms and conditions.

Assessment Method: A process for collecting and evaluating data in determination of either a performance standard or a performance measure.

Audit of Treatment or Charges: a qualitative or quantitative review of services rendered or proposed by a health provider. The review can be carried out in a number of ways: a comparison of clinical records and claims form information, consumer questionnaires, a review of hospital and practitioner records, or a pre- or post-treatment clinical examination of the service recipient. Some audits may involve fee verification.

Beneficiary (Also eligible; enrollee; member): Individual who is either using or eligible to use public mental health benefits in Michigan, including health insurance benefits, under an insurance contract.

Billed Claims: Fees submitted by comprehensive providers and providers for services rendered to a covered person.

Board Certified (Boarded, Diplomate): Describes a physician who has passed a written and oral examination given by a medical specialty board and who has been certified as a specialist in that area.

Board Eligible: Describes a physician who is eligible to take the specialty board examination by virtue being graduated from an approved medical school, completing a specific type and length of training, and practicing for a specified amount of time.

CAC: Certified Addiction Counselor

Claims Review: The method by which an enrollee's health care service claims are reviewed prior to reimbursement. The purpose is to validate the medical necessity of the provided services and to be sure the cost of service is not excessive.

Clinical Data Repository: That component of a computer-based patient record (CPR) which accepts, files, and stores clinical data over time from a variety of supplemental treatment and intervention systems for such purposes as practice guidelines, outcomes management, and clinical research. May also be called a data warehouse.

Clinical Pathways: A "map" of preferred treatment/intervention activities. Outlines the types of information needed to make decisions, the timelines for applying that information, and what action needs to be taken by whom. Provides a way to monitor care "in real time."

Centers for Medicare and Medicaid Services (CMS): The federal government agency with the Department of Health and Human Services, which directs and oversees the Medicare and Medicaid programs and conducts research to support those programs.

Clinical Practice Guidelines: Protocols or statements adopted by the Northern Affiliation as to the procedures appropriate for clinicians to employ in making a diagnosis and treating it. The goal of guidelines is to make decision-making more uniform, reduce inappropriate and unnecessary care.

Coding: A mechanism for identifying and defining provider services. Coding provides universal definition and recognition of diagnoses, procedures and level of care. Lack of consistency of documentation can earmark a record as "up-coded" which is considered fraud.

Community Based Services: Habilitative and rehabilitative services designed to teach people with disabilities skills in everyday, community-based settings as opposed to special facility-based environments.

Compliance: Accurately following the government's rules on Medicaid billing system requirements and other regulations. A compliance program is a self-monitoring system of checks and balances to ensure that an organization consistently complies with applicable laws relating to its business activities.

Comprehensive Provider: Comprehensive providers are CMHSPs that contract directly with the Northern Affiliation. These organizations have a longstanding history of managing local service delivery, are accredited, have Michigan Department of Community Health certified recipient rights programs and either directly provide or contract with a variety of sub-contracted providers.

Concurrent Review: A method of reviewing care to validate the necessity of current care and to explore alternatives to more restrictive or expensive care. Affiliation staff does the review of a procedure or hospital admission during the same time frame that the care is provided.

Conditions of Participation: Standards a facility or supplier of services, desiring to participate in the Northern Affiliation is required to meet. These conditions include meeting statutory definition of the particular organization, conforming to federal, state and local laws and having an acceptable utilization review plan.

Consumer Self-Report Data: Data collected through survey or focus group.

Continued Stay Review: Review conducted by an internal or external auditor to determine if the current place of service is still the most appropriate to provide the level of care required by the person.

Continuity of Care: The degree to which the care of a person from the onset of illness is continuous and without interruption.

Continuum of Care: A range of medical, nursing treatments and social services in a variety of settings that provides services most appropriate to the level of care required.

Contract Year: A period of twelve (12) months, commencing with each anniversary date; usually consistent with the fiscal year.

Contract: A legal agreement between a payer and a subscribing group or individual which specifies rates, performance covenants, the relationship among the parties, schedule of benefits, and other pertinent conditions. The contract usually is limited to a 12-month period and is subject to renewal thereafter.

Coordination of Benefits: A process wherein if an individual has two group health plans, the amount payable is divided between the plans so that the combined coverage amounts to, but does not exceed, 100 percent of the total.

Cost Effectiveness: The efficacy of a program in achieving given intervention outcomes in relation to the program costs. Follow-up studies, outcome studies and quality programs attempt to assess treatment efficacy, while cost effectiveness would provide a ratio of this measurement with costs.

Cost-benefit analysis: An analytic method in which a program's cost is compared to the program's benefits for a period of time, expressed in dollars as an aid in determining the best investment of resources. Cost-benefit analysis can also be applied to specific medical tests and treatments.

Credentialing: The process of determining eligibility for clinical staff membership, and privileges to be granted to physicians. Credentials and performance are periodically

reviewed, which could result in a provider's privileges being denied, modified, or withdrawn.

D.O.: Doctor of Osteopathy is generally similar to an M.D. but have additional training in physical manipulation techniques somewhat similar to chiropractic.

D.S.W.: Doctor of Social Work is an advanced social work degree.

Days per Thousand (per 1,000): A measurement of the number of days of hospital care used in a year per 1,000 members.

Decision Support Systems: Computer technologies, which allow the Northern Affiliation to collect and analyze data in more sophisticated, and complex ways. Activities supported include case mix, budgeting, cost accounting, clinical protocols and pathways, outcomes, and actuarial analysis.

De-institutionalization: Policy that calls for the provision of supportive care, medical and social services and treatment in the community rather than in an institutional setting.

Department of Health and Human Services (HHS): The federal agency that oversees Medicare, Medicaid and other federal health care programs.

Department of Justice: The federal agency that enforces the law and handles criminal investigations. As the nation's largest law firm, the DOJ protects citizens through effective law enforcement, crime prevention and crime detection. It is the agency that prosecutes those in the health care system guilty of proven "fraudulent" activity.

Desk Audit: The Northern Affiliation will periodically request that copies of relevant materials be submitted for review.

Developmental Disability. Means either of the following: (a) If applied to an individual older than 5 years, a severe, chronic condition that meets all of the following requirements (i) is attributable to a mental or physical impairment or a combination of mental and physical impairments, (ii) Is manifested before the individual is 22 years old, (iii) Is likely to continue indefinitely, (iv) Results in substantial limitations in 3 or more of the following major life activities (A) Self-care, (B) Receptive and expressive language, (C) Learning, (D) Mobility, (E) Self-direction, (F) Capacity for independent living, (G) Economic self-sufficiency, (v) Reflects the individual's need for a combination and sequence of special, interdisciplinary, or generic care, treatment, or other services that are of lifelong or extended duration and are individually planned and coordinated. (b) If applied to a minor from birth to age 5, a substantial developmental delay or a specific congenital or acquired condition with a high probability of resulting in developmental disability as defined in subdivision (a) if services are not provided.

Discharge Planning: Procedures wherein aftercare services are determined for after discharge from the inpatient or outpatient service.

Dual Eligible: A Medicare beneficiary who also receives the full range of Medicaid benefits.

Early and Periodic Screening, Diagnosis, and Treatment (EPSDT): EPSDT program covers screening and diagnostic services to determine physical or mental health needs to recipients under age 21, as well as health care and other measures to correct or ameliorate chronic conditions.

Ed.D.: Doctor of Education

Electronic Claim: A digital representation of a medical bill generated by a provider or the provider's billing agent for submission using telecommunications to the Northern Affiliation.

Electronic Data Interchange (EDI): The automated exchange of data and documents in a standardized format. Some common uses of this technology include claims submission and payment, eligibility, and referral authorization.

Emergency Situation: Means a situation in which an individual experiences a serious mental illness or development disability, or a child is experiencing a serious emotional disturbance, and one of the following applies: (a) the individual can reasonably be expected within the near future to physically injure himself, herself, or another individual, either intentionally or unintentionally.

Encounter Data: Data relating to treatment or service rendered by a provider to a patient, regardless of whether the provider was reimbursed on a capitated or fee-for-service basis.

Encounter: A single unit of service. There may be a variety of services performed at an encounter.

Enrollee: Synonymous with member, a person eligible to receive or receiving, public mental health or substance abuse benefits.

Enrollment Area: The geographic area within a designated radius of the Northern Affiliation including Alcona, Alpena, Antrim, Charlevoix, Cheboygan, Emmet, Iosco, Kalkaska, Montmorency, Ogemaw, Oscoda, Otsego and Presque Isle Counties.

EQRO: Federal law and regulations require states to use an External Quality Review Organization to review the care provided by capitated managed care entities.

Exclusions: Conditions or situations not considered covered under contract or plan.

F.A.C.P.: is a Fellow, American College of Physicians

Focused Studies: State required studies that examine a specific aspect of care for a defined point in time. For example, the MDCH required QAPIP study on natural supports.

Fraud: Misrepresentations that can result in criminal prosecution, civil liability and administrative sanctions.

Freedom of Choice: A principle of Medicaid, which allows a recipient the freedom to choose among participating Medicaid providers.

Grievance Procedures: The process by which a member can air complaints and seek remedies.

Group Home: Residence, which offers housing and personal care services for 3 to 16 residents. Owner or manager usually provides services.

Health Insurance Portability and Accountability Act (HIPAA): Federal health insurance legislation passed in 1996, which sets standards for access, portability, and renewability that apply to group coverage-both fully insured and self-funded-as well as to individual coverage.

Health: the state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity. Health has many dimensions and is largely culturally defined.

Hold Harmless Clause: A contractual clause whereby the affiliation and the provider hold each other not liable for malpractice or corporate malfeasance if either of the parties is found liable.

Home and Community-based waivers: Permits states to offer, under a waiver, a wide array of home and community-based services that an individual may need to avoid institutionalization. Regulations to implement the act list the following services as community and home-based services which may be offered under the waiver program: case management, homemaker, home health aide, personal care, adult day health care, habilitation, respite care, and other services.

Horizontal Integration: Merging of two or more organizations at the same level of production in some formal, legal relationship.

Hospital Day: a term to describe any twenty-four hour period commencing at 12:00 a.m., used by the Northern Affiliation to determine a hospital day, during which a patient receives inpatient psychiatric services at the hospital.

Incurred But Not Reported: Refers to a financial accounting of all services that have been performed but, as a result of a short period of time, have not been paid. Estimates of costs for services provided for which a claim has not yet been reported. Refers to claims, which reflect services already delivered, but, for whatever reason, have not been reimbursed.

Incurred Claims: All claims with dates of service within a specified period

Joint Commission on the Accreditation of Healthcare Organizations (JCAHO): The accrediting organization of the Northern Affiliation. The Joint Commission usually surveys organizations once every 3 years, sending in a medical and administrative team to review policies, clinical records, professional credentialing procedures, governance, and quality improvement programs.

L.P.C.: Identifies a Licensed Professional Counselor

Level of Care Guidelines: The Northern Affiliation guidelines which describe the amount of service needed by consumers at various levels of disability, which may determine their eligibility for programs and services.

M.D.: Medical doctor

M.Ed.: Masters in Education

M.S or M.A: Masters of Science or Masters of Art

M.S.W.: Masters in Social Work is the traditional degree of social workers.

Managed Care: Systems and techniques used to control the use of health care services. Includes prospective, concurrent and retrospective review of medical necessity. The Northern Affiliation's body of clinical, financial and organizational activities designed to ensure the provision of appropriate behavioral health care services in a cost-effective manner.

Management Information System (MIS): Common term for the computer hardware and software that provides the support for managing the plan.

Mandated Benefits: Benefits that health plans are required by law to provide.

MCO/PHP Standards: These are standards that states set for plan structure, operations, and the internal quality improvement/assurance system that each MCO/PHP must have in order to participate in the Medicaid program.

Medicaid (Title XIX): Government entitlement program for the poor who are blind, aged, disabled or members of families with dependent children (AFDC). Each state has its own standards for qualification. A federally aided, state-operated and administered program, which provides medical benefits for certain indigent or low-income persons in need of health and medical care. Title XIX of the Social Security Act authorizes the program.

Medically Necessary: A determination that a specific service is medically (clinically) appropriate, necessary to meet the person's mental health needs, consistent with the

person's diagnosis, symptomatology, and functional impairments, is the most cost-effective option in the least restrictive environment, and is consistent with clinical standards of care.

Member Services: These are the services provided by the Northern Affiliation to assist members in using their public mental health services, requesting information or registering complaints.

Member: A person eligible to receive, or receiving, benefits from the Northern Affiliation. Includes both those who are receiving services and those who are eligible to receive public mental health services.

Member Feedback: The process for monitoring complaints and soliciting member feedback through satisfaction surveys, focus groups or interviews.

Monitoring Standards: Activities related to the monitoring of standards that have been set for structure, operations, and quality improvement/assurance to determine that standards have been established, implemented, adhered to, etc.

National Practitioner Data Bank: A computerized data bank maintained by the federal government that contains information on physicians against whom malpractice claims have been paid or certain disciplinary actions have been taken. The Northern Affiliation requires provider organizations to utilize NPDB prior to credentialing physicians in their facilities.

Network: An affiliation of providers through formal contracts and agreements. The Northern Affiliation provider network includes both comprehensive providers and providers who deliver a full range of behavioral health care services to the members.

Non-Participating Provider or Out-of-Network Provider: a provider that does not sign a contract to participate in a health plan. This refers to providers who are therefore not obligated to accept assignment on all Northern Affiliation claims. If a beneficiary receives services from an out of network provider, the Northern Affiliation will pay for the service at a reduced rate or will not pay at all.

Office of Inspector General (OIG): The office responsible for auditing, evaluating, and criminal and civil investigating for the Department of Health and Human Services, as well as imposing sanctions, when necessary, against health care providers.

On-Site Reviews: Reviews performed on-site at provider organizations by the Northern Affiliation to assess the physical resources, operational practices, policies and procedures in place to deliver and document the provision of public mental health services. On-site reviews may include clinical record review, staff or consumer interviews.

Operations Committee: Committee of the Northern Affiliation composed of affiliation staff and representatives of Comprehensive Provider organizations.

Organized Delivery System: A network of organizations that provide a coordinated continuum of services to a defined population and is held clinically and fiscally accountable for the outcomes and health status of the population being served.

Outcome: A functional or clinical outcome is the result of intervention or nonintervention.

Outcomes Management: The structural and procedural methodology for managing care in a way that produces the best outcomes. The Northern Affiliation is increasingly interested in learning to manage the outcome of care rather than just managing the cost of care. It is thought through a database of outcomes and experiences, both managers and providers will know better which treatment modalities and support services result in consistently better outcomes for people being served.

Outcomes Measurement: System used to track functional and clinical treatments and supports as well as the responses to those treatments and supports.

Outcomes Research: Research on measures of change in outcomes over time including health status, functional status, quality of life and satisfaction, resulting from specific interventions and supports. Attributing changes in outcomes to the care and services received requires distinguishing the effects of care from the effects of the many other factors that influence peoples' health, quality of life and satisfaction. Outcomes research will also be used by the Northern Affiliation to identify potential partners on the basis of good outcomes.

Partners in Care (PIC): The name of the Northern Affiliation's consumer council. The PIC reviews policy and procedures, provides input on quality improvement studies, and recommends components of procedures that are important to beneficiaries and their families.

Primary care physician (also referred to as PCP): The physician who provides primary health care services to a beneficiary and whose services must be communicated and coordinated with the provision of behavioral health care services. Predominantly primary care physicians include general or family practitioners.

Periodic Reports: Report submissions made by the provider to the Northern Affiliation on a specifically defined schedule and frequency.

Person Centered Planning (also referred to as PCP): Means a process for planning and supporting the individual receiving services that builds upon the individual's capacity to engage in activities that promote community life and that honors the individual's preferences, choices, and abilities. The person-centered planning process involves families, friends, and professionals as the individual desires or requires.

Peer Review: The mechanism used by the affiliation work with staff representatives of comprehensive providers to evaluate the quality of total health care managed by the Northern Affiliation. The evaluation is ongoing and covers how well services are performed and how appropriate the services are to meet the persons identified needs.

Per Diem Cost: Cost per day; hospital or other institutional cost for a day of care.

Per Eligible Per Month (PEPM): Generally used by the Northern Affiliation and comprehensive providers as an indicator of revenue, expenses, or utilization of services per eligible member per one-month period.

Performance Measures: Specific quantitative or qualitative measures of care and services delivered to service recipients or the end result of that care and services. Performance measures are used to assess other aspects of an individual or organization's performance such as access and availability of care, utilization of care, health plan stability, beneficiary characteristics, and other structural and operational aspects of behavioral health care services.

Performance Standards: Standards of performance also called compliance measures set by the State of Michigan or Northern Affiliation, which comprehensive providers will need to meet in order to maintain its organizational credentialing, renew its contract or avoid penalty. The standards include measures of access, quality and efficiency of care delivered per time period.

Ph.D.: A Doctor of Philosophy is qualified to teach at a college or university.

Pre-Admission Screening: Review of "need" for inpatient care or other care before admission. This refers to a decision made by the comprehensive provider or Northern Affiliation prior to admission. The authorizing agent determines whether or not the Northern Affiliation will pay for the service. This is a method of controlling and monitoring utilization by evaluating the need for service prior to the service being rendered.

Provider Profiling: Aggregation, review and analysis of profiles to identify and assess patterns of behavioral health care services across affiliation partners. Expressing a pattern of practice as a rate such as a measure of utilization or outcome aggregated over time for a defined population or geographic region. This is used to compare practice patterns of comprehensive providers and other providers.

Prospective Review: A method of reviewing possible service delivery prior to admission, to determine necessity, alternatives, and estimated reasonable length of stay.

Protocol: Description of course of treatment or established practice pattern.

Provider Data: Data collected through survey or focus group of comprehensive providers and other providers who participate in the Northern Affiliation and have provided services to enrolled Medicaid beneficiaries.

Provider: Refers to a mental health, developmental disability or substance abuse provider (individual or organization) who contracts directly with the Northern Affiliation to provide direct service to an eligible member.

Psy.D.: Doctor of Psychology. A clinical psychology degree, which places more emphasis on practice than research.

Quality Assurance: Activities and programs intended to assure the quality of care in a defined setting. Such programs include peer or utilization review components to identify and remedy deficiencies in quality. The program must have a mechanism for assessing its effectiveness and may measure care against pre-established standards.

Quality Assessment Performance Improvement Project (QAPIP): Projects that examine and seek to achieve demonstrable sustained improvement in major areas of clinical and non-clinical services according to the standards defined in the Quality Improvement Systems in Managed Care (QISMC) regulations.

Quality Improvement: This is the more commonly used term in healthcare, replacing QA. QI implies that concurrent systems are used to continuously improve quality, rather than reacting when certain baseline statistical thresholds are crossed. Quality improvement programs use tools such as cross-functional teams, task forces, statistical studies, flow charts, process charts, and Pareto charts.

Quality Oversight Committee: The Northern Affiliation committee that includes consumer representatives and disciplinary members of comprehensive provider organizations in the ongoing coordination and management of the monitoring and evaluation activities of the Northern Affiliation.

Quality Management: A formal set of activities to assure the quality of services provided. Quality management includes quality assessment and corrective actions taken to remedy any deficiencies identified through the assessment process.

Quality: A measure of the degree to which delivered behavioral health care services meet established professional standards and judgments of value to the consumer. May also be seen as the degree to which actions taken or not taken to maximize the probability of beneficial clinical and functional outcomes and minimize risk and other adverse outcomes, given the existing state of behavioral health technology. Quality is described as having three dimensions: quality of input resources, quality of the process of services delivery, and quality of outcome of service use.

Referral Authorization: A verbal or written approval of a request for a member to receive behavioral health services outside of the participating Northern Affiliation providership.

Referral: The process of sending a consumer from one practitioner to another for health or behavioral health care services.

Retrospective Review Process: System for analyzing medical necessity and appropriateness of services rendered; a review that is conducted after services are provided to the member. The review focuses on determining the appropriateness, necessity, and reasonableness of behavioral health care services provided.

Risk: Potential threats associated with fiscal and clinical management of services. Various categories of direct risk include morbidity, demand, utilization, Beta, and price risk; indirect types of risk include regulatory, insurance, liability, contract, infrastructure and professional risk.

Risk Management: Acknowledgment of the existence of risk and specific processes designed to minimize the impact of actual and potential source of risk.

Risk Pool: A pool of money that is at risk for being used for defined expenses.

Sanction: Reprimand of a provider by a health plan.

Sentinel Event: An unexpected occurrence involving the death or serious physical or psychological injury or risk thereof. Serious injury specifically includes loss of limb or function. The phrase, 'or risk thereof' includes any process variation for which a reoccurrence would carry a significant chance of serious adverse outcome.

Serious Emotional Disturbance: Means a diagnosable mental, behavioral, or emotional disorder affecting a minor that exists or has existed during the past year for a period of time sufficient to meet diagnostic criteria specified in the most recent diagnostic and statistical manual of mental disorders published by the American psychiatric association and approved by the department that has resulted in functional impairment that substantially interferes with or limits the minor's role or functions in family, school, or community activities. The following disorders are included only if they occur in conjunction with another diagnosable serious emotional disturbance: (a) A substance abuse disorder, (b) a developmental disorder, (c) "V" codes in the diagnostic and statistical manual of mental disorders.

Serious Mental Illness: Means a diagnosable mental, behavioral, or emotional disorder affecting an adult that exists or has existed within the past year for a period of time sufficient to meet diagnostic criteria specified in the most recent diagnostic and statistical manual of mental disorders published by the American psychiatric association and approved by the department and that has resulted in functional impairment that substantially interferes with or limits 1 or more major life activities. Serious mental

illness includes dementia with delusions, dementia with depressed mood, and dementia with behavioral disturbance but does not include any other dementia unless the dementia occurs in conjunction with another diagnosable serious mental illness. The following disorders also are included only if they occur in conjunction with another diagnosable serious mental illness: (a) A substance abuse disorder, (b) a developmental disorder, (c) a “V” code in the diagnostic and statistical manual of mental disorders.

Severity of Illness: A risk prediction system to correlate the seriousness of a disease in a particular patient with the statistically expected outcome.

Standing Referral: A referral to a specialist provider that covers routine visits to that provider. It is common practice to permit the access center to make referrals for only a limited number of visits. In cases where the medical condition requires regular visits to a specialist, this type of referral eliminates the need to return to the access center each time the initial referral expires.

Sub-Contracted Provider: A behavioral health care provider under contract with a comprehensive provider to provide direct services to Northern Affiliation members. Sub-contracted provider contracts are managed by comprehensive providers as described in the Northern Affiliation Delegation unified procedure.

Transition Services: Means a coordinated set of activities for a special education student designed within an outcome-oriented process that promotes movement from school to post-school activities, including post-secondary education, vocational training, integrated employment including supported employment, continuing and adult education, adult services, independent living, or community participation.

Termination Date: Date that a contract expires or an individual is no longer eligible for benefits.

Treatment Episode: The period of treatment between admission and discharge from a modality or the period of time between the first procedure and last procedure on an outpatient basis for a given diagnosis.

Trending: Methods of estimating future costs of health services by reviewing past trends in cost and utilization of these services.

Triage: Triage is the act of categorizing consumer need according to acuity and by determining which will receive services first; the classification of people by severity of condition.

Urgent Situation: Means a situation in which an individual is determined to be at risk of experiencing an emergency situation in the near future if he or she does not receive care, treatment, or support services.

Utilization Management: Evaluation of the necessity, appropriateness, and efficiency of the use of behavioral health care services, procedures, and facilities.

Utilization Review: Evaluation of the necessity, appropriateness, and efficiency of the use of medical services and facilities. Helps insure proper use of health care resources by providing for the regular review of such area as admissions, length of stay, services performed and referrals.

Wellness: A dynamic state of physical, mental, and social well-being; a way of life which equips the individual to realize the full potential of his/her capabilities and to overcome and compensate for weaknesses; a lifestyle which recognizes the importance of nutrition, physical fitness, stress reduction, and self-responsibility.

Withhold: The portion of monthly capitation payment withheld until the end of the year or their time period to create an incentive for efficient care. The withhold is at risk; i.e., if the provider exceeds utilization norms, he does not receive it. It serves as a financial incentive for lower utilization.

