Washington State Health Care Authority

Washington Apple Health (Medicaid)

Reentry Targeted Case Management (rTCM) Billing Guide

July 1, 2025

(Prerelease)

Washington State Health Care Authority

Disclaimer

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

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About this guide[1]

This publication takes **effect July 1, 2025**. This guide explains when Reentry Targeted Case Management (rTCM) services may be offered and the process that HCA, managed care organizations (MCOs), carceral facilities, and the Third-Party Administrator (TPA) must follow. This guide lays out the billing requirements necessary to deliver reentry services under the Demonstration Waiver 1115 framework. 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.

> 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. Apple Health is administered by the Washington State Health Care Authority (HCA).

Refer also to HCA's ProviderOne billing and resource guide for valuable information to help you conduct business with HCA.

How can I get HCA Apple Health provider documents?

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

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

Confidentiality toolkit for providers

The Washington State Confidentiality Toolkit for Providers is a resource for providers required to comply with health care privacy laws.

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[1] This publication is a billing instruction.

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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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Resources Available

Topic	Resource
HCA Medicaid Transformation Project (MTP) 2.0	See HCA's Medicaid Transformation Project (MTP) webpage
HCA-CMS Agreement (Special Terms and Conditions/STC)	See the agreement on HCA's website
Reentry Resources for Apple Health (Medicaid) After Release from Incarceration	See the handout on HCA's website
HCA billing guides and other publications	See HCA's Provider billing guides and fee schedules webpage.
Reentry Demonstration Initiative FAQ for carceral facilities	FAQ for Reentry Demonstration Initiative
Confidentiality Toolkit for Providers	The Washington State Confidentiality Toolkit for Providers is a resource for providers required to comply with health care privacy laws.
Definition of an inmate of a public institution	See 42 CFR 435.1010
Patient Review and Coordination program	See HCA's Patient Review and Coordination (PRC) webpage
Telemedicine	See HCA's telehealth rules (WAC 182-501-0300) See HCA's Provider billing guides and fee schedules web page, under *Telehealth*, for more information on the following: • Telemedicine policy, billing, and documentation requirements, under *Telemedicine policy and billing* • Audio-only procedure code lists, under *Audio-only telemedicine*

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Available Forms for rTCM

Form	Form Number
Reentry health screening form	HCA 05-0005
Authorization and information sharing consent—Reentry care management form	HCA 13-0141
Reentry health assessment addendum	HCA 05-0006
Intake Screening Form produced by Washington Association of Sheriffs & Police Chiefs (WASPC)	See waspc.org.

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

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Definitions

This section defines terms and abbreviations, including acronyms, used in this billing guide. Some of the terms and definitions below are from the Apple Health-Integrated Managed Care (AH-IMC) contract. Refer to Chapter 182-500 WAC and Chapter 182-563 WAC for a complete list of definitions for Washington Apple Health and reentry-related services.

Adjudication - A legal process that involves reviewing evidence and arguments to reach a decision. The decision is based on applying a standard set of guidelines to an individual's specific circumstances.

Children's Health Insurance Program (CHIP) – Provides access to medical care for children under Title XXI of the Social Security Act, the Children's Health Insurance Program Reauthorization Act of 2009, RCW 74.09.470 and Chapter 182-505 WAC.

Community Care Hub – Centralized case management, outreach, and education that provides linkages to state and federal benefit programs, benefit program application assistance, and benefit program application fees. Services also include coordination for health-related social needs (HRSN) and necessary referrals.

Consolidated Appropriation Act, 2023 (CAA) - Enacted as P.L. 117-328, section 5121 requires postadjudication services and section 5122 allows preadjudication services for eligible juveniles within a public institution.

Eligible juvenile - An incarcerated individual who is either of the following:

- An Apple Health client covered under Medicaid or CHIP who is 20 years of age or younger
- An individual between the ages of 18 and 26 who is eligible under the mandatory former foster care children group

Healthcare Common Procedure Coding System (HCPCS) – See WAC 182-531-0050.

Health-related social needs (HRSN) – A client's unmet, adverse social conditions (e.g., housing instability, homelessness, nutrition insecurity) that contribute to poor health and are a result of underlying social determinants of health (conditions in which people are born, grow, work, and age).

Health-related social needs (HRSN) services - Addresses a client's unmet, adverse social conditions that contribute to poor health. These needs, including food insecurity, housing instability, unemployment, and/or lack of reliable transportation, can drive health disparities across demographic groups.

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Informed consent – See WAC 182-531-0050.

Medicaid Transformation Project 2.0 (MTP 2.0) - Washington's section 1115 Medicaid Demonstration Waiver between HCA and the Centers for Medicare and Medicaid Services (CMS). Under MTP 2.0, HCA's goals are to:

- Expand coverage and access to care
- Advance whole-person primary, preventive, and home-based and community-based care
- Accelerate care delivery and payment innovation focused on HRSN

Preadjudication - The period before a court entered the disposition of an individual's case.

Postadjudication - The period after a court entered the disposition of an individual's case (e.g., individual was found guilty of an offense and remains incarcerated).

Reentry care manager - A qualified provider who provides the Reentry Targeted Case Management benefit.

Reentry initiative – As part of MTP 2.0 and the CAA, 2023, this initiative allows payment for targeted reentry services in situations where Medicaid law would typically prohibit such payment allowed.

Reentry initiative services - A targeted set of Apple Health services provided to support the health of an individual's release from a carceral facility.

Reentry targeted case management (rTCM) - A person-centered, recovery-focused approach to address the health of justice-involved Apple Health clients. rTCM is a mandatory service for the Reentry Initiative.

Third party administrator (TPA) - The contractor serving as the clearinghouse for claims payment and technical assistance for the Reentry Initiative.

Warm handoff – A process in which one professional or service provider personally introduces a client or patient to another professional or service provider, ensuring a smooth transition of care or services. A warm hand-off involves an active exchange of information, often face-to-face or through a direct, personal communication (e.g., phone call or video conference), to ensure continuity, clarity, and a more seamless experience for the client or patient. This approach is intended to help build trust, minimize gaps in care, and ensure that the client is supported throughout the process.

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Program Overview

Reentry initiative services

The Health Care Authority (HCA) covers Reentry Initiative services under the following authorities:

- **MTP 2.0 Reentry Demonstration Initiative.** Subject to available funds, under the MTP 2.0 Reentry Demonstration Initiative, HCA has authority to cover a limited set of services for incarcerated individuals who are eligible for Medicaid or Children's Health Insurance Program (CHIP) benefits for up to 90 days before their release from carceral facilities within Washington state.
- **Consolidated Appropriations Act, (CAA) 2023**. The CAA gives authority to HCA to cover a limited set of services for eligible juveniles. Reentry Initiative services under the CAA vary based upon whether the eligible juvenile is preadjudication or postadjudication.
    - **Preadjudication benefits:** Section 5122 of the CAA, 2023 allows HCA to cover Medicaid and CHIP benefits for eligible juveniles that are incarcerated in public institutions pending disposition.
    - **Postadjudication benefits:** Section 5121 of the CAA, 2023 requires HCA to cover the following:
        - Clinical assessment and evaluation for eligible juveniles (diagnostic services and medical, behavioral, and dental screenings) provided within 30 days prerelease or no later than one week postrelease
        - Thirty days of rTCM prerelease and for at least 30 days postrelease

As the MTP 2.0 Reentry Demonstration Initiative provides coverage over an expanded timeframe compared to the CAA, coverage is available to all eligible individuals under MTP 2.0 authority when possible. For more information on coverage, see **Coverage** and HCA's **Reentry Policy and Operations Guide**.

Reentry Targeted Case Management (rTCM)

rTCM is vital for the successful transition of clients reentering the community after incarceration. Reentry Care Managers play a significant role in supporting those leaving a carceral setting. Reentry Care Managers will:

- Assess a person's health care needs
- Develop **Reentry Care Plans**
- Support access to treatment, including but not limited to, SUD treatments of Medications for Opioid Use Disorder (MOUD) and Alcohol Use Disorder (MAUD)
- Facilitate referrals and transportation to treatment following reentry
- Connect clients to available health-related social needs (HRSN) services, including Apple Health-covered HRSN services

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Goals of rTCM

The intent of rTCM is to:

- Improve care transitions upon reentry into the community
- Increase continuity of health coverage
- Prevent unnecessary disruptions in care
- Reduce emergency department visits and inpatient hospital admissions
- Reduce decompensation, suicide-related deaths, overdoses, overdose-related deaths and all-cause deaths
- Lead to improved health outcomes in general

rTCM uses a whole-person approach, addressing physical, behavioral health, and HRSN. rTCM focuses on addressing health conditions which are prevalent in the individuals who are incarcerated. In particular, rTCM focusses on the following health conditions:

- Substance use disorders (SUDs), to include Opioid Use Disorder (OUD) and Alcohol Use Disorder (AUD)
- Mental health conditions
- Infectious diseases, including Hepatitis C and HIV

rTCM is voluntary for clients and is not a prerequisite to accessing other reentry prerelease services or Apple Health benefits.

Client Eligibility

Clients must meet eligibility criteria to receive Apple Health Reentry Initiative services before release from incarceration. See the Re*entry Initiative Policy and Operations Guide* located on HCA's website for more information.

> **Note:** To receive reentry services under the Reentry Initiative, an individual must be enrolled in Medicaid or CHIP. Reentry Initiative benefits are only available to individuals eligible for federally funded Medicaid programs. For more information, visit Reentry from a carceral setting on HCA's website.

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Provider Eligibility

Who may provide reentry targeted case management (rTCM) services?

rTCM must be delivered by a qualified professional, referred to as a Reentry Care Manager, acting within their scope of practice and as listed below. The clinician may operate in a team-based model, delegating services within their scope of practice to other rTCM team members, which may include individuals with lived experience (e.g., certified peer counselors, community health workers [CHWs], etc.). When hiring staff, providers are encouraged to be mindful of the increased background checks required by carceral facilities for professionals coming into the facility, such as ensuring a clear understanding of a carceral facility's background check requirements and any exclusionary criteria for hiring any staff required to enter a carceral facility.

The following health care professional types may be a Reentry Care Manager:

- The following behavioral health clinicians:

Type of behavioral health clinician	Taxonomy
Licensed independent clinical social worker (LICSW)	104100000X
Licensed independent clinical social worker associate (LSWAIC)	104100000X 101Y00000X
Licensed mental health counselor (LMHC)	101YM0800X
Licensed mental health counselor associate (LMHCA)	101Y00000X 101YM0800X
Licensed marriage and family therapist (LMFT)	106H00000X
Licensed marriage and family therapist associate (LMFTA)	101Y00000X 106H00000X
Certified agency-affiliated counselor (MCO only)	101Y99995L
Licensed agency-affiliated counselor (MCO only)	101Y99996L

- Other practitioners working within health care facilities (e.g., carceral facility enrolled as an Apple Health provider, federally qualified health center [FQHC], rural health clinic [RHC], individual health care provider [IHCP], or managed care organization [MCO]). Reentry Care Managers in these settings must have licensure that allows all rTCM components, including assessment and care planning for medical and behavioral health needs (e.g., registered nurse). Additionally, providers may submit claims to MCOs using the RN taxonomy (163W00000X).

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rTCM provider requirements

Providers of rTCM must:

- Meet the general provider requirements in Chapter 182-502 WAC.
- Be enrolled with Medicaid, meeting all the following:
  - Have an individual national provider identifier (NPI)
  - Be enrolled in ProviderOne
  - Have a signed core provider agreement with HCA.
- Have the licensure to provide all the core elements of rTCM services. For core elements of rTCM, see What are the mandatory requirements to provide rTCM.
- Bill HCA using only the allowed procedure codes published within this billing guide.
- Ensure appropriate clinical oversight is applied when required by the scope of practice for the licensure type and when a service is delegated to another rTCM team member (e.g., certified peer counselors, CHWs, etc.).
- Ensure duplicate billing does not occur. The activities performed by any rTCM team members who are Community Health Workers (CHWs), if billed to HCA, may not duplicate billing under the CHW services Apple Health benefit. rTCM providers may refer clients to Community Care Hubs for community supports and services. However, services delivered by Community Care Hubs within the MTP 2.0 HRSN Initiative are not billable as rTCM.

rTCM delivery system organizations

Providers billing for these services may be working as a community provider (e.g., an FQHC, native-serving organization or Indian Health Care Provider, community practice, etc.) or working within specific organizations (i.e., a carceral facility [referred to as embedded staff able to serve as Apple Health providers], an Apple Health MCO, or the HCA-contracted Reentry TPA). In the pre and postrelease period, a specific entity is responsible for ensuring which entity is to provide access to rTCM. The entity providing rTCM is identified by the responsible entity listed in the delivery system tier structure table.

In the prerelease period, carceral facilities are responsible for ensuring all eligible clients have access to medically necessary rTCM. Carceral facilities that choose not to serve in this role with their own qualified staff or via a community provider must notify HCA with a 90-day notice of the need for MCO or TPA support. MCOs are available to support rTCM for their own enrollees and the TPA is available to support FFS clients.

In the postrelease period, the responsible entity varies by the delivery system in which the client is engaged: the MCO is responsible to ensure all eligible managed care enrollees have access to medically necessary rTCM and the TPA is responsible for fee-for-service (FFS) client access.

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An HCA-contracted MCO may serve enrollees receiving care in the following programs: Apple Health Integrated Managed Care (IMC), Apple Health Integrated Foster Care (IFC), and Behavioral Health Services Only (BHSO).

Delivery system tier structure table

Provider Organization	Prerelease – For All Apple Health Clients	Postrelease for MCO Enrollees	Postrelease for FFS Clients
Carceral Facility	Responsible Entity*	If the entity is identified by and contracted with the MCO	If the entity is identified by the TPA
Community provider	If the entity is identified by the carceral facility and contracted with the MCO and TPA	If the entity is identified by and contracted with the MCO	If the entity is identified by the TPA
MCO	If the entity is identified by the carceral facility, it may serve the MCO's enrollees	Responsible Entity*	If the entity is identified by the TPA
TPA	If the entity is identified by the carceral facility, it may serve FFS clients	If the entity is identified by and contracted with the MCO	Responsible Entity*

** Responsible entity role - The organization required to identify the rTCM organization as available for the population served and facilitate communications accordingly. TPA is available for technical assistance.*

Reentry health screening

Carceral facilities participating in the MTP 2.0 Reentry Demonstration Initiative are required to conduct an eligibility verification and application in addition to screenings for unmet care needs as early as possible. This is called a Reentry Health Screening. For more information, see the *Reentry Policy and Operations Guide* located on HCA's website.

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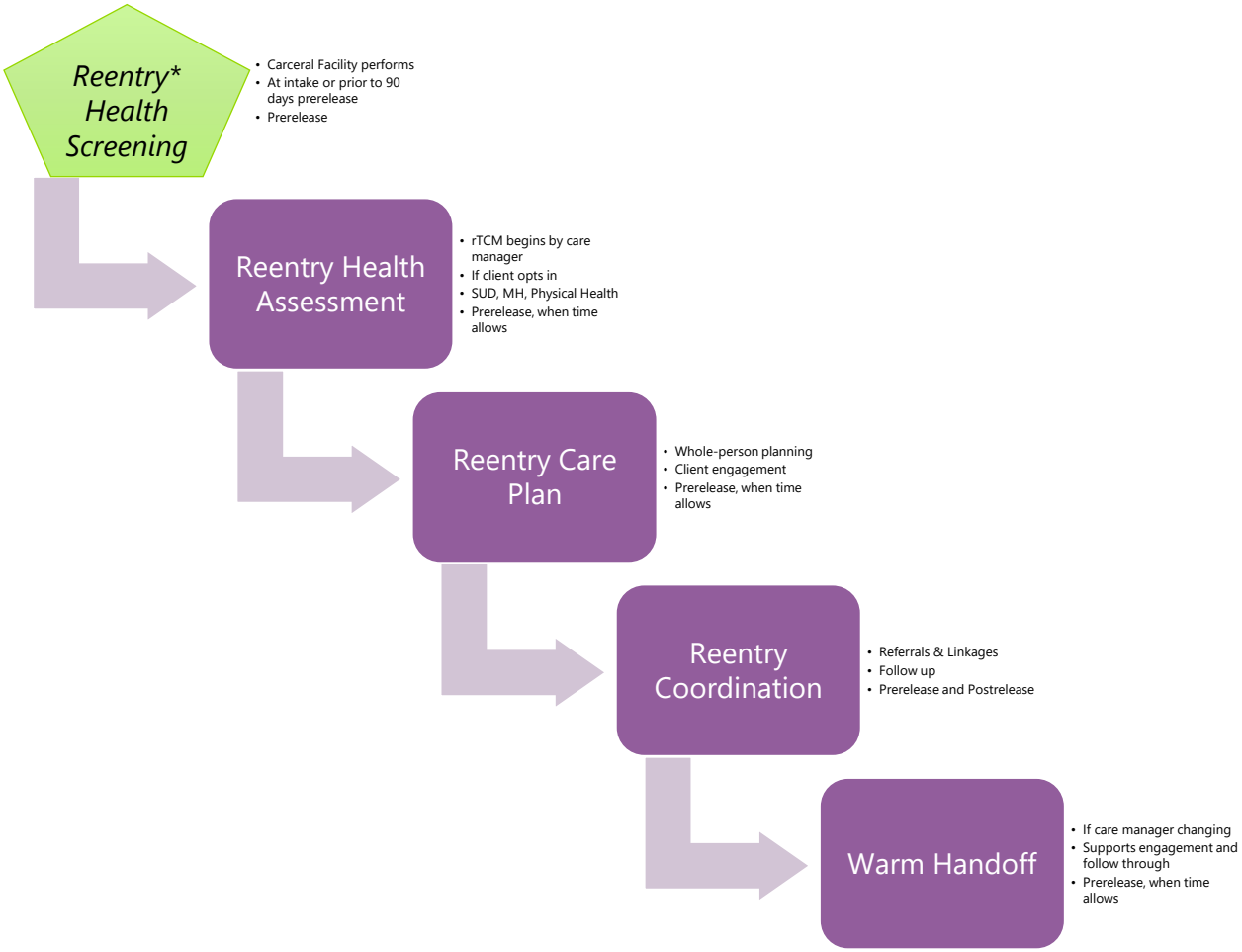
Coverage

What is covered?

Reentry targeted case management (rTCM) is covered for up to 90 days prerelease and postrelease when medically necessary, as defined in WAC 182-500 0070, and the minimum requirements (core elements) are provided. When billing HCA, providers must follow the instructions in this guide.

Pathway to Coordination



**The Reentry Health Screening (green box) is a carceral facility requirement and is not payable as rTCM. The remaining boxes in purple are rTCM requirements.*

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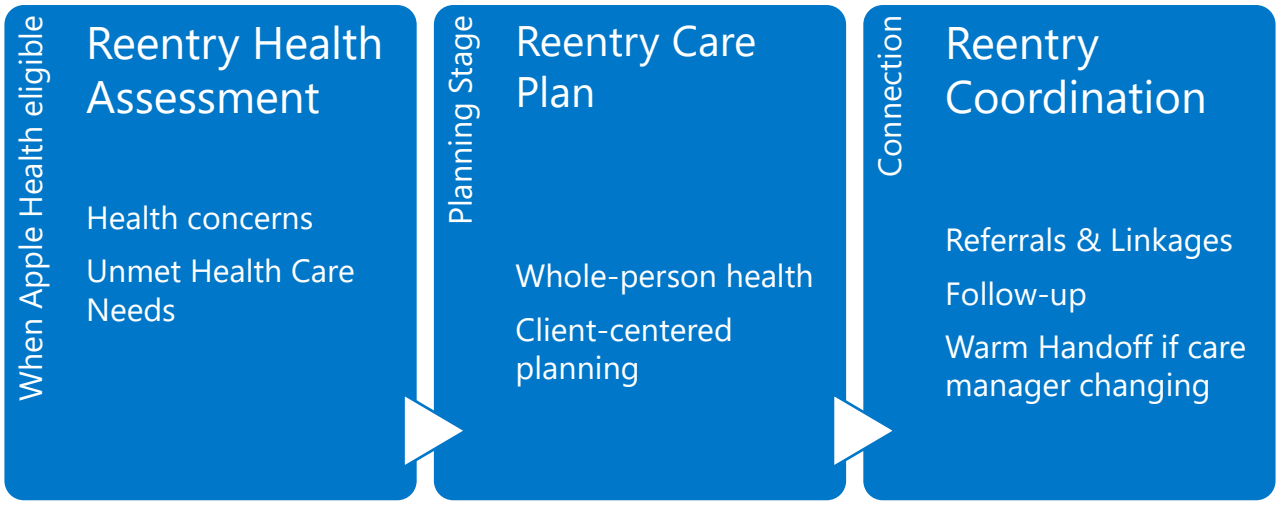
Mandatory requirements (core elements) of rTCM

Mandatory requirements (core elements) of rTCM include the following:

- Reentry Health Assessment to identify unmet care needs
- **Reentry Care Plan** developed according to Reentry Health Assessment
- **Reentry Coordination** according to the Reentry Care Plan. Includes scheduling, linkages to services, monitoring and follow-up activities to ensure the Reentry Care Plan is effectively implemented and needs are being addressed. Reentry Coordination requires routinely communicating with the client and others, including discussion with the client at a minimum of once per month in person, via audio-visual telemedicine, or via audio-only telemedicine. Additional activities may occur throughout the month to support the minimum requirements.
- **Reentry Warm Handoff** required if the Reentry Care Manager is changing (e.g., during prerelease period, pre to post Reentry Care Manager change such as to an MCO care coordinator or to a Health Home, etc.).



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Medical necessity criteria

HCA considers rTCM to be medically necessary for an Apple Health Medicaid or CHIP-eligible client, or a client who would otherwise be eligible for CHIP if not for their incarceration status, has a diagnosis that corresponds with one of the ICD codes listed in the **Covered diagnosis codes** table, and who meets one of the following requirements:

- Is an inmate of a public institution, as defined in 42 CFR 435.1010, and are incarcerated in a state prison, tribal facility, county or city jail, or youth correctional facility
- Was released from incarceration from a public institution, as specified by 42 CFR 435.1010, and was incarcerated in a state prison, tribal facility, county or city jail, or youth correctional facility within the last 12 months

HCA considers rTCM to be medically necessary for each incarceration that clients experience; therefore, the covered period prerelease is calculated from the most current estimated release date.

For adults who are ineligible for CAA (adults age 21 and older unless the client is eligible due to foster care status) and for eligible juveniles incarcerated in an MTP 2.0-participating carceral facility, postrelease rTCM is limited to releases occurring in all the following:

- From carceral facilities enrolled in MTP 2.0
- When the carceral facility is active in the Reentry Initiative
- When the release occurs after July 1, 2025.

For clients eligible for CAA (eligible juveniles), medically necessary rTCM is not limited to an MTP 2.0-participating facility or by release date (e.g., incarcerations and/or release may occur before or after July 1, 2025).

Continue postrelease rTCM for as long as medically necessary, which is typically 30 days after release and no longer than 12 months after release; most postrelease coordination needs are addressed within 12 months. The discharge criteria provide a basis for when rTCM is no longer medically necessary and rTCM must end.

Note: Services may be initiated postrelease whether or not the client was able to engage with rTCM during incarceration (e.g., short incarceration, client opted out of rTCM).

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Discharge criteria

Discharge criteria include any of the following:

rTCM no longer medically necessary	The client no longer requires rTCM expertise for stabilization in the community, (i.e., expertise on reentry transitions and health impacts from incarceration are no longer needed to attain health goals) such as when the following components are completed: • **Reentry Health Assessment** • Discussion of health goals and development of **Reentry Care Plan** • Client informed of appropriate follow-up care • Providers identified and appointments scheduled • Coordination between carceral facility health care system and community providers • **Reentry Warm Handoff**, if appropriate (e.g., transition to another coordinator)
Client transitioned to another coordinator	Examples include when the client: • Is eligible for and opts to enroll in, or is already enrolled in, a health home • Is eligible for and receiving another targeted case management service • No longer requires rTCM expertise (i.e., expertise on reentry transitions and health impacts from incarceration are no longer needed to attain health goals) and another coordination function is appropriate Postrelease coordinators available through Apple Health include but are not limited to: • The MCO for a managed care enrollee (including IMC, IFC, and BHSO enrollees) • Targeted Case Management for specific populations (e.g., HIV case management) • American Indian client's Primary Care Case Management (PCCM) provider or Indian Health Care Provider for either an MCO enrollee or FFS client • Health Homes coordinator for either an MCO enrollee or FFS client

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Client ineligible	Client is ineligible for Apple Health entirely or is ineligible for rTCM within the client's Apple Health coverage (e.g., clients who are served with rTCM at the start of incarceration and then have eligibility suspended due to a longer-term sentence)
Client choice	Client chooses to discharge from rTCM or is not able to be contacted **Note:** HCA considers the client as "not able to be contacted" when there is an inability to contact the client after three attempts on three different days, times, and methods.

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Reentry Health Assessment

The Reentry Health Assessment (RHA) is a requirement for providing rTCM when screening has not been completed, or the Reentry Health Screening identifies an unmet care need. An RHA assesses the needs of the client to inform development of a Reentry Care Plan and is intended to support identification of service needs pre and postrelease. The RHA includes all available information, including information from the screening and any other sources. If information becomes available after the initial RHA, the Reentry Care Manager must continue to seek information to inform the Reentry Care Plan development. The focus of the Reentry Care Plan is to address physical, behavioral health and HRSN, but should also consider social, educational, and other underlying needs, such as vocational services or employment.

The Reentry Care Manager may use a data collection tool of their choosing but it must cover all the required components (see **Required components of the Reentry Health Assessment**). Clients have the right to refuse to participate in the entirety of the assessment without declining rTCM entirely; however, this must be documented. The **WASPC Intake Screening form** meets the intent of the majority of the Reentry Health Assessment when completed or reviewed by a Reentry Care Manager; the missing element is the mental health assessment.

HCA's rTCM Assessment Addendum form (HCA 05-0006) may be used to support the WASPC Intake Screening form. If this form was completed by a carceral facility staff member who is not licensed as or supervised by an rTCM provider (e.g., correctional officer), it should be shared with the Reentry Care Manager along with a rTCM referral so the details may be considered as part of the Reentry Health Assessment as documentation to support the comprehensive rTCM clinical assessment.

A key function of the Reentry Care Manager is to perform a comprehensive assessment by gathering and assimilating information from an array of sources, such as documents in multiple systems and across different formats, to ascertain the health needs of an incarcerated individual.

The assessment may include any past medical history; medical records; other assessments; screenings; diagnostic services; information available from the corrections system; interviews with the client; and information from health plans, state Medicaid agencies, providers, and other sources that may be available to the Reentry Care Manager.

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Required components of the Reentry Health Assessment

The required components of the Reentry Health Assessment are:

Comprehensive, whole-person assessment	Covers physical health, mental health, substance use disorder, and HRSN, including:
	• Any acute or chronic illnesses
	• Substance use (drugs, alcohol), current and historical use
	• Mental health, including risk of self-injury
	• Physical health, including:
	  ○ Screening for infectious disease, including Hepatitis C, Tuberculosis, and HIV
	  ○ Physical limitations and any ADA accommodations
	  ○ Oral health
	• Current medications and any medical supplies in use
	• Allergies
	• HRSN, including housing, employment, transportation, education, and financial stress
	• The need for or use of supportive services and resources

Identification of individual needs included in the Reentry Care Plan	Includes the determination of the need for any medical, education, social or other services, such as the following: • DSHS' Developmental Disabilities Administration (DDA) • Program models to support individuals when released into the community, such as Wraparound for Intensive Services (WISe), New Journeys, or Program for Assertive Community Treatment (PACT) • DSHS' Home and Community Services (HCS)
Assessment of client's level of engagement	Includes assessment of client's stage of change and readiness to engage in treatment
Periodic reassessment of individual needs	Done upon significant change or as clinically indicated

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Reentry Care Plan

The Reentry Care Plan is a requirement for providing rTCM and includes Reentry Care Plan development (and periodic revision) of a care plan. The Reentry Care Plan is an actionable person-centered tool that engages the client at the center of decision-making to:

- Support early identification and diagnosis of health conditions
- Connect to care and services
- Improve health stability postrelease and beyond

The reentry care plan is created with the client, based on the client's goals and priorities, and based on the information collected from treating clinicians and through needs identified in the Reentry Health Screening, Reentry Health Assessment, and any subsequent rTCM activities. When created in the prerelease period, the Reentry Care Plan is created with input from the following:

- The treating clinician for prerelease services
- The carceral facility's reentry planning team, such as awareness of criminal legal obligations

The extent of the Reentry Care Plan depends on the health and social complexity of the client. The Reentry Care Manager must decide the extent of detail required in the Reentry Care Plan for each client.

The Reentry Care Plan may be created within one client interaction or in multiple interactions. The Reentry Care Manager must update the Reentry Care Plan when:

- There is a significant health change
- The client is released from incarceration (required within 30 days of release)
- New information is identified in a Reentry Health Assessment reassessment review
- As clinically indicated

The Reentry Care Manager may use a care planning tool of their choosing, but it must cover all the required components (see Required components of the Reentry Care Plan).

Carceral facilities assist in obtaining client engagement and informed consent for rTCM, informing the Reentry Care Plan development, identifying needed referrals and appointments, and discussing any impact for changes in release date.

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Required components of the Reentry Care Plan

The required components of the reentry care plan are:

Identified Health Conditions	A presentation of the diagnosis(es) and health conditions that does the following: • Addresses physical health, behavioral health, and HRSN. It must examine past needs and services, and document and facilitate current and future needs and services. • Includes known treating providers • Addresses social, educational, and other underlying needs, such as vocational services or employment • Prioritizes the health conditions being focused on

Action Planning	An action plan, including:
	
	• Reentry health goals developed with the client
	• Services identified pre or postrelease to support goals achievement. Document and facilitate services to be provided either prerelease or postrelease to diagnose health conditions and provide treatment, as appropriate. When created in the prerelease period, the plan:
	  ○ Addresses the use of prerelease and postrelease services to assess and address physical health and behavioral health needs and identified HRSNs
	  ○ Ensures that prerelease benefit packages are provided to clients who are eligible during the prerelease period as appropriate and attempts to coordinate receipt of these services with the client's receipt of other services (e.g., provided directly by the carceral facility)
	• A referral to the Community Care Hub to address HRSN needs, if appropriate, such as housing, transportation, food, finance, education, and employment

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	• The support of client SUD treatment engagement and counseling via the following:
	  ○ Choice counseling using shared decision-making tools (e.g., opioid use disorder [OUD]) and discussion of options and risks
	  ○ Assessment of the stage of change and the readiness to engage in treatment
	  ○ Use of motivational interviewing to help the client progress further in readiness
	  ○ Referral to an appropriate provider assessment visit for diagnosis and prescription of medication for opioid use disorder (MOUD)/medication for alcohol use disorder (MAUD) if appropriate, including clinical determination for the amount of medication supply for SUD prescriptions to have in hand to take home at release to meet the need between release and the transition to a community provider.

Supports Planning	A plan for engagement of identified supports for the client (e.g., family, friends, probation/community corrections officer, and other community supports as identified)
Barriers	The identification, monitoring, and management of barriers

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Reentry coordination

Reentry Coordination is a requirement for providing rTCM. Reentry Coordination is provided in alignment with the **Reentry Care Plan**. Coordination of care is necessary to ensure that the Reentry Care Plan is implemented and adequately addresses the client's success postrelease.

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Required components of Reentry Coordination

The required components of Reentry Coordination are:

Motivational interviewing	Supports client progress in readiness/engagement in care and recovery. During incarceration and in release planning, providers educate clients on treatment choices and the process for continuation of access to MOUD, as appropriate
Referral and linkages to services prerelease or postrelease (such as scheduling appointments for the client)	Helps the client obtain needed supportive and stabilizing services, including activities that help link the client with medical, social, and educational providers or other programs and services that can provide needed services to address identified needs and achieve goals specific in the reentry care plan. The following are included: • Identification of the client's primary care provider. Providers ensure alignment of the identified primary care provider assigned through an enrollee's MCO and the Patient Review & Coordination (PRC) program, as applicable. If needed, providers initiate a primary care provider change to ensure appointments and information are shared with the appropriate provider. • Identification and scheduling of appointments for necessary health care services, including but not limited to diagnostic, family planning, primary care, specialty, mental health, substance use, dental, or other services. Providers make appointments for primary and specialty care according to the Reentry Care Plan, addressing both prerelease and postrelease services to ensure stabilization and continuity of care within the transition to the community and help support the client with supportive and stabilizing services postrelease that help achieve the goals listed on the Reentry Care Plan. Providers schedule the next wellness exam and immunizations for clients age 20 and younger within one week of release or as soon as practicable. • Linkages to community-based services and supports, including but not limited to educational, social, prevocational, vocational, housing, nutritional, transportation, childcare, child development, and mutual aid support groups

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	• Referrals for appropriate long-term services and supports (LTSS), community service, and HRSN (e.g., nutrition, housing, transportation, etc.) as available, including Apple Health-covered HRSN services
	• Coordination between prescribers and pharmacies, such as:
	  ○ Fills or refills of prescribed medications
	  ○ Assuring active scripts are available such as transferring script from home pharmacy to carceral facility pharmacy
	  ○ Supporting resolution of any script edits needed before release
	  ○ Establishing next day availability of SUD medications whether prescribed or required to receive in-person
	  ○ Supporting information about the client for the pharmacy (e.g., allergies)
	  ○ Coordination with the PRC program
	• At least a 30-day supply of prescribed medications at release. In addition to providing medications in hand upon release, the carceral facility must provide a prescription for any active medication to be refilled at a postrelease pharmacy as appropriate and feasible, so the client has access to refills.

Coordination of logistics (e.g., nonemergency medical transportation and postrelease medications and supplies)	Includes addressing any prior authorizations, if necessary

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Frequent communication	Includes communication with the client, treating providers, collateral contacts, and others necessary to support client engagement in treatment and progress in achieving the Reentry Care Plan, including discussion with the client prerelease and postrelease at a minimum of once per month via in-person, audio-visual telemedicine, or audio-only telemedicine. Additional activities may occur throughout the month to support the Reentry Care Plan and rTCM minimum requirements such as: • Connecting with providers to share the Reentry Care Plan, unmet care needs, or appropriate records to support the Reentry Care Plan in accordance with the client's informed consent and health care confidentiality regulations (e.g., HIPAA, **42 CFR Part 2**). • Obtaining informed consent, as appropriate, to furnish services or to share information with other entities to improve coordination of care • Collaborating to assure continuation of care between prerelease and postrelease providers
Monitoring and follow up activities	Includes activities and contact that are necessary to ensure that the Reentry Care Plan is effectively implemented and adequately addresses the needs of the client. This may be conducted as frequently as necessary with the client, family members, services providers, or other entities or clients and include at least one annual monitoring to determine whether the following conditions are met: • Services are being furnished in accordance with the client's Reentry Care Plan • Services in the Reentry Care Plan are adequate • Changes in the needs or status of the client are reflected in the Reentry Care Plan. **Note**: Conducting follow up must ensure engagement with community-based providers, behavioral health services, and other aspects of discharge/reentry planning, as necessary, no later than 30 days after release.

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Documentation of appropriate coordination and follow-through in achieving goals	
Review and revision of the Reentry Care Plan	As appropriate every month, within 30 days after release, and as clinically indicated. See Discharge Criteria for guidance on the appropriate length of service

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Reentry Warm Handoff

The Reentry Warm Handoff is a requirement for providing rTCM if the Reentry Care Manager changes. Warm handoffs include the incoming and outgoing care managers and client and may be required multiple times during a client's rTCM service segment to preserve client trust and engagement and to support continuity of rTCM. The Reentry Warm Handoff also includes a review of the Reentry Care Plan and the next steps to ensure continuity of case management and follow-up needs for the client's transition into the community.

Examples of when a warm handoff is required include the following:

- A transition of Reentry Care Managers, either during the prerelease period (e.g., jail to the Department of Corrections) or postrelease period (e.g., MCO enrollment change)
- Between pre and postrelease Reentry Care Manager (e.g., juvenile detention Reentry Care Manager to MCO or TPA Reentry Care Manager)
- Upon discharge from rTCM when continued coordination activities are clinically needed (e.g., postrelease Reentry Care Manager to MCO care manager, PCCM, or Health Home)

The Reentry Warm Handoff should occur:

- At least 14 days before release and when most clinically effective (e.g., after the Reentry Health Assessment and Reentry Care Plan have been developed if time allows)
- Within 7 calendar days after release (e.g., if the client is released by court order earlier than expected or has a very short stay) if it is not possible for the Reentry Warm Handoff to occur before the client's release

The outgoing Reentry Care Manager (the current Reentry Care Manager who has been working with the client, such as the prerelease Reentry Care Manager) must initiate the Reentry Warm Handoff. Clients incarcerated for less time should be given an informational handout upon release with contact information for Apple Health and crisis services, such as HCA's Reentry Resources for Apple Health (Medicaid) After Release from Incarceration (HCA 19-066).

The Reentry Care Manager may use a documentation tool of their choosing, but it must cover all the required components.

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Required components of the Reentry Warm Handoff

The required components of the Reentry Warm Handoff are:

A person-to-person connection	To discuss the transition and status of the Reentry Care Plan, inclusive of both outgoing and incoming Reentry Care Managers. Person-to-person connection may be in person or via audio-visual or audio-only telemedicine.
Sharing the rTCM status with the incoming Reentry Care Manager	Includes sharing the following: • The completed consent, Reentry Health Screening, and Reentry Health Assessment forms • The Reentry Care Plan with follow-up provider information identified including name, phone number, and clinic address at minimum • The status of any outstanding needs or appointments The Reentry Care Plan must be communicated to the client's primary care provider and the enrollee's MCO (if applicable) within 14 days before release if release data is known and no later than 7 calendar days after release.
Communication within the health care team	To support seamless care handoff, following consent and data-sharing requirements

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Washington State Health Care Authority

Billing for Reentry Targeted Case Management

General billing information

Prior authorization (PA) is not required to provide reentry targeted case management (rTCM). Any refusal of services by the client must be documented in the client's health care record. Providers must follow standard coding practices when billing and follow applicable HCA and MCO rules.

When billing for clients age 20 and younger, see HCA's **EPSDT Well-Child Program Billing Guide**.

Carceral facilities must not charge Apple Health-eligible individuals or health care providers for any Reentry Initiative services or activities associated with those services nor may health care providers charge Apple Health-eligible individuals for Apple Health-covered services.

Location where services may be delivered

Providers may offer targeted prerelease services within carceral facilities, in the community, or via audio-visual or audio-only telemedicine. Reentry Care Managers must work with facilities to identify how clients will access providers either in-person or remotely for the provision of care.

Fee-for-service fee schedule information

Maximum allowable fees for all codes, including CPT® codes and selected HCPCS codes, are listed on the **rTCM fee schedule**. Limitations or requirements detailed in HCA billing guides and Washington Administrative Code (WAC) remain applicable. HCA's fee schedules are available on HCA's **Professional billing guides and fee schedules** web page and **Hospital reimbursement** web page.

rTCM billing

When billing for rTCM services, submit the claim to HCA without any other services on the claim. The Third-Party Administrator (TPA) is available to provide technical assistance and to act as the claims clearinghouse for providers newly billing for MTP 2.0 (i.e., embedded staff within MTP 2.0-enrolled carceral facilities). Both rTCM entities participating in the warm handoff may bill for the month in which the handoff occurs when the care is moving from one rTCM Delivery System Organization to another.

Note: Each incarceration event may initiate rTCM.

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Nonpayable rTCM

HCA does not pay for rTCM when the following other coordination services are engaged and providing services to the client. HCA considers this a duplication of services. Clients may choose to engage in rTCM or another service and a warm handoff should occur to support the transition at that time. The following are considered to be duplicative of rTCM:

- Other targeted case management (available postrelease only) such as SUD Case Management and HIV/AIDS Case Management
- Health Homes (available postrelease only)

> **Note:** HCA may pay for rTCM when the following services are involved, and HCA has determined no duplication of service exists:
>
> - Primary Care Case Management (PCCM)
> - Health-Related Social Needs (HRSN) case management provided by the Community Care Hub

Billing information to be included on the claim

When billing HCA for rTCM:

- Use one of the rTCM-allowable HCPCS codes in the Services procedure codes table with the appropriate rTCM-allowable modifier in the Modifiers table.
- Include the following information on the claim line when providing rTCM via audio-only telemedicine. See HCA's Telemedicine policy billing guide for more information regarding audio-only telemedicine:
  - The HCPCS code plus the appropriate reentry modifier
  - The appropriate audio-only telemedicine modifier (93 or FQ)
- Indicate the appropriate diagnosis code listed in the Covered diagnosis codes table.

> **Note**: HCA limits payment to one HCPCS code billed (or encountered) every 30 days when the minimum activities are completed according to the rTCM Timeline. Exceptions may apply when clinically appropriate. **For example:** A client is released and rebooked in the same month, requiring rTCM for both incarcerations.

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Service procedure codes

HCPCS procedure code	Short description	Comments
T1023	Program intake assessment	**Initial Month, when Reentry Care Plan developed** Includes Reentry Health Assessment Initial TCM month for activities pre or postrelease in which completion of initial Reentry Care Plan is performed Warm Handoff completed; rTCM client interaction (in person or via audio-visual or audio-only telemedicine) May be billed once per client per incarceration
T2023	Targeted case mgmt per month	**Initial Month, when only Reentry Health Assessment completed** Initial month for TCM activities pre or postrelease Warm Handoff completed; rTCM client interaction (in person or via audio-visual or audio-only telemedicine) May be billed once per client per incarceration
T2022	Case management, per month	**Subsequent Month rTCM** Subsequent month for TCM activities pre or postrelease Warm Handoff completed; rTCM client interaction (in person or via audio-visual or audio-only telemedicine)

Modifiers

Modifier	Modifier Description	Timeframe
QJ	Services/items provided to a prisoner or patient in state or local custody, however the state or local government, as applicable, meets the requirements in 42 CFR 411.4 (b)	Prerelease
TS	Follow-up service	Postrelease

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Covered diagnosis codes

ICD dx code	ICD dx code description	Timeframe
Z65.1	Imprisonment and other incarceration	**Prerelease**: Client incarcerated, and release anticipated within the next 90 days
Z65.2	Problems related to release from prison (Code can be used to reflect release from any incarcerated setting)	**Postrelease**: Client released from incarceration

rTCM Timeline

HCA pays for rTCM when provided:

- **Prerelease:** Providers may bill for rTCM prerelease when a client's release from incarceration to the community is known or anticipated to be within 90 days. Initiate prerelease rTCM as soon as possible and as clinically appropriate to support and stabilize the client at reentry. For example:
  - For clients without a known estimated release date (ERD), timing is usually urgent to assess and coordinate unless other barriers exist such as a high probability of the client remaining incarcerated greater than 90 days, where a release must be identified prior to release, where client needs may be causing a delay in release, etc.
  - For clients with a known ERD, the Reentry Care Manager must intervene immediately or evaluate the urgency to determine when it is most clinically appropriate to initiate services. Factors may impact the appropriateness of intervention such as known release address (when required), known legal decision maker, sentence timing and immediacy of ERD, and complexity of need, etc.
- **Postrelease:** Providers may bill for rTCM postrelease whether or not rTCM was initiated while the client was incarcerated. Postrelease services are available when medically necessary.

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Timeframes for rTCM Connections

The following activities are required to be performed no later than the following periods of time:

Length of time since Apple Health enrollment confirmed	Activities Required
Within 24 hours	• Reentry Health Screening • Reentry Resources Handout provided
Within 48 hours	• Reentry Care Manager assignment if positive screen and interested in rTCM • Warm Handoff, when Reentry Care Manager changes. Requirement can occur at any point before release and no later than 7 days postrelease.
Within 3 business days	• Reentry Health Assessment with needs identified
Within 4 business days	• Reentry Care Plan completed

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