Inpatient Hospital Review Program (IHRP) 2.0: Initial Joint Operating Committee (JOC)
December 5, 2022

Presenters: Dr. Peter Walsh, Chief Medical Officer
Katie Denney, UM Program Supervisor
Chantal Hunt, Executive Director Colorado UM, Kepro

Participants:

Stakeholders	Department	Kepro
Albert (Tra) Trabert	Diva Wood	Aimee Mosher-Lehmann
Brent Rikhoff	Elizabeth Romero	Amy Brintzinghoffer
Brittany Bear	Erik Holt	Ashley Walley
(Raj) Chaudhuri	Gretchen Deruiter	Chantal Hunt
Eric Cibak	Jessica Short	
Dena Corry	Karen Hecker	
Desiree Baca	Katherine Denney	
Gail Abeyta	Katie Dobler	
Heather Corsentino	Michele Patarino	
Jessica Trujillo	Peter Walsh	
Jill Callahan	Raine Henry	
Kathleen Novotny		
Kim Cook		
Laurel Burns		
Laurel Chiaramonte		
Loni Clements		
Lily Sanford		
Megan Axelrod		
Meredith Kruse		
Michelle Carter		
Michelle Linder		
Stephanie Tuiafono		
Stephanie Warth		
Todd Grivetti		

Welcome/Introductions

Ms. Denney and Dr. Walsh welcomed participants.

Dr. Walsh will provide oversight to the re-implementation of the Inpatient Hospital Review Program. He explained that the previous iteration of this program impacted most admissions; the new one has a narrower focus on concurrent review and discharge planning processes for members with complex issues, making it a very different program. The Department's target go live date is April 3, 2023, after we complete significant testing and collaboration.

Ms. Denney mentioned that the meeting was being recorded and asked participants not to mention PHI.

Joint Operating Committee Purpose and Goals

Ms. Denney reviewed the purpose of the Inpatient Hospital Review Program (IHRP) Joint Operating Committee (JOC). The Joint Operating Committee is a recurring meeting that was established during the original launch of IHRP (IHRP 1.0). It is a forum with hospital providers, Department staff, and the Department's Utilization Management (UM) Vendor. Eventually we will explore including other partners and individuals to participate like the Regional Accountable Entities (RAEs) and Case Management Agencies (CMAs).

We are using this initial JOC meeting to introduce IHRP 2.0 to hospital leaders and set the stage for our relaunch. The mission and goal of JOC post go-live will be to discuss issues and concerns and answer questions in real time, and as much as possible identify issues before they become significant or large so we can collaborate to identify resolutions and workarounds and share best practices, processes and methods that are working well for our providers. We would like this to be a forum that helps all participants to leverage shared knowledge and achieve success in their teams and systems.

IHRP Background

The initial program implemented was based on direction in SB 18-266 Controlling Medicaid costs. It was suspended as of April 1, 2020. The Department evaluated results and feedback from IHRP 1.0 to redesign the program during our pandemic pause. Working with Kepro, our new UM vendor, we reviewed our data and industry best practices to develop a second-generation program. We also incorporated HTP goals. Our intention continues to be appropriate utilization and improved care coordination and quality of care, leveraging Kepro's enhanced experience and capabilities.

IHRP 2.0

In short, IHRP 2.0 is newer, better, and smarter.

Newer

Newer refers to our vendor, system, and program design. Ms. Hunt from Kepro reviewed Kepro's background, as illustrated in the table below.

PA/UM Scope Element	Florida AHCA	West Virginia DHHR	Illinois HFS	Virginia, DMAS	Maine DHHS	Mississippi DOM	South Carolina DHHS	Colorado HCPF	Minnesota DHS	Arkansas DHS	Alabama Medicaid	North Dakota DHS	Nebraska DHHS
Years of Service	30	22	20	16	15	15	10	10	7	3	2	2	2
Inpatient PA	■	■	■	■	■	■	■	■	■	■	■	■	■
Inpatient Concurrent Review	■	■	■		■	■	■		■	■			■
Surgery PA	■	■	■	■			■	■	■		■	■	■
Transplant PA	■	■	■	■			■	■	■		■	■	
Call Center Services	■	■	■	■	■	■	■	■	■	■	■	■	■
Quality Assurance	■	■	■	■	■	■	■	■	■	■	■	■	■
Data Transfer & File Maintenance	■	■	■	■	■	■	■	■	■	■	■	■	■
Reporting & Analytics	■	■	■	■	■	■	■	■	■	■	■	■	■
Stakeholder & Provider Engagement and Education	■	■	■	■	■	■	■	■	■	■	■	■	■

Kepro's UM and Care Management (CM) program footprint includes 34 State Medicaid contracts – including 16 UM contracts, more than three times the number of contracts held by the next largest UM vendor. Kepro performs 10 million utilization reviews annually. They bring three decades of UM and Quality Review experience. The organization is URAC accredited, a certified QIO and has QIO-like certification. Their provider friendly portal allows providers to submit requests 24-hours, 7 days a week, attach documentation, complete review specific forms, communicate electronically with Kepro staff (including the clinical reviewers), and manage and track requests for authorization.

During 2021 alone, the provider portal served over 27,000 enrolled providers, over 87,000 provider users and handled over 50,000 provider portal submissions monthly. The provider portal, Atrezzo, has proven to be a differentiator for Kepro, helping to drive a ninety-five percent (95%) customer satisfaction rate measured by annual provider surveys. The Atrezzo provider portal includes the ability for providers to:

- Submit requests for authorization
- Attach documents, faxes, or other forms to the request
- Complete review-specific forms ("Smart" forms)
- Review the results of the request
- Communicate electronically with Kepro staff (including the clinical reviewer)
- Manage and track requests for authorization

Kepro has already incorporated feedback from IHRP 1.0 into the Atrezzo system. Requests are more streamlined than in the prior system. Enhancements include:

- Search and sort function by PAR ID, client ID, client name (first and last), dates
- Streamlined ability to access denial reasons
- More person-specific and detailed denial reasons

Kepro has a dedicated provider relations and education team which has engaged with and assisted Colorado providers over the past year.

In response to a question, Ms. Hunt said that Kepro uses MCG, InterQual and state-defined criteria. The Department and Kepro will clarify specifics during training.

Better

The Department believes IHRP is better because it is a smaller, more focused and refined program. Ms. Denney reviewed a table comparing the original and new versions of IHRP:

IHRP 1.0	IHRP 2.0
All admissions except maternity and rehab (LTAC) required PAR	Small subset of admissions: Bariatric Surgeries, Back Surgeries, Organ Transplants, Aesthetic Surgeries, Transgender Surgeries, Hernia Repair *(Department will provide list)*
Concurrent review on every member still inpatient at Day 4	● Post-Admission Clinical Review on small subset on Day 6: Neonatal stays and specific diagnoses (sepsis, cellulitis, pulmonary edema and respiratory failure, thoracic and abdominal vascular procedures) *(Department will provide list)* ● Post-Admission Clinical Review on **all stays** at Day 30 and every 30 days thereafter. Focus on opportunities for care coordination/transitions of care
RAEs received all admissions and concurrent review data, but did not use information	Supplement ADT data for effective discharge planning/transitions of care including: 1. Connect member with primary care/other provider to give follow up support and prevent readmissions; also perform medication management 2. RAE engagement regarding discharge; coachable moment to address acute issues 3. RAE engagement regarding ongoing/chronic conditions while patient is still at hospital 4. RAE/HCPF engagement to move hard-to-place members from the hospital We have solicited input from RAEs on how to enhance this process and we are reviewing and utilizing their feedback and lessons learned regarding data-sharing opportunities between the Utilization Management Team and RAEs
	Department will use IHRP 2.0 data to inform other programs including Provider Integrity (PI), Quality of Care (QOC) and Recovery Audit Contractor (RAC)

The Department will provide a code list for prior authorization requests (PARs) and concurrent reviews. Concurrent review will not result in the denial of payment. Providers will be able to enter a concurrent review without a finalized inpatient PAR.

Smarter

A smarter IHRP focuses on enhanced data shared between the hospitals and the RAEs. The Department is already data sharing with the RAEs about PARs and determinations in other benefit areas and will use those processes to engage RAEs on transitions/discharge planning. In Kepro's system, providers will complete a survey on the concurrent reviews to assist with discharge planning and care coordination including asking questions about:

- Need for RAE coordination
- Who the RAE should contact
- Identified social determinants of health needs
- Identified comorbidities
- Identified barriers to discharge/transition
- Identified areas transition assistance needed

The Department utilized feedback from IHRP 1.0 regarding care coordination with the RAEs and discharge planning and will leverage Atrezzo's capabilities to assist with care coordination, effective transitions and discharge planning. We have aligned with HTP as well.

Timeline

- December 2022/January 2023- IHRP Provider Survey sent out
- January 2023- Regular Joint Operating Committee Meetings Begin
- February 2023- Training Sessions Begin
- Training schedule to be posted on ColoradoPAR Program website
- April 3, 2023: IHRP 2.0 Launches

Providers begin submitting PARs and concurrent reviews for dates of service on/after April 3, 2023.

Next Steps

Ms. Denney asked that participants continue to identify key staff to be involved with IHRP 2.0 by completing the stakeholder form or emailing hcpf_um@state.co.us. Who also asked for feedback, suggestions, and as the program begins, open dialogue about what works, what doesn't work, how we can improve the program and make it more efficient and effective. Finally, please ensure you are signed up for communication sent via Gainwell. Additional JOC meetings will be scheduled starting in January. Tentatively we are planning to begin weekly meetings on January 5 at 1pm (MT).

Questions/Discussion

1. Please clarify day 4 vs. day 6 concurrent reviews?

   IHRP 1.0 required concurrent review on Day 4. IHRP 2.0 will have concurrent review for a subset of members on Day 6.

2. Does IHRP decrease the need for RAC audits?

   The Department's UM Program works independently from the RACs but will share data.

3. Will frontend and backend criteria be the same?

   We anticipate using the same criteria for concurrent reviews and prior authorizations. However, please note that concurrent reviews won't be about approval or denial of claims. They will facilitate care coordination and transition planning.

4. Hospitals were told we would have six months to train/hire staff. Why has that been cut down to four months?

   The Department has communicated that IHRP would be restarting, and we have significantly scaled down the requirements from IHRP 1.0. We met with CHA in late September to start the dialogue with the hospitals and know that the start date was shared after that.

   We will work collaboratively to ensure that our timeline can be supported.

5. If I send a H&P is that all you need for the 6-day review?

   Concurrent reviews will include a questionnaire in Atrezzo. Again, the questions are aligned with HTP so we are not adding new data-gathering requirements for hospitals.

6. Is the Day 1 PAR tied to approval or denial? Can we still get a denial from RAC if PAR is approved?

   Yes; PARs do impact claims payment.

   We anticipate that as the RAC looks at whether an admission was appropriate, our PAR determination will be aligned. In the past, the RAC has not reviewed claims that had a PAR.

   But again, it is an independent program that covers two issues: (1) was the admission appropriate (same topic covered by PAR) and (2) was the LOS appropriate.

   We will coordinate with the appropriate Department staff to formulate a more specific answer on these issues.

7. What are the consequences of not completing the concurrent review?

   While we have acknowledged that concurrent reviews will not impact claims payment, we need your participation so we can evaluate the success of working with RAEs to improve the process for discharge. If that doesn't happen, we will evaluate our strategy. Failure to submit concurrent reviews by specific hospitals will be noted and addressed as needed.

8. Why would a hospital do a day 6 review if no needs are identified?

   We will include this question in our program evaluation and collaborate to ensure the program is both efficient and effective.

9. Do observation admissions need review?

   No – only on admission.

10. One of the barriers of IHRP 1.0 was technical/system capabilities that took some preparation. I am looking forward to more information.

Details are forthcoming; in the meantime, please note that the Department used your feedback on IHRP barriers in our UM vendor selection and Kepro's capabilities will address many of your concerns.

Wrap Up

Megan Axelrod from the Colorado Hospital Association (CHA) thanked the Department for recognition of outstanding concerns relative to IHRP 1.0 and how that implementation went. Megan will gather feedback from clinical management experts and start a conversation with CHA members.

Ms. Denney and Dr. Walsh thanked everyone for their participation and input. Dr. Walsh reminded everyone that the Department is required to have this program by the legislation and noted that we are trying to make it more targeted and streamlined. Ms. Denney repeated that she looks forward to stakeholder dialogue to help get the program right.