Washington State Health Care Authority

Washington Apple Health (Medicaid)

Health-Related Social Needs (HRSN) Services Billing Guide

October 1, 2025

Washington State Health Care Authority

Disclaimer

Every effort has been made to ensure this guide's accuracy. If an actual or apparent conflict arises between this document and a governing statute or Health Care Authority (HCA) rule, the governing statute or HCA rule applies.

Billing guides are updated on a regular basis. Due to the nature of content change on the internet, we do not fix broken links in past guides. If you find a broken link, please check the most recent version of the guide. If this is the most recent guide, please notify us at medicaidtransformation@hca.wa.gov.

About this guide*

This publication takes effect **October 1, 2025**. Unless otherwise specified, the program in this guide is governed by the rules found in **Chapter 182-565 WAC**. This HRSN Services Billing Guide is intended to provide managed care organizations (MCOs) and providers with programmatic details and expectations for delivering HRSN services.

HCA is committed to providing equal access to our services. If you need accommodation or require documents in another format, please call 1-800-562-3022. People who have hearing or speech disabilities, please call 711 for relay services.

The HRSN Services Billing Guide explains what HRSN services are, when an HRSN service can be offered, and the process that HCA, MCOs, and providers must follow. This guide lays out the requirements necessary to deliver HRSN services under the Medicaid Transformation Project (MTP), also known as Washington State's Section 1115 Medicaid demonstration waiver.

Sections of the guide will be added over time as additional HRSN services are implemented.

> Washington Apple Health means the public health insurance programs for eligible Washington residents. Washington Apple Health is the name used in Washington State for Medicaid, the Children's Health Insurance Program (CHIP), and state-only funded health care programs. Washington Apple Health is administered by HCA.

If billing through ProviderOne for HRSN services, refer also to HCA's **ProviderOne billing and resource guide** for valuable information to help you conduct business with the Health Care Authority.

* This publication is a billing instruction.

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How can I get HCA Apple Health provider documents?

To access provider alerts, go to HCA's **provider alerts webpage**.

To access provider billing guides or fee schedules, go to HCA's **provider billing guides and fee schedules webpage.**

Health care privacy toolkit

The **Washington Health Care Privacy Toolkit** is a resource for providers required to comply with health care privacy laws.

Where can I download HCA forms?

To download an HCA form, see HCA's **Forms & Publications** webpage. Type only the form number into the Search box (Example: 13-835).

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What has changed?

The table below briefly outlines how this publication differs from the previous one. This table is organized by subject matter. Each item in the *Subject* column is a hyperlink that, when clicked, will take you to the specific change summarized in that row of the table.

Subject	Change	Reason for Change
New Guide 10/1/2025		

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General - Client Eligibility

Most Apple Health clients are enrolled in an HCA-contracted managed care organization (MCO). This means that Apple Health pays a monthly premium to an MCO for providing preventative, primary, specialty, and other health services to Apple Health clients. Clients in managed care must see only providers who are in their MCO's provider network, unless prior authorized or to treat urgent or emergent care. See HCA's Apple Health managed care page for further details.

It is important to always check a client's eligibility prior to providing any services because it affects who will pay for the services.

How do I verify a client's eligibility?

Check the client's services card or follow the two-step process below to verify that a client has Apple Health coverage for the date of service and that the client's benefit package covers the applicable service. This helps prevent delivering a service HCA will not pay for.

Verifying eligibility is a two-step process:

Step 1. **Verify the patient's eligibility for Apple Health**. For detailed instructions on verifying a patient's eligibility for Apple Health, see the *Client Eligibility, Benefit Packages, and Coverage Limits* section in HCA's ProviderOne Billing and Resource Guide.

If the patient is eligible for Apple Health, proceed to **Step 2**. If the patient is **not** eligible, see the note box below.

Step 2. **Verify service coverage under the Apple Health client's benefit package**. To determine if the requested service is a covered benefit under the Apple Health client's benefit package, see HCA's Program Benefit Packages and Scope of Services webpage.

Note: Patients who are not Apple Health clients may apply for health care coverage in one of the following ways:

- **Online**: Go to **Washington Healthplanfinder** - select the "Let's Get Started" button. For patients age 65 and older or on Medicare, go to **Washington Connections** select the "Apply Now" button.
- **Mobile app:** Download the **WAPlanfinder app** – select "sign in" or "create an account".
- **Phone**: Call the Washington Healthplanfinder Customer Support Center at 1-855-923-4633 or 1-855-627-9604 (TTY).
- **Paper**: By completing an *Application for Health Care Coverage (HCA 18-001P)* form.
  To download an HCA form, see HCA's Free or Low Cost Health Care, **Forms & Publications** webpage. Type only the form number into the Search box (Example: **18-001P**). For patients age 65 and older or on Medicare, complete the *Washington Apple Health Application for Aged, Blind, Disabled/Long-Term Services and Support (HCA 18-005)* form.

HRSN clients can reach out to Community Care Hubs for assistance with getting Apple Health coverage. See the Community Care Hub Referral Pathways on HCA's **Community Care Hubs website** for region specific information.

Are clients enrolled in an HCA-contracted managed care organization (MCO) eligible?

Yes. Most Apple Health clients are enrolled in one of HCA's contracted managed care organizations (MCOs). For these clients, managed care enrollment will be displayed on the client benefit inquiry screen in ProviderOne.

All medical services covered under an HCA-contracted MCO must be obtained by the client through designated facilities or providers. The MCO is responsible for:

- Payment of covered services
- Payment of services referred by a provider participating with the plan to an outside provider

Note: A client's enrollment can change monthly. Providers who are not contracted with the MCO must receive approval from **both** the MCO and the client's primary care provider (PCP) prior to serving a managed care client.

Send claims to the client's MCO for payment. Call the client's MCO to discuss payment prior to providing the service. Providers may bill clients only in very limited situations as described in WAC 182-502-0160.

Managed care enrollment

Apple Health clients are enrolled in an HCA-contracted MCO the same month they are determined eligible for managed care as a new or renewing client. Some clients may start their first month of eligibility in the fee-for-service (FFS) program because their qualification for MC enrollment is not established until the month following their Apple Health eligibility determination.

New clients are those initially applying for benefits or those with changes in their existing eligibility program that consequently make them eligible for Apple Health managed care. Renewing clients are those who have been enrolled with an MCO but have had a break in enrollment and have subsequently renewed their eligibility.

Checking eligibility

Providers must check eligibility and know when a client is enrolled and with which MCO. For help with enrolling, clients can refer to **HCA's Apply for or renew coverage webpage**.

Clients' options to change plans

Clients have a variety of options to change their plan:

- **Available to clients with a Washington Healthplanfinder account**:

  Go to Washington Healthplanfinder website.

- **Available to all Apple Health clients:**
  - Visit the ProviderOne Client Portal website:
  - Call Apple Health Customer Service at 1-800-562-3022. The automated system is available 24/7.
  - Request a change online at ProviderOne Contact Us (this will generate an email to Apple Health Customer Service). Select the topic "Enroll/Change Health Plans."

For online information, direct clients to HCA's Apple Health Managed Care webpage.

> **Note**: HRSN clients must be enrolled in Apple Health (Medicaid), have the social and clinical risk factors as described in each specific HRSN service, and the specific HRSN service must be determined to be medically appropriate for the client.

Clients who are not enrolled in an HCA-contracted managed care plan for physical health services

Some Apple Health clients do not meet the qualifications for managed care enrollment. These clients are eligible for physical health services under the fee-for-service (FFS) program.

In this situation, each managed care plan will have a Behavioral Health Services Only (BHSO) benefit available for Apple Health clients who are not in integrated managed care. The BHSO covers only behavioral health treatment for those clients. Eligible clients who are not enrolled in an integrated HCA-contracted managed care plan are automatically enrolled in a BHSO except for American Indian/Alaska Native clients. If the client receives Medicaid-covered services before being automatically enrolled in a BHSO, the FFS program will reimburse providers for the covered services. Examples of populations that may be exempt from enrolling into a managed care plan are Medicare dual-eligible, American Indian/Alaska Native, Adoption Support and Foster Care Alumni.

Integrated managed care

Clients qualified for enrollment in an integrated managed care plan receive all physical health services, mental health services, and substance use disorder treatment through their HCA-contracted managed care organization (MCO).

Integrated Apple Health Foster Care (AHFC)

Children and young adults in the Foster Care, Adoption Support and Alumni programs who are enrolled in Coordinated Care's (CCW) Apple Health Core Connections Foster Care program receive both medical and behavioral health services from CCW.

Clients under this program are:

- Age 17 and younger who are in foster care (out of home placement), or in the Unaccompanied Refugee Minors program
- Age 20 and younger who are receiving adoption support
- Age 18-21 years old in extended foster care
- Age 18 to 26 years old who aged out of foster care on or after their 18th birthday (alumni)

> These clients are identified in ProviderOne as "**Coordinated Care Healthy Options Foster Care**."

The Apple Health Customer Services team can answer general questions about this program. For specific questions about Adoption Support, Foster Care or Alumni clients, contact HCA's Foster Care and Adoption Support (FCAS) team at 1-800-562-3022, Ext. 15480.

Apple Health Expansion

Individuals age 19 and older who do not meet the citizenship or immigration requirements to receive benefits under federally funded programs and who receive all physical health services, mental health services, and substance use disorder treatment through their HCA-contract health plan. For more information, visit **Apple Health Expansion**.

American Indian/Alaska Native (AI/AN) Clients

American Indian/Alaska Native (AI/AN) clients have two options for Apple Health coverage:

- Apple Health Managed Care
- Apple Health coverage without a managed care plan (also referred to as fee-for-service [FFS])

If an AI/AN client does not choose a managed care plan, they will be automatically enrolled into Apple Health FFS for all their health care services, including comprehensive behavioral health services. See the Health Care Authority's **American Indian/Alaska Native webpage**.

What if a client has third-party liability (TPL)?

If the client has third-party liability (TPL) coverage (excluding Medicare), prior authorization must be obtained before providing any service requiring prior authorization. For more information on TPL, refer to HCA's **ProviderOne Billing and Resource Guide**.

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Medical Respite Care (MRC) (recuperative care and short-term post-hospitalization housing)

Service Description

Medical Respite Care (MRC), also known as recuperative care and short-term post-hospitalization housing, provides a safe and stable place for eligible clients to receive treatment on a short-term basis. MRC provides post-acute care for clients experiencing homelessness who are too ill or frail to recover from a physical illness or injury while living on the streets, but who no longer require a hospital stay.

Time Limits

MRC may be provided for up to 90 consecutive days per client, per stay. This may not exceed a combined total of six months during the five-year demonstration period (July 1, 2023, through June 30, 2028).

Providers must review the duration of MRC services to ensure they are within the time limits.

> **Note**: For all HRSN housing interventions that include room and board, combined time limits cannot exceed the global cap of 6 months per the five-year demonstration period. There is no limitation extension.

Service procedure code

HCPCS code T2033

Required components of MRC services

Service procedure code T2033 is considered to encompass key components of MRC models under the National Institute for Medical Respite Care (NIMRC), defined as:

- Shelter, which consists of a minimum of the following:
  - Room and board, with 24-hour bed access
  - Three meals daily
  - Laundry services
- Safe storage for personal belongings and medications
- One wellness check per 24-hour period

- Clinical oversight that includes a baseline clinical assessment of the client's health and ongoing reassessments as clinically appropriate to determine whether treatment and care plans are effective, behavioral health screening, medication monitoring, and minor treatments for medical conditions (e.g., wound care, infection control, non-pharmacological pain management, or other minor treatment of uncomplicated medical conditions)
- Client centered coordination of health care, psychosocial care, support in accessing benefits, and housing
- Transportation to appointments not otherwise covered under the Apple Health (Medicaid) Nonemergency Medical Transportation (NEMT) benefit
- Access to a phone/tablet to support telemedicine appointments and/or communications related to medical needs

Provider requirements for MRC

To be paid for MRC services, providers must meet all the following requirements:

- Meet the general provider requirements in chapter 182-502 WAC, including:
  - Be enrolled with ProviderOne, including:
    - Having an individual National Provider Identifier (NPI)
    - Submitting a signed Core Provider Agreement (CPA) with HCA
    - Approval from HCA's provider enrollment team
- Be enrolled as a Washington Apple Health (Medicaid) provider for claims to be paid. For enrollment information, go to the Enroll as a provider webpage.
- Meet the Standards for Medical Respite Care Programs according to the National Health Care for the Homeless Council (NHCHC) guidelines.
- Follow the guidelines of the National Institute of Medical Respite Care (NIMRC).
- Submit the completed *Attestation for Medical Respite Care Provider* form (HCA 19-0083) via email to HCA. To download an HCA form, see HCA's Forms & Publications webpage.

HCA notifies the provider when the attestation has been approved.

Both clinical and non-clinical staff may perform MRC services within their scope of practice in the medical respite care setting.

Providers must notify HCA by email if they no longer meet the requirements to provide MRC as described in this section.

> **Note:** HCA may conduct a post pay review to ensure MRC requirements have been met. If these requirements were not met at the time of billing, HCA may recoup payment.

MRC fee-for-service (FFS) billing instructions

HCA pays a daily rate for MRC services. For each day of MRC services rendered, providers may submit a claim using HCPCS code T2033 (residential care, not otherwise specified (NOS) waiver; per diem). Enter the date of service only, leaving the admit date blank.

HCA may pay for some additional services provided to a client during a medical respite stay when medically necessary, such as behavioral health services, professional services, or hospice. For more information, go to HCA's provider billing guides and fee schedules webpage and select the appropriate billing guide.

Bill HCA or the applicable MCO using only allowed procedure codes. Providers are responsible for identifying the appropriate information for billing including NPI and taxonomy.

Facility requirements

A facility that provides MRC services must meet local codes and ordinances for licensing, safety, and occupancy.

MRC Settings

Implementation settings for MRC must have access to clinicians licensed or certified by the state of Washington and qualified to provide the required services within their scope of practice, including both medical and/or behavioral health care as appropriate for a client. Medical respite care settings may use qualified clinicians on staff or, if the facility is without clinicians on site, must work closely with a local Federally Qualified Health Center (FQHC) to ensure access to clinically appropriate care. Examples of MRC settings include:

- Adult family homes
- Assisted living facilities
- Community centers
- Hospitals, health centers, and other clinics
- Residential group homes or small apartment buildings
- Skilled nursing facilities
- Social service centers
- Transitional housing facilities
- Wellness/respite centers
- Other as approved by the state

The following settings are excluded:

- Facilities primarily used for room and board without the required components of MRC
- Facilities providing congregate sleeping space
- Facilities that have been temporarily converted to shelters (e.g., gymnasiums or convention centers)
- Facilities where sleeping spaces are not available to residents 24 hours a day

MRC-specific eligibility requirements

MRC services are available to Medicaid clients enrolled in **either** of the following:

- A Medicaid Managed Care program (Integrated Managed Care [IMC], Integrated Foster Care [IFC], Behavioral Health Services Only [BHSO])
- Apple Health Fee-for-Service (FFS) (for Apple Health clients without a managed care plan)

Claims for MRC services for enrollees in the IMC or IFC programs will be covered by the enrollee's MCO. Claims for managed care enrollees in the BHSO program will be covered as FFS by HCA.

In addition to the service being medically appropriate for the individual, clients receiving MRC services must meet social and clinical risk factor criteria.

Clients must meet the following social risk factor:

- Meet the definition of homeless, chronically homeless, at risk of homelessness, or transitioning out of an emergency shelter as defined by 24 CFR 91.5, with the exception of the annual income requirement in 24 CFR 91.5 (1) (i).

Clients must meet the following clinical risk factors:

- Be at risk of incurring other Medicaid State Plan services, such as inpatient hospitalizations or emergency department visits; and
- Are assessed to have an acute medical condition that can be safely managed in a sheltered outpatient setting.

Clients must meet the facility's requirements to receive MRC services.

Guidance documents

See HCA's **Provider billing guides and fee schedules** webpage for this guide and future revisions.

The following documents are also available on HCA's website:

Encounter Data Reporting Guide (EDRG) is available under Regional Resources – Claims billing-encounter data

HIPAA Electronic Data Interchange (EDI) website (includes companion guides)

Resources for behavioral health providers for information on service encounter and program reporting, coding guidelines, and data

HRSN infrastructure protocol

HRSN service protocol

MTP 2.0 **HRSN website**.

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Authorization

Note: Prior authorization is not required for medical respite care services.

What are the general guidelines for authorization?

When a procedure's expedited prior authorization (EPA) criteria have not been met or the covered procedure requires prior authorization (PA), providers must request prior authorization from HCA.

If the client does not meet the EPA clinical criteria in this section, HCA uses the process in WAC 182-501-0165 to consider prior authorization requests and approves services that are medically necessary.

When the provider does not properly request authorization, HCA returns the request to the provider for proper completion and resubmission. HCA does not consider the returned request to be a denial of service.

HCA's authorization of service(s) does not guarantee payment.

HCA may recoup any payment made to a provider if HCA later determines that the service was not properly authorized or did not meet the EPA criteria. See WAC 182-502-0100 and WAC 182-544-0560.

When is a limitation extension (LE) required?

Note: Medical respite care services do not require a limitation extension. Refer to the Time Limits section for additional information.

HCA evaluates requests for authorization of covered HRSN services that exceed limitations in this billing guide on a case-by-case basis in accordance with WAC 182-501 0169. The provider must justify that the request is medically necessary (as defined in WAC 182-500-0070) for that client.

Providers may submit LE requests for additional units when any of the following are true:

- The criteria for an expedited prior authorization (EPA) does not apply.
- The number of available units under the EPA have been used and services are requested beyond the limits.
- A new qualifying condition arises after the initial six visits are used.

> **Note**: Requests for an LE must be appropriate to the client's eligibility and/or program limitations. Not all eligibility programs cover all services.

Providers may submit their request by direct data entry into ProviderOne or by fax to 1-866-668-1214. See the HCA's prior authorization webpage for details.

See **Where can I download HCA forms**? for the appropriate service authorization form.

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Billing

All claims must be submitted electronically to HCA, except under limited circumstances.

For more information about this policy change, see Paperless billing at HCA.

For providers approved to bill paper claims, see HCA's Paper claim billing resource.

Are referring provider NPIs required on all claims?

Yes. Providers must use the referring provider's national provider identifier (NPI) on all claims to be paid. If the referring provider's NPI is not listed on the claim, the claim may be denied. Providers must follow the billing requirements listed in HCA's ProviderOne Billing and Resource Guide.

How do I bill claims electronically?

Instructions on how to bill Direct Data Entry (DDE) claims can be found on HCA's Billers, providers, and partners webpage, under Learn how to use ProviderOne, select Webinars.

For information about billing Health Insurance Portability and Accountability Act (HIPAA) Electronic Data Interchange (EDI) claims, see the ProviderOne 5010 companion guides on the HIPAA Electronic Data Interchange (EDI) webpage.

What are the general billing requirements?

Providers must follow HCA's ProviderOne Billing and Resource Guide. These billing requirements include, but are not limited to:

- Time limits for submitting and resubmitting claims and adjustments
- What fee to bill the Health Care Authority for eligible clients. See HCA's Provider billing guide and fee schedules webpage for fee schedule information.
- When providers may bill a client
- How to bill for services provided to primary care case management (PCCM) clients
- Billing for clients eligible for both Medicare and Medicaid
- Third-party liability
- Record keeping requirements

Bill timely. Timely billing is required as the claims will pay in date of service order. If a claim comes in for a previous date of service, the system will automatically pay the earlier date and recoup or adjust the later date.