Making Smart Referrals

This tool helps the care coordinator (CC) and providers understand how to make appropriate referrals for specialty health care or community resources for patients in a community-based care coordination (CCC) program to obtain the highest quality care at the lowest cost, thus increasing the opportunity for shared savings and reduced risk.

Time needed: 1 hour

Suggested other tools: Quality Scores Monitoring and Reporting; CCC Program Evaluation; Physician Engagement; Provider Resource Directory; Community Resource Directory

Table of Contents

How to Use

1. **Review** the concept of referral management and how that is changing within the context of health reform initiatives.

2. **Discuss** how making smart referrals to reduce risk can be achieved in a CCC program environment.

Traditional Referral Management

Referral management has typically been a process by which primary care physicians (PCPs) determine if they need to refer a patient either to a specialist or for services to be performed outside the PCP's office (such as diagnostic tests, outpatient surgery, home health care, etc.). If a referral is necessary, the PCP also needs to decide to whom the referral is made, for how long, and for what services.

Many physician practices have developed or used managed care company referral guidelines for common diagnoses that describe the tests, therapies, and/or treatments a PCP should perform prior to making a referral. This helps manage situations in which patients may be referred unnecessarily, or in which patients may be referred without the pre-referral steps necessary for the specialist to be reimbursed for providing the service.

Another issue in referral management is the need to track that the patient actually was seen by the specialist, that all intended services were provided, and that information about follow-up care, medication reconciliation, and other post-referral care delivery aspects are provided to the PCP by the specialist.

Referral management often includes obtaining a referral authorization from an insurance company, especially when the specialist may not be in the same network or different insurers may be involved. This situation has commonly been referred to as a "narrow network." The result has become a highly complex, time-consuming, and paper-based process that physicians themselves must engage in heavily. The PCP needs to decide on the number of visits to have authorized and identify the services to be performed, often when this information is not yet known because the patient has yet to be seen by the specialist. This results in additional paperwork when the information does become available.

From the patient's perspective, referrals are often delayed as a result of these issues. Also, referrals may not be made (or requested, but denied) without the patient fully understanding that it is not the fault of either provider but by circumstances created by the insurance companies. In such cases, the non-referral may result in delayed treatment or complications of a health condition, which may reduce the patient's quality of life and add to the cost of care.

Referral Management in Health Reform

With a focus on health reform, "high-value" provider networks (also called "value-based" provider networks) are emerging. Such networks are part of a larger effort to redesign insurance benefits by creating financial incentives to encourage the utilization of higher-value treatments and services, such as evidence-based preventive care, lower utilization of unnecessary treatments and services, and adherence to referral guidelines both in pre-referral services and post-referral information exchange.

In constructing high-value networks, evidence-based measures of provider performance, such as those endorsed by the National Quality Forum (NQF), are used. Health plans and employers can create networks comprised of providers (both PCP and specialists) and facilities (hospitals, nursing homes, home health agencies, rehab facilities, etc.) that score well on measures of efficiency and quality. Measures tend to focus on cardiovascular conditions, diabetes, preventive

services, and patient safety, which are also areas of focus for many accountable care organizations (ACOs), patient-centered medical homes, and other pay-for-performance initiatives. Evidence has begun to demonstrate the benefits of high-value provider networks, with savings ranging from 7% to 25%.[1]

Implementing Use of a High-Value Provider Network

CCC programs should take a critical look at high-value provider network opportunities in their communities. If not yet in place, major health plans and employers may be lobbied to support such a network. Although already existing in certain communities, federal regulations are being created to address characteristics that need to be included (*see below*), as well as how to make a high-value network work in an environment with Stark Law, Anti-Kickback Statutes, medical liability, and other regulatory issues.

A high-value provider network should include:

- A *defined population to manage*, which should be consistent with the CCC program's provider resource directory. Federal regulation is proposing that high-value provider networks (which they continue to refer to as narrow networks) include a certain percentage of community safety net and essential providers.

- An *IT infrastructure* capable of population health management that both providers and health plans could tap to manage risk. CCC programs are starting to utilize such technology in order to stratify their patient population.

- An *incentive-based payment model*. Many CCC programs get their start when agreeing to form an ACO under the Medicare Shared Savings Program or through other federal or commercial payer initiative.

- *Provider-health plan alignment* where both stakeholders ensure effective care and risk management.

- *Consumer choice* and *transparency*.

Although having a formal, high-value provider network already in place makes use of the 'smart referral' approach easier, individual providers can be aware of the value and characteristics of the network by using existing quality measurement data to identify providers and facilities they believe afford the most value. The CCC program can then include those providers and facilities in their list of provider resources. (See *Provider Resource Directory.*) This encourages providers to seek legal counsel, continuously monitor fair market value (to avoid Stark and Anti-Kickback issues), receive guidance from content experts on a regular basis, and evaluate the network's effectiveness in light of the CCC program's goals.[2]

References

[1] America's Health Insurance Plans (2013). Issue Brief: High-Value Provider Networks. Available at: http://www.ahipcoverage.com/2013/12/04/high-performance-provider-networks-ensuring-affordable-high-value-health-care/

[2] Pawlak, V. and M. Fadel (2012). "Narrow Networks Help Create Value in a More Regulated Health care Landscape," Becker's Hospital Review. Available at: http://www.beckershospitalreview.com/leadership-management/narrow-networks-help-create-value-in-a-more-regulated-health care-landscape.html

Key Health Alliance
Regional Extension
Assistance Center for HIT

StratisHealth