Fee-for-Service Behavioral Health

Indiana Health Coverage Programs
Gainwell Technologies
2024 IHCP Works Annual Seminar

Agenda

- Behavior Health Member Eligibility
- Applied Behavior Analysis (ABA)
- Intensive Outpatient Therapy (IOT)
- Opioid Treatment Program (OTP)
- Psychiatric Therapy
- Medicaid Rehabilitation Option (MRO)
- Child Mental Health Wraparound (CMHW)
- Residential Substance Use Disorder (SUD)
- Mobile Crisis Unit
- Helpful Tools
- Questions

Behavior Health Member Criteria

The information included in today's presentation is intended for the behavioral health services outlined below, as provided to fee-for-service (FFS) members.

- This applies to all programs and benefit plans including Presumptive Eligibility, except for:
  - Package E – Emergency services only (ESO)
  - Emergency Services Only with Pregnancy Coverage (Pkg B)
  - Family Planning Eligibility Programs – Only pays for family planning services
  - Qualified Medicare Beneficiary (QMB) Only – Only pays for Medicare coinsurances/deductibles
  - Specified Low-Income Medicare Beneficiaries (SLMB)

Applied Behavior Analysis (ABA)

ABA Therapy Coverage Criteria

The member must meet all the following criteria:

Diagnosed with Autism Spectrum Disorder (ASD) by a qualified healthcare provider, defined as one of the following:

- Licensed physician (including licensed psychiatrists and pediatricians)
- Licensed Health Services Provider Psychology (HSPP)
- Other behavioral health specialist with training and experience in the diagnosis and treatment of ASD

Has had a comprehensive diagnostic evaluation that meets both the following:

- Completed the most recent version of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (DSM) at the time of the evaluation
- Includes a recommended treatment referral for ABA therapy services

ABA services provide services to members aged 20 and under.

ABA Therapy Provider Criteria

Provider must be an IHCP enrolled provider type 11 (Behavioral Health Provider) with specialty of 615 (Applied Behavioral Analysis Therapist).

Rendering providers must have a National Provider Identifier (NPI) and hold a valid professional license/certification as:

- HSPP- Health Service Provider in Psychology
- BCBA- D- Board Certified Behavioral Analyst - doctoral
- BCBA- Board Certified Behavioral Analyst - masters level
- BCaBA- Board Certified Behavioral Analyst - bachelors level
- RBT- Registered Behavioral Technician*
  - **RBT's cannot enroll as a rendering provider**

Reminder: Rendering providers must be linked to individual service locations.

ABA PA Documentation Requirements

Documentation must describe an individual treatment plan developed by a licensed or Certified Behavior Analyst and include all the following:

- The identified behavioral, psychological, family, and medical concerns
- Measurable short-term, intermediate, and long-term goals that address the behaviors for which the intervention will be applied
- Plans for parent/guardian training and school transition
- Certification that ABA services will be developed and delivered by a provider who is licensed or certified as a behavior analyst.

ABA Therapy Prior Authorization

- All ABA therapy requires prior authorization (PA)

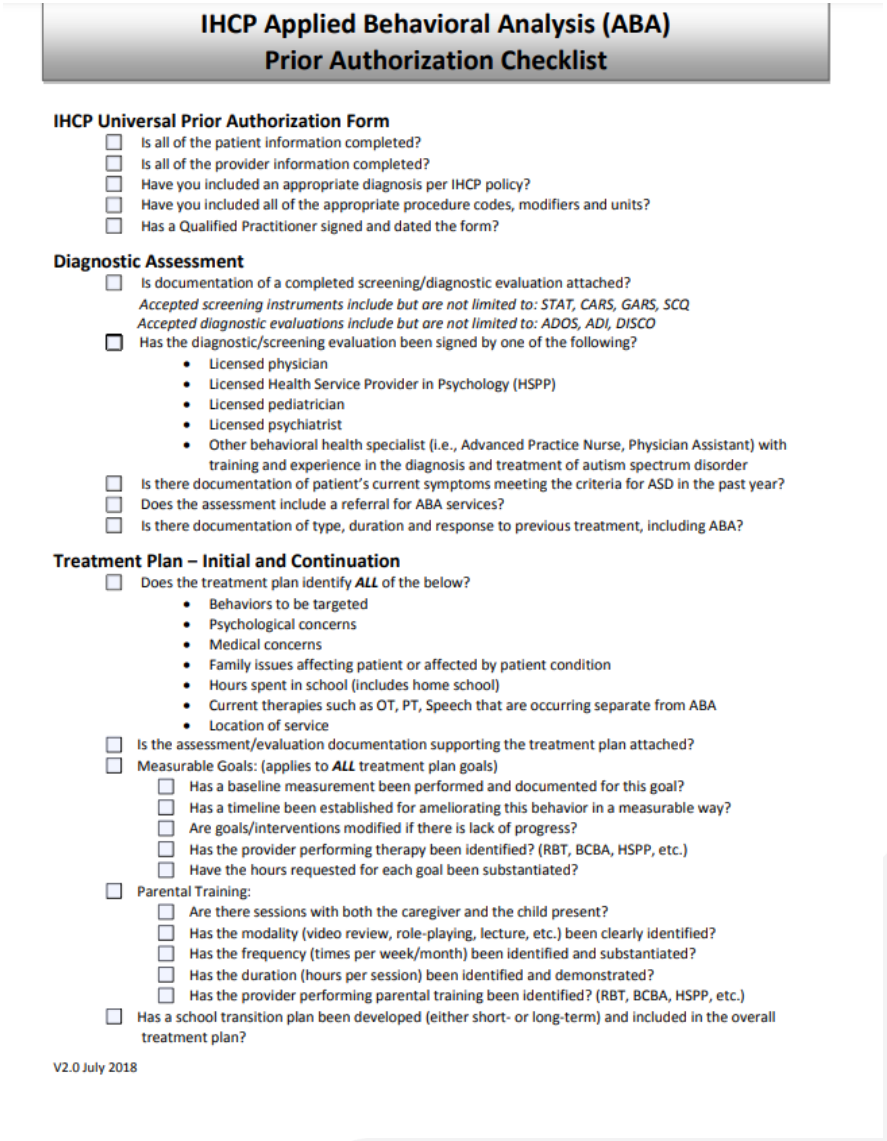
  PA requests must include:

  – Individual treatment plan and supporting documentation
  – Number of hours requested with supporting documentation
- Limited to 40 hours per week
- Additional services beyond three years may be prior approved if medically necessary.
- PA requests for continued ABA therapy will not be approved for longer than a six-month duration and must include an updated treatment plan with the appropriate supporting documentation, as required.

ABA Prior Authorization Checklist

Providers can use the IHCP Applied Behavior Analysis (ABA) Prior Authorization Checklist to prepare comprehensive PA requests for ABA therapy, which should reduce suspensions for requests for additional information.

The checklist is available on the Forms page at in.gov/medicaid/providers.



IHCP Applied Behavioral Analysis (ABA)
Prior Authorization Checklist

IHCP Universal Prior Authorization Form

- ☐ Is all of the patient information completed?
- ☐ Is all of the provider information completed?
- ☐ Have you included an appropriate diagnosis per IHCP policy?
- ☐ Have you included all of the appropriate procedure codes, modifiers and units?
- ☐ Has a Qualified Practitioner signed and dated the form?

Diagnostic Assessment

- ☐ Is documentation of a completed screening/diagnostic evaluation attached?
  Accepted screening instruments include but are not limited to: STAT, CARS, GARS, SCQ
  Accepted diagnostic evaluations include but are not limited to: ADOS, ADI, DISCO
- ☐ Has the diagnostic/screening evaluation been signed by one of the following?
  - Licensed physician
  - Licensed Health Service Provider in Psychology (HSPP)
  - Licensed pediatrician
  - Licensed psychiatrist
  - Other behavioral health specialist (i.e., Advanced Practice Nurse, Physician Assistant) with training and experience in the diagnosis and treatment of autism spectrum disorder
- ☐ Is there documentation of patient's current symptoms meeting the criteria for ASD in the past year?
- ☐ Does the assessment include a referral for ABA services?
- ☐ Is there documentation of type, duration and response to previous treatment, including ABA?

Treatment Plan – Initial and Continuation

- ☐ Does the treatment plan identify ***ALL*** of the below?
  - Behaviors to be targeted
  - Psychological concerns
  - Medical concerns
  - Family issues affecting patient or affected by patient condition
  - Hours spent in school (includes home school)
  - Current therapies such as OT, PT, Speech that are occurring separate from ABA
  - Location of service
- ☐ Is the assessment/evaluation documentation supporting the treatment plan attached?
- ☐ Measurable Goals: (applies to ***ALL*** treatment plan goals)
  - ☐ Has a baseline measurement been performed and documented for this goal?
  - ☐ Has a timeline been established for ameliorating this behavior in a measurable way?
  - ☐ Are goals/interventions modified if there is lack of progress?
  - ☐ Has the provider performing therapy been identified? (RBT, BCBA, HSPP, etc.)
  - ☐ Have the hours requested for each goal been substantiated?
- ☐ Parental Training:
  - ☐ Are there sessions with both the caregiver and the child present?
  - ☐ Has the modality (video review, role-playing, lecture, etc.) been clearly identified?
  - ☐ Has the frequency (times per week/month) been identified and substantiated?
  - ☐ Has the duration (hours per session) been identified and demonstrated?
  - ☐ Has the provider performing parental training been identified? (RBT, BCBA, HSPP, etc.)
- ☐ Has a school transition plan been developed (either short- or long-term) and included in the overall treatment plan?

V2.0 July 2018

Modifiers Required for ABA Billing

Modifiers used on the billing claim:

- U1 = Delivered by credentialed registered behavior technician (RBT)
- U2 = Delivered by bachelor-level board certified assistant behavior analyst (BCaBA)
- U3 = Delivered by physician, doctoral-level board certified behavior analyst-doctoral (BCBA-D), master's-level board certified behavior analyst (BCBA), or health service provider in psychology (HSPP)

Modifiers are not required on the PA request.

BT202401 – clarification on PA/Billing for ABA Therapy

Intensive Outpatient Therapy (IOT)

IOT Provider Qualifications

The following providers are authorized to deliver IOT:

- Licensed professional
- QBHPs – Qualified behavioral health professionals
- OBHPs – Other qualified behavioral health professionals

A licensed addiction counselor (LAC) or licensed clinical addiction counselor (LCAC) are not required to be a direct service provider when IOT services are provided to a member with an SUD diagnosis.

Intensive Outpatient Treatment (IOT)

IOT is a treatment program that operates at least three consecutive hours per day and at least three days per week for the rehabilitation of drug/alcohol use or severe mental health diagnosis in a group setting available for all ages.

Each three-hour session must include two hours of one the following:

- Group, family, or individual therapy
- Skills training
- Medication training
- Peer recovery services
- Care coordination
- Counseling

IOT is billed as one unit for each three-hour program per day.

Therapeutic Interventions

The IHCP requires the provision of at least 120 minutes of therapeutic interventions per three-hour session.

Example: Individual, family, or group therapy

H0015 *CMS-1500 Professional Claim* **OR** Revenue Code 906 *UB-04 Institutional Claim*	• Chemical dependency • Requires prior authorization
S9480 *CMS-1500 Professional Claim* **OR** Revenue Code 905 *UB-04 Institutional Claim*	• Psychiatric • Requires prior authorization

Procedure codes are not allowed when billing revenue codes 905 or 906.
Rev codes will be considered stand-alone and will be reimbursed at a flat rate per day.

Program Standards

- IOT services require prior authorization.
- Regularly scheduled sessions, within a structured program, must be at least three consecutive hours per day and at least three days per week.
  - If the member does not attend three full sessions a week, it cannot be billed as IOT. Any service that is less than three consecutive hours may be billed as psychotherapy (if provider qualifications and program standards are met).
- IOT must be provided in an age-appropriate setting for members younger than 21 years of age.
- Documentation must support how the service benefits the member.

Limitations

Limitations for IOT:

- Members are not allowed to receive any combination of procedure code H0015, procedure code S9480, revenue code 905 or revenue code 906 on the same date of service.

- Members are limited to procedure codes H0015 and S9480 in a professional setting.

Opioid Treatment Program (OTP)

OTP Criteria

Members 18 years and older	• Must be addicted to an opioid drug • Must have been addicted for one year before admission to the OTP • Must meet the criteria for the opioid treatment services (OTS) level of care to all six dimensions of American Society of Addictions Medicine (ASAM) Patient Placement Criteria
Members under the age of 18	• Must be addicted to an opioid drug • Must have two documented unsuccessful attempts at short-term withdrawal management or drug-free addiction treatment within a 12-month period • Must meet the criteria OTS level of care to all six dimensions of ASAM Patient Placement Criteria
Individuals exempt from one-year requirement	• Members released from a penal institution if the individual seeks OTP services within six months of release • Pregnant women • Previously treated individuals if the individual seeks OTP services within two years after treatment discharge

OTP Provider Requirements

Opioid treatment programs that want to bill for the administration of methadone and other related services are required to enroll as IHCP providers.

Provider type 11

- Specialty 835 – Opioid Treatment Program

Must have:

- Drug Enforcement Administration (DEA) license
- Division of Mental Health and Addiction (DMHA) certification

OTP billable codes can be found at Behavioral Health Code Sets on Table 2.

OTP Provider Specialty

Indiana Health Coverage Programs (IHCP) recognizes the following enrolled individuals rendering individual, group or family counseling services in an OTP setting:

- Physician (such as psychiatrist)
- Health Service Provider in Psychology (HSPP)
- Licensed psychologist
- Licensed clinical social worker (LCSW)
- Licensed marriage and family therapist (LMFT)
- Licensed mental health counselor (LMHC)
- Licensed clinical addition counselor (LCAC)
- Physician assistant
- Licensed advanced practice registered nurse (APRN)

OTP Bundled Rate

The weekly per diem rate for OTP includes reimbursement for the following services:

- U.S. Food and Drug Administration (FDA)-approved opioid agonist and antagonist medication-assisted treatment (MAT) medications
- Dispensing and administering MAT medications, if applicable
- Substance use counseling
- Individual and group therapy
- Toxicology testing
- Intake activities
- Periodic assessments

Coding bundles and billing information are featured in bulletin BT202357.

Prior authorization is not required for OTP services. However, providers must maintain documentation demonstrating medical necessity and that coverage criteria is met, as well as indicating the individual's length of treatment.

Benefit Plans not Eligible for OTP

OTP services are not covered under the following benefit plans:

- Individuals only eligible for Family Planning Eligibility Program
- Individuals only eligible for Package E – Emergency Services
- Individuals only eligible for Medicare Savings Programs – Qualified Medicare Beneficiary (QMB)-Only, Specified Low Income Medicare Beneficiary (SLMB)-Only, or Qualified Individual (QI)
- Medical Review Team (MRT)

Presumptive Eligible for Pregnant Women (PEPW) members are eligible for OTP services requires specific pregnancy-related diagnoses. PEPW Code Sets.

Psychiatric Therapy

Psychiatric Provider Requirements

Reimbursement for all outpatient behavioral health services requires the following IHCP enrolled individuals:

- Physician
- Health Service Provider in Psychology (HSPP)
- Licensed clinical social worker (LCSW)
- Licensed marriage and family therapist (LMFT)
- Licensed mental health counselor (LMHC)
- Licensed clinical addition counselor (LCAC)
- Licensed advanced practice registered nurse (APRN)

Only these provider are allowed to complete intake assessments.

Psychiatric Therapy Codes

PA is required for certain services that exceed 20 units per member, per billing or rendering provider, per rolling 12-month period.

Outpatient therapy codes in combination are subject to 20 units per rolling year:

- 90785
- 90832-90834
- 90836-90840
- 90845-90849
- 90853
- 90855
- 90857
- 90899

- Providers must track visits internally and submit PA requests prior to 21st visit.
- Retroactive authorizations may not be accepted.

Psychiatric Diagnostic Evaluations

Psychiatric Diagnostic Evaluations

- 90791 and 90792 are limited to one unit without prior authorization per member, per provider, per rolling 12-month period.
  - Additional evaluations require prior authorization.

- Two units allowed when member is separately evaluated by physician, HSPP, or behavioral health practitioner per rendering NPI, per rolling 12-month period without prior authorization. One unit must be provided by each rendering provider.

- Facilities enrolled with the IHCP as acute care or psychiatric hospitals may be reimbursed for 90791 or 90792 when billing the service on an outpatient claim along with revenue code 900 – Behavioral Health Treatments/Services.

Evaluation and Management Services (E/M) must not be billed on the same day performed by the same individual for the same patient with codes 90791 and 90792.

Medicaid Rehabilitation Option (MRO)

MRO Provider Qualifications

The following providers are authorized to deliver MRO services only at Community Mental Health Centers:

- Licensed professional – defined as a licensed Physician, HSPP, licensed Psychologist, LCSW, LMHC, LMFT, or LCAC
  - QBHPs – Qualified behavioral health professionals
  - OBHPs – Other qualified behavioral health professionals

MRO Services

MRO services include community-based mental healthcare for individuals with serious mental illness, youth with serious emotional disturbance, and/or individuals with substance use disorders.

- Specific to Community Mental Health Centers (CMHC)
- Aligns with Behavioral and Primary Healthcare Coordination (BPHC)
- MRO members acquiring BPHC during the MRO segment will have the BPHC units prorated to align with the MRO package end date.
- Members with an MRO package that has an end date transition to Adult Mental Health Habilitation (AMHH) the following day.
- Members cannot have an MRO package and receive AMHH services on the same day.

MRO, AMHH, and BPHC services are carved out of the managed care programs and must be approved, and claims submitted to Fee-For-Service.

Child Mental Health Wraparound (CMHW)

CMHW Provider Criteria

Provider criteria:

- Must be DMHA certified as individual (Respite Only) or agency/group
- Must enroll as individual or group depending on DMHA certification
- Must have NPI specific to certification type
- Provider type 11, Specialty 611 - no subspecialties

Group providers:

- Must screen potential employees/contractors to verify they are not an excluded individual (exclusions.oig.hhs.gov).
- Habilitation & Caregiver training- requires one licensed rendering/supervisor.
  - Non-licensed no longer required to enroll
- Wraparound facilitation does not require licensed rendering/supervision.

Individual providers:

- Respite only - unlicensed staff required to enroll as renderings.

CMHW Billing Guidance

When billing for a CMHW service, the provider must use the service procedure code, modifier and units of service associated with an approved service, as documented on the service authorization.

All CMHW service claims are billed through the IHCP on the professional claim (CMS-1500 claim form, 837P electronic transaction or IHCP Provider Healthcare Portal professional claim).

A claim may include DOS within the same month. Do not submit a claim with dates that span more than one month on the same claim.

Personal care services require documentation of each visit through Electronic Visit Verification (EVV).

Child Mental Health Wraparound services are carved out of the managed care programs and must be approved and paid through the Fee-For-Service delivery system.

CMHW Common Denials

Claims may be denied for the following reasons:

- The service billed is not an approved service on the service authorization.
- The service provider is not authorized to provide the billed service.
- The date of service being billed does not match the date range for the DMHA-approved service.
- The units of service billed exceed the authorized amount.
- The code/modifier on the claim is not the approved code/modifier on the service authorization.

Residential Substance Use Disorder (SUD)

SUD

PA is required for all residential SUD stays via the PA/UM vendor, Acentra. Admission criteria is based on the following American Society of Addictions Medicine (ASAM) Patient Placement criteria:

- ASAM Level 3.1 – Clinically Managed Low-Intensity Residential Services
- ASAM Level 3.5 – Clinically Managed High-Intensity Residential Services

The documentation may be submitted as follows:

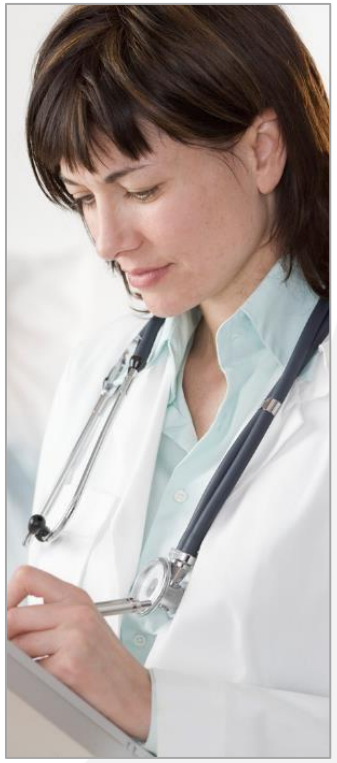
- Residential or Inpatient SUD treatment PA request
- Initial assessment form for SUD treatment admission
- Reassessment form for continued SUD treatment
- All necessary documentation to demonstrate medical necessity.
- PA requests must include U1 or U2 modifier.

SUD Provider Criteria

- Must be certified by Division of Mental Health and Addiction (DMHA)
- Enroll as a billing provider type 11, specialty 836
- Physician, Physician Assistant, or APRN must see member face-to-face every seven days
- Billing submitted on professional claim form
- Paid on a per diem reimbursement methodology

Treatment Services

- Short-term, low- and high-intensity residential treatment
  - Average length of stay is 30 calendar days
- Settings of all sizes, including Institutions for Mental Disease (IMD)
- PA required for all stays
- Reimbursable on per diem basis:
  - H2034 U1 or U2 – Low-intensity residential treatment – does not bypass Medicare
  - H0010 U1 or U2 – High-intensity residential treatment – does bypass Medicare



Physician visits and physician-administered drugs are separately reimbursable.

Mobile Crisis Unit

Mobile Crisis Enrollment

Mobile crisis units will be classified using the following provider enrollment type and specialty codes:

- Provider type 11 – Behavioral Health Provider
- Provider specialty 622 – Mobile Crisis Unit
- To enroll with the IHCP under the new provider specialty, mobile crisis units must have the following:
  - Internal Revenue Service (IRS) W-9 form
  - Federal Employer Identification Number (FEIN)
  - National Provider Identifier (NPI)
  - Signed copy of the Agency Designation Agreement for Mobile Crisis Response Services from the Division of Mental Health and Addiction (DMHA)

Mobile Crisis Specialties

Mobile crisis units will be required to enroll as a group provider classification with at least one of the following rendering providers associated with the enrollment:

- Type 09 – Advanced Practice Registered Nurse

- Type 11 – Behavioral Health Provider
  - ❖ Specialty 618 – Licensed Clinical Social Worker (LCSW) ¨
  - ❖ Specialty 619 – Licensed Marriage and Family Therapist (LMFT) ¨
  - ❖ Specialty 620 – Licensed Mental Health Counselor (LMHC) ¨
  - ❖ Specialty 621 – Licensed Clinical Addiction Counselor (LCAC)
  - ❖ Type 31 – Physician

Provider specialty 622 – Mobile Crisis Unit can be a stand-alone specialty or be added to an existing provider type 11.

Out of state Mobile crisis units are not allowed to enroll.
Mobile crisis units will be considered a moderate risk level at both initial enrollment and upon revalidation (every five years).

Mobile Crisis Service Descriptions

What services can Mobile Crisis Units provide?

- **Triage/Screening:** Determines the level of risk that is faced by the individual in crisis and assessing the most appropriate response.
- **Assessment:** Collects information on the circumstances of the crisis event, safety and risk related to the individual and others involved, medication and substance use, strengths and resources of the individual, recent inpatient hospitalizations or mental health services, mental health conditions, medical history, and other pertinent information.
- **De-escalation through brief counseling:** Brief counseling techniques specific to the crisis that aims to lower risks and resolve the crisis so that a higher level of care is not needed.
- **Safety planning:** Engagement of the individual in a crisis planning process, resulting in the creation or update of planning tools, including an individualized safety plan. The safety plan aims to keep an individual in crisis and their environment safe and may include lethal means counseling and other evidence-based interventions.
- **Peer recovery support:** Support provided by paraprofessional with lived experience with mental health and/or substance use disorder concerns.
- **Follow-up stabilization services:** Follow up contacts in-person, via phone, or telehealth up to 14 days following initial crisis intervention and can be billable up to 90 days.

Mobile Crisis Service Codes

S9484, Mobile crisis response without transportation, up to 3 hours
S9484 UB, Mobile crisis response with transportation, up to 3 hours

Covers triage/screening, assessment, brief counseling, safety planning, peer recovery support, and follow-up stabilization services.

S9485, Mobile crisis response without transportation, 3 hours or more
S9485 UB, Mobile crisis response without transportation, 3 hours or more

Covers triage/screening, assessment, brief counseling, safety planning, peer recovery support, and follow-up stabilization services.

H0034 U9, Medication training and support, per 15 minutes

Covers monitoring medication compliance, providing education and training about medications, monitoring medication side effects, and providing other nursing/medical assessments, and allows for monitoring of medication-assisted treatment (MAT) and/or psychotropic medication services.

H2011 UA, Crisis intervention service, per 15 minutes

Covers a follow-up crisis assessment, crisis planning and counseling specific to the crisis.

Mobile Crisis Bulletins

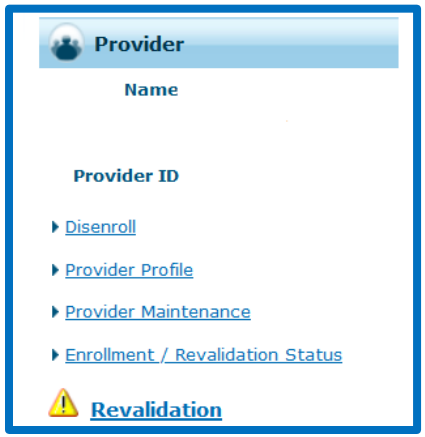
For additional information on Mobile Crisis enrollment and coverage refer to bulletins:

BT202430 - Specialty
BT202414 - TPL Exemptions
BT202364 - Coverage
BT2023173 - Retroactive Coverage

Helpful Tools

Revalidation Reminders

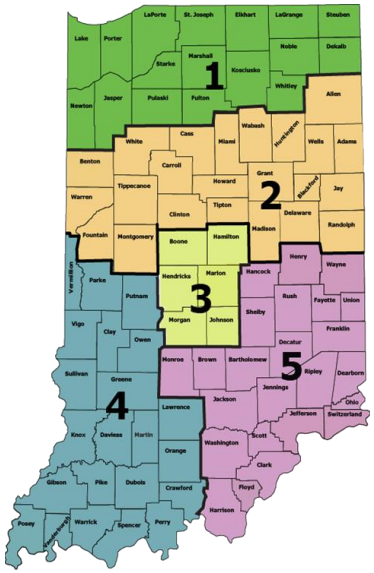
- Notifications with instructions for revalidating are sent to the ***MAIL TO ADDRESS in each service location Provider Profile*** 90 and 60 days in advance of the revalidation due date - that's 30 days ahead of the final deadline date. That extra time is there to make sure providers submit on time because otherwise, the enrollment will be closed.
- The Provider Enrollment Revalidation webpage provides a list of providers with upcoming revalidation due dates.
- Providers will also see a reminder on the home page of their Provider Profile, on the IHCP Provider Healthcare Portal.
  - ***The revalidation reminder is service location specific***



- **Revalidation must be finalized before the revalidation end date.**
- ***Providers that fail to revalidate will be required to re-enroll as new providers.***

Provider Relations Team

Region	Consultant	Email	Telephone	Counties Served
1	Jean Downs	INXIXRegion1@gainwelltechnologies.com	317-488-5071	Dekalb, Elkhart, Fulton, Jasper, Kosciusko, LaGrange, Lake, LaPorte, Marshall, Newton, Noble, Porter, Pulaski, St. Joseph, Starke, Steuben, Whitley
2	Jill Harris	INXIXRegion2@gainwelltechnologies.com	317-488-5080	Allen, Adams, Benton, Blackford, Cass, Carroll, Clinton, Delaware, Fountain, Grant, Howard, Huntington, Jay, Madison, Miami, Montgomery, Randolph, Tippecanoe, Tipton, Wabash, Warren, Wells, White
3	Jeannette Curtis	INXIXRegion3@gainwelltechnologies.com	317-488-5324	Boone, Hamilton, Hendricks, Johnson, Marion, Morgan
4	Emily Redman	INXIXRegion4@gainwelltechnologies.com	317-488-5153	Clay, Crawford, Daviess, Dubois, Gibson, Greene, Knox, Lawrence, Martin, Orange, Owen, Parke, Perry, Pike, Posey, Putnam, Spencer, Sullivan, Vanderburgh, Vermillion, Vigo, Warrick
5	Tami Foster	INXIXRegion5@gainwelltechnologies.com	317-488-5186	Bartholomew, Brown, Clark, Dearborn, Decatur, Fayette, Floyd, Franklin, Hancock, Harrison, Henry, Jackson, Jefferson, Jennings, Monroe, Ohio, Ripley, Rush, Scott, Shelby, Switzerland, Union, Washington, Wayne



Provider Assistance

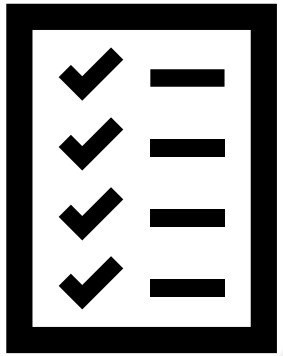
Your Provider Relations Consultant can:

- Assist you with complex claim denial issues.
- Provide free IHCP Provider Portal training.
- Assist you with the enrollment or revalidation process.
- Assist you in understanding member eligibility.
- Conduct 1:1 virtual or in-person on-site training and provider workshops.
- Help you in navigating the IHCP provider website/modules.

Contact Checklist

Emails and calls should always include:

- Provider NPI and Provider ID
- Contact name, phone number, and email
- Exact reason for the email or call:
  - Claim example and exact claim information
  - Member information including the Member Medicaid number
  - Nature of issues
- Include application tracking number (ATN) if related to provider enrollment.
- Any other information to help Provider Relations research prior to returning the email or call.



Email is the preferred method of contact.
If sending protected health information (PHI), send via secure email.

Helpful Tools and Resources

Indiana Medicaid for Providers website:

- Provider References > IHCP Provider Reference Modules
- Contact Information > Provider Relations Consultants

Customer Assistance:

- 800-457-4584
- Live assistance available Monday–Friday, 8 a.m. – 6 p.m. Eastern Time

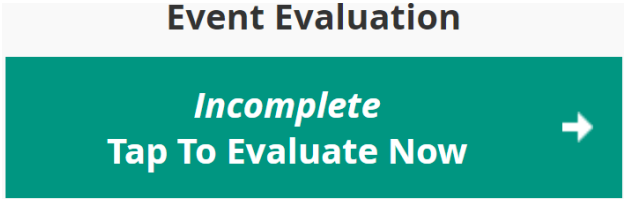
Secure Correspondence:

- Via the IHCP Provider Healthcare Portal
  - Registered account required.
  - After logging in to the IHCP Portal, click **Secure Correspondence** to submit a request.

Evaluation Survey

WE WANT TO HEAR FROM YOU!!

Log into the 2024 IHCP Works Annual Seminar app website



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Choose any session's evaluation from the list below the green box (in alphabetical order)

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Make sure to answer all questions marked required to avoid errors

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Questions