Community Health
Partnership Services

HMA

Reentry Healthcare Contracting

July 29, 2026

Today’s Speaker

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Community Health
Partnership Services

Join us in the session!

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Today’s Focus and Objectives

Reviewing the agreements you need to successfully implement and sustain the Reentry Initiative

- **Today’s Focus**: Healthcare contract implementation under the Washington Reentry Initiative
- **Learning Objectives:**
  - Identify which contracts, MOUs, job descriptions, and vendor agreements may need review to successfully implement and sustain the Reentry Initiative.
  - Recognize where staffing, clinical, pharmacy, billing, data, and partner workflows create contracting risk.
  - Use contracting pre-work to reduce role confusion, rework, missed handoffs, and staff fatigue.
  - Name early contract amendments or agreements that can make implementation more sustainable.

Contracting readiness principle

If the work is not in the contract, role description, MOU, or workflow, it may not happen reliably. You should think about this early in implementation.

Acronyms and Terms

Common Reentry Initiative acronyms defined

Term	What it means
ACH	Accountable Community of Health. Nine regional non-profits; each runs a Community Care Hub.
BAA	Business Associate Agreement. HIPAA contract with any vendor handling PHI for you.
CCH	Community Care Hub. The only entity that can deliver HRSN screening and referral.
CHPS	Community Health Partnership Services (administered by Community Health Plan of Washington). Reentry Initiative third-party administrator and claims clearinghouse.
CQI	Continuous Quality Improvement.
DSA / DUA	Data Sharing Agreement / Data Use Agreement.
HRSN	Health-Related Social Needs, such as housing, food, and transportation.

Term	What it means
MCO	Managed Care Organization
MOUD / MAUD	Medications for Opioid Use Disorder/Alcohol Use Disorder.
MTP 2.0	Medicaid Transformation Project 2.0, Washington's Section 1115 waiver.
NPI	National Provider Identifier. Type 1 is an individual clinician; Type 2 is an organization.
ProviderOne	Washington's Medicaid system for claims, payment tracking, and eligibility checks.
ROI	Release of Information, the individual's consent to share their records.
RTCM	Reentry Targeted Case Management, a mandatory Reentry Initiative service.

Why Contracting Preparation Matters

Reentry Initiative work changes who does what, when, where, and how it is documented

The work starts earlier

Services, eligibility work, care planning, medications, and handoffs begin up to 90 days before release.

The work crosses systems

Facility, custody, clinical, reentry, MCO/TPA, provider, pharmacy, and community partner workflows must connect.

Contracts define reliability

Agreements should make ownership, documentation, access, timelines, and escalation explicit.

Pre-work reduces burden

Clear contracting prevents last-minute workarounds, duplicate entry, billing rework, and staff burnout.

Implementation principle

Contracting is not separate from implementation; it is how the implementation model becomes operational.

Reentry Initiative Contracting Map

Who you contract with, and for what

Who you contract with	Typical agreement	What the agreement must cover
Facility staff and labor unions	Job descriptions, classifications, collective bargaining agreements	New duties, hours, caseloads, supervision, and licensure or delegation limits
In-facility health services vendor	Professional services contract or amendment	Pre-release services, telehealth, documentation standards, credentialing
Pharmacy	Pharmacy services contract or MOU	Short-notice fills, medication-in-hand, MOUD continuity, after-hours coverage
CHPS (third-party administrator)	State onboarding and clearinghouse agreements	No contract needed. You can just call to get help! Please do so. Also does rTCM (FFS clients only)
Managed care organizations	Provider agreement or MOU	Pre-release engagement, care management connection, post-release follow-up
Community providers	MOU or subcontract	First appointments, closed-loop referral, escalation, backup coverage
ACH Community Care Hub	Referral agreement or MOU	HRSN screening and referral, housing, transportation, and benefits navigation
Anyone who touches PHI	DSA, BAA, DUA, and client ROI	What is shared, with whom, when, and under what legal authority

Reentry Initiative Contracting Work Plan

A repeatable 5-step workflow

1

Map the work

List every Reentry Initiative task from identification through 30 days post-release.

2

Name the owner

For each task, name who does it and who covers when they are out.

3

Find the paper

Is it already in a contract, MOU, job description, or written workflow?

4

Close the gap

Amend, add, or clarify. Decide who signs it and by when.

5

Make it visible

Add documentation, reporting, and CQI expectations so you can tell it is working.

Implementation principle

Capture the details for routine workflows and exceptions in your contracts

Labor Contracts, Job Classifications, and Role Scope

Are you redesigning roles or adding work?

Question	What to look for
Are duties changing?	Pre-release care coordination, eligibility work, documentation, warm handoffs, data tracking, or partner coordination.
Does the role allow it?	Union agreements, civil service classifications, job descriptions, licensure, delegation, supervision, and credentialing.
Will hours or schedules change?	Overtime, standby, weekend release support, caseloads, shift coverage, and competing priorities.
Is this the best role?	Do not assign work only because someone is available; align responsibility with skills, authority, and sustainability.

Early action

Flag likely role changes for HR, labor relations, leadership, and operations before workflows are finalized.

Contracting readiness principle

The question is not only:
“Can staff do this?”
It is:
“Are they authorized, supported, and the right people to do it?”

Provider and Clinical Service Contracts

Confirm that contracted services can be delivered in a carceral pre-release setting

Services Covered

Primary care, behavioral health, SUD, psychiatry, MOUD/MAUD, care management, peer/community health worker, labs, DME, and consultation.

Setting and Access

In-facility care, telehealth, private clinical space, security clearance, scheduling, and custody movement.

Capacity and Timing

Release timelines, urgent releases, no-shows due to court or lockdown, and backup staffing.

Documentation

Where notes live, who documents, required fields, billing-ready records, and data sharing.

- ✓ Does the current contract explicitly allow pre-release services and facility-based or telehealth delivery?
- ✓ Does it define handoff expectations when release dates change?
- ✓ Does it name who is responsible for referral closure and follow-up?
- ✓ Does it include participation in implementation meetings or CQI review?

Implementation principle

Existing provider contracts may need small amendments before they can support Reentry Initiative workflows reliably.

Pharmacy, Medication, and MOUD Continuity Contracts

Medication access is both a clinical risk and a contracting readiness issue

Contract question	Implementation risk if not resolved
Can meds be filled for short-notice releases?	People may leave without medication-in-hand or bridge prescriptions.
How are after-hours/weekend releases handled?	Continuity gaps occur when pharmacy availability does not match release timing.
Who pays if Medicaid billing is not ready?	Payment disputes can delay fills or create unfunded facility costs.
Do pharmacy and provider workflows align?	Orders, reconciliation, prior authorization, and discharge documentation may break down.
Is MOUD/MAUD continuation explicit?	Treatment interruption increases clinical and reentry risk.

✓ *Look at*

Medication reconciliation, medication-in-hand, prior authorization, specialty meds, chain of custody, delivery, and documentation.

✓ *Ask early*

What happens if release is tomorrow, tonight, on a weekend, or earlier than expected?

✓ *Design for*

Routine releases and exceptions; both need a contract-supported workflow.

Partner Agreements and Handoff Expectations

Make the handoff a workflow, not just a relationship. Clarity of expectations are essential to best partner and serve.

Facility Role

Identify eligible individuals, initiate release planning, coordinate movement, document facility-side actions.

CHPS/TPA Role

Operational and data/reporting coordination consistent with Washington implementation design.

MCO/Provider Role

Pre-release engagement, appointment support, care management and community connection, post-release follow-up.

Community Role

Additional behavioral health, SUD, primary care, housing/HRSN, peer support, transportation, and benefits help.

Agreement element	Questions to answer
Referral workflow	Who sends, receives, accepts, and closes the loop?
Release changes	Who is notified and how quickly when date, time, or destination changes?
Escalation	Who resolves urgent medication, appointment, eligibility, or documentation issues?
Back-up coverage	Who covers vacations, turnover, clearance delays, or provider capacity gaps?

Data Sharing, Consent, and System Access

The right people need the right information at the right time

Agreement	Full name	Who you sign it with	What it covers
DSA	Data Sharing Agreement	HCA, CHPS, MCOs, county and city partners	What data moves, how often, in what format, and for what purpose
BAA	Business Associate Agreement	Any vendor handling PHI on your behalf	HIPAA safeguards, permitted uses, subcontractors, breach notification
DUA	Data Use Agreement	Analytics, evaluation, or limited data set recipients	Permitted uses, re-disclosure limits, retention and destruction
ROI	Release of Information	The individual	Consent to share, scope, duration, and how it is revoked
Part 2 consent	42 CFR Part 2 consent	SUD treatment record holders	Separate, specific consent before SUD information is shared

Contract readiness principle

A workflow that depends on sharing data cannot be reliable if the data-sharing permission is informal.

- ✓ Identify which systems do not talk to each other.
- ✓ Write out a list of who needs to be involved to best serve clients.
- ✓ Avoid creating new spreadsheets unless ownership and retirement criteria are clear.
- ✓ Decide which source of truth will be used for each key field
- ✓ What contracts do you have? Inventory what systems are in place.

Medicaid Enrollment and Billing Basics

The foundational pieces every facility needs in place before the first claim goes out

Eligibility and Coverage

- Reentry services cover people eligible for Apple Health (Medicaid) or CHIP up to 90 days before release
- Know whether each person is enrolled with an MCO or in fee-for-service, as it changes who you coordinate with
- Confirm eligibility in Provider One rather than assuming it from the booking record

National Provider Identifier

- NPI Type 1 identifies an individual clinician
- NPI Type 2 identifies an organization such as a facility or vendor
- Most reentry claims need both, and a missing or mismatched NPI is a common denial reason

Provider One and Enrollment

- Provider One is the system used to submit reimbursable Reentry Initiative claims
- It also lets facilities track Apple Health payments and confirm eligibility
- Enroll as an Apple Health provider early; enrollment is a prerequisite, not a formality

Reentry pro tip

Enrollment steps, fee schedules, and codes change. Work from the current Reentry Services Billing Guide and fee schedules on the HCA site rather than a saved copy and check the version date before you build a workflow on it.

Billing, Claims, Documentation, and Revenue Cycle Contracts

Decide before go-live who turns services into billable, reportable records

Function	Contracting questions
Provider enrollment/ credentialing	Who must be enrolled or credentialed and by when?
Documentation standards	What fields, signatures, timelines, and locations are required?
Claim submission	Who submits, through what system, and with what supporting documentation?
Denials and appeals	Who owns denied claims, appeals, and resubmissions, and on what timeline?
Financial reconciliation	How will services, claims, payments, and reinvestment assumptions be reconciled?

Contracting readiness principle

Billing readiness starts with documentation design, not with claims submission.

Early action

Put billing and documentation expectations into provider scopes of work and implementation checklists.

Contracting ≠ Credentialing

Two separate processes, both required before a service becomes a paid claim

Contracting

The business agreement between two organizations.

- Sets scope of services, rates, terms, and obligations
- Signed by authorized signatories for each organization
- Answers: what will be delivered, by whom, and for what payment

Credentialing

The verification of an individual clinician's qualifications.

- License, education, training, work history, sanctions, and privileges
- Performed by the payer or health plan, one clinician at a time
- Answers: is this specific person approved to bill for this service

HOW THEY INTERTWINE

A signed contract does not make anyone billable. Claims are denied when the organization is contracted but the individual clinician is not credentialed and enrolled. Both must be complete, and credentialing usually takes far longer than the contract negotiation.

ACTION FOR FACILITIES USING THE ONE-YEAR CREDENTIALING WAIVER

If your in-facility providers came on under the one-year credentialing waiver, find the expiration date now and complete full credentialing before it lapses. Track this by individual clinician, not by vendor, and build the renewal into the vendor contract.

Technology, Telehealth, and Facility Access Contracts

Operational access can determine whether contracted services actually happen

Telehealth Readiness

Platform, equipment, bandwidth, private space, support, scheduling, interpretation, and backup plan.

Security Clearance

Background checks, orientation, badging, PREA/security training, permitted items, and renewal timelines.

Facility Movement

Escort needs, appointment windows, lockdown protocol, court conflicts, and clinical confidentiality.

Risk	Contract Question
Telehealth fails near release	Who troubleshoots and what is the fallback?
Vendor staff cannot clear security	Is there alternate staff or telehealth coverage?
No private space is available	Can services be rescheduled, relocated, or delivered another way?
Custody movement limits access	Do service timelines reflect facility operations?

Transportation and Release Logistics

Warm handoffs fail when the practical release plan is not contract-supported

Transportation

Rides, non-emergency medical transportation coordination, rural release needs, weekend options, and destination changes.

Appointment Access

First visit scheduling, reminder workflows, missed appointment response, and closed-loop confirmation.

Release Exceptions

Court releases, short-notice releases, late-day releases, transfers, and unknown destinations.

Implementation principle

A care plan is only as strong as the contracted and operational supports that make the first 24-72 hours feasible.

Performance and Quality Improvement Clauses

Contracts should help teams see whether the work is happening reliably

Contract element	Example expectation
Timeliness	Referral accepted, appointment scheduled, or documentation completed within agreed timeframes.
Participation	Vendor or partner attends implementation huddles, case escalation, and CQI review as needed.
Reporting	Submit basic activity, barrier, and rework data using agreed definitions and cadence.
Quality Improvement	Participate in root-cause review and workflow changes when performance gaps emerge.
Equity and Access	Support review of variation by facility, geography, language, disability, race/ethnicity, and need.

Contracting readiness principle

A good contract makes the work visible enough to improve it.

Do not overbuild

Start with a few actionable measures tied to decisions, not a long list of reports.

Facility Contracting Readiness Checklist

A concise pre-work tool for leadership, operations, HR, legal, fiscal, and program teams

Readiness Check	Yes/No/Needs Work
Is the function already in a contract, MOU, job description, or workflow?	
Does the agreement define owner, backup, timeline, documentation, and escalation?	
Can the service be delivered inside the facility or by secure telehealth?	
Can data be shared legally and practically with the people who need it?	
Does the workflow support billing, reporting, and monitoring requirements?	
Does the contract address short-notice, weekend, or changed release dates?	
Does the agreement reduce duplicate work rather than create more of it?	

Red Flags to Look For

Most contracting risks are predictable and easier to fix before go-live

“Nursing will probably do it”

Ask: Who owns it, where is it written, how is it documented, and what is the backup? Are there labor implications, do we need to notify the union, do we need to look at workload?

“We will figure it out later”

Ask: Who owns it, where is it written, how is it documented, and what is the backup?

“The pharmacy can probably get the medications”

Ask: Who owns it, where is it written, how is it documented, and what is the backup? What about meds that are harder to get? What about at midnight?

“We do not need to amend the contract”

Ask: Who owns it, where is it written, how is it documented, and what is the backup?

“The vendor already comes here, so they can add this”

Ask: Who owns it, where is it written, how is it documented, and what is the backup? Will they need to be compensated for additional work? Do you have money for that/ Do you need to seek money for that?

“The MCO will handle the handoff”

Ask: Who owns it, where is it written, how is it documented, and what is the backup? How does the MCO know what is happening in your facility?

“We have a spreadsheet”

Ask: Who owns it, where is it written, how is it documented, and what is the backup?

“Release dates change too much to plan.”

Ask: Who owns it, where is it written, how is it documented, and what is the backup?

In Closing

Use contracting preparation to build it once and improve continuously

- ✓ Contracts should match the actual implementation model, not the old way of working.
- ✓ Labor, provider, pharmacy, data, billing, telehealth, transportation, and partner agreements all affect readiness.
- ✓ Good contracting reduces ambiguity, duplicate work, missed handoffs, denials, and staff fatigue.
- ✓ The goal is not more paperwork; the goal is a reliable system for people leaving custody and the staff supporting them.

What is one contract, MOU, or role description we should review now to make implementation easier later?

Resources

- Policy and Operations Guide
- Reentry Services Billing Guide
- Fee schedules
- CHPS Technical Assistance Hub
  - Claims Help Desk: 1-800-461-0305 or claims.chps@chpw.org

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Q&A and Discussion

Peer Learning Opportunity

Bring your contracting questions and hear how other facilities have handled them

Wednesday, August 5, 2026

10 – 11am PST

Scan to register:

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Thank You