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BEHAVIORAL HEALTH ISSUE BRIEF SERIES

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An Analysis of Contracts for the Delivery of Managed Behavioral Health Care Services in State Correctional Facilities

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Introduction

This issue brief, prepared by the George Washington University Center for Health Services Research and Policy (CHSRP), presents an analysis of a sample of contractual agreements entered into by State Departments of Corrections with managed care organizations (MCOs) for the provision of managed behavioral health care services in State prisons. It is part of a series of contract studies undertaken by CHSRP that examine the implications of managed care contracting by public and private sector purchasers for the financing and delivery of behavioral health care services.¹

Over the last decade, State governments have had to cope with increases in the size of their prison populations, coupled with a concomitant rise in the costs of providing health care to inmates. State prison populations have increased as a result of States' use of mandatory sentencing guidelines and increased criminal justice efforts (particularly in regards substance abuse-related crimes), leading to more prisoners serving longer sentences. In addition, prison populations are aging and inmates often have health care needs involving long-term chronic and complex physical and mental health conditions. In the face of these increasing demands, State Departments of Corrections have, to varying degrees, attempted to contain costs by contracting with private sector MCOs and managed behavioral health organizations (MBHOs) rather than providing such services by State-employed health care professionals. Their intent mirrors that of employers and public agency purchasers of health care services such as Medicaid and Medicare, which have contracted with MCOs and MBHOs to control costs and ensure quality care by introducing managed care techniques such as utilization review, quality assurance, performance measurement, claims management, and incentivized reimbursement methods such as capitation and the use of restricted drug formularies.² The delivery of effective behavioral health care services to the current 1.2 million State prison inmates is especially important, to the extent that many of them have mental health and substance abuse needs that pre-date their incarceration, and all must also cope with living in stressful environments that are often volatile and potentially violent.

This issue brief begins with an overview of the demand for, and utilization of, behavioral health care services in State prisons. This is followed by an analysis of the structure and content of the contracts, organized under common contractual domains. To our knowledge, this is the first in-depth study to examine the actual contractual agreements between State Departments of Corrections and managed care entities. Each section of the issue brief includes references to contract language excerpts, which are located in the Appendix to this report. Finally, we conclude with observations regarding the challenges of financing and delivering behavioral health care services to inmates, both while in prison as well as in communities following their release.

¹ These issue briefs can be found at <http://www.gwhealthpolicy.org>.

² California State Auditor, Bureau of State Audits. (2000). "California Department of Corrections: Utilizing Managed Care Practices Could Ensure More Cost-Effective and Standardized Health Care." Report Number 99027. January 2000. Available at <http://www.bsa.ca.gov/bsa>. Accessed December 15, 2001. *See also*, Ross, EC (ed.). 2001. Managed Behavioral Health Care Handbook. Aspen Publishers, Inc. Gaithersburg, MD.

Background

Growth in State Correctional Facility Inmate Population

Between 1990 and mid-year 2000, the number of incarcerated individuals in State correctional facilities grew by 5.9% annually, reaching a current population across States of 1,242,962 persons. State correctional facilities house the largest number of inmates in the U.S. prison system; an additional 131,496 inmates were in Federal prisons and 621,149 inmates were in local jails at mid-year 2000. The 1990-2000 growth rate of the State correctional facility populations represents an increase equivalent to 1,585 inmates per week. U.S. Justice Department officials estimate that the State correctional inmate population will increase to 1.5 million by 2005, assuming current annual growth rates are stable.³

Prevalence of Mental Illness and Addiction Disorder Conditions Among State Correctional Facility Inmates

Inmates have a variety of health care needs which may both pre-date, and develop during, their time of incarceration. In 1997 the Bureau of Justice Statistics (BJS) estimated that 326,256 (31%) of State correctional inmates had a physical impairment or mental condition; 105,536 (10%) reported a mental condition. State correctional inmates appear to be in worse health than their counterparts in the Federal prison system: BJS estimated in 1997 that 23.4% of Federal inmates reported a physical impairment or mental condition; 4.8% reported a mental condition, less than half the percentage of State inmates.⁴ The prevalence of mental illness disorders among State inmates increases to over 30% when reports of utilization of mental health services are included, as shown in the following table from a 1997 BJS report:

Table 1. – Measures of Pre-Incarceration Mental Illness Among State Prison Inmates, 1997

Measurement Criteria (self-reported by inmates)	State Prison Inmates	
	Percent	Cumulative Percent
Reported a mental or emotional condition	10.1%	10.1%
Because of a mental or emotional problem, inmate had --		
Been admitted to a hospital overnight	10.7%	16.2%
Taken a prescribed medication	18.9%	23.9%
Received professional counseling or therapy	21.8%	29.7%
Received other mental health services	3.3%	30.2%

Source: Ditton, PM. "Mental Health and Treatment of Inmates and Probationers." Bureau of Justice Statistics Special Report. U.S. Department of Justice, Office of Justice Programs. July 1999. Available at <http://www.ojp.usdoj.gov/bjs>.

In the area of alcohol and drug addiction disorders, a separate 1997 BJS report estimated that 52.5% of State correctional inmates reported being under the influence of alcohol or other drugs at the time of their arrest (37.2% reported alcohol use and 32.6% reported other drug use).⁵ There has

³ Beck, AJ and Karberg JC. "Prison and Jail Inmates at Midyear 2000." Bureau of Justice Statistics Bulletin. U.S. Department of Justice, Office of Justice Programs. March 2001. Available at <http://www.ojp.usdoj.gov/bjs>.

⁴ Maruschak LM and Beck AJ. "Medical Problems of Inmates, 1997." Bureau of Justice Statistics Special Report. U.S. Department of Justice, Office of Justice Programs. January 2001. Available at <http://www.ojp.usdoj.gov/bjs>.

⁵ Mumola CJ. "Substance Abuse and Treatment, State and Federal Prisoners, 1997." Bureau of Justice Statistics Special Report. U.S. Department of Justice, Office of Justice Programs. January 1999. Available at <http://www.ojp.usdoj.gov/bjs>.

been a six-fold increase in the number of drug offenders in State correctional custody, increasing from 38,900 in 1985 to 227,400 in 1997.⁶ The following table contrasts State and Federal inmates for alcohol and other drug use at time of arrest:

Table 2. – Measures of Pre-Incarceration Alcohol and Drug Use Among State and Federal Inmates, 1997

	Percent of Inmates	
	State	Federal
Current drug offense	20.7%	62.6%
Current DWI offense	1.6	--
Alcohol/drug influence at time of offense	52.5	34.0
Drug use in the month prior to offense	56.5	44.8
3 or more positive CAGE responses [†]	24.4	16.2
Alcohol- or drug-involved inmates	76.2%	82.1%

Source: Mumola CJ. “Substance Abuse and Treatment, State and Federal Prisoners, 1997.” Bureau of Justice Statistics Special Report. U.S. Department of Justice, Office of Justice Programs. January 1999. Available at <http://www.ojp.usdoj.gov/bjs>.

[†] The CAGE questionnaire is a diagnostic survey instrument used to determine a person’s likelihood of alcohol abuse by the number of positive responses to the questions on the survey.

Utilization of Mental Illness and Addiction Disorder Treatment Services During Incarceration

The 1997 BJS reports show that, despite the seemingly high prevalence of mental illness and addiction disorder conditions among inmates, treatment services during incarceration were not utilized by all inmates who may need them. Mental health treatment services were used by just under twice the percentage of inmates (60.5%) as addiction disorder treatment services (37.7%).

Table 3. – Utilization of Mental Health and Addiction Disorder Treatment Services by State Correctional Facility Inmates During Incarceration, 1997

	Percent of Mentally Ill Inmates
Since admission, the offender had --	
Received any mental health service	60.5%
Taken a prescribed medication	50.1
Received counseling or therapy	44.1
Been admitted overnight to a mental hospital or treatment program	23.6
Percent of Alcohol- or Drug-Involved Inmates	
Participated since admission	37.7%
Any treatment	14.6
Residential facility or unit	8.5
Counseling by a professional	6.2
Detoxification unit	1.0
Maintenance drug	0.3
Other alcohol/drug programs	31.9
Self-help group/peer counseling	26.7
Education program	14.8

Sources: Derived from Ditton, PM. “Mental Health and Treatment of Inmates and Probationers” and Mumola CJ. “Substance Abuse and Treatment, State and Federal Prisoners, 1997.” op. cit.

⁶ “Substance Abuse Treatment in Adult and Juvenile Correctional Facilities: Findings from the Uniform Facility Data Set 1997 Survey of Correctional Facilities.” Office of Applied Studies, Substance Abuse and Mental Health Services Administration, DHHS. April 2000. Available at <http://www.samhsa.gov>.

One reason for the lower utilization of addiction disorder treatment services is that State correctional facilities do not offer such services as frequently as mental health services. According to SAMHSA’s 1997 Survey of Correctional Facilities, of 1,187 State prisons responding to the survey, 60.3% provided substance abuse treatment services to 99,000 inmates, although the percentages among States varied from 30% to 100% depending on the State. By comparison, 93.8% of U.S. Federal prisons nationally provided substance abuse treatment services to inmates.⁷

Cost of Providing Health Care to State Correctional Facility Inmates

The average annual cost of providing health care to state correctional facility inmates is substantially higher than the average annual cost of health care for the rest of the non-incarcerated U.S. population. The U.S. Bureau of Justice Statistics (BJS) reported that in 1996 (the most recent data available) States spent nearly \$2.5 billion, 12.5% of their annual operating expenditures, on inmate medical and dental care. This translates to an average of \$2,386 per inmate per year, or \$6.54 per inmate per day. By contrast, the average U.S. resident spent \$1,807 per year, or \$4.95 per day, on health care in 1995. Expenditures on other inmate programs, which include substance abuse treatment, added another \$1.2 billion to State correctional costs.⁸

Table 4. – State Prison Expenditures for Medical Care and Inmate Programs, 1996

Expenditure Category	Total	Percent of Annual Operating Expenditure	Per Inmate	
			Per Year	Per Day
Medical and dental care	\$2,456,300,000	11.8%	\$2,386	\$6.54
Inmate programs [†]	\$1,231,100,000	5.9%	\$1,196	\$3.28
TOTAL	\$3,687,400,000	17.7%	\$3,582	\$9.82

Source: Stephan J. “State Prison Expenditures, 1996.” Bureau of Justice Statistics. U.S. Department of Justice, Office of Justice Programs. August 1999. Available at <http://www.ojp.usdoj.gov/bjs>.

[†] Programs include work activities such as prison industries and facility support services, educational activities like academic and vocational training, counseling activities like substance abuse treatment and employment skills training, and recreation and exercise activities. Figures include salaries and wages of correctional staff involved in the described activities for both medical and dental care and inmate programs.

The Use of Managed Health Care Services in State Correctional Facilities

A National Institute of Corrections report in 2000 noted that 39 State Departments of Corrections have utilized some form of managed care technique for the delivery of both physical and behavioral health care services for their inmates.⁹ These techniques range from establishing utilization review systems for existing programs delivered by State employees to contracting on a capitated basis with private sector MCOs (e.g., a fixed reimbursement defined as “per inmate/per month”). The use of private sector MCO contracting for correctional health care is driven by many of the same factors as its use in Medicaid, e.g., the States’ need to contain the rise in health care costs while striving to

⁷ Ibid.

⁸ Stephan J. “State Prison Expenditures, 1996.” Bureau of Justice Statistics. U.S. Department of Justice, Office of Justice Programs. August 1999. Available at <http://www.ojp.usdoj.gov/bjs>.

⁹ Lamb-Mechanick D and Nelson J. “Prison Health Care Survey: An Analysis of Factors Influencing Per Capita Costs.” U.S. Department of Justice, National Institute of Corrections Information Center. 2000. Available at: <http://www.nicic.org/pubs/prisons.htm>.

assure the appropriate scope, level, and quality of needed services.¹⁰ These services are delivered by health care providers who are part of MCOs' networks, rather than by state-employed personnel. In some cases, the providers are State employees and the MCO is contracted to provide only administrative services such as utilization review, prior authorizations, claims processing, quality assurance, etc.

Study Methods

To obtain a sample for this study, we sent letters in December 1999 to all fifty State Departments of Corrections Directors requesting that they send copies of any Requests for Proposals (RFPs) or executed contracts they had for the provision of managed behavioral health care in their State prisons. We received 12 documents from eight States (located in the Southeast, Northeast, Midwest and Far West) covering a range of small to large prisons. One contract covered both adult and juvenile offenders, and one contract was for a women's prison only. One State provided its RFP rather than its executed contracts. The contracts typically covered all Statewide facilities, ranging in number from one to 22, or one facility only. To the extent that our methodology resulted in a convenience rather than a purposive sample, care should be taken in extrapolating our findings to all State correctional health care systems. We believe, however, based on extensive review of the published literature, that the sample is fairly representative of the scope and range of managed behavioral health care services for State prison inmates. While four of the documents covered the provision of both general health care and mental illness/addiction disorder (MI/AD) services, our analysis focuses specifically on provisions concerning coverage, treatment service duties, reimbursement, and other issues for MI/AD services.

We reviewed the documents using a customized review instrument typologized by common contractual domains identified in our previous contract study work for SAMHSA. Relevant contractual language was transcribed into standardized matrices for each State in order to facilitate the analysis and comparison of documents. We then conducted a side-by-side analysis of each domain to identify both common and unique contractual requirements.

For confidentiality purposes, identifying information regarding the names of States, the correctional facilities, or the MCOs with which States hold contracts is not disclosed in this issue brief.

General Findings

1. The contracts varied widely in both form and substance. Examples ranged from contracts for comprehensive health services that include MI/AD services to MI/AD specialty carve-out contracts.
2. Consistent with previously published BJS and SAMHSA data, fewer facilities offer addiction disorder treatment than mental health treatment services. In the contracts that do offer addiction disorder treatment, however, the scope of services is much more detailed and specific for addiction disorder treatment than for mental health treatment services.

¹⁰ Pollack H, Khoshnood K, and A. F. Health care delivery strategies for criminal offenders. *Journal of Health Care Finance* 1999;26(1):63-77.

3. Two States reported that although their RFPs included the provision of MI/AD services, they received bids only on their general physical health services.
4. Health education in MI/AD treatment and prevention issues, both for inmates and facility staff, appears to be an important role for MCOs to assume. Since non-health care personnel such as prison guards and fellow prisoners interact on a daily basis with inmates, training regarding how to recognize the early signs and symptoms of MI/AD conditions is important for ensuring early entry into treatment to prevent the escalation of symptoms and deterioration of conditions.
5. The importance of discharge planning and aftercare is recognized in half of the contracts; however, the contracts vary widely in what planning and aftercare services are covered. Discharge planning and aftercare services were more comprehensively and specifically defined for inmates with addiction disorders than for those with mental illness. The specific inclusion of a variety of community-based treatment services following release from institutionalization highlights two States' recognition of the role of discharge planning and aftercare in reducing recidivism rates. None of the contracts, however, addressed transitional planning to include assisting inmates in obtaining Medicaid or other medical assistance program benefits, although employment and housing needs were addressed.
6. There is a lack of common clarity in the criteria used to define terms used in the contracts. These include such basic terms as "medical necessity" and "emergency." None of the contracts included medical necessity and emergency definitions specifically incorporating MI/AD requirements, and some of them did not define these terms in any context.

Specific Contract Findings

1. Scope of Contractual Services

The RFPs and contracts received from the eight State Departments of Corrections covered the following services: (1) general health care, (2) administrative services only (ASO), and (3) MI/AD specialty carve-outs.

Service	State							
	ST1	ST2	ST3	ST4	ST5	ST6*	ST7*	ST8*
<i>General Health Services</i>	✓	R	✓	✓	✓			
<i>Mental Health</i>	X	R	✓	✓	X	✓	✓	✓
<i>Substance Abuse</i>	X	R					✓	
<i>Administrative Services</i>	✓	R	✓	✓		✓	✓	✓

* = Specialty mental health/substance abuse carve-out contracts.
 ✓ = Executed Contract. X = Service was in RFP but not in contract. R = From RFP only.

2. Covered Populations

Besides inmates, two of the contracts covered work-related health needs of facility staff and emergency services for visitors. The ST3 contract required the contractor to provide employment physicals for new employees and Hepatitis B and tuberculosis testing and treatment. The ST8

contract called for the provision of psychological evaluations for newly-hired correctional staff and probation officers.

ST2's correctional facilities also house inmates from other States. Except in emergency circumstances, the Contractor must obtain authorization from the inmate's State of origin before providing treatment to these inmates.

3. Classes of Services

3.1. Mental Health Treatment Services

The scope of mental health services covered by the contracts included a wide range of treatments and services as outlined in Table 3.1 below. The most frequently included services were: individual therapy treatment and consultations; provision of psychotropic medications and management; arrangements for inpatient hospitalizations; training of facility staff in mental health issues; and intake screening examinations of newly-arrived inmates. The ST5 contract included mental health services in its language, however those sections in the contract instrument provided were crossed out by hand. A telephone call confirmed that no bids were placed for these services and that the State is continuing to provide them through State employees. The State's DOC does require, however, that its contractor file a monthly Psychotropic Usage Report (other pharmaceuticals are included in coverage by this contract). Analyses of contractual language relating to the mental health service delivery provisions appear following Table 3.1. (Substance abuse and addiction disorder services are addressed in Section 3.2 below.)

Service	State								Frequency
	ST1	ST2	ST3	ST4	ST5	ST6*	ST7*	ST8*	
<i>Individual Therapy Treatment and Consultations</i>	✓	✓	✓	✓		✓	✓	✓	7 (88%)
<i>Psychotropic Medications and Management</i>	✓	✓	✓		✓	✓	✓	✓	7 (88%)
<i>Arrangements for Inpatient Hospitalizations</i>	✓	✓	✓	✓	✓		✓		6 (75%)
<i>Training for Facility Staff in Mental Health Issues</i>	✓		✓	✓	✓	✓	✓		6 (75%)
<i>Intake Screening Examinations</i>	✓	✓	✓			✓		✓	5 (63%)
<i>Crisis Intervention</i>		✓	✓			✓	✓		4 (50%)
<i>Emergency Access</i>	✓			✓		✓	✓		4 (50%)
<i>Group Therapy Treatment</i>		✓	✓			✓	✓		4 (50%)
<i>Discharge Planning for Services Following Incarceration</i>		✓	✓			✓	✓		4 (50%)
<i>Psychiatric and Psychological Services (broadly referenced)</i>				✓	✓	✓		✓	4 (50%)
<i>Individual Treatment Plans</i>			✓				✓	✓	3 (38%)
<i>Sex Offender Treatment</i>	✓	✓			✓				3 (38%)
<i>Behavior/ Anger Management Program</i>	✓	✓					✓		3 (38%)

Table 3.1. – Scope of Mental Health Services by Frequency of Service Mentions in Contracts									
Service	State								Frequency
	ST1	ST2	ST3	ST4	ST5	ST6*	ST7*	ST8*	
<i>Psychological Evaluations for Parole Board Hearings</i>						✓	✓		2 (25%)
<i>Reintegration Program</i>		✓							1 (13%)
<i>Medication Upon Release (14 Days Supply)</i>		✓							1 (13%)
Frequency	8 (50%)	11 (69%)	8 (50%)	5 (31%)	5 (31%)	10 (63%)	11 (69%)	5 (31%)	

* Specialty Behavioral Health Contracts. The ST8 contract used broad terms that could be interpreted to include more specific services.

3.1.1 Psychiatric and Psychological Services

Contractual language regarding the provision of psychiatric and psychological services ranged from very broadly defined to highly specific. Three of the States’ contracts (ST4, ST5, and ST8) required these services without detailed information about their scope and the circumstances under which they are to be provided. See examples 3.1.1.a, 3.1.1.b, and 3.1.1.c in the Appendix.

Five of the contracts provided much more detailed information about the scope of psychiatric and psychological services to be provided. The ST7 specialty behavioral health contract, as in example 3.1.1.d, distinguished between the services of M.D. psychiatrists and doctoral-level psychologists.

3.1.2 Individual and Group Treatment Modalities

Only one contract (ST6) distinguished between requirements for treatment to be provided in either individual or group settings. As seen in example 3.1.2.a in the Appendix, the State’s preference was for group therapy in the interests of cost-effectiveness, and the contract restricted individual therapy to those clients deemed “likely to benefit” from it and subject to available staffing resources:

[Example 3.1.2.a:]
F. Group Treatment

In order to maximize resources while providing a psycho-therapeutic model of treatment, the Contractor will place an emphasis on provision of group therapy. The Contractor will also participate in group design and treatment planning. In addition, the Contractor is expected to assign each professional, providing services under this contract, to facilitate treatment to one (1) IMHTU and three (3) outpatient mental health groups. The Contractor will provide each group participant with a clinical note after each session.

G. Individual Treatment

Of limited duration and as staffing permits, individual therapy will be provided to those clients identified by the multi-disciplinary staffing team as likely to benefit from this treatment modality.

[ST6 Contract]

3.1.3 Psychotropic Drugs and Medication Management

All of the contracts except one (ST4) specifically addressed to varying degrees the use of psychotropic drugs for inmates. Two contracts specified the use of the MCO's formulary, and three required the use of a State-defined formulary; the remaining three contracts were silent on the issue of formulary use. ST3's contract specified that the MCO's formulary must include a full range of "current and contemporary" medications, but it limited the risk for prescription costs to the MCO by capping medication expenditures to fixed amounts (see example 3.1.3.a in the Appendix).

Some of the contracts were very detailed in their requirements for oversight and management of psychotropic drug use, while others offered only the most minimal specifics, as seen in example 3.1.3.b.

The ST5 and ST7 contracts contained the most comprehensive specifications for monitoring and management psychotropic drug prescriptions, with ST5 being the only State contract requiring a psychotropic utilization report. See examples 3.1.3.c and 3.1.3.d.

3.1.4 Inpatient Hospitalization Arrangements

All contracts except ST6 and ST8 (both of which are specialty behavioral contracts) addressed Contractors' service duties and financial responsibility for inmates who require inpatient hospitalization for treatment of a mental illness. The contracts for ST4 and ST5 required the Contractor to provide and assume all costs for inpatient hospitalizations. The ST2 and ST3 contracts explicitly excluded the cost of hospitalizations from their contracts. While the ST1 and ST7 contracts also did not include the costs of hospitalizations in the contract price, they did require Contractors to coordinate inpatient referrals and establish agreements with inpatient facilities both inside and outside the prisons. See examples 3.1.4.a and 3.1.4.b.

3.2 Addiction Disorder Treatment Services

The ST1, ST2, and ST7 contracts provided for on-site substance abuse education for inmates. The ST1, ST7 and ST8 contracts provided for on-site substance abuse treatment programs. The ST1, ST2, ST5 and ST7 contracts also stipulated extended treatment to residential/therapeutic community-based programs following an inmate's release from incarceration. Both the ST2 and ST7 contracts specifically included mandatory urinalysis testing as part of their program. See example 3.2.a.

The ST7 contract further required that the Contractor develop a four-phase comprehensive drug and alcohol treatment program based on a Therapeutic Community Model for female felony offenders as shown in example 3.2.b. The ST7 contract covering felony drug offenders housed at a boot camp facility, as shown in example 3.2.c.

The ST2 contract sought proposals from Contractors to run a substance abuse program at its facilities. The program consisted of treatment both during incarceration as well as upon release, as shown in example 3.2.d.

Additionally, the ST2 contract required contractors to address the needs of groups of offenders by dividing them into three categories based on their length of sentence: (1) short-term offenders serving eight months or less, (2) minimum custody offenders, and (3) long-term offenders serving eight months or more. See example 3.2.e.

3.3 Provision of Emergency Health Care

Emergency coverage may extend to both physical and MI/AD conditions. [Contractual definitions of emergencies are discussed in Section 4 below.] All contracts, except ST8, included provisions regarding emergency care for both physical and MI/AD conditions. The ST6 and ST7 contracts specifically provided for mental-health related emergency care.

Although the ST6 contract did not address the use of ambulance services or hospital emergency department use, it did stipulate the need to provide for emergency evaluations and management. It defined both provider duties and compensation arrangements (see example 3.3.a). The ST2 contract, on the other hand, was more detailed in its specifics, as seen in example 3.3.b.

3.4 Health Services and Education

3.4.1 For Facility Staff

Educational services were also covered in a number of contracts. These fell into two categories: procedural and informational. Procedural education educates and familiarizes facility staff with the Contractor's policies and procedures. Informational education deals with teaching risks and potential health problems inherent in prison populations (such as communicable diseases and administering programs for MI/AD treatment in a correctional facility setting). See example 3.4.1.a.

The ST7 contract focused on educating facility staff specifically on recognition of MI/AD conditions, as seen in example 3.4.1.b.

3.4.2 For Inmates

In a number of contracts, educational requirements extended to inmates. The ST3 contract included a general requirement for education but did not go into detail – “Medical preventive maintenance and health education will be made available to all prisoners and juvenile offenders.” In the ST2 contract (see example 3.4.2.a), the importance of inmate education and its role in the program is stressed.

During the main treatment phase of their incarceration, inmates in a facility-based residential alcohol and drug treatment services program in ST7 were to receive 50 hours of therapeutic activities per week. Drug abuse education was a mandatory component of these services. The ST1 contract required the Contractor to provide self-help programs such as Alcoholics Anonymous, education programs, out-patient treatment and residential/therapeutic community treatment programs and anger management services for inmates, as shown in example 3.4.2.b.

3.5 Care Coordination and Case Management

Care coordination and case management are closely related terms and often used interchangeably in health services literature. For this analysis, “care coordination” is defined as an active process by which the MCO, provider, or specialized personnel and specialty-care providers work together as a group to provide an overall care plan for the patient that includes both physical and behavioral health care services. “Case management” refers to the designation of a manager who is responsible for reviewing the medical information regarding the patient and creating a care plan based on that information. Care coordination and case management are complicated, especially in circumstances where the patient has a dual diagnosis of both mental illness and addiction disorder conditions and when there are comorbidities that encompass physical and mental health problems.

All contracts, except ST8, specifically provided for some form of coordination of care and/or case management. ST6 required its providers to “actively participate in multi-disciplinary staffing of all individuals on their case load” and for the provision of progress reports as requested by the Mental Health Director. Other States required more detailed participation. ST3, as shown in example 3.5.a, required the Contractor to provide both care coordination and case management.

Example 3.5.a:

1. The Contractor shall make referral arrangements with medical specialists for treatment of those prisoners and juvenile offenders with problems which may extend beyond the scope of services provided on site.
2. Psychiatric Services: Meeting with representatives and staff of the facility weekly as coordinated by the facility’s Medical Director or other designated person in a combined clinical case conference for the purpose of treatment planning.
3. Psychiatric Services: Maintaining uninterrupted coverage for the provision of all psychiatric services by a qualified psychiatrist for the term of the contract.
4. Special Medical Program: For prisoners or juvenile offenders with special medical conditions requiring close medical supervision, including chronic and convalescent care, a written individualized treatment plan shall be developed by the attending physician. The plan should include orders to health care and other personnel regarding their roles in the care and supervision of the patient.

[ST3 Contract]

3.6 Discharge Planning and Aftercare

Discharge Planning

Discharge planning is a focused process designed to facilitate inmates’ ability to receive needed health care following release from incarceration. While discharge planning is also used in the context of facilitating the transition from inpatient hospitalization to outpatient care, the focus of this analysis is on planning and transitional services for post-release care when the inmate moves from the prison to the community. According to the American Psychiatric Association, discharge planning should encompass:

1. Providing the patient with a written discharge plan;

2. Providing the patient with a temporary supply of medication and renewal of prescriptions, if necessary;
3. Providing the patient with referrals and linkages to community mental health care providers; and
4. Assisting the patient in obtaining necessary financial benefits, housing, placements, and appropriate linkages.¹¹

In recent years, lack of proper discharge planning has become a growing concern – especially when potentially mentally ill and/or dually diagnosed inmates are released into the community without regard for their continued care and treatment needs. For example, in a September 12, 2000 decision, a New York State Court required New York City to provide discharge planning for jail inmates as a result of a class action suit filed on their behalf by the Urban Justice Center. The case, *Brad H. v City of New York*, was unanimously upheld on October 31, 2000 by the Appellate Division of the New York State Supreme Court. The appeals court accepted an amicus brief submitted by the Bazelon Center for Mental Health Law, the National Alliance for the Mentally Ill and 12 other organizations and coalitions that provided extensive information about the need for discharge planning and its link to increased recidivism in its absence.¹²

Four the States’ contracts did not address discharge planning. Of the other four States, two referred to discharge planning requirements without specific definitions of the services required, as shown in examples 3.6.a and 3.6.b.

The ST2 contract required targeted discharge planning for inmates with MI/AD disorders, with a special emphasis on the needs on inmates who have been in long-term segregation in the prison. ST2 was also the only State to explicitly require the provision of a supply of medications following release from the facility, as shown in example 3.6.c.

The ST2 contract and the ST7 contract for addiction disorder treatment had more detailed requirements for discharge planning, including coordinating non-treatment services such as employment and housing. The ST2 contract was the only one to define standards for evaluating the contractor’s performance in discharge planning activities. This contract defined discharge planning for persons with MI/AD conditions as step-wise phases leading to community reintegration. See examples 3.6.d and 3.6.e.

[Example 3.6.e]

A.I.1.3. The Contractor shall design the following four phase treatment program that will accommodate a minim of 125 (45 MLRC and 80 TPW) female offenders statewide.

[...]

Phase III Reintegration – During this phase offenders are preparing for community release or release to general population. The primary focus of this phase shall be on addressing transitional issues. All participants shall be required to attend one family group session per week. All program participants shall be required to develop a life plan. Each offender shall receive approximately 20 hours of therapeutic activities per week. Therapeutic activities shall include group counseling, vocational skills

¹¹ American Psychiatric Association. 2000. *Psychiatric Services in Jails and Prisons (2nd Edition)*. pp. 38-39, 46.

¹² Bazelon Center for Mental Health Law. 2000. “Discharge Planning for Inmates Being Released from Jail or Prison.” Available at <http://www.webcom.com/bazelon/dischargeplanning.html>. The Brief for *Amici Curiae* is also available at this site. See also, Barr H. (2001). “Prisons and Jails: Hospitals of Last Resort: The Need for Diversion and Discharge Planning for Incarcerated People With Mental Illness in New York. Urban Justice Center. New York, NY. Available at <http://www.soros.org/crim/MIRep-main.htm>. Accessed August 28, 2001.

development, and participation in self-help groups. This phase should last approximately two to three months. Program participants that have successfully completed this phase of treatment shall be successfully terminated from the Therapeutic Community.

Phase IV Aftercare – This is the final phase of the in-prison treatment program. The primary focus of this phase is to provide support and monitor the progress of program graduates. Program participants that have graduated from the treatment program receive at a minimum two hours of group programming per week until they are released from the institution.

A.I.2.11 The contractor shall also provide a weekly follow-up or aftercare session for program graduates to monitor progress and provide support..]

A.I.2.2 The Contractor shall conduct an initial needs assessment and a follow-up assessment, toward the end of the program period, on each program participant.

[ST7 Contract]

None of the contracts made reference to transition planning activities related to assisting inmates with obtaining Medicaid or other medical assistance program benefits. Per Federal law, inmates who are incarcerated for 12 or more consecutive months lose their eligibility for Medicaid¹³ and must re-apply following release from the facility. Federal rules on Supplemental Security Income (SSI) and Supplemental Security Disability Income (SSDI) benefits (for which many inmates with MI/AD conditions qualify as a result of their disability status) are complex, as are State Medicaid rules on eligibility and benefits for inmates released from custody. Thus, inmates typically need the assistance of case managers and other professionals with income and medical assistance expertise in order to understand how to navigate the paperwork and administrative requirements.

The lack of language addressing this issue in the contracts is not surprising, inasmuch as, according to a Bazelon Center for Mental Health Law report, “Very few states and localities have adopted policies and procedures of assisting inmates with severe mental illness in claiming or maintaining federal benefits upon their release. [...] Without income support or health coverage, many people with severe mental illnesses become caught in a cycle of recidivism.”¹⁴

Aftercare Services

The ST2 contract defined discharge planning so as to incorporate aftercare services in inpatient, outpatient, and community residential settings. Depending upon their clinical needs at release, inmates may be placed in one of three treatment settings for continuing services: Intermediate Inpatient Treatment, Outpatient Counseling, and Community Residential Beds (CRBs), as shown in example 3.6.f.

The ST7 contract provided for three months of “Community-Release Transitional Treatment Services” for thirty program graduates and women currently on parole in the one county who were in need of treatment services. See example 3.6.g.

¹³ 20 C.F.R. § 416.1335.

¹⁴ Bazelon Center for Mental Health Law. Undated. “For People with Serious Mental Illnesses: Finding the Key to Successful Transition from Jail to the Community: An Explanation of Federal Medicaid and Disability Program Rules.” Available at <http://www.webcom.com/bazelon/findingthekey.html>.

3.7 Exclusionary Provisions

The ST3 contract specifically excluded inpatient psychiatric hospitalization from coverage by the Contractor. The ST1 contract excluded the following mental health services relating to parole board evaluations, and hormonal and surgical treatment for transsexualism, as shown in example 3.7.a.

Furthermore, the ST1 contract contained unique language authorizing the potential denial of non-emergency services based on the proximity of an inmate's parole date, despite a prior determination of medical necessity. The term "near future" was not defined in the contract:

Example 3.7.b. The PAC will review the information to determine if the admission and/or services meet appropriate guidelines for medical necessity. **Services may be determined to be medically necessary, but authorization denied if offender's parole date [...] is in the near future and postponing services does not put the offender at risk for pain, suffering or deterioration of his/her condition.** [emphasis added] Additional information will be requested if needed. [ST1 Contract]

4. Medical Necessity and Emergency Definitions

Only two of the contracts provided a specific definition of medical necessity. The ST1 and ST8 Contracts used definitions commonly found in MCO provider contracts. They allocated broad decision-making power to the MCO medical director and referenced the criteria for accepted standards and appropriateness. See example 4.a and 4.b.

Only the ST1 contract defined "emergency" for the provision of covered emergency services, as shown in example 4.c; however, it was not specific to MI/AD conditions. None of the contracts addressed medical necessity or emergency definitions in the specific context of MI/AD services.

5. Prior Authorization Requirements

Only the ST1 contract for administrative services included provisions outlining requirements for providers to obtain prior authorizations before providing health care services to inmates. This is because the medical staff were the employees of the State Department of Corrections rather than outside contracted providers of the MCO. In the other States, the contracts between the State and the MCO would not need to define prior authorization requirements, since the expectation is that the contracts between the MCOs and their network providers would embody them. Though the language is not specific to MI/AD conditions, it does address requirements for primary care provider and specialist referrals. See example 5.a.

6. Monitoring of Quality of Care and Performance Improvement Requirements

To ensure quality, standards of care for inmates have been established by various organizations with expertise in correctional health care issues. Standards may be specific to particular diseases or treatments (e.g., MI/AD conditions) or may focus more broadly on specific populations (e.g., juveniles and women).

As previously discussed, case management, coordination of care, and discharge planning also play roles in the quality of care. Other ways quality can be measured include mandatory minimum credential requirements for health care providers performing specific tasks, setting maximum acceptable waiting periods for the delivery of health services, requiring mandatory reporting of service utilization, and review by independent audits.

6.1 Treatment Standards and Guidelines

A number of independent organizations set general and specialty quality standards for health care in correctional settings. With the exception of ST1, each of the contracts required that care be provided in accordance with the standards of the American Corrections Association (ACA) or the National Commission on Correctional Health Care (NCCHC) or some other published set of guidelines and standards. This is similar to the requirement by other purchasers, such as State Medicaid agencies and private sector companies, that their contracted MCOs have achieved accreditation by bodies such as the National Committee for Quality Assurance (NCQA) or the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO). Table 6.1 shows a breakdown by State of which set of standards its Contractors are obligated to meet.

Standard	ST1	ST2	ST3	ST4	ST5	ST6	ST7	ST8
<i>ACA</i>			✓	✓				
<i>NCCHC</i>		✓	✓		✓	✓		✓
<i>ASI</i>							✓	
<i>CDC</i>								✓
<i>State Dept. of Corrections</i>		✓						✓

The NCCHC, the organization most frequently cited in our sample of contracts, was established in the 1970s as a program of the American Medical Association and became an independent organization in the 1980s. Its aims are to establish standards, provide technical assistance on correctional health care management and policy, develop and publish research on correctional health care, and foster professionalism. It also operates a national certification program for correctional health care professionals.¹⁵ The NCCHC publishes separate volumes of *Standards for Health Care Services* specific to jails, prisons, and juvenile confinement facilities. Its 1999 publication, Correctional Mental Health Care: Standards and Guidelines for Delivering Services, provides specific commentary on mental health and substance abuse services corresponding to its 1997 *Standards for Health Services in Prisons*.

These standards are the ones used by the NCCHC to measure a prison’s health care program for the purposes of voluntary accreditation. Facilities can seek the accreditation regardless of whether they operate their own health care programs or contract with outside providers and MCOs. The standards cover nine areas:

1. facility governance and administration;
2. managing a safe and healthy environment;
3. personnel and training;

¹⁵ National Commission on Correctional Health Care (NCCHC). 1999. Correctional Mental Health Care: Standards and Guidelines for Delivering Services. Chicago, IL. p. ix. See also: <http://www.ncchc.org>.

4. health care services support;
5. inmate care and treatment;
6. health promotion and disease prevention;
7. special inmates needs and services;
8. health records; and
9. medical-legal issues¹⁶

The NCCHC states that its recommended standards “are not meant to be discipline or practice guidelines. They provide the framework for delivery of quality care and reference specific practice guidelines where appropriate.”¹⁷ For example, the guideline for mental health assessment states:

Mentally disordered and developmentally disabled inmates must be identified and their treatment needs addressed within 14 days of admission to alleviate their distress and prevent exploitation or further deterioration. The urgency of the problem determines the response. Acutely suicidal and psychotic inmates are emergencies and should be placed immediately in a treatment setting. If this is within the correctional facility, there must be a sufficient and appropriate response to address the immediate needs of the inmate. If such a level of service is not available within the facility, the inmate/patient must be transferred to an appropriate outside facility. Less seriously disturbed inmates should be housed in a specially designated area with frequent observation by qualified health care professionals (when available) or by health-trained correctional personnel.¹⁸

The contracts also specified other guidelines to be followed as part of the agreed upon services. This allows for special needs of any particular population to be addressed. As seen in example 6.1.a, a women’s facility in ST7 required that treatment reflect the facility’s population.

[Example 6.1.a]

Treatment programming shall focus on the issues that are unique to women such as guilt, wellness, depression, STDs, anger, sexual abuse, co-dependency, powerlessness, responsibility, fulfillment and self-actualization, incest, sexual dysfunction, battering, relationships, shame, self-image and self-esteem, parenting, leisure time planning, criminal thinking, spirituality, nutrition, victim rights, and choices.

[ST7 Contract]

Another facility in ST7 required that programming “must meet the unique needs and concerns of racial and ethnic minority individuals, including such factors as cultural orientations, beliefs, and value systems relevant to this population.” The ST7 contract also specifically required use of the Addiction Severity Index (ASI)¹⁹ for the assessment of patients’ needs, treatment plan development, and follow-up evaluations.

¹⁶ “National Commission on Correctional Health Care Health Services Accreditation.” Available at: <http://www.ncchc.org/accreditation.html>.

¹⁷ NCCHC. 1999. *op. cit.* p. xi.

¹⁸ *Ibid.* pp. 61-62.

¹⁹ According to the National Institute on Alcohol Abuse and Alcoholism, “The ASI is a semistructured interview designed to address seven potential problem areas in substance abusing patients: medical status, employment and support, drug use, alcohol use, legal status, family/social status, and psychiatric status. In 1 hour, a skilled interviewer can gather information on recent (past 30 days) and lifetime problems in all of the problem areas. The ASI provides an overview of problems related to substance, rather than focusing on any single area. The ASI can be used effectively to explore problems within any adult group of individuals who report substance abuse as their major problem. It has been used with psychiatrically ill, homeless, pregnant, and prisoner populations, but its major use has been with adults seeking treatment for substance abuse problems.” <http://www.niaaa.nih.gov/publications/asi.htm>. See also, McLellan, A.T.;

6.2 Provider Credentialing

All contracts required that health care providers be licensed, certified, or registered to provide services within the contracting State. For example, the ST2 contract stated that mental health providers in Kansas be required to hold specific degrees and it also specified qualifications for Substance Abuse Program Coordinators, Counselors, and Treatment Providers. See examples 6.2.a and 6.2.b. The ST3 contract required that mental health providers hold a Masters-level degree or higher in either psychology or social work.

The ST1 contract required that Prior Authorization Coordinators and Case Managers hold at least an RN or LPN. Prior Authorization Coordinators must be trained in utilization and Case Managers must be trained and experienced in case management. Only physicians, however, could make a service denial based on lack of medical necessity or other criteria.

6.3 Treatment Timelines

Treatment timelines covered a wide range of services and varied considerably from state to state. The ST2, ST3 and ST5 contracts made no mention of timelines. The others categorized timelines such as: access to care, appointment scheduling, maximum office waiting times, emergency care, non-urgent treatment, and provision of prescription medications. For example, during non-urgent situations, the ST8 contract required triage within 24 hours and an examination within 48 hours (72 hours on weekends).

The ST1 and ST7 contracts specifically required that services be available on a 24-hour basis. The ST4 contract required emergency services be rendered within two hours upon their necessity and non-urgent care be rendered within 48 hours. Only the ST1, ST7, and ST8 contracts specified timelines for appointments. The shortest timeline, described in ST7, required that non-emergency appointments be made within 72 hours of their request. The ST8 contract set the maximum wait for appointments at one week. The ST1 contract permitted a maximum of a 4-week wait for appointments. Only the ST1 contract, however, specified the maximum amount of time a patient is to wait during an office visit – 30 minutes under normal circumstances and a two-hour maximum under any circumstances. The contract did not specify what would or would not qualify as a “normal circumstance.”

The ST4 and ST5 contracts set maximum waiting periods for prescription medications. Both required immediate provision in emergency situations. When the need for medication is non-urgent, the ST4 contract allowed up to a 24-hour wait and the ST5 contract allowed a 48-hour wait.

6.4 Quality Improvement Programs, Mandatory Reports, and Third Party Audits

All the contracts, with the exception of ST4, required some form of Quality Assurance other than those previously examined (e.g., care coordination, case management, discharge planning, minimum credentials, standards of care). Requirements and the methods for their implementation varied by each state.

Kushner, H.; Metzger, D.; Peters F.; et al. (1992). The fifth edition of the Addiction Severity Index. *J Subst Abuse Treat* 9:199-213.

The ST7 contract required the submission of numerous reports regarding the quality of MI/AD services to the State Department of Corrections. These included proposed outcomes measures within ninety days of contract execution and instruments for their measurement within one hundred and twenty days. Should the Contractor fail to meet these “milestones” or numerous other clinical and administrative requirements as outlined in the agreement, the DOC may impose fines in the form of liquidated damages upon the Contractor. These damages ranged from \$50.00 through \$200.00 per event depending upon the deficiency and may be assessed, in the case of the above-mentioned reports, on a daily basis until the Contractor was in compliance. See example 6.4.a. The ST1 contract required the Contractor to participate in a detailed Quality Management and Improvement Program as shown in example 6.4.b.

The ST2 contract required contractors to maintain and provide monthly reports detailing the levels of medical, dental, and mental health services rendered. Other mandatory reports included those from each Medical Audit Committee, the Medical Director, the Mental Health Director, and from the Regional Manager (whose report must include the range of services provided at each site and identifications of problems and proposed solutions).

The ST6 contract required Contractors to actively participate in the Department of Corrections’ Continuous Quality Improvement Program. The ST3 contract required Contractors to initiate a Quality Assurance Program (QAP) to ensure that high quality health services are provided to prisoners and juvenile offenders. The QAP required the Contractor to meet at least once each quarter to evaluate onsite and offsite health services. See example 6.4.c.

The ST5 contract provided that, in addition to meeting or surpassing the NCCHC Standards, the State may request, at the Contractor’s expense, independent compliance and/or performance audits. See example 6.4.d.

The ST8 contract limited the Contractor’s financial responsibility for independent peer reviews to \$15,000.00 annually. Additionally, the Contractor must submit to monthly compliance review audits. If found in non-compliance, the Contractor is liable for financial penalties calculated on a per-institution basis. See example 6.4.e.

7. Confidentiality of Medical Records

The contracts addressed confidentiality regarding the business terms of the contracts as well as confidentiality of inmates’ medical records. The latter is the focus of this analysis. All the contracts, with the exception of ST6, mandated some form of patient confidentiality. The contracts from ST2, ST4, ST7, and ST8 each mandated that applicable State and/or Federal laws governing the confidentiality of medical records would prevail.

The ST3 contract contained the most detailed requirements defining patient confidentiality and outlines particular requirements for inmates with MI/AD conditions, as well as for inmates tested for HIV infection. These confidentiality requirements have taken on increasing importance over the last 20 years as larger numbers of inmates have entered incarceration with co-morbid HIV infection addiction disorders, and mental illness.

[Example 7.a]

4. Special Rules on Disclosure of Certain Types of Records:

1. Records not to be Disclosed. The following types of records and information contained within those records may be disclosed only to persons employed by the Department of Corrections and persons or agencies under contract to the Department, but not parties with whom a fee for service contract has been made in an individual case, but only if, such disclosure is necessary to enable the fulfillment of a statutory function of the Department:

- a. Records containing information obtained for the purpose of evaluating a person's ability to participate in a community based program, such as community sentiment information;

5. AIDS Test Results: The results (whether positive or negative) of an HIV (AIDS) test may be disclosed only to:

- a. A Department of Corrections employee or person or agency under contract to the Department of Correction or other correctional agency provided that the recipient is authorized to receive those results by the Commissioner of Corrections (note: the law does not permit the Commissioner to authorize persons employed by or under contract to the Division of Probation and Parole to receive those results);
- b. The person tested
- c. A parent or guardian of the person tested
- d. A person or entity authorized to receive those results by a release of information form signed by that person's parent or guardian.
- e. A person or entity authorized to receive those results by a court order.

6. Information Acquired in the Course of Substance Abuse Treatment: Information acquired during the provision of substance abuse treatment services may be disclosed only to:

- a. The person who received the substance abuse treatment services;
- b. A person or entity authorized to receive that information by a release of information form signed by the person who received the services, and, if necessary, by that person's parent or guardian . . . (Note: the law does not permit the parent or guardian of an adult to receive such substance abuse information without the consent of the person who received the treatment).
- c. A person or entity authorized to receive that information by a court order;
- d. The Department of Human Services if, but only if, the information disclosed consists solely of a report of suspected child abuse or neglect, and
- e. Medical personnel if, but only if, the information disclosed is needed by those personnel so that they can treat a condition which poses an immediate threat to health and which requires immediate medical intervention.

The disclosure of information acquired during the provision of substance abuse treatment services must be made in compliance with the Department of Corrections.

[ST3 Contract]

Four of the contracts restricted Contractors from publishing or reporting any data without written approval of the State Department of Corrections, as seen in example 7.b.

8. Grievances and Appeals

Should a dispute arise regarding coverage, treatments, or other issues relating to the contract, resolution is best reached if procedures and authority are spelled out in advance and included in the contract language. The ST2, ST3, ST4, ST6, and ST8 contracts included procedures for resolution of contractual disputes arising between the contracting parties into account. The ST5 and ST7

contracts contained no language regarding either Contractors' or inmates' grievances and appeals. Only the ST2 and ST3 contracts included language that defined processes for handling inmates' grievances and appeals regarding their health care services.

The contracts detailed timelines for filing complaints and appeals. They specified whom to contact for addressing complaints for each party. Initial response times to complaints or grievances were limited in three of the contracts. These limitations spanned between five and ninety days. Procedures for appealing initial decisions and for subsequent appeals were also included. Generally, a party could only proceed to court with a complaint once they had followed procedures outlined in the contract both for the initial filing and appellate process.

The ST3 contract had the most detailed language regarding inmate grievances and appeals. It used a three-level administrative internal review process and included a means for handling emergency appeals. No external review by an entity not associated with the Department of Corrections was provided for. See example 8.a.

9. Contract Term and Termination

9.1 Contract Term

The length of the contracts generally ranged between one and five years. Most agreements gave the contracting State Agency the option to extend the contract for an additional one or two one-year period. The ST2, ST3, and ST5 contracts contained clauses giving the State DOCs the option of terminating the contract if future legislative budgets did not include adequate funding to continue their program. Modifications to the contractual term, if allowed, required written agreements signed by both parties.

9.2 Terminations With Cause

Five of contracts included language for termination of the agreement with cause. The contracts allowed for immediate termination if the Contractor was found to be either in non-compliance or substantial failure with regard to the agreements. The ST7 contract also reserved liquidated damages for the State if the Contractor did not comply with the agreement.

9.3 Terminations Without Cause

Six of the contracts included language allowing State to terminate the agreements without cause. This language gives the State unilateral power over the Contractor. Only the ST6 and ST8 contracts allowed the Contractor to terminate the agreement without cause provided sufficient notice of intent to terminate was given.

The ST2, ST6, and ST7 contracts required only that the State give the Contractor at least thirty days written notice of their intent to terminate the agreement. The ST4 and ST8 contracts stipulated a ninety day advance notice period.

10. Reimbursement/Payment for Services

Methods and amounts of payments varied greatly from State to State. Amounts varied due to differences in the type of services being provided (e.g., administrative services only, general health services, or MI/AD specialty carve-outs). Other factors influencing the amounts paid include the size of the inmate population, the number of facilities covered, and the credentials of health care providers.

The ST2 contract pays a capitated fee “per offender per month” for administrative services based on the size of the population covered (See Table 10.1 below). As the inmate population increases, the amount of the capitated fee decreases. Under this contract, the State had an annual maximum financial obligation for the initial year (ending 30 June 1999), of \$934,000.00.

Offender Population	Capitation Rate (Per Offender Per Month)
< 14000	\$8.00
14000 – 17999	\$7.50
> 18000	\$7.00

Similarly, the ST3 contract paid a capitated fee with a maximum financial obligation. The contract, however, was for provision of all health and administrative services. The amount of the capitated fee did not vary with population size. The maximum liability of the State, for the entire length of the agreement (32 months) was set at \$13,280,653.00. Based on an inmate population of 1,898 (1,624 adult and 274 juvenile offenders), the above maximum figure was divided into thirty-two monthly payments. Should the inmate population vary by more than 10%, adjustments to the payment would be made. If the variance was due to a smaller population, then a per diem credit of \$2.85 per inmate (only the number comprising the variance) would be deducted from the payment. If the variance was due to an increase in inmate population of more than 10%, then an additional per diem rate of \$2.85 per excess offender would be added to the payment. If the variance lasted for more than thirty days, both parties reserved the right to renegotiate the contract. See example 10.a.

The contract also required that the State DOC be credited for days when the Contracted positions were not properly staffed. The credit amounts varied by position. See example 10.b.

The ST4 contract for general health care and administrative services was based on an annual fixed fee for a predetermined population size, as shown in example 10.c.

The ST5 contract for comprehensive medical services was paid on a straight capitation method. For the initial contract year (01 October 1996 through 30 September 1997), the contractor was paid a rate of \$4.26 per inmate per day. Each subsequent year allowed for an increase in the capitation rate to a maximum of \$4.74 during the final renewal period. No annual maximum or base population size was specified.

The ST6 contract was a fee-for-service contract, with an agreed upon hourly fee when services are rendered within defined service provision limits. The contract provided for a maximum of 100

hours of services per week paid at the hourly \$21.59. The maximum annual liability for the State under this agreement was \$112,268.00 based on the provision of 2.5 full-time professionals providing a combined one hundred hours of service weekly (52 weeks/year). Any hours in excess of one hundred per week had to be approved by the State DOC Chief of Psychological Services.

The ST7 contract was based on an annual capitated payment system. For the initial full contract year (01 Jan 1998 through 31 December 1998), based on a projected inmate population of 15,482, the Contractor was compensated an “annual fixed capitated rate” of \$99.28 plus an “annual variable capitated rate” of \$39.89 (total annual capitated rate = \$139.17) per inmate. If the inmate population exceeded the projected total, the contract required an amendment and new rate negotiation. The Contract, however, specified that the maximum liability of the State for the initial three years of the contract shall not exceed \$6,608,182.00. The Contractor bore the financial risk should the inmate population exceed the projected number.

The ST7 contract for provision of facility-based residential alcohol and drug treatment services based payment on hourly compensation rates with differentials by type of position held by counselors. Table 10.2 below provides a breakdown of compensation by position for the initial year (10 November 1997 through 30 June 1998) of the Contract. The contractual maximum liability of the state, however, was \$1,171,000.00. See example 10.d.

Based on the required number of employees working 52 40-hour weeks per year (16-hours for weekend employees) at the initial hourly rates (without taking annual increases into account), the Contractor price would be \$1,171,140.00:

Job Title	Hourly Rate	Number Employed
<i>Lead Counselor</i>	\$30.87	1
<i>Certified Counselors</i>	\$25.20	6
<i>Weekend Counselors</i>	\$20.87	4

Conclusions

As with Medicaid managed care, a State’s decision to shift from directly providing health care services to inmates using State employees (or direct provider contracts) to purchasing these services from private sector MCOs constitutes an effort to both contain costs and to improve the coordination of services. Unlike Medicaid, however, where there is a Federally-defined minimum scope of benefits and performance standards that State programs must meet, there is no Federal standard for the scope or quality of health care services for State correctional facility inmates. The standards promulgated by professional organizations such as ACA, APA, NCCHC, APHA, etc. serve to provide useful benchmarks, rather than mandates, for scope and quality of care. Based on our review of a small number of contracts, we have found wide variations in the scope of MI/AD treatment services and mechanisms for measuring the performance and accountability of Contractors in carrying out their duties. This variation is due, in part, to States’ discretionary latitude in deciding which services to offer inmates and the means by which they are purchased and financed. Inter-state variations are also affected by the nature of local managed care markets,

legislative budget processes, and the willingness and ability of MCOs to meet the States' contractual terms.²⁰

The contracts addressed a broad range of MI/AD treatment modalities, though there was little mention of preventive services, normally a staple of managed care. Service delivery specifications tended to be more comprehensively and specifically defined for addiction disorder treatment than for mental illness treatment. A few of the contracts had a far-ranging view of services that extend beyond the facility's walls to the community and they required MCOs to cover the costs of such care regardless of location of treatment.

The absence of medical necessity and emergency definitions is likely a reflection of the nature of the relationship between the contracting parties. In this case, the contracts are between State agencies and MCOs. These definitions are most typically found in contracts between MCOs and their contracted providers. Thus, to the extent that the State contracts do not impose upon the MCOs medical necessity and emergency definitions, this represents the States ceding to the MCOs that right in the context of their relationships with their contracted providers.

The use of capitation payments based on inmate population size, coupled with maximum liability limits for the States, shifts a portion of the financial risk to the MCOs. Since the MCOs' contracts with their network providers were not included in this study, it is not known to what extent the MCOs further shift this financial risk to their contracted providers.

Education in MI/AD issues (both health information and procedural issues) for both offenders and facility staff was seen as an important part of providing care. Half of the contracts reflected an awareness of the importance of discharge planning and aftercare – realizing that the offender's treatment cannot simply end upon release from the institution. Notably absent, however, were requirements for discharge planning efforts to include assisting inmates in obtaining Medicaid or other medical assistance program eligibility following release from the facility.

Since we did not collect data on States' correctional health care services prior to entering into managed care arrangements, it is not possible to determine what effects contracting has had, if any, on the level of professional qualifications of the staff providing inmates their care. It is not known, for example, whether the contracts have resulted in the use of higher or lower levels of provider credentials (e.g., M.D. vs. Ph.D., R.N., vs. L.P.N., the use of physician assistants, nurse practitioners, etc.) Finally, it is not possible to determine effects of managed care on the outcomes of inmates' health, both within the facilities and post-release. This is an area for future development, depending on the availability of data, expansion of contractual requirements to collect outcomes data, and progress in the science of outcomes measurement itself.

²⁰ LIS, Inc. March 1994. "Cost Containment Measures and Impacts in Six Departments of Correction." Prepared for the National Institute of Corrections Prison Division. Longmont, CO. Available at <http://www.nic.org>. See also: LIS, Inc. February 2001. "Provision of Mental Health Care in Prisons." Prepared for the National Institute of Corrections, U.S. Department of Justice. Longmont, CO. Available at <http://www.nic.org>.

Commentary: Challenges in the Financing and Delivery of Managed Behavioral Health Care in State Prisons

Based upon our review of this sample of contracts as well as a review of published literature on prison health care services, the following areas represent challenges to financing and delivering effective behavioral health care services in State prisons:

- *Financing Streams and Stability:* Budgetary outlays for inmate health care are part of an overall department of corrections budget that includes outlays for facility management and maintenance, security services, personnel, food service, etc. Since the overall budget is determined at the State level as part of its legislative process, it is subject to variations that may rise and fall depending on current State resources and must compete with other State priorities such as education, transportation, public safety, Medicaid, etc. This can present dilemmas for DOC officials who must potentially balance shrinking budgets with an increase in inmate populations as well as an increase in inmate health needs. For example, State budget shortfalls in Nebraska in 1991 – 1994 caused the State Department of Corrections to institute cuts in its programs and services in order to comply with the Governor’s “no-growth” policy. In addition to instituting a hiring freeze, reducing educational offerings and pre-release training, the DOC reduced its level of substance abuse treatment programming for inmates following the loss of federal funding in 1994. A State statute mandated substance abuse treatment programming as a condition of parole eligibility. Due to the loss of funding, approximately 320 – 380 inmates were ineligible for parole since the number of treatment slots was limited.²¹ These yearly variations in budgetary resources likely account for the fact that the majority of contracts in our sample were for 12 months. Most of them included clauses that set a fixed price upper limit on expenditures based on the State budget and required renegotiations in the event of budget changes during the term of the contract. These clauses introduce a level of uncertainty for contractors who must manage financial risk in order to provide services within the negotiated contract amount. Uncertainties in State budget processes may be of such a level that the State will have difficulty attracting MCOs to bid on their RFPs, as was seen in two States in our sample.
- *Care Coordination Across Physical and Behavioral Health Conditions:* It is not uncommon for inmates to experience simultaneous co-morbid conditions such as mental illness, addiction disorders, and HIV, tuberculosis, diabetes, hypertension, liver disease, etc. Female inmates, in particular, experience higher rates of drug use and HIV infection and treatment programming should be designed to meet gender-specific needs.²² Effective treatment of these co-morbid conditions requires close supervision of the inmate’s health along with appropriate mechanisms for accessing specialists. Medication management is of the utmost importance since, for example, certain antidepressants can affect the efficacy of some HIV medications.²³ Contracts should require that the inmate’s mental health provider, primary care provider, and other care specialists communicate regularly to monitor his or her conditions from both the physical and behavioral health perspectives. While prisons represent a highly specialized environment, the care

²¹ Ibid.

²² Academy for Educational Development. August 2001. “Women, Injection Drug Use, and the Criminal Justice System.” Produced for the U.S. Centers for Disease Control and Prevention. Available at <http://www.cdc.gov/edu>.

²³ Treisman GJ, Angelino AF and Hutton HE. 2001. Psychiatric issues in the management of patients with HIV infection. *JAMA* 296(22). December 12, 2001. pp. 2857-2864.

coordination specifications developed by CHSRP for SAMHSA would be a useful resource for DOCs developing RFPs for MCO contracts for inmate health care.²⁴ A holistic approach to inmate health care requires that the contract embody care coordination requirements that encompass an adequate provider network as well as systems for facilitating access to specialty referrals both within and outside of the facility. In States where prisons are located in rural areas, however, it may be difficult for an MCO to establish such a network in light of a lack of providers generally in rural areas, including primary care providers.

- *Data Collection, Quality Assurance, and Performance Improvement:* Effective contract management requires access to comprehensive, meaningful, and timely data on inmate health status. State DOCs, as purchasers, should provide contractors with specific requirements for data reporting that will enable them to monitor the extent to which: a) contract terms are being met; and b) inmate health status is improving. This is of particular importance when health care services are privatized and the DOC no longer directly employs its own behavioral health providers. Obtaining baseline data on inmate behavioral health status may be problematic. For example, in February 2001 the National Institute of Corrections published a report on the provision of mental health care in prisons that indicated that from a sample of 25 State DOCs, all reported an increase in mental illness among prisoners but 16 (64%) had only anecdotal data to support this observation.²⁵ The nine states that had statistical data used indicators such as the number of inmates with prescriptions for psychotropic medications, current caseloads carried by mental health staff, number of initial mental health screenings of inmates, and percentage of inmates receiving psychiatric consultations.²⁶ Accreditation by a professional organization such as the NCCHC is a necessary, but not sufficient, indicator of the adequacy of services. As noted in a 1999 Federal decision of a class action suit brought by inmates against the Texas Department of Criminal Justice regarding its health care programs, "...the NCCHC's evaluation focuses on the written standards, policies, protocols, bureaucracy, and infrastructure that makes up the medical care system. [...] It is beyond question that the true measure of a medical care system's constitutionality is not its brilliantly crafted policies and state of the art facilities, but its accessibility by, and quality of service to, real people in need of actual medical service."²⁷ Thus, State DOC purchasers must include in their MCO contracts quality assurance and performance indicators that go beyond structural and procedural measures to include meaningful outcomes data to provide evidence of the effectiveness of behavioral health treatment regimens for inmates.
- *Cost Effectiveness of Privatization of Prison Behavioral Health Care Services:* A National Institute of Corrections report in 2000 noted that States using some form of capitated contract for inmate health care achieved an average savings of \$2.22 per inmate per day in direct medical costs.²⁸ Not included in these calculations, however, are the administrative overhead costs involved in contracts with private sector MCOs, e.g., development of RFPs, negotiation of contract proposals, and contract monitoring and enforcement activities. To the extent that State DOCs contemplate conversion to privatized health care delivery for inmates, estimates of these costs

²⁴ Rosenbaum S, Mauery D, and Kamoie B. (2001). Issue Briefs 11 and 12: "Care Coordination and Physical and Behavioral Service Integration in Managed Care Contracts: Analysis and Sample Purchasing Specifications." Prepared for the Substance Abuse and Mental Health Services Administration. (*forthcoming*).

²⁵ LIS, Inc. February 2001. "Provision of Mental Health Care in Prisons." *op.cit.*

²⁶ *Ibid.*

²⁷ *David Ruiz, et al., v. Gary Johnson, Director of TDCJ-ID*. 37 F. Supp. 2d 855; 1999 U.S. Dist. LEXIS 2060.

²⁸ Lamb-Mechanick D. and Nelson J. *op. cit.*

(whether borne solely by the DOC or shared with other State administrative agencies) should be calculated in order to obtain a complete picture of whether such conversions will ultimately save the State money without compromising the quality of inmate health care.

- *Development of a Prison/Community Continuum of Care:* Forward-looking contracts for prisoner health care recognize the importance of providing a continuum of mental health and addiction disorder services for inmates, as well as transition services for income maintenance, housing, and employment, following their release from the facility into the community, where they are typically under supervised parole. Failure to provide such services has been demonstrated to increase recidivism rates, as offenders may return to criminal behavior without the necessary supports to receive treatment for their behavioral and physical conditions. This requires that purchasers, MCOs, and providers have a broader view of inmate health care as extending beyond the four walls of the facility. Contracts should include provisions requiring MCOs to establish linkages with community-based programs skilled in assisting inmates with re-establishing their lives outside of the prison. Collaborative agreements that explicitly detail each organization's duties, coupled with a commitment to partner to improve client-centered care, are fundamental to success.²⁹ This will require ongoing communication and rational allocation of responsibilities for different offices in DOCs charged with inmate health while in prison and when released to the community, such as parole divisions.³⁰

²⁹ Academy for Educational Development. 2001. "Working With the Criminal Justice System." Prepared for the U.S. Centers for Disease Control and Prevention. Available at <http://www.cdc.gov/idu>.

³⁰ LIS, Inc. 1996. "Privatization and Contracting in Corrections: Results of an NIC Survey." Prepared for the National Institute of Corrections. Available at <http://www.nic.org>.

APPENDIX: Contract Language Examples

Example Number	Contract Language
<i>3.1.1 Psychiatric and Psychological Services</i>	
3.1.1.a	<p>Contractor will provide and assume all costs for providing health care services . . . including: [...] f) On-site and off-site psychiatric services. [...] [ST4 Contract]</p>
3.1.1.b	<p>1.1 The contractor’s services shall include comprehensive programs in the one or more of the following areas, as specified in the Notice of Award section of the contract: 1.1.1 On-site and off-site general medical services, medical specialty services, and general and specialty dental services. 1.1.2 On-site psychiatric services and psychotropic medications. 1.1.3 Intensive sex offender psychological treatment. [ST5 Contract, p. 10]</p>
3.1.1.c	<p>C. Mental Health Services</p> <p>The following Mental health services will be provided by [MCO]:</p> <ol style="list-style-type: none"> 1. Psychiatric services for all “General Population Inmates” 2. All staffing, including the Mental Health Unit Director, Psychiatrists, Psychologists, Social Workers and Nurses, necessary to provide mental health services to the Sheltered Care Mental Health Unit and Special Housing (Segregation, Isolation, Detention) Units. 3. All medications associated with the provision of Mental Health services. <p>[ST8 Contract]</p>
3.1.1.d	<p>2. PSYCHIATRIC SERVICES</p> <ol style="list-style-type: none"> A. Psychiatric services shall be provided by licensed physicians who are board eligible or board certified in psychiatry. Standards of practice shall be according to those of the community and in compliance with state and federal laws. B. Evaluate and diagnose in accordance with the current DSM criteria those inmates referred by the Mental Health Treatment Team or other health care staff. C. Complete psychiatric evaluations/assessments as necessary and provide and individual treatment plan specific for those patients requiring psychiatric intervention to include medication. D. Patients shall have a documented physical assessment prior to the prescribing of a psychotropic medication. E. Provide that all medications shall be reviewed, and orders renewed if necessary, at least every thirty days as specified by policy. F. Patients receiving psychiatric medications shall receive a direct assessment from a psychiatrist prior to ninety (90) days elapsing. G. Prescribe only those medications approved in the [DOC’s] formulary, unless otherwise approved as [DOC] procedure dictates. H. Provide consultation to mental health service staff and administrative staff and participate in the treatment team reviews when clinically necessary. I. Provide accessibility to twenty-four (24) hours per day, seven (7) days per week per calendar year emergency consultation with the mental health and health care staff. Such availability may be by telephone unless circumstances necessitate on-site delivery. J. Provide a direct assessment to a patient within 72 hours from the time a telephone order was given for cases involving restrictive therapeutic dispositions. K. Provide clinical recommendations/consultations and coordination of patient referrals to other specialized [DOC] programs, or designated contract hospitals. The contractor(s) must secure appropriate privileges at the designated hospital to provide services if required. Said services may be provided in a written format and/or visual presentation, role play,

Example Number	Contract Language
	<p>teleconferencing medium, etc.</p> <p>L. Provide an appropriate level of psychiatric monitoring of patients requiring psychotropic medication intervention.</p> <p>M. When applicable, provide or assist in the provision of a mental health education program to other institutional staff that shall include, but not be limited to, the following:</p> <ol style="list-style-type: none"> (1) Early detection of potential mental health problems, i.e., signs and symptoms of mental illness, retardation, and chemical dependency. (2) Crisis intervention/suicide precaution programs. (3) Said services may be provided in written format, audio/visual presentation, role play, teleconferencing medium, etc. <p>3. PSYCHOLOGICAL SERVICES</p> <p>A. The delivery of doctoral level psychological services shall be provided by psychologists with health service provider designation who are licensed by the State [...] or who have legal reciprocity to practice in the State [...]. Standards of practice shall be according to those of the community and with State and Federal laws.</p> <p>B. Evaluate and diagnose in accordance with the current DSM criteria those inmates referred by the Mental Health Treatment Team or other health care staff.</p> <p>C. Complete psychological evaluations/assessments as necessary and provide an individual treatment plan specific for those patients requiring psychological intervention(s).</p> <p>D. When clinically/programmatically deemed appropriate, provide individual and/or group therapy/consultation.</p> <p>E. Participate in the treatment team reviews when necessary.</p> <p>F. Be responsible for twenty-four (24) hours per day, seven (7) days per week per calendar year emergency consultation with the health care or other mental health staff. Such availability may be by telephone unless circumstances necessitate on-site delivery.</p> <p>G. Provide clinical recommendations and coordination of referrals of patients to [name] Special Needs Facility or other specialized [DOC] treatment units.</p> <p>H. Provide clinical supervision and/or consultation to institutional psychological examiner(s), mental health program specialist(s), alcohol and drug counselors, and health care staff.</p> <p>I. The Contractor shall provide or assist in the provision of a mental health education program to other institutional staff that shall include, but not be limited to, the following:</p> <ol style="list-style-type: none"> (1) Early detection of potential mental health problems, i.e., signs and symptoms of mental illness, retardation, and chemical dependency. (2) Crisis intervention/suicide precaution programs. (3) Provide consultation supervisory services to mental health staff involved in special programs. Said services may be provided in written format, audio/visual presentation, role play, teleconferencing medium, etc. <p>J. Complete the initial thirty (30) and ninety (90) day mental health assessments on specially segregated inmates as policy dictates. Review findings documented by other licensed professionals.</p> <p>K. Provide psychological evaluations upon the request of the Board of Paroles.</p> <p>L. Provide psychological evaluations to all newly hired correctional officer/probation officers with the [...] Department of Corrections.</p> <p>[ST7 Contract]</p>
	<p><i>3.1.2 Individual and Group Treatment Modalities</i></p>
<p>3.1.2.a</p>	<p>F. Group Treatment</p> <p>In order to maximize resources while providing a psycho-therapeutic model of treatment, the Contractor will place an emphasis on provision of group therapy. The Contractor will also participate in group design and treatment planning. In addition, the Contractor is expected to assign each professional, providing services under this contract, to facilitate treatment to one (1) IMHTU and three (3) outpatient mental health groups. The Contractor will provide each group participant with a clinical note after each session.</p>

Example Number	Contract Language
	<p>G. Individual Treatment</p> <p>Of limited duration and as staffing permits, individual therapy will be provided to those clients identified by the multi-disciplinary staffing team as likely to benefit from this treatment modality.</p> <p>[ST6 Contract, p. 2]</p>
<p><i>3.1.3 Psychotropic Drugs and Medication Management</i></p>	
<p>3.1.3.a</p>	<p>1. At [facility] the contractor’s cost of psychotropic medications will be capped at \$20,000 in the first contract period (8 months) and \$30,000 a year (12 months) thereafter unless amended. Any expenditure over and above the \$20,000 in the first eight months and \$30,000 a year thereafter will be reimbursed by the facility. If the cost falls below the cap, the Contractor will credit the DOC the difference between the actual cost and the \$30,000 cap.</p> <p>[...]</p> <p>3. Maintaining a formulary that includes a full range of current and contemporary medications for the treatment of mental illness. The formulary shall be reviewed annually and revised as necessary. Psychotropic medications are the responsibility of the Contractor up to a cap of \$20,000 in the first 8 months and an annual cap of \$30,000 thereafter.</p> <p>[ST3 Contract]</p>
<p>3.1.3.b</p>	<p>C. Mental Health Services</p> <p>The following Mental health services will be provided by [MCO]:</p> <p>[...]</p> <p>3. All medications associated with the provision of Mental Health services.</p> <p>[...]</p> <p>Inmates who are prescribed medication(s) for mental disorder(s) will be seen by the Psychiatrist at least monthly.</p> <p>[ST8 Contract]</p>
<p>3.1.3.c</p>	<p>8.15.1 The contractor shall be responsible for the provision of all prescription and non-prescription medications. All medications must be prescribed or countersigned by the responsible physician and records of administration maintained. A system of inmate medication profile must be developed. Reports of medication use must be reported monthly to the Pharmacy and Therapeutics Committee. A state formulary must be specified subject to review and input from the state agency. [p. 25]</p> <p>[...]</p> <p>8.17.7 Psychotropic Utilization Report: This report is due by the fifth day of each month. The contractor shall submit the report to the state agency’s Contract Monitoring Office. The actual structure (format) of the report shall be to the mutual agreement of the contractor and the state agency’s Chief of Mental Health Services. The report shall provide for retrieval of information from a three-tiered database to include, at a minimum:</p> <ul style="list-style-type: none"> Drug identification by brand name or generic name. Individual client name. Individual client register number. Start order date and stop order date. Individual client dosage. Prescribing physician. [pp. 26-26a] <p>[ST5 Contract]</p>
<p>3.1.3.d</p>	<p>2. PSYCHIATRIC SERVICES</p> <p>[...]</p> <p>E. Provide that all medications shall be reviewed, and orders renewed if necessary, at least every thirty days as specified by policy.</p> <p>F. Patients receiving psychiatric medications shall receive a direct assessment from a psychiatrist prior to ninety (90) days elapsing.</p>

Example Number	Contract Language
	<p>G. Prescribe only those medications approved in the [DOC's] formulary, unless otherwise approved as [DOC] procedure dictates. [...]</p> <p>L. Provide an appropriate level of psychiatric monitoring of patients requiring psychotropic medication intervention.</p> <p>[ST7 Contract]</p>
<i>3.1.4 Inpatient Hospitalization Arrangements</i>	
3.1.4.a	<p>Psychiatric Treatment and Management. This includes psychiatric consultation, psychotropic medication as needed, specialized inpatient placements through the [State] Department of Corrections Infirmaries and/or the [State] Mental Health Institute at [city], and specialized housing at the [...] Correctional Facility.</p> <p>[ST1 Contract]</p>
3.1.4.b	<p>Provide clinical recommendations/consultations and coordination of patient referrals to other specialized [DOC] programs, or designated contract hospitals. The contractor(s) must secure appropriate privileges at the designated hospital to provide services if required. Said services may be provided in a written format and/or visual presentation, role play, teleconferencing medium, etc.</p> <p>[ST7 Contract]</p>
<i>3.2 Addiction Disorder Treatment Services</i>	
3.2.a	<p>The contractor shall be responsible for administering and processing all drug screens.</p> <p>A. All program participants shall receive and initial drug and alcohol screen.</p> <p>B. All positive screens shall be confirmed through a second methodology.</p> <p>C. The Contractor shall provide the state with the agency's policy and procedures regarding urinalysis testing and chain of custody.</p> <p>[...]</p> <p>Urinalysis testing shall be used as part of the treatment program as a tool for monitoring program compliance and to identify problems.</p> <p>[ST7 Contract]</p>
3.2.b	<p>A.I.1.2. The Contractor shall design and implement a four phase treatment program that includes the following treatment elements:</p> <ol style="list-style-type: none"> 1. Classical Therapeutic Community Structure: <ol style="list-style-type: none"> A. Encounter groups B. Job Functions C. House Rules D. Community Dynamics E. Community Meetings 2. Assessment 3. Drug Education 4. Substance Abuse Treatment 5. Individual and Group Counseling 6. Structured Self-Help 7. Drug Testing, and 8. Transitional Related Services. <ol style="list-style-type: none"> F. Encounter groups G. Job Functions H. House Rules I. Community Dynamics J. Community Meetings 9. Assessment 10. Drug Education 11. Substance Abuse Treatment 12. Individual and Group Counseling 13. Structured Self-Help

Example Number	Contract Language
	<p>14. Drug Testing, and 15. Transitional Related Services.</p> <p>A.I.1.3. The Contractor shall design the following four phase treatment program that will accommodate a minimum of 125 (45 MLRC and 80 TPW) female offenders statewide.</p> <p>Phase I Orientation – This is the initial phase of the program. During this phase offenders receive a needs assessment and treatment plan. They are orientated to the Therapeutic Community Model and program rules and regulations. This phase of the program should last approximately 30 days. During this phase, each offender shall receive a minimum of 30 hours of therapeutic activities per week. Therapeutic activities may be divided between: community service work and drug education programming.</p> <p>Phase II Main Treatment – This is the intensive stage of treatment in which each offender shall receive a minimum of 50 hours of therapeutic activities per week. During this phase offenders shall be involved in drug education, individual and group treatment, community service work, and academic and vocational programming. Each participant shall be required to attend one, tow hour family group session per month. During this phase, offenders shall also be encouraged to participate in structured self-help groups. This phase of treatment should last approximately six to nine months.</p> <p>Phase III Reintegration – During this phase offenders are preparing for community release or release to general population. The primary focus of this phase shall be on addressing transitional issues. All participants shall be required to attend one family group session per week. Al program participants shall be required to develop a life plan. Each offender shall receive approximately 20 hours of therapeutic activities per week. Therapeutic activities shall include group counseling, vocational skills development, and participation in self-help groups. This phase should last approximately two to three months. Program participants that have successfully completed this phase of treatment shall be successfully terminated from the Therapeutic Community.</p> <p>Phase IV Aftercare – This is the final phase of the in-prison treatment program. The primary focus of this phase is to provide support and monitor the progress of program graduates. Program participants that have graduated from the treatment program receive at a minimum two hours of group programming per week until they are released from the institution.</p> <p>[ST7 Contract]</p>
3.2.c	<p>A.2. The Contractor will provide substance abuse treatment services with emphasis, at a minimum, in the following areas:</p> <ul style="list-style-type: none"> (a) Cognitive skills development, (b) Relapse prevention, (c) Family issues, (d) Addiction, (e) Self Control, (f) Anger management, (g) Enabling, (h) Codependency, and (i) Discharge planning and conflict resolution <p>[ST7 Contract]</p>
3.2.d	<p>1.2.1 [DOC] intends to rely largely upon the expertise and knowledge of the vendor to propose the specific curricula and components of the substance abuse treatment program that will best serve the interest of [DOC] and the State [...]. [DOC] requires that programming include at least the following elements:</p> <ul style="list-style-type: none"> ▪ Cognitive-behavioral model addressing behavioral change; ▪ Open entry, open exit;

Example Number	Contract Language
	<ul style="list-style-type: none"> ▪ A schedule that is compatible with the correctional facility and/or parole region; ▪ A minimum of one multi-substance spectrum UA [urinalysis] for each treatment cycle (facility); ▪ A minimum of two multi-substance spectrum UAs per month as well as a UA following each unsupervised community trip (community); ▪ A clinically sound assessment process with respect to assessing offenders for placement in treatment components; ▪ A clinically sound pre-test and post-test that will measure gains and impact of the program [vendor shall specify the proposed instrumentation to be used for pre-testing and post-testing]; ▪ Incentives for engaged participants and/or graduated sanctions for less cooperative offenders so that every reasonable effort will be made to retain participants in the program; ▪ Regular (preferably daily) aerobic exercise activities (community); ▪ Effective reintegration (job development; family counseling; budget planning, etc). <p>[With respect to UA testing, the contractor shall complete and forward to appropriate designated location(s) any and all substance abuse testing report forms required by [DOC].]</p> <p>[ST2 Contract]</p>
3.2.e	<p>5.2.3.(A) Facility programming –</p> <p><u>Short Term Offenders:</u> Programming for this population should be concise in duration (45-60 days), meaty and stimulating. This programming should, at a minimum, include a cognitive behavioral component and, at certain sites, a neuro-feedback (a/k/a alpha-theta brainwave) component.</p> <p><u>Minimum Custody Offenders:</u> Programming for this population may be of longer duration (as much as 90-120 days), and must ordinarily be part-time and in some places made available during evening hours (though not necessarily daily). This programming should, at a minimum, include cognitive behavioral and educational components and, at certain sites, a neuro feedback (a/k/a alpha-theta brainwave) component.</p> <p><u>Long Term Offenders:</u> Programming for this population may be of longer duration (as much as 90-120 days), may be less than daily or full-time but should generally be provided during regular (daytime) work hours. This programming should, at a minimum, include cognitive behavioral and educational components. [[DOC] is providing therapeutic community programming for most “long term” offenders. Contractor shall be expected to provide services for those relatively small number of “long term” offenders who are not serviced by such therapeutic community programming.]</p> <p>[ST2 Contract]</p>
<i>3.3 Provision of Emergency Health Care</i>	
3.3.a	<p>D. On-Call Services: On a rotation basis with other mental health workers at [prison], the Contractor will be assigned “on-call” responsibility to provide emergency evaluations and management. (The Contractor will be credited with on-call compensation in accordance with the guidelines for similar positions at [prison]. Upon agreement by both parties, the compensation schedule will be attached to this contract as Attachment A. These hours will be applied toward the 100 hour/week goal and the Contractor will be compensated accordingly.</p> <p>[ST6 Contract]</p>
3.3.b.	<p>Contractor shall make provisions and be responsible for all costs for 24-hour emergency medical, mental health, and dental care, including, but not limited to, 24-hour medical on-call services and ambulance services when necessary. Written policy and procedure shall provide:</p> <ul style="list-style-type: none"> a. Emergency transport of the inmate from the facility when required; b. Use of emergency medical vehicle; c. Use of state owned vehicles;

Example Number	Contract Language
	<ul style="list-style-type: none"> d. Use of one or more designated hospital emergency departments or other appropriate facilities; e. Emergency on-call physician, psychiatrist, and dentist; f. Security procedures for immediate medical transfer of the inmate; g. All health care and correctional staff on shift will be trained in emergency procedures for obtaining emergency medical care and responding to emergencies; h. Qualified health care personnel are Basic Life Support trained. <p>[ST2 Contract]</p>
<i>3.4.1 Health Services and Education for Facility Staff</i>	
3.4.1.a	<p><u>Health Education</u>: The Contractor must provide health education services. Health Education must include education to the inmate population (individual or group). The Contractor shall also provide training at training classes conducted by the state agency at the facility sites for corrections officers and other state agency staff. Subjects to be provided, at a minimum, are those that deal with the recognition and handling of medical complaints, suicide potential, mental illness, communicable diseases, chemical dependency, and complete screening procedures and forms.</p> <p>[ST5 Contract]</p>
3.4.1.b	<p>When applicable, provide or assist in the provision of a mental health education program to other institutional staff that shall include, but not be limited to, the following:</p> <ul style="list-style-type: none"> 1. Early detection of potential mental health problems, i.e., signs and symptoms of mental illness, retardation, and chemical dependency. 2. Crisis intervention/suicide prevention programs. <p>Provide consultation supervisory services to mental health staff involved in special programs. Said services may be provided in written format, audio/visual presentation, role play, teleconferencing medium, etc.</p> <p>[ST7 Contract]</p>
<i>3.4.2 Health Services and Education for Inmates</i>	
3.4.2.a	<p>The purpose of issuing this RFP is to seek the greatest amount of substance abuse treatment/education service and structured residential service for the largest number of offenders within available resources.</p> <p>[ST2 Contract]</p>
3.4.2.b	<p>1. Covered Services Include: Substance Abuse Education and treatment. This includes self-help programs such as Alcoholics Anonymous, education programs, out-patient treatment and residential/ therapeutic community treatment programs.</p> <p>Special Support Services for Mentally Retarded/Developmentally Disabled Inmates. There are services for inmates with learning problems and/or deficits in intellectual functioning. These include assessment, special psycho-educational programs, vocational training and support services, transitional services and specialized housing at the [facility].</p> <p>Anger Management. This is a structured psycho-educational and treatment for inmates who have significant problems with violence / assaultiveness. This includes Domestic Violence.</p> <p>[ST1 Contract]</p>
<i>3.5 Care Coordination and Case Management</i>	
3.5.a	<ul style="list-style-type: none"> 4. The Contractor shall make referral arrangements with medical specialists for treatment of those prisoners and juvenile offenders with problems which may extend beyond the scope of services provided on site. 5. <u>Psychiatric Services</u>: Meeting with representatives and staff of the facility weekly as coordinated by the facility's Medical Director or other designated person in a combined clinical case conference for the purpose of treatment planning.

Example Number	Contract Language
	<p>6. <u>Psychiatric Services</u>: Maintaining uninterrupted coverage for the provision of all psychiatric services by a qualified psychiatrist for the term of the contract.</p> <p>4. <u>Special Medical Program</u>: For prisoners or juvenile offenders with special medical conditions requiring close medical supervision, including chronic and convalescent care, a written individualized treatment plan shall be developed by the attending physician. The plan should include orders to health care and other personnel regarding their roles in the care and supervision of the patient.</p> <p>[ST3 Contract]</p>
<i>3.6 Discharge Planning and Aftercare</i>	
3.6.a	<p>The Contractor will make referrals to appropriate community health settings and participate in the facility discharge planning process.</p> <p>[ST3 Contract]</p>
3.6.b	<p>Other Contract staff may be assigned to administer other systems for the delivery of mental health services at [prison]. This will include, but not be limited to, cases on the mental health treatment unit, providing individual treatment, treatment planning, and discharge planning.</p> <p>[ST6 Contract]</p>
3.6.c	<p>O. Mental Health Services – [DOC] will provide all reception and diagnostic services for male and female inmates. The contractor will provide all other comprehensive mental health services to the entire population, except for acute inpatient care which is provided at [...] State Hospital. The vendor shall include, in the proposal:</p> <p>2. how long-term segregation inmates will be reintegrated with special emphasis on reintegration into the community;</p> <p>7. Aftercare Services for Substance Abuse and Sex Offender Treatment Programs where not otherwise available;</p> <p>9. Specialized chronic mentally ill treatment program at [facility] reintegration program at [facilities];</p> <p>15. Reintegration of long-term segregation inmates, especially into the community upon release;</p> <p>18. A proposal to develop a reintegration unit at the [...] Correctional Facility, [...] Correctional Facility, and the [...] Correctional Facility to include specialized officer training;</p> <p>19. A proposal to provide a discharge planning program at [...] Correctional Mental Health Facility, [...] Correctional Facility, [...] Health Facility, and [...] Correctional Facility.</p> <p>Q. 5 The contractor is required to provide a fourteen (14) day supply of prescribed medications to inmates upon release from [DOC].</p> <p>[ST2 Contract]</p>
3.6.d	<ul style="list-style-type: none"> ▪ Transitional services shall be provided in accordance with a written, individualized plan based on each client’s transition needs which specifies weekly goals and objectives for the client to meet. These services shall include, but not be limited to, job development and referral services, transportation assistance and educational assistance in independent living skills (housing, nutrition, budgeting, etc.) NOTE: Job development services shall include the active seeking out and facilitation of employment opportunities for the client caseload, accomplished in conjunction with professional organizations, local employers, state and local employment resources, etc. ▪ Mandatory Budgeting for Residents. Contractor shall be responsible for establishing an individual budget with each resident based on the resident’s net income to insure to the resident a significantly enhanced ability to live independently. ▪ Recreational Services. The program shall provide for, and encourage, productive use and active monitoring of aerobic exercise and appropriate leisure time activities. ▪ Support Services Referral. The program shall provide for appropriate referrals to community support services such as mental health counseling and education/vocational training.

Example Number	Contract Language
	<ul style="list-style-type: none"> ▪ Re-entry Program Plan. The contractor shall provide the general daily, weekly and monthly schedules, goals and objectives to be met, projected average program length, and individualized completion criteria (including the amount of money to be saved, stability of employment, support system developed, etc.) <p>5.2.3.C General Expected Practices and Procedure:</p> <p>All programming provided under this RFP shall include:</p> <ul style="list-style-type: none"> ▪ Written discharge summaries will be provided within 5 working days of the date of removal; ▪ A written relapse prevention plan will be available upon completion of the program; ▪ A written prognosis will be provided upon completion of the program, with terms being utilized that are clear and defined, and with a logical correlation between the offender's completion status and prognosis; ▪ Recommendations for community treatment should be compatible with release living plans; ▪ A pre-placement assessment should be provided, which addresses risk and responsivity; ▪ A pre-parole assessment or evaluation as requested by the [State] Parole Board that sets forth a prognosis regarding successful completion of parole/post-release supervision and recommendations that the offender should follow in order to successfully complete parole/post release supervision; ▪ All program components must be ADAS certified, unless not required by ADAS. Community Residential Beds (CRBs), as described in this Request for Proposal, do not require ADAS licensure/certification. <p>[ST2 Contract]</p>
3.6.e	<p>A.I.1.3. The Contractor shall design the following four phase treatment program that will accommodate a minim of 125 (45 MLRC and 80 TPW) female offenders statewide.</p> <p>[...]</p> <p>Phase III Reintegration – During this phase offenders are preparing for community release or release to general population. The primary focus of this phase shall be on addressing transitional issues. All participants shall be required to attend one family group session per week. All program participants shall be required to develop a life plan. Each offender shall receive approximately 20 hours of therapeutic activities per week. Therapeutic activities shall include group counseling, vocational skills development, and participation in self-help groups. This phase should last approximately two to three months. Program participants that have successfully completed this phase of treatment shall be successfully terminated from the Therapeutic Community.</p> <p>Phase IV Aftercare – This is the final phase of the in-prison treatment program. The primary focus of this phase is to provide support and monitor the progress of program graduates. Program participants that have graduated from the treatment program receive at a minimum two hours of group programming per week until they are released from the institution.</p> <p>A.I.2.11 The contractor shall also provide a weekly follow-up or aftercare session for program graduates to monitor progress and provide support..]</p> <p>A.I.2.2 The Contractor shall conduct an initial needs assessment and a follow-up assessment, toward the end of the program period, on each program participant.</p> <p>[ST7 Contract]</p>
3.6.f	<p>Intermediate Inpatient Treatment: Location of these beds should be in major metropolitan areas where the largest populations of offenders are to be found, such as [cities]. Programming for this population should be of moderate duration (60-90 days), intense, full-time, inpatient and stimulating.</p>

Example Number	Contract Language
	<p>Outpatient Counseling: Services should be made available throughout the state so that most, if not all, of the offender population can be provided with these services locally. This programming should be provided weekly at times and places convenient to the offenders.</p> <p>Community Residential Beds: The location of these slots should be in major metropolitan areas where the largest population of offenders are to be found, such as in [cities]. Every site providing CRB slots must satisfy all federal, state, and local laws and licensure, code and zoning requirements. Programming for this population should be of moderate duration (60-120 days), and should encourage employment and reintegration into society while providing substance abuse education and surveillance, focusing on relapse prevention. Additionally, CRB sites should satisfy the following criteria:</p> <ul style="list-style-type: none"> ▪ Contractor shall be responsible for the provision and appropriate scheduling of all meals and nutrition (3 meals per day, 7 days per week), establishing and monitoring healthy sleep schedules and structured leisure activities. The contractor shall provide for 24-hour coverage by residential center staff to include active monitoring of movement, location and activity of residents. The Contractor shall provide for monitoring of menus by an appropriately qualified dietician, and for monitoring housekeeping and cleanliness. ▪ Transitional services shall be provided in accordance with a written, individualized plan based on each client’s transition needs which specifies weekly goals and objectives for the client to meet. These services shall include, but not be limited to, job development and referral services, transportation assistance and educational assistance in independent living skills (housing, nutrition, budgeting, etc.) Note: Job development services shall include the active seeking out and facilitation of employment opportunities for the client caseload, accomplished in conjunction with professional organizations, local employers, state and local employment resources, etc. ▪ Mandatory Budgeting for Residents. Contractor shall be responsible for establishing an individual budget with each resident based on the resident’s net income to insure to the resident a significantly enhanced ability to live independently. ▪ Recreational Services. The program shall provide for, and encourage, productive use and active monitoring of aerobic exercise and appropriate leisure time activities. ▪ Support Services Referral. The program shall provide for appropriate referrals to community support services such as mental health counseling and education/vocational training. ▪ Re-entry Program Plan. The Contractor shall provide the general daily, weekly, and monthly schedules, goals, and objectives to be met, projected average program length, and individualized completion criteria (including monthly amount to be saved, stability of employment, support system developed, etc.) <p>[ST2 Contract]</p>
3.6.g	<ol style="list-style-type: none"> 1. The Contractor shall provide three months or 48-hours of outpatient services per participant that focuses on wellness, relapse, prevention, family issues, and transitional issues. 2. The Contractor shall use licensed alcohol and drug treatment counselor(s) to deliver outpatient treatment services. 3. The Contractor shall provide transitional release services for a minimum of 30 offenders on an annual basis. 4. The Contractor shall include random drug-testing as a major component of the treatment program. Drug testing will be used as a tool for monitoring program compliance. Drug testing will be conducted on a regular and frequent basis. All program participants shall receive an initial drug screen. All positive tests will be confirmed through a second methodology. <p>[ST7 Contract]</p>
<i>3.7 Exclusionary Provisions</i>	
3.7.a	MENTAL HEALTH SERVICES [from Exhibit A]

Example Number	Contract Language
	<p>1. Covered Services do not include:</p> <p>a. Mental health staff may provide evaluations in response to requests from the Parole Board to include information regarding program participation, progress and completion. Mental health staff will not conduct evaluations for the purpose of recommendations regarding parole suitability, nor will mental health staff write letters of reference/support for the courts.</p> <p>b. The [State] Department of Corrections mental health staff will not initiate hormonal treatment of transsexualism, nor will any surgical treatment for transsexualism be provided.</p> <p>[ST1 Contract]</p>
3.7.b	<p>a. The PAC will review the information to determine if the admission and/or services meet appropriate guidelines for medical necessity. Services may be determined to be medically necessary, but authorization denied if offender’s parole date (indicated in the phone number field of the NPE) is in the near future and postponing services does not put the offender at risk for pain, suffering or deterioration of his/her condition. [emphasis added] Additional information will be requested if needed.</p> <p>[ST1 Contract]</p>
<p><i>4. Medical Necessity and Emergency Definitions</i></p>	
4.a	<p>Any health care service required to preserve the Covered Offender’s health and which, as determined by the Medical Director or his/her designee is: (1) consistent with accepted standards for the treatment of disease and disability; (2) appropriate with regard to accepted medical practice; (3) not solely for the convenience of the Covered Offender, his/her physician(s), hospital or other providers; and (4) the most appropriate supply or level of service which can be provided Covered Offender.</p> <p>[ST1 Contract]</p>
4.b	<p>Medically necessary care shall mean treatment, that if not provided, will reasonably be expected to result in deterioration of that convict prior to release, and/or will result in permanent material impairment, permanent loss of function, or unmanageable pain.</p> <p>[ST8 Contract]</p>
4.c	<p>An emergency condition shall mean any medical condition (including active labor and delivery) manifested by acute symptoms of sufficient severity (including severe pain) that the absence of immediate medical attention could reasonably expect to result in (a) placing of the patient’s health in serious jeopardy; (b) serious impairment to bodily functions; or (c) serious dysfunction of any bodily organ or part.</p> <p>[ST1 Contract]</p>
<p><i>5. Prior Authorization Requirements</i></p>	
5.a	<p>A. Prior Authorization</p> <p>1. <u>Department Provider Utilization Management Requirements:</u> Department Provider encompasses not only the assigned PCP, but another [DOC] PCP, a [DOC] physician’s assistant or nurse practitioner.</p> <p>a. The Department provider may refer or perform limited services and treatments without prior authorization from [MCO]. A list of services or treatments that do not require prior authorization are outlined in the [MCO/DOC] Provider Manual.</p>

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	<p>b. If additional test, services or treatments are required, a phone request must first be submitted to [MCO] for prior authorization. A list of services or treatments that require prior authorization are outlined in the [MCO/DOC] Provider Manual. The list is not all-inclusive.</p> <p>c. The Department provider may request consultation to a specialist when the offender’s medical condition warrants a more detailed evaluation by a physician or provider with a particular area of expertise. Such consultations require a phone request to [MCO] for prior authorization.</p> <p>2. <u>Specialty Care Provider Utilization Management Requirements:</u></p> <p>a. The specialty care provider (SCP) may order or perform limited services and treatments without prior authorization from [MCO]. A list of services or treatments that do not require prior authorization are outlined in the [MCO/DOC] Provider Manual.</p> <p>b. If the SCP has been given authorization to provide a consultation and wishes to request authorization of a procedure or service that requires prior authorization and can be performed at the specialist’s office or clinic at the time of the visit, the specialist must contact [MCO] for prior authorization while the offender is waiting. A list of services or treatments that require prior authorization are outlined in the [MCO/DOC] Provider Manual. The list is not all-inclusive.</p> <p>c. If the requested procedure or service cannot be performed at the time of the consultation and requires prior authorization, the specialist must contact [MCO] for prior authorization. [MCO] will notify the SCP, Department Provider, the facility where the services will take place and [DOC] Scheduler of approved services. The SCP, Department Provider, the [DOC] scheduler and [DOC] Chief Medical Officer will be notified of denied services. [DOC] will be responsible for scheduling approved requests for services.</p> <p>d. If the SCP determines a referral to a secondary specialist is necessary, the request must be communicated to the Department provider. The Department provider will then contact [MCO] for the appropriate prior authorization.</p> <p>[ST1 Contract]</p>
<i>6.1 Treatment Standards and Guidelines</i>	
6.1.a	<p>Treatment programming shall focus on the issues that are unique to women such as guilt, wellness, depression, STDs, anger, sexual abuse, co-dependency, powerlessness, responsibility, fulfillment and self-actualization, incest, sexual dysfunction, battering, relationships, shame, self-image and self-esteem, parenting, leisure time planning, criminal thinking, spirituality, nutrition, victim rights, and choices.</p> <p>[ST7 Contract]</p>
<i>6.2 Provider Credentialing</i>	
6.2.a	<p>5.3 SERVICES TO BE PROVIDED <u>DEFINITIONS</u></p>

Example Number	Contract Language
	<p>[...] Mental Health Personnel: Registered or licensed Ph.D., LMLP, LSCSW, LMSW, Psychiatrist (MD, DO), and Activity Therapist.</p> <p>[ST2 Contract]</p>
6.2.b	<p>Contractor shall provide a statewide Substance Abuse Program Coordinator who will be directly responsible for the timely and satisfactory completion of any work or project assigned under this RFP and who will be directly responsive to [DOC] monitoring staff. The Substance Abuse Program Coordinator shall have the following minimum credentials/qualifications/experience: Graduate of a 4-year accredited college or university with a bachelor’s degree in social work, sociology, psychology, substance abuse counseling, or closely related field; at least one (1) year experience providing substance abuse services to an offender population; at least one (1) year of administrative experience; and, is a state of [...] licensed, registered, or certified substance abuse counselor.</p> <p>Persons employed by contractor to provide direct delivery of counseling/treatment services to offender shall have at least the following credentials/qualifications/experience: Graduate of a 4-year accredited college or university with a bachelors degree in social work, sociology, psychology, substance abuse counseling, or closely related field; or at least one (1) year of experience providing substance abuse services to an offender population; and is a state of [...] licensed, registered or certified substance abuse counselor. At least 30% of this staff must hold the above-described bachelors degree.</p> <p>[ST2 Contract]</p>
<p><i>6.4 Quality Improvement Programs, Mandatory Reports, and Third Party Audits</i></p>	
6.4.a	<p>C. The Contractor shall measure various clinical/programmatic mental health outcomes. At a minimum, the State shall require the Contractor to evaluate response to prescribed psychiatric medications, improvement in mental health status, patient functioning/sense of well-being, etc. The State in a cooperative effort shall assist in the development of additional outcome measures. The Contractor shall abide by the following milestone schedule for the development, standardization, and reporting requirements of the outcome measures.</p> <p><u>Within 90 days from Contract Execution:</u> The Contractor shall propose in writing to the Director of Mental Health Services draft standardized outcome measures to be utilized regionally/statewide.</p> <p><u>Within 120 days from Contract Execution:</u> The Contractor shall have revised and developed, in consultation with the Director of Mental Health Services, functional outcome measurement instruments that can be used regionally/statewide. The instruments will be applied and data gathered in such a manner as to allow the collection of both time-series and cross-sectional data. The instruments may vary based upon the treatment objectives and geographical location, (i.e., [...] Special Needs Facility) but the instrument must be universal enough to report meaningful information to both the Director of Mental Health Services and the Director of Contracts Administration.</p> <p>Failure to meet these milestones will be considered an incident of non-compliance for each week they are not performed. The mechanism outlined in E.15. “Special Terms and Conditions” may be applied in the event the milestones are not met (See Attachment A).</p> <p>[ST7 Contract]</p>
6.4.b	<p>VII. QUALITY OF CARE</p> <p>A. Contractor Quality Management and Improvement Program</p> <p>1. The Contractor shall maintain an internal quality oversight and credentialing program (the Program) using guidelines relative to this network and population. The Program guidelines shall be utilized for completion of credentialing activities and for evaluating adverse quality events that occur in the course of medical treatment rendered by providers in the contractor developed network. The Program shall be capable of identifying opportunities</p>

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	<p>to improve care and shall work with Participating Providers, other staff of the Contractor, and the Department to improve all aspects of health care and services administered by the Contractor, and provided by its Participating Providers and Subcontractors.</p> <ol style="list-style-type: none"> 2. The Contractor shall submit an annual written summary report of the Program to the Department. 3. At least annually and at any other time necessary as determined by the Department, the Department will evaluate the extent to which the Contractor meets or exceeds the requirements of this section. If the Department determines that a quality of care problem exists that negatively impacts Covered Offenders, the Department will require a corrective action plan and may require other remedial actions as described in Sections XVII and XIII. Annual review of Contractor performance shall include evaluation of the effectiveness of the Program in overseeing quality and addressing adverse events which ere found in the course of care provided to Covered Offenders. <ol style="list-style-type: none"> a. The Contractor’s Program shall include the components specified in Section VII which will form a basis of evaluation by the Department. b. On a schedule to be determined by the Department, the Contractor shall submit for Department review a copy of its written quality oversight program description. c. The Contractor shall submit quarterly reports related to any adverse quality events and oversight activities, to include recommendations for corrective actions necessary for resolution. d. At the discretion of the Department, the Contractor may be deemed to be in compliance with requirements under all or part of this section upon documentation of current accreditation from a nationally recognized accreditation body. Criteria and methods for such deemed compliance will be developed by the Department in consultation with the Contractor as described in Section XIII. However, the Contractor is not exempt from reporting requirements under Section XI. [...] <p>A. Priorities for Quality Improvement</p> <ol style="list-style-type: none"> 1. The Contractor shall consult with the Department in evaluation of the Department’s priority clinical and/or service delivery issues and development of quality improvement objectives. The Contractor shall consult on studies including aspects regarding the provision of data, including clinical data, necessary to develop clinical performance measures, develop practice guidelines, and evaluate performance. 2. Based on external review findings, the Contractor’s process for monitoring and evaluating important aspects of care and service, and the Department’s monitoring and evaluation of Contractor performance, the Contractor and the Department shall agree on specific quality improvement objectives to be implemented and a time frame for assessment of the extent to which objectives have been met. 3. The Contractor shall participate in a quality improvement work group to be established by the Department to identify quality improvement priorities, develop performance review criteria, and develop monitoring protocols and specifics of reporting formats. <p>[ST1 Contract]</p>
6.4.c	<ol style="list-style-type: none"> 1. Quality and Timeliness of Services 2. Records Documentation 3. Continuity of Care 4. Medication Changes 5. Chronic Care Treatment Plans 6. Staff training, 7. Chart Review by the Medical Director in accordance with NCCHC and/or ACA Standards <p>...</p> <p>The Contractor shall be responsible to establish a Medical Utilization Review process for patient care. The Contractor shall also be responsible to assure that all medical services are provided in the most cost effective manner. Procedures shall include practices to assure effective quality care and cost containment.</p>

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6.4.d	<p>[ST3 Contract]</p> <p>4.1.1 The performance of the contractor’s health personnel and administration as well as the delivery of medical services must meet or exceed standards established by the NCCHC as they currently exist and may be amended. The contractor shall comply with all established medical policies of the [State] Department of Corrections Institutional Services Policy and Procedures Manual.</p> <p>5.2 Throughout the duration and term of the contract at the contractor’s expense and if requested by the state agency, the contractor shall obtain an independent compliance and/or performance audit of the specific services provided. All independent audits shall be mutually agreed upon by and between the state agency and the contractor. The contractor shall provide the state agency with any and all reports concerning any review of general services.</p> <p>5.2.1 As may be requested by the state agency, the contractor shall obtain independent mortality and morbidity reviews on selected cases. The contractor shall utilize a qualified organization and/or individual subject to state agency approval.</p> <p>g. 8.17 Monitoring and Reporting Requirements: The state agency shall provide monitoring staff for professional contract management assistance through continuous contract oversight, observation of treatment, and assessment of program outcome.</p> <p>[ST5 Contract]</p>
6.4.e	<p>F. Contract Monitoring Criteria/Non-performance Penalties</p> <p>Criteria for monitoring the quality of administrative and clinical performance, with associated penalties for non-compliance are contained in Attachment 1 to this Agreement. . . .</p> <p>Non-compliance penalties will be assessed quarterly, based on the combined results of monthly audits which do not meet the threshold of compliance. The monthly compliance review shall be performed by the DOC. Prior to the assessment of penalties, the DOC will provide [MCO] with details documenting the violation for which the penalty is to be assessed, and [MCO] will have fifteen (15) days to appeal the assessment of damages. All appeals will be filed with the Director of Health Services for the DOC, who will have the authority to make the final decision regarding the appropriateness of the penalty. If penalties are assessed, the dollar value of said penalties shall be deducted by the DOC from the next monthly invoice received. Penalties shall be calculated on a per institution basis.</p> <p>The monthly compliance reviews shall start upon execution of this Agreement, however, the assessment of penalties shall not become effective until the beginning of the second quarter after this Agreement’s effective date or opening of the facility.</p> <p>G. External Quality Assurance Audits</p> <p>Quality of care reviews will be performed at the request of the DOC, which will have the right to choose the consultant performing the review. The cost of such reviews will be shared equally by the DOC and [MCO], however, the total annual cost to be borne by [MCO] will be limited to a total of \$15,000.00, whether such cost relates to the performance of a review at a single correctional center or any combination of reviews at multiple correctional centers.</p>

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	<p>Provide reports related to overall medical operation. Such reports shall be submitted to the Warden(s) or his/her designee on a mutually agreed upon basis which is to be confirmed in writing. [MCO] will cooperate with the DOC in response to reporting requests necessary to support any provision of this Agreement and will supply requested reports without any additional fee.</p> <p>[ST8 Contract]</p>
<p><i>7. Confidentiality of Medical Records</i></p>	
<p>7.a</p>	<ol style="list-style-type: none"> 2. All Departmental procedures concerning access to and confidentiality of the medical records must be followed. 3. The Contractor shall not publish any findings based on the data obtained from the operation of the Contract without prior written consent of the DOC. The Department reserves the right to publish any material as it pertains to the operation of the contract. 4. Department Policy: It is the policy of the Department of Corrections that records pertaining to persons receiving services from the Department be kept confidential and that disclosure of those records be made only when such disclosure take place in a uniform manner throughout the Department. 5. <u>Special Rules on Disclosure of Certain Types of Records:</u> <ol style="list-style-type: none"> 1. <u>Records not to be Disclosed.</u> The following types of records and information contained within those records may be disclosed only to persons employed by the Department of Corrections and persons or agencies under contract to the Department, but not parties with whom a fee for service contract has been made in an individual case, but only if, such disclosure is necessary to enable the fulfillment of a statutory function of the Department: <ol style="list-style-type: none"> a. Records containing information obtained for the purpose of evaluating a person’s ability to participate in a community based program, such as community sentiment information; 6. <u>AIDS Test Results:</u> The results (whether positive or negative) of an HIV (AIDS) test may be disclosed only to: <ol style="list-style-type: none"> a. A Department of Corrections employee or person or agency under contract to the Department of Correction or other correctional agency provided that the recipient is authorized to receive those results by the Commissioner of Corrections (note: the law does not permit the Commissioner to authorize persons employed by or under contract to the Division of Probation and Parole to receive those results); b. The person tested c. A parent or guardian of the person tested d. A person or entity authorized to receive those results by a release of

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	<p>information form signed by that person’s parent or guardian.</p> <p>e. A person or entity authorized to receive those results by a court order.</p> <p>7. <u>Information Acquired in the Course of Substance Abuse Treatment:</u> Information acquired during the provision of substance abuse treatment services may be disclosed only to:</p> <p>a. The person who received the substance abuse treatment services;</p> <p>b. A person or entity authorized to receive that information by a release of information form signed by the person who received the services, and, if necessary, by that person’s parent or guardian . . . (Note: the law does not permit the parent or guardian of an adult to receive such substance abuse information without the consent of the person who received the treatment).</p> <p>c. A person or entity authorized to receive that information by a court order;</p> <p>d. The Department of Human Services if, but only if, the information disclosed consists solely of a report of suspected child abuse or neglect, and</p> <p>e. Medical personnel if, but only if, the information disclosed is needed by those personnel so that they can treat a condition which poses an immediate threat to health and which requires immediate medical intervention.</p> <p>The disclosure of information acquired during the provision of substance abuse treatment services must be made in compliance with the Department of Corrections.</p> <p>[ST3 Contract]</p>
7.b	<p>Contractor will not make any reports, information, data, or other medical information given to, prepared by, or assembled by the Contractor, which the DOC requests to be kept confidential, available to any individual or organization without the State Agency’s prior written approval, except in cases of Contractor’s compliance with court order or applicable law.</p> <p>[ST4 Contract].</p>
<i>8. Grievances and Appeals</i>	
8.a	<p>Client Grievance Policy and Procedures:</p> <p>V. Procedures:</p> <p>A: Client Grievance Procedures, General.</p> <ol style="list-style-type: none"> 1. The Chief Administrative Officer (CAO) of each correctional facility shall appoint, subject to approval by the Commissioner of Corrections, a Grievance Review Officer (GRO). 2. His/her function will be to receive and process all client grievances. 3. Persons housed at contract agencies shall direct grievances to the GRO at the facility from which they were transferred. 4. Each district office of the Division of Probation and Parole shall have a GRO appointed by the Director of the Division of Probation and Parole. 5. A grievance must be filed with the GRO within five days of the action, decision, or event which is the subject of the complaint. Exceptions may be granted by the GRO in extraordinary circumstances or in cases where it was

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	<p>not possible for the client to file a complaint within the five-day period.</p> <ol style="list-style-type: none"> 6. Each correctional facility, contract agency, and District Probation and Parole Office must designate a place or places where the grievance may be filed by the client in a confidential and timely manner. 7. No client using this grievance procedure shall be subjected to reprisals. 8. A client shall be entitled to pursue, through the grievance procedure, any complaint that reprisal has occurred. <p>B: Filing Grievances.</p> <ol style="list-style-type: none"> 1. Before filing any grievance, the client shall make an attempt to resolve the complaint in an informal manner, if possible. 2. If a client believes that it is not possible or fails in attempting to informally resolve the complain, he/she shall state the complaint in writing on a form which will be provided in readily-accessible locations within the institution, the Probation and Parole Office, or the Agency. 3. The Director of a contract agency must forward all client grievance forms to the GRO of the facility from which the client was transferred. 4. As part of the grievance process, the client must indicate what steps he/she has taken, or has attempted to take, in order to informally resolve the complaint. 5. If no attempt at informal resolution has been made, the client must indicate the reason on the form. 6. The client must state, as briefly and concisely as possible, the specific nature of his/her complaint and the remedy requested. 7. Any client may withdraw his/her grievance at any time by written request to the GRO. <p>C: First Level Review of a Client Grievance</p> <ol style="list-style-type: none"> 1. After having been filed by the client at the proper location, the grievance form will be received initially by the GRO. 2. The GRO shall assign to the form a control number, which shall also be noted on a receipt which shall be returned to the client. The control number will be used to identify the specific complaint through the entire grievance process. 3. The GRO shall cause an investigation concerning the complaint to be made and may require written reports from any and all parties involved in the matter. 4. The GRO must respond to the complaint, in writing, not later than 20 days following receipt of the grievance form. 5. If the GRO is not authorized to provide the requested remedy, he/she shall forward the complaint, together with all investigative reports and other documentation, to the CAO or the Director of Probation and Parole (DPP) for review and shall so advise the client. 6. If a response cannot be made within the 20 days, the GRO shall so advise the client and shall indicate when the response will be made, which must not be later than an additional 10 days. He/She must also specify the reasons for the delay in his/her response to the client.

Example Number	Contract Language
	<p>D. Second Level Review of A Client’s Grievance.</p> <ol style="list-style-type: none"> 1. If, after the receipt of the response from the GRO, the client is dissatisfied with the response or believes that the response does not adequately address the problem, he/she may, within three days, indicate on the grievance form his/her reasons why the response is unsatisfactory and may then return the grievance form to the GRO, who shall forward the grievance, together with all prior correspondence and documentation, to the CAO or to the DPP. 2. The CAO or DPP shall review all prior responses and documentation and may require additional investigation or documentation before filing a written response to the client, which must be done within 20 days of the receipt of the complaint. 3. If the CAO or DPP is not authorized to provide the requested remedy, he shall forward the complaint, with his recommendation and all prior documentation, to the Commissioner of Corrections and shall so advise the client. <p>E. Third Level Review.</p> <ol style="list-style-type: none"> 1. If, upon receipt of the written response from the CAO of the facility or the DPP, the client still believes that the matter has not been resolved, he/she may, after stating his/her reasons on the grievance form, return the form within three days to the GRP, who shall forward the complaint, along with all prior documentation, responses, statements, and reports previously involved in the matter, to the Commissioner of Corrections. 2. The Commissioner shall respond in writing to the client within 30 days of receipt of the complaint. 3. This level shall be the final administrative level of appeal.. <p>F. Emergency Appeal of Grievances.</p> <ol style="list-style-type: none"> 1. In those instances in which the client believes that his/her complaint is of an emergency nature requiring immediate action, he/she should so note on the grievance form and should state his/her reasons for requesting emergency processing of the complaint. 2. The GRO shall review the reasons stated for emergency and shall make a determination as to the emergency nature of the grievance. If he/she believes that the matter qualifies as an emergency grievance, the GRO shall cause an immediate investigation to be made and shall immediately respond to the complaint within 72 hours or shall immediately forward the complaint, without substantive review, to the level at which action can be taken. <p>[ST3 Contract]</p>
	<i>10. Reimbursement/Payment for Services</i>
10.a	<p>Fees under this contract, unless amended, will not exceed the total of \$13,280,653 to be paid in 32 payments beginning November 1, 1999 through June 30, 2002. If the population falls below a 10% variance, an adjustment will be made to the monthly billing based on the per diem rate of \$2.85, per prisoner or juvenile offender, per day. Should the population exceed the 10% variance, DOC will pay the additional per diem rate. If the population falls below the 10% variance, the contractor will credit the DOC for the per diem amount. If the population exceeds or falls below the 10% variance for a period of thirty (30) or more consecutive days, or any of the contract facilities are closed or consolidated , the DOC and [MCO] mutually reserve</p>

Example Number	Contract Language																
	<p>the right to renegotiate the price of the contract.</p> <p>[ST3 Contract]</p>																
<p>10.b</p>	<p>In the event that, on any day or shift, each position is not staffed as agreed by the contractor and contract administrator by a person possessing qualification at least as high as those required by that position, a deduction as indicated below will be made from the contractual payment. Cross coverage (one individual assigned to two positions simultaneously) will not be considered coverage under this Contract. No deduction shall be taken for any [MCO] clinical or non clinical staff who may be absent from their assigned positions as a result of providing emergency coverage at another DOC facility at the request of the DOC.</p> <table data-bbox="345 573 797 810"> <tr> <td>a. Physician</td> <td>\$100.00/hr</td> </tr> <tr> <td>b. Psychiatrist</td> <td>125.00/hr</td> </tr> <tr> <td>c. Dentist</td> <td>80.00/hr</td> </tr> <tr> <td>d. Dental Assistant</td> <td>12.00/hr</td> </tr> <tr> <td>e. Health Svc. Administrator</td> <td>30.00/hr</td> </tr> <tr> <td>f. Nurse-RN</td> <td>25.00/hr</td> </tr> <tr> <td>g. Nurse-LPN</td> <td>20.00/hr</td> </tr> <tr> <td>h. Unit Clerk</td> <td>12.00/hr</td> </tr> </table> <p style="text-align: center;">Other to be Determined</p> <p>[ST3 Contract]</p>	a. Physician	\$100.00/hr	b. Psychiatrist	125.00/hr	c. Dentist	80.00/hr	d. Dental Assistant	12.00/hr	e. Health Svc. Administrator	30.00/hr	f. Nurse-RN	25.00/hr	g. Nurse-LPN	20.00/hr	h. Unit Clerk	12.00/hr
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g. Nurse-LPN	20.00/hr																
h. Unit Clerk	12.00/hr																
<p>10.c</p>	<p>An annual capitated fee of \$8,096,000 for a base population of 5,625 inmates with an additional per diem payment of \$2.75 for daily populations exceeding 5,625 inmates. The annual capitated fee includes a pharmaceutical HIV cap. The DOC will increase the capitated fee and per diem rates by 4% each year on the anniversary of the contract.</p> <p>[ST4 Contract]</p>																
<p>10.d</p>	<p>C.1. <u>Maximum Liability</u>. In no event shall the maximum liability of the State under this Contract exceed one million one hundred seventy-one thousand dollars (\$1,171,000.00). The hourly rates in Section C.3. shall constitute the entire compensation due the Contractor for the Service and all of the Contractor's obligations hereunder regardless of the difficulty, materials or equipment required. The Hourly Rates include, but are not limited to, all applicable taxes, fees, overheads, profit, and all other direct and indirect cost incurred or to be incurred by the Contractor.</p> <p>C.2. <u>Compensation Firm</u>. The Hourly Rates in Section C.3 and the maximum liability of the State under this Contract are firm for the duration of the Contract and are not subject to increase for any reason unless amended.</p> <p>[ST7 Contract]</p>																