Dying for Legislation: Rehabilitating Correctional Health Care in the United States

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Introduction

In 2003, Cynthia Beatrice Scott entered the Fluvanna Correctional Center for Women (FCCW)—a state-run prison located in central Virginia—as a healthy 31-year-old inmate.[1] In the years that followed, however, she experienced a steady decline in her health.[2] By her forty-second birthday, Ms. Scott had developed multiple chronic health conditions after being subjected to what can fairly be deemed cruel and unusual punishment at the hands of the American prison health care system.[3] Deprived of even minimal levels of adequate health care during those eleven years, Ms. Scott decided to take legal action and led a lawsuit against the Commonwealth of Virginia Department of Corrections and its private for-profit health care contractor, Corizon Health Inc.[4]

As alleged in her lawsuit, Ms. Scott's problems began in 2009, approximately six years into her prison sentence, when she found that she was having trouble breathing and she turned to Corizon for care.[5] Corizon delayed treatment, misdiagnosed her conditions, and dismissed treatment regimens prescribed by the specialists at University of Virginia Medical Center (UVA) to whom she was belatedly referred.[6] On two separate occasions, Corizon allowed Ms. Scott's

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1 Scott v. Clarke, No. 3:12-CV-00036, 2016 WL 452164, at *1, *4 (W.D. Va. Feb. 5, 2016).

2 *Id.*

3 *See id.* (discussing Ms. Scott's delayed diagnosis due to the prisons conditions, and effect on her overall health).

4 *See* Second Amended Complaint at 4, Scott v. Clarke, No. 3:12-CV-00036, 2016 WL 452164, at *1 (W.D. Va. July 15, 2013).

5 *Id.* at 11.

6 *Id.* at 11-12.

conditions to deteriorate to the point that she needed to be rushed to UVA.[7] In July 2010, after multiple misdiagnoses by Corizon, Ms. Scott was diagnosed with sarcoidosis,[8] an inflammatory disease in which "groups of immune cells form lumps, called granulomas, in various organs in the body."[9] Additionally, in May 2012, UVA emergency physicians found a blood clot in Ms. Scott's left leg, which had travelled to her lungs.[10] She is now unable to move around without a cane or a wheelchair.[11] Ms. Scott is just one example of inmates suffering from constitutionally inadequate health care resulting from prison medical services, which are frequently provided by contracted private for-profit companies.[12]

Mass incarceration in the United States has produced a private prison industry in which government corrections departments contract with for-profit companies to build and operate facilities.[13] The private prison industry purportedly serves to reduce government costs and meet the demand for prison cells and services, with health care being one of the most commonly outsourced services.[14] Although privatized prison health care systems may appear cost effective in the short run, these systems contain fatal flaws.

Health care expenses make up a significant portion of the overall cost of prison operations.[15] This is because of the high cost of health care services in the United States, and the prison population having higher reported rates of adverse health conditions than the general population.[16] Influenced by market pressures and benefitting from

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[7] *Id.* at 12, 14.

[8] *Id* at 12.

[9] *Sarcoidosis*, NAT'L HEART, LUNG & BLOOD INST., U.S. DEP'T OF HEALTH & HUMAN SERVS., https://www.nhlbi.nih.gov/health-topics/sarcoidosis (last visited Jan. 4, 2019).

[10] Second Amended Complaint, *supra* note 4, at 14.

[11] Scott v. Clarke, No. 3:12-CV-00036, 2016 WL 452164, at *1, *4 (W.D. Va. Feb. 5, 2016).

[12] *See* OFF. OF THE INSPECTOR GEN., U.S. DEP'T OF JUST., REVIEW OF THE FEDERAL BUREAU OF PRISONS' MONITORING OF CONTRACT PRISONS 32-34 (2016), https://oig.justice.gov/reports/2016/e1606.pdf.

[13] *Id.* at 1.

[14] Kimberly Leonard, *States Efforts To Outsource Prison Health Care Come Under Scrutiny*, KAISER HEALTH NEWS (July 22, 2012), https://khn.org/news/prison-health-care/.

[15] *See* Chris Mai & Ram Subramanian, *The Price of Prisons: Examining State Spending Trends, 2010-2015*, VERA INST. OF JUST. 15 (May 23, 2017), https://www.vera.org/downloads/publications/the-price-of-prisons-2015-state-spending-trends.pdf (attributing health care costs as the reason for increasing prison expenditures over time).

[16] PEW CHARITABLE TRS., HOW AND WHEN MEDICAID COVERS PEOPLE UNDER CORRECTIONAL SUPERVISION 1 (2016), https://www.pewtrusts.org/-/media/assets/2016/08/how_and_when_medicaid_covers_people_under_correctional_supervision.pdf.

their position and capacity to command favorable terms, prison health care companies are incentivized to maximize profits and conduct business in a manner that benefits investors. As this Comment will show, however, prison health systems incentivized to be cost-effective can—and almost by definition *must*—diminish the level of care inmates receive. In turn, prison health systems often fail to meet the constitutional requirement that prisoners receive the adequate health care services mandated by the Eighth Amendment to the U.S. Constitution.[17]

Part I of this Comment will address the legal authorities which clearly establish and describe the constitutional right to adequate health care on the part of incarcerated persons, while Part II will examine the current state of medical care in U.S. prisons. Part III will review how litigation has been employed to remedy inadequate conditions of confinement due to poor prison health care, Part IV will consider the budgetary and political dynamics of privatized prison health care services, and Part V will highlight innovations in the health care industry that address quality and cost of care. Next, Part I of the analysis section will analyze the shortcomings of litigation as a driver of prison health care reform, and finally, Part II will outline legislative proposals to improve prison health care services and public health through public funding models.

BACKGROUND

The United States has the highest incarceration rate[18] and the largest prison population in the world.[19] On any given day, the United States houses roughly 2,234,200 adults in correctional facilities—approximately 1,506,800 adults across state and federal prison facilities,[20] and an additional 727,400 people in local jails.[21] Managing health care services for such a large incarcerated population presents

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17 *See infra* Part I, Section A.

18 *Highest to Lowest - Prison Population Rate*, WORLD PRISON BRIEF, https://www.prisonstudies.org/highest-to-lowest/prison_population_rate?field_region_taxonomy_tid=all (last visited Jan. 4, 2019).

19 John Gramlich, *America's incarceration rate is at a two-decade low*, PEW RES. CTR. (May 2, 2018), http://www.pewresearch.org/fact-tank/2018/05/02/americas-incarceration-rate-is-at-a-two-decade-low/ (explaining that it is possible that China has a larger total prison population due to approximately 650,000 people currently being detained without a conviction or sentencing).

20 E. ANN CARSON, BUREAU OF JUST. STAT., U.S. DEP'T OF JUST., NCJ 251149, PRISONERS IN 2016, at 1 (2018), https://www.bjs.gov/content/pub/pdf/p16.pdf. The latest Department of Justice Figures are from December 31, 2016.

a multi-dimensional challenge encompassing government interests in public health, public safety, fiscal policy, and constitutional obligations.[22] In fiscal year 2015, state departments of corrections spent a combined $8.1 billion—roughly 20% of all prison outlays—on carceral health care services.[23] The rising level of prison health care spending can be traced to Supreme Court decisions requiring a higher standard of prison health care under the Eighth Amendment.[24] Despite significant reforms attributed to the results of litigation, the current model of prison health care delivery continues to be systematically flawed in practice, making it clear that litigation alone cannot rectify the problem. Instead, a new care delivery model is necessary.

I. ESTELLE, FARMER, AND A CONSTITUTIONAL RIGHT TO HEALTH CARE

Throughout U.S. history, inmates have routinely experienced a myriad of prison health care system problems such as understaffing, inattention and failure to respond to emergency medical situations, and inadequate resources.[25] Issues with respect to health care in prisons only gained public awareness and transformed in the late 1960s when courts finally began considering claims that poor health care services could constitute constitutionally-deficient conditions of incarceration.[26] For example, in *Newman v. Alabama*, a 1974 decision, the U.S. Court of Appeals for the Fifth Circuit acknowledged, when discussing prison medical treatment, that "[t]he most critical infirmity, from which no institution has escaped, is insufficient staffing."[27] In *Newman*, systemic understaffing throughout the Alabama Penal System forced unqualified and "unsupervised inmate assistants [to] administer treatment and medication, take x-rays, give injections, and

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21 DANIELLE KAEBLE & MARY COWHIG, BUREAU OF JUST. STAT., U.S. DEP'T OF JUST., NCJ 251211, CORRECTIONAL POPULATIONS IN THE UNITED STATES, 2016, at 2 (2018), https://www.bjs.gov/content/pub/pdf/cpus16.pdf.

22 *See* PEW CHARITABLE TR., PRISON HEALTH CARE: COSTS AND QUALITY 3 (2017), https://www.pewtrusts.org/-/media/assets/2017/10/sfh_prison_health_care_costs_and_quality_final.pdf.

23 *Id.* at 1.

24 Margo Schlanger, *The Constitutional Law of Incarceration, Reconfigured*, 103 CORNELL L. REV. 357, 368-69 (2018).

25 *See* Newman v. Alabama, 503 F.2d 1320, 1321-22 (5th Cir. 1974); Douglas C. McDonald, *Medical Care in Prisons*, 26 CRIME & JUST. 427, 431 (1999).

26 Schlanger, *supra* note 24, at 365; McDonald, *supra* note 25, at 431.

27 *Newman*, 503 F.2d at 1322.

perform suturing and minor surgery on patients."[28] Understaffing also forced medical staff members to perform tasks beyond their competencies and available resources.[29] In *Newman*, for example, "[b]ecause of the unavailability of a surgeon to attend an inmate who had sustained a serious head injury, a doctor was forced to employ towels and clamps to remove the inmate's skull from his brain."[30]

Although *Newman* presents an extreme example, the U.S. General Accounting Office[31]—a federal agency that investigated and evaluated federal programs and operations—described prison health care facilities in the 1970s as "old, small, dark, crowded, noisy, and lacking modern or sufficiently available technical equipment and supplies."[32] Health care professionals described conditions at the time as "lower than the health care systems found in many developing countries," and "virtually primitive."[33] Prison conditions litigation eventually exposed the pervasive problem of inadequate prison health care and advanced efforts to develop a more humane system.[34]

The Supreme Court first found that prisoners have a constitutional right to adequate health care services in 1976 in *Estelle v. Gamble*.[35] In *Estelle*, the Supreme Court found that the Eighth Amendment's prohibition on cruel and unusual punishment covers "physically barbarous punishments," including "punishments which are incompatible with the evolving standards of decency that mark the progress of a maturing society" and those "that involve unnecessary and wanton infliction of pain."[36] Moreover, the Court found that the government's "deliberate indifference to serious medical needs of prisoners constitute[d] the 'unnecessary and wanton infliction of pain' . . . proscribed by the Eighth Amendment."[37] The Court noted that many states already passed legislation following the common-law doc-

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28 *Id.* at 1323.

29 *See id.*; *see also* OFF. OF THE ST. AUDITOR OF TEX., AN AUDIT REPORT ON MANAGED HEALTH CARE AT THE TEXAS DEPARTMENT OF CRIMINAL JUSTICE 93 (1998) ("The substitution of lower qualified staff is a common trend in managed care settings today among providers in . . . correctional health care corporations.").

30 *Newman*, 503 F.2d at 1324.

31 U.S. General Accounting Office is now the Government Accountability Office (GAO).

32 McDonald, *supra* note 25, at 434.

33 *Id.*

34 *See id.* at 430

35 *See* Estelle v. Gamble, 429 U.S. 97, 103-04 (1976).

36 *Id.* at 102-03 (quotations omitted).

37 *Id.* at 104 (quoting Gregg v. Georgia, 428 U.S. 153, 173 (1976)).

trine that "[i]t is but just that the public be required to care for the prisoner, who cannot by reason of the deprivation of his liberty, care for himself."[38] Ultimately, Justice Marshall, joined by six colleagues, found that the government has an:

> . . . obligation to provide medical care for those whom it is punishing by incarceration. An inmate must rely on prison authorities to treat his medical needs; if the authorities fail to do so, those needs will not be met. In the worst cases, such a failure may actually produce physical "torture or a lingering death," . . . the evils of most immediate concern to the drafters of the Amendment. In less serious cases, denial of medical care may result in pain and suffering which no one suggests would serve any penological purpose. The infliction of such unnecessary suffering is inconsistent with contemporary standards of decency . . . .[39]

Justice Stevens, as the lone dissenter, agreed with the majority's interpretation that the government is constitutionally required to provide adequate medical care to prisoners.[40] However, he argued that the Court did not go far enough to protect prisoners, and called for analyzing prisoner medical care under an objective standard.[41] He argued that the government had an obligation to provide prisoners:

> . . . a health care system which meets minimal standards of adequacy. As a part of that basic obligation, the State and its agents have an affirmative duty to provide reasonable access to medical care, to provide competent, diligent medical personnel, and to ensure that prescribed care is in fact delivered.[42]

In *Farmer v. Brennan*, the Court, in 1994, clarified that "deliberate indifference" for the purposes of liability under the Eighth Amendment arises when a prison official "act[s] or fail[s] to act despite his knowledge of a substantial risk of serious harm."[43] The Court chose a criminal recklessness standard as the appropriate culpa-

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38 *Id.* at 103-04 (quoting Spicer v. Williamson, 132 S.E. 291, 293 (N.C. 1926)) (alteration in original) (internal quotations omitted).

39 *Id.* at 103 (quoting *In re* Kemmler, 136 U.S. 436, 444 (1890)).

40 *See* Schlanger, *supra* note 24, at 371.

41 *See id*. at 371-72.

42 *Estelle*, 429 U.S. at 116 n.13 (1976) (Stevens, J., dissenting).

43 Farmer v. Brennan, 511 U.S. 825, 842 (1994); *see also* Schlanger, *supra* note 24, at 384.

bility requirement for deliberate indifference.[44] This subjective standard permits a "finding of recklessness only when a person disregards a risk of harm of which he is aware."[45] As such, a prison official can be found liable only if "the official knows of and disregards an excessive risk to inmate health or safety."[46] In defining the knowledge requirement, the Court held that "the official must both be aware of facts from which the inference could be drawn that a substantial risk of serious harm exists, and he must also draw the inference."[47] The Court reasoned that although the Eighth Amendment prohibits cruel and unusual punishments, it does not prohibit cruel and unusual conditions.[48] Therefore, "an official's failure to alleviate a significant risk that he should have perceived but did not, while no cause for commendation, cannot under our cases be condemned as the infliction of punishment."[49]

In the twenty years following *Estelle*, court challenges to prisoners' conditions of confinement arose in all but three states.[50] By 1996, thirty-six states and the District of Columbia were under court order or consent decree to improve prison conditions, a majority of which included mandated improvements to health care services.[51] Although prisoners now have a constitutional right to adequate, appropriate health care services, no federal statute or a federal court decision has established a uniform or specific standard or baseline for what constitutes adequate prison medical care.[52]

II. PRISON HEALTH CARE TODAY

A. *Mass Incarceration*

Estelle held that prisoners have a constitutional right to adequate health care services around the same time the U.S. prison population

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44 *Farmer*, 511 U.S. at 837.

45 *Id.*

46 *Id.*

47 *Id.*

48 *Id.* at 838.

49 *Id.*

50 McDonald, *supra* note 25, at 437.

51 *Id.* ("No single federal court decision, applicable to all prisoners in all prisons, has detailed all the specific services that must be provided.").

52 *See* McDonald, *supra* note 25, at 437.

began growing exponentially.[53] Within the same time period that *Estelle* was decided, Congress was in the process of enacting legislation providing for mandatory minimum sentences for non-violent drug offenses.[54] Concurrently, state legislatures were crafting "three strikes" laws that would yield much longer sentences for repeat offenders, even for petty crimes.[55] In 1980, the U.S. prison population was 329,122, with an incarceration rate of 140 per 100,000.[56] By the end of 2016, the U.S. prison population was 1,506,800, a rate of 450 per 100,000.[57] A report by the National Academies of Sciences concluded that "the growth in the incarceration rate in the United States [from 1973 to 2009] is historically unprecedented and internationally unique."[58] This surge in incarceration, occurring at the same time that federal courts were recognizing a constitutional mandate to improve prison health care, resulted in state governments having to simultaneously accommodate a rapid influx of inmates and either reform their prison health care systems or confront potential legal liability for failing to do so.[59] More recently, the economic consequences of the 2008 recession amplified this challenge.[60]

B. *Privatization and Payment Models*

In the late 1970s, all states directly provided prison health care services.[61] As courts began to require states to affirmatively remedy inadequate prison health care services, demand for medical professionals grew quickly and added to traditional prison staffing chal-

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53 *See* Estelle v. Gamble, 429 U.S. 97, 104 (1976); *see also* Editorial Board, *End Mass Incarceration Now*, N.Y. TIMES (May 24, 2014), https://www.nytimes.com/2014/05/25/opinion/Sunday/end-mass-incarceration-now.html.

54 *See* Editorial Board, *supra* note 53.

55 *See id.*

56 BUREAU OF JUST. STAT., U.S. DEP'T OF JUST., PRISONERS IN 1980, at 1 (1981).

57 CARSON, *supra* note 20, at 1.

58 NAT'L ACAD. OF SCI., THE GROWTH OF INCARCERATION IN THE UNITED STATES: EXPLORING CAUSES AND CONSEQUENCES 2 (Jeremy Travis & Bruce Western eds., 2014). Moreover, "[t]he unprecedented rise in incarceration rates can be attributed to an increasingly punitive political climate surrounding criminal justice policy formed in a period of rising crime and rapid social change. This provided the context for a series of policy choices—across all branches and levels of government—that significantly increased sentence lengths, required prison time for minor offenses, and intensified punishment for drug crimes." *Id.* at 4.

59 *See* PEW CHARITABLE TR., *supra* note 22, at 6.

60 *See id.*

61 *Id.* at 11.

lenges.[62] As a result, states began to outsource inmate health care and other prison services to private companies—a practice that continues today.[63]

Prison health care payment models are significant to patients because payment models are linked to treatment decisions.[64] Modern prison health care payment models commonly distinguish on-site care and off-site care.[65] On-site care includes primary care and some outpatient services.[66] On-site care is generally delivered in one, or some combination, of the following models: a direct model in which care is provided by state employees; a contracted model in which private companies employ the clinicians; or a state university model in which the state medical school is responsible for on-site care.[67] Off-site care supplements on-site care and is complicated by transportation and security issues.[68]

In 2017, Pew Charitable Trusts researchers surveyed all fifty states to analyze prison health care costs and quality.[69] As of 2015, government staff directly provided the majority of health care services in seventeen states, while twenty states contracted with private entities for health care delivery.[70] Four states tied their corrections department to a public medical school or affiliated organizations.[71] Eight states had hybrid models that contract out some prison services, while government employees directly provided other services.[72]

The two most common payment models for states that use some or all contract providers are "fee-for-service" and "capitation."[73] In the fee-for-service model, vendors submit their expenses to the state

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62 *Id.*

63 *Id.* at 11-12.

64 PEW CHARITABLE TR., *supra* note 22, at 12.

65 PEW CHARITABLE TR., STATE PRISONS AND THE DELIVERY OF HOSPITAL CARE 4 (2018), https://www.pewtrusts.org/-/media/assets/2018/07/prisons-and-hospital-care_report.pdf.

66 *Id.*

67 *Id.*

68 *See id.*

69 PEW CHARITABLE TR., *supra* note 22. New Hampshire is the only state that did not provide data. *Id.* at 8.

70 *Id.* at 10-11.

71 *Id.*

72 *Id.* Virginia is an outlier among these hybrid states as it outsources the operation of certain facilities and some services, while directly managing other facilities. *Id.*

73 PEW CHARITABLE TR., *supra* note 22, at 12. Capitation is also known as fixed reimbursement, or fixed-rate contracting. *See also* Dan Weiss, *Privatization and Its Discontents: The Troubling Record of Privatized Prison Health Care*, 86 U. COLO. L. REV. 725, 749 (2015).

and add a fee for managing the service.[74] In the capitation model, on the other hand, vendors are paid a fixed fee—per inmate or per bed in a facility—irrespective of the services provided to each person or the needs of the patient.[75] Most states that outsource on-site care enter capitation contracts.[76]

In traditional fee-for-service contracts, the government payor—in this context, the state—assumes all risk and reward.[77] When inmate care costs less than the budgeted amount, due to low utilization or relatively inexpensive services, the government saves money, but when expenses exceed actuarial estimates, the government loses money.[78] Meanwhile, the provider—the private health care company—earns a fee for each service rendered.[79] Capitation payment models, by contrast, place the risk on the provider, meaning the provider reaps a reward for utilizing fewer or less expensive services than estimated in setting the fixed contract price, and bears the burden of covering costly medical treatments.[80] Under this model, providers estimate the cost of providing health services within a prison for one year, generally based on a presumed cost of care per inmate for the particular population involved, plus a management fee and a reasonable profit margin, and then places a bid or negotiates with the state.[81]

Some states take a middle approach to share risk between both parties.[82] Michigan, for example, implements contracts that include a baseline capitation rate and a provision that the state and the private provider must split any excessive costs or any surplus.[83] States can apply this approach to the entire contract or to specific services, such as hospitalization.[84]

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74 PEW CHARITABLE TR., *supra* note 22, at 12.

75 *Id.*; Weiss, *supra* note 73, at 749.

76 PEW CHARITABLE TR., *supra* note 22, at 12. In FY 2015, nineteen of the twenty-eight privatized or hybrid public-private states operated under a capitation arrangement, while two states used the fee-for-service model, and the remaining nine states deemed their system to be something other than a strait fee-for-service or capitation payment system. *Id.*

77 *Id.*

78 *Id.*

79 Paul B. Ginsburg, *Fee-For-Service Will Remain A Feature Of Major Payment Reforms, Requiring More Changes In Medicare Physician Payment*, 31 HEALTH AFF. 1977, 1977 (2012).

80 PEW CHARITABLE TR., *supra* note 22, at 12.

81 *See id.*

82 *Id.*

83 *Id.*

84 *Id.*

Cost predictability and vendor transparency are important aspects of payment systems and have an inverse relationship when comparing capitation to fee-for-service.[85] Under the fee-for-service model, each service and the associated fee becomes clear because the private provider essentially submits an invoice to the state for payment of the service rendered.[86] Capitation is not always so transparent.[87] Because the state is paying a predetermined rate, private providers may not report an itemized list of services and expenses.[88] Capitation provides a cost certainty for the state; however, it sacrifices accountability through lack of transparency and diminished oversight.[89]

When focusing on patient outcomes, managing incentives for the state and the private provider is perhaps the most important factor for managing health care services.[90] Economizing is a central feature of the capitation model's incentive structure.[91] Capitation empowers private providers to decide the appropriate treatment plan for each patient while the spending limits incentivize providers to be frugal.[92] In contrast, the fee-for-service model incentivizes private providers to generate fees by providing an inflated volume of services,[93] thus prioritizing volume and fees over patient health.[94] Moreover, the provider has no incentive to innovate and come up with more efficient ways to get the same or better outcomes.[95] The result of fee-for-ser-

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85 In fact, "[t]hirty-three states reported that they were unable to provide spending data for the categories Pew and Vera surveyed, with a majority of them citing as barriers systems that do not allow for parsing spending in this fashion or a lack of access to detailed spending records from contractors." *Id.* at 17.

86 PEW CHARITABLE TR., *supra* note 22, at 12.

87 *Id.*

88 *Id.*

89 *Id.*

90 *Id.* at 13.

91 *Id.*

92 PEW CHARITABLE TR., *supra* note 22, at 13.

93 *Id.*; ROBERT A. BERENSON ET AL., URB. INST., PAYMENT METHODS AND BENEFIT DESIGNS: HOW THEY WORK AND HOW THEY WORK TOGETHER TO IMPROVE HEALTH CARE: PRIMARY CARE CAPITATION 2 (2016), http://www.urban.org/sites/default/files/02_primary_care_capitation_2.pdf.

94 PEW CHARITABLE TR., *supra* note 22, at 13; BERENSON ET AL., *supra* note 93, at 2.

95 Jason Furman & Matt Fielder, *Continuing the Affordable Care Act's Progress on Delivery System Reform Is an Economic Imperative*, THE OBAMA WHITE HOUSE BLOG (Mar. 24, 2015, 4:35 PM), https://obamawhitehouse.archives.gov/blog/2015/03/24/continuing-affordable-care-act-s-progress-delivery-system-reform-economic-imperative.

vice is increased costs for the government and suboptimal treatment for the patient.[96]

Cost-sharing provisions are another problematic method of controlling costs by shifting risk.[97] These types of provisions are associated with capitation contracts and are similar to a deductible in that the private provider has to pay all costs on certain services up to a specific cap, at which point the state will cover all excess.[98] Off-site care, for example, includes hospitalization and specialty services that are typically more expensive than treatment on prison grounds.[99] As such, states and municipalities are incentivized to shift these costs to private providers.[100] In addition to saving the government money, cost-sharing provisions incentivize private providers to weigh the company's cost of paying for emergency services or specialty care against the patient's benefits of accessing medically necessary specialty care or emergency services from a qualified professional with the appropriate resources.[101] This arrangement creates tension between a physician's Hippocratic Oath and her employer's incentive to cut costs, which may mean discounting serious conditions and providing on-site treatment with inadequate staff and resources.[102]

III. *SCOTT*, *PARSONS*, AND LIMITS TO LITIGATION AS A REMEDY

A. Scott v. Clarke

The systemic problems associated with prison health care services provided by for-profit corporations are well illustrated by FCCW in Troy, Virginia. Opened in 1998 and operated by the Virginia Department of Corrections (VDOC), FCCW is Virginia's largest state-run women's prison with approximately 1,200 residents.[103] FCCW was designed to provide the most comprehensive medical care of all

96 *Id.*

97 Weiss, *supra* note 73, at 749.

98 *Id.* at 751-52.

99 PEW CHARITABLE TR., *supra* note 22, at 21.

100 States also turn to Medicaid to cover inpatient hospital services, especially those states that have expanded Medicaid eligibility under the Affordable Care Act. *Id.* at 22.

101 Weiss, *supra* note 73, at 752.

102 *Id.* at 752-53.

103 Gary A. Harki, *At Fluvanna Correctional Center For Women, horror story after horror story in medical care*, THE VIRGINIAN PILOT (Dec. 10, 2016), https://pilotonline.com/news/government/politics/virginia/article_9096368d-54ce-5018-beb7-bea8732e8965.html.

women's prison facilities in Virginia, and currently serves as the primary correctional facility for female inmates with serious health concerns.[104] As a result, nearly three-quarters of FCCW's population consists of women with at least one chronic medical condition.[105] To meet the significant health care needs of FCCW's inmate population, VDOC has always contracted with private, for-profit companies to provide health care.[106] Since 2006, VDOC has contracted with two for-profit corporations—Corizon Health, Inc. (formerly known as Prison Health Services, Inc.) and Armor Correctional Health Services, Inc.—to provide all medical, dental, and mental health services on a capitated basis to all prisoners residing at FCCW.[107] Although this VDOC contract changed hands over the years—from Corizon to Armor then back to Corizon—the medical staff and treatment policies have largely remained the same.[108]

On July 24, 2012, five prisoners residing at FCCW initiated a class-action lawsuit against VDOC, prison officials, Armor Correctional Health Services, and Armor medical staff, alleging constitutionally deficient medical care within the prison in violation of the Eighth Amendment and 42 U.S.C. § 1983.[109] Allegations outlined in the complaint included:

> . . . prison officials changing or disregarding the recommendations or prescriptions of medical specialists; failure to timely respond to medical emergencies or to non-emergencies such that medical conditions worsened; failure to administer medications or doing so under extreme conditions (such as outdoors in inclement weather at two or three o'clock in the morning); insufficient medical staffing; refusal to provide medical services on grounds of cost or pretextual security con-

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104 *See* Scott v. Clarke, 61 F. Supp. 3d 569, 573 (W.D. Va. 2014). Fluvanna includes a 68,000-square foot medical building, which serves the prisons general population. Second Amended Complaint, *supra* note 4, ¶ 20.

105 Harki, *supra* note 103.

106 *See Scott*, 61 F. Supp. 3d at 573.

107 Second Amended Complaint, *supra* note 4, at 6-7; *see also* Stephen Weiss, Senior Health Pol'y Analyst, Commonwealth of Va. Joint Comm'n on Health Care, Presentation at the Joint Commission on Health Care October 5, 2016 Meeting: Medical Care Provided in State Prisons – Study of the Costs 5 (Oct. 5, 2016), http://jchc.virginia.gov/4.%20Medical%20Care%20Provided%20in%20State%20Prisons%20CLR.pdf.

108 Second Amended Complaint, *supra* note 4, at 6-8.

109 See Complaint at 2-3, Scott v. Clarke, No. 3:12-CV-00036, 2016 WL 452164 (W.D. Va. July 24, 2012).

cerns; and the failure to treat known, obvious, or suspected medical conditions such as MRSA, cancer, or diabetes.[110]

In August 2009, Cynthia Scott—the first named plaintiff, discussed previously in the introduction—had difficulty breathing and filed a health complaint to initiate the sick call process.[111] "Sick call" is the term for the process in which a prison's non-physician medical staff evaluate prisoners' health issues in regard to which they seek treatment, administer first aid, and, in a given case, determine whether the prisoner requires an appointment with a physician.[112] FCCW medical staff conducted an initial sick call visit and a follow-up examination at the end of September, by which point Ms. Scott had lost her appetite and a significant amount of weight while her breathing difficulty persisted.[113] Despite those problems, Ms. Scott was not seen by a FCCW staff physician until February 2010, six months after her symptoms appeared.[114] The physician, a Corizon employee, identified a protein deficiency and oversimplified Ms. Scott's condition by attributing her symptoms to early stage menopause.[115]

Over the course of the first half of 2010, Ms. Scott lost more than 40 pounds and her breathing became more problematic.[116] Corizon medical staff eventually performed a chest x-ray in June 2010 and found large masses in each of her lungs.[117] Ms. Scott was sent to the UVA Medical Center for observation and testing in July 2010.[118] In August 2010, a full year after her initial sick call request, a UVA pulmonologist diagnosed Ms. Scott with sarcoidosis.[119] Specialists at UVA prescribed Ms. Scott a ninety-day steroid regimen, after which her condition would be reevaluated.[120] When she returned to the prison, however, a Corizon physician immediately reduced the pre-

110 *Scott*, 2016 WL 452164, at *1, *2-3.

111 *See* Second Amended Complaint, *supra* note 4, at 11.

112 *Id.* at 10.

113 *Id.* at 11.

114 *Id.*

115 *See id.*

116 *Id.*

117 Second Amended Complaint, *supra* note 4, at 11-12.

118 *Id.* at 12.

119 *Id.*

120 *Id.* at 12.

scribed dosage of Ms. Scott's medication without consulting the UVA specialists.[121]

In November 2011, Ms. Scott made another sick call request as her lower left leg began swelling and by May 2012, it had swollen to the point that she lost feeling in her toes.[122] The Corizon physician first recommended that Ms. Scott stop taking the birth control pills that she took for many years, and so she did.[123] When the swelling worsened, the physician next advised that the swelling was caused by arthritis and concluded that a pair of support stockings would solve the problem.[124] A few days later, a different Corizon physician rejected his colleague's diagnosis and ordered an ultrasound on Ms. Scott's leg.[125] On May 10, 2012—six months after Ms. Scott's sick call regarding painful leg swelling—Ms. Scott was once again rushed to the emergency room and the UVA Medical Center.[126] Doctors at UVA found that Ms. Scott had a blood clot in her left leg that had travelled to her lungs.[127] Upon her return to FCCW, Corizon medical staff once again immediately undercut the UVA specialist's prescribed treatment for Ms. Scott.[128] From August 2009 to May 2012—a span of almost three years—Ms. Scott endured immense pain and suffering at the hands of the Corizon medical staff, who repeatedly delayed her treatment, misdiagnosed her conditions, and refused to properly treat her symptoms.[129] Although tragic, this case was not unique, but rather representative of the systemic inadequacies of the privatized health care delivery system at FCCW.[130] For example, another inmate had MRSA—a bacteria that causes skin infections, pneumonia, and potentially life-threatening sepsis—which went undiagnosed for a full year after her initial sick call.[131]

The inmates at FCCW who suffered extensively under the prison's health care system filed suit against FCCW in July 2012, alleg-

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121 *Id.*

122 *Id.* at 13.

123 Second Amended Complaint, *supra* note 4, at 13.

124 *Id.*

125 *Id.* at 14.

126 *Id.*

127 *Id.*

128 *Id.* at 15.

129 Second Amended Complaint, *supra* note 4, at 15.

130 *See* Scott v. Clarke, 61 F. Supp. 3d 569, 573, 592 (W.D. Va. 2014) (granting plaintiff's motion to certify a class consisting of approximately 1,200 female prisoners at FCCW).

131 *See id.* at 579; *see also* Second Amended Complaint, *supra* note 4, at 24-25.

ing that state and prison officials and the private providers failed to provide adequate prison health care services as required under the Constitution.[132] In *Scott v. Clarke*, the District Court granted the plaintiffs' motion for class action certification, recognizing the systemic nature of the problems at FCCW.[133] The class included all "women who currently reside or will in the future reside at FCCW and have sought, are currently seeking or will seek adequate, appropriate medical care for serious medical needs, as contemplated by the Eighth Amendment."[134] On November 25, 2014, the court granted partial summary judgment in favor of the plaintiffs,[135] and the parties agreed to settle that same day.[136] Plaintiffs filed the settlement agreement with the court on September 15, 2015,[137] and the court approved the agreement on February 5, 2016.[138]

Despite the settlement agreement, health care services at FCCW remain constitutionally deficient.[139] On January 2, 2019, the court found the defendants breached the settlement agreement.[140] The court issued an injunctive order enforcing the settlement agreement and providing remedies for the breach.[141] Judge Norman K. Moon concisely summarized the situation:

> Over six years ago, women at FCCW filed this lawsuit, seeking a remedy for pervasive constitutionally deficient medical care. Their quest continues. Some women have died along the way. But this case has survived because Defendants have not upheld their Eighth Amendment obligations nor the Settlement Agreement they reached to effectuate those obligations.[142]

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132 *See* Complaint, *supra* note 109.

133 *Scott*, 61 F. Supp. 3d at 592.

134 *Id*. at 572-73.

135 *Scott*, 64 F. Supp. 3d 813, 815 (W.D. Va. 2014) (granting "Plaintiffs' motion seeking partial summary judgment on two key elements of their complaint—that is, that Defendants bear a non-delegable 'constitutional duty to provide adequate medical treatment to' Plaintiffs and that the specific health problems and conditions of which the named Plaintiffs complain constitute 'serious medical needs[.]'") (citing West v. Atkins, 487 U.S. 42, 56 (1988)).

136 *See* Settlement Agreement at 2-3, Scott v. Clarke, No. 3:12-CV-00036, 2016 WL 452164 (W.D. Va. Sept. 15, 2015).

137 *Id.*

138 Final Judgment Order, Scott v. Clarke, No. 3:12-CV-00036, 2016 WL 452164 (W.D. Va. Feb. 5, 2016).

139 Scott v. Clarke, 355 F. Supp. 3d 472, 477-48 (W.D. Va. 2019).

140 *Id.* at 477.

141 *Id.* at 506.

142 *Id.*

B. Parsons v. Ryan

Parsons v. Ryan is another recent case, in which thirteen inmates filed a lawsuit under the Eighth Amendment against the State of Arizona and a for-profit health care contractor for systemically deficient health care services.[143] The plaintiffs in *Parsons* identified ten substandard practices within the health care system, amounting to deliberate indifference to the needs of all inmates. These practices included (1) failure to provide timely access to health care, (2) failure to provide timely emergency treatment, (3) failure to provide necessary medication and medical devices, (4) insufficient health care staffing, (5) failure to provide care for chronic diseases and protection from infectious disease, (6) failure to provide timely access to medically necessary specialty care, (7) failure to provide timely access to basic dental treatment, (8) practice of extracting teeth that could be saved by less intrusive means, (9) failure to provide mentally ill prisoners medically necessary mental health treatment, and (10) failure to provide suicidal and self-harming prisoners basic mental health care.[144]

The district court certified a class that included all 30,000 inmates detained in ten prisons across Arizona.[145] The parties reached a settlement in October 2014, four months after the Ninth Circuit affirmed the district court's class certification.[146] The settlement established 103 performance measures the Arizona Department of Corrections (ADC) and its contractors would be obligated to meet to raise its physical and mental health care services to align with the constitutional mandate to provide minimally adequate health care.[147]

The settlement agreement also required the court to conduct monthly status conferences with the parties to discuss monthly progress reports.[148] In June 2017, the court told the defendants that each failure to comply with select measures "would result in an order to show cause as to why $1,000 fine [per violation, per member of the

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143 Parsons v. Ryan, 289 F.R.D. 513 (D. Ariz. 2013).

144 *Id.* at 522-523.

145 Parsons v. Ryan, 754 F.3d 657, 690 (9th Cir. 2013) (affirming the district court's order certifying a class).

146 Joint Notice of Settlement, Parsons v. Ryan, No. 12-cv-601 (D. Ariz. Oct. 15, 2014).

147 Katie Campbell, *Prison health care case shaping up for years of litigation*, ARIZ. CAPITOL TIMES (July 13, 2018), https://azcapitoltimes.com/news/2018/07/13/arizona-chick-arnold-sarn-parsons-ryan-prison-health-care-case-shaping-up-for-years-of-litigation/.

148 Parsons v. Ryan, No. CV-12-0601-PHX-DKD, 2018 U.S. Dist. LEXIS 104793, at *6 (D. Ariz. June 22, 2018).

class] should not be imposed."[149] In June 2018, a federal judge held ADC officials in contempt for repeat violations of the 2014 settlement agreement and imposed $1.46 million in sanctions.[150] In *Parsons*, as in *Scott*, significant litigation continues five years after the parties reached a settlement agreement.[151]

Although five-year efforts to enforce a settlement seems long, unfortunately this timeframe is by no means unheard of in state health care cases. Health care advocates in Arizona have compared *Parsons* to *Arnold v. Sarn*, a class-action case filed against Arizona in state court in 1981 for the State's failure to implement a state statute requiring a statewide comprehensive mental health care system.[152] The Arizona Supreme Court ruled in favor of the plaintiff class in 1989.[153] In 1991, the parties crafted an initial plan to implement an adequate mental health care system.[154] In 2014, the parties finally reached an agreement sufficient to terminate the litigation—33 years later.[155]

David Fathi, Director of the American Civil Liberties Union's National Prison Project and attorney for the plaintiffs in *Parsons*, expressed his disappointment with the enduring litigation: "[It's] unfortunate . . . first and foremost, [for] the prisoners who are at the mercy of a broken system. It's unfortunate for the taxpayers of Arizona who are paying the private law firm millions of dollars. It's unfortunate for everyone."[156]

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149 *Id.* at 7.

150 Michael Kiefer, *Judge finds Arizona Corrections, officials in contempt, orders them to pay $1.45M*, ARIZ. REPUBLIC (June 22, 2018), https://www.azcentral.com/story/news/local/arizona/2018/06/22/az-corrections-contempt-charles-ryan-corizon/727335002/.

151 *See* Elizabeth Whitman, *Facing $1.2 Million Fine, ADC Blames Corizon-Centurion Handoff for Its Failures*, PHOENIX NEW TIMES (August 21, 2019), https://www.phoenixnewtimes.com/news/arizona-corrections-fine-ryan-federal-judge-corizon-centurion-prison-11347261; Melissa Blasius, *Inmates' lawyers ask judge to take over AZ prison healthcare,* ABC 15 ARIZ. (Sept. 6, 2019), https://www.abc15.com/news/local-news/investigations/inmates-lawyers-ask-judge-to-take-over-az-prison-healthcare.

152 *See Arnold v. Sarn*, ARIZ. HEALTH CARE COST CONTAINMENT SYS., https://www.azahcccs.gov/AHCCCS/HealthcareAdvocacy/arnoldvsarn.html (last visited Jan. 4, 2019).

153 *Id.*

154 *Id.*

155 *Id.*

156 Campbell, *supra* note 147.

IV. BUDGETARY & POLITICAL CONCERNS

A. *Prison Health Care Cost Drivers*

State spending on prison health care services is growing, in part, because of the particular demographics of the U.S. prison population.[157] The current situation largely developed because of the war on drugs and the closure of mental institutions across the United States.[158] This resulted in "correctional facilities increasingly [becoming] a setting in which individuals with serious health conditions—especially infectious diseases, substance use disorders, and mental illnesses—were diagnosed and treated."[159] Beyond the large number of people with mental illness, the prison population also has a higher rate of individuals afflicted with an array of physical conditions and diseases.[160] The Vera Institute of Justice, a nonprofit criminal justice research and policy organization,[161] found that some infectious diseases are far more prevalent among incarcerated individuals than the general population.[162]

An aging prison population is another factor contributing to the cost of prisoner health care. According to the Pew Charitable Trusts:

> . . . [f]rom 1999 to 2015, the number of people age 55 or older in state and federal prisons . . . increased 264 percent" while the number of younger inmates grew five percent.[163] The increase in the older inmate population is a significant factor in health care budgets because older individuals are "more likely to experience dementia, impaired mobility . . . loss of hearing and vision, [and] are more susceptible to costly chronic medical conditions.[164]

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157 PEW CHARITABLE TR., *supra* note 22, at 3, 9.

158 *Id*.

159 *Id.* at 3.

160 *Id.* at 4.

161 *About Us*, VERA INST. OF JUST., https://www.vera.org/about (last visited Jan. 4, 2019).

162 For example, the study found that "[t]uberculosis is more than four times [more prevalent in prison] and Hepatitis C occurs at rates 8 to 21 times higher among incarcerated people." David Cloud, *On Life Support: Public Health in the Age of Mass Incarceration*, VERA INST. OF JUST., 6 (2014), https://www.vera.org/downloads/Publications/on-life-support-public-health-in-the-age-of-mass-incarceration/legacy_downloads/on-life-support-public-health-mass-incarceration-report.pdf.

163 PEW CHARITABLE TR., *supra* note 22, at 25.

164 *Id.* at 27.

Therefore, the annual cost of incarcerating a person 55 or older is significantly higher than the cost of incarcerating a younger person.[165]

B. *Profitability of Privatized Services*

States face opposing forces when working to both improve the quality of prison health care and cut costs.[166] Prison health care is a significant budgetary issue for states due to "expensive treatments for some common conditions, the downstream costs of delayed or inadequate care, and the legal and financial consequences of being found to violate inmates' constitutional rights to 'reasonably adequate' care."[167] When states decide to privatize some or all prison health care services, tensions arise between the state's obligation to "make their constituents safer and healthier, and to spend taxpayer dollars . . . prudently"[168] and the contracting corporation's need to make a profit.[169] Moreover, there is "a disconnect between the party that provides care (the contractor) and the party that is legally accountable if care is not adequate (the state)."[170] The privatization of health care services leads to conflict between states and for-profit providers, such that "[m]any states . . . have struggled to maintain long-term contractual relationships with private comprehensive health care contractors."[171]

In 2012, Florida discovered both sides of the problem of conflicting public and private obligations when it contracted with two companies—including Corizon Health—to provide statewide correctional health services, and both contracts were terminated early.[172] Corizon terminated its contract claiming that it was losing $1 million per month,[173] and the State terminated the other contract due to concerns

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165 *Id.*

166 *Id.* at 6.

167 *Id.* at 1.

168 *Id.* at 56.

169 JOINT LEGIS. AUDIT & REVIEW COMM'N, COMMONWEALTH OF VA., REPORT TO THE GOVERNOR AND THE GENERAL ASSEMBLY OF VIRGINIA: SPENDING ON INMATE HEALTH CARE 2018, at 9 (2018), http://jlarc.virginia.gov/pdfs/reports/Rpt511.pdf.

170 *Id.*

171 *Id.*

172 JOINT LEGIS. AUDIT & REVIEW COMM'N, *supra* note 169, at 10; *see* Julio Ochoa, *Health Care Costs Continue to Rise in Florida Prisons*, WMFE (July 25, 2018), http://www.wmfe.org/health-care-costs-continue-to-rise-in-florida-prisons/89701.

173 Ochoa, *supra* note 172.

about the quality of care.[174] Virginia also realized this inherent challenge in 2013, when:

> . . . a private company [Corizon] secured a comprehensive health care services contract for 17 facilities by significantly underbidding other vendors. The contract price ultimately was an estimated $15 million lower than the actual cost to provide care, and the company terminated the contract less than a year later due to financial losses.[175]

C. *Political Power Imbalance*

States continue to contract with private companies that provide constitutionally inadequate health care services, in part, because of the imbalance in political power between prisoners' rights organizations and the lobbying forces of private for-profit correctional services companies. The corporations profiting from public contracts have significant political influence.[176] Private corporations work to influence legislation and earn government contracts at both the state and federal level by contributing to political parties and candidates, lobbying legislatures, and working with corrections trade associations.[177] Corizon, for example, retained sixty-four lobbyists across fourteen states in 2015.[178]

In contrast, advocates for prisoners' rights lack the resources or political influence of corporations. Indeed, many people convicted of a felony have been stripped of their right to vote, the fundamental right of citizens in democratic societies.[179] In 1976, 1.17 million people were disenfranchised—or deprived of the right to vote—due to a felony conviction.[180] By 2016, an estimated 6.1 million people had no voting rights due to felony disenfranchisement laws.[181] In Virginia,

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174 *Id.*

175 JOINT LEGIS. AUDIT & REVIEW COMM'N, *supra* note 169, at 9.

176 Ochoa, *supra* note 172.

177 *See* IN THE PUBLIC INTEREST, BUYING INFLUENCE: HOW PRIVATE PRISON COMPANIES EXPAND THEIR CONTROL OF AMERICA'S CRIMINAL JUSTICE SYSTEM, 3 (2016), http://www.inthepublicinterest.org/wp-content/uploads/ITPI_BuyingInfluence_Oct2016.pdf.

178 *Id.* at 8.

179 CHRISTOPHER UGGEN ET AL., THE SENT'G PROJECT, 6 MILLION LOST VOTERS: STATE-LEVEL ESTIMATES OF FELONY DISENFRANCHISEMENT, 2016, at 3 (2016), https://www.sentencingproject.org/wp-content/uploads/2016/10/6-Million-Lost-Voters.pdf.

180 *Id.* at 9.

181 *Id.* at 3.

22% of voting-age African Americans are disenfranchised.[182] Because voting power has been eliminated for prisoners and many other citizens with prior felony convictions, political representatives are less incentivized to address their concerns.

Prisoners and their families are also prevented from engaging with public officials and lawmakers because they generally lack the financial resources necessary to compete with corporate advocacy efforts. A recent Brookings Institution study linking prisoners to their tax records and found that "individuals incarcerated in their early 30s are much more likely to have grown up in poverty, in single parent families, and in neighborhoods of concentrated economic distress and with large minority populations."[183]

Despite this relative lack of power, there is some interest at the federal level in the protection of prisoners' rights to adequate health care services. Democratic members of Congress introduced a corrections reform bill, the Justice is Not For Sale Act, in the previous two sessions of Congress.[184] The legislation would, among other things, prohibit federal, state, and local governments from privatizing prisons or core correctional services.[185] The bill was introduced in the U.S. Senate in September 2015 and expired at the end of the 114th Congress with zero cosponsors.[186] An identical bill was introduced in the U.S. House of Representatives in 2015 and 2017.[187] These bills expired at the end of their respective sessions with thirty cosponsors in the 114th Congress, and fifty-two co-sponsors in the 115th Congress.[188]

Legislators are coming to realize the broad societal harms of overincarceration, as illustrated by the enactment of the First Step Act of 2018. The First Step Act is a federal criminal justice reform law that addresses, *inter alia*, sentencing, reentry, and recidivism reduction.[189] Passage of the First Step Act was a significant bipartisan

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182 *Id.* at 16.

183 ADAM LOONEY & NICHOLAS TURNER, BROOKINGS INST., WORK AND OPPORTUNITY BEFORE AND AFTER INCARCERATION 2 (2018), https://www.brookings.edu/wp-content/uploads/2018/03/es_20180314_looneyincarceration_final.pdf.

184 *See, e.g.*, Justice is Not For Sale Act of 2017, H.R. 3227, 115th Cong. (2017).

185 *Id.*

186 Justice is Not For Sale Act of 2015, S. 2054, 114th Cong. (2015).

187 H.R. 3227; Justice is Not For Sale Act of 2015, H.R. 3543, 114th Cong. (2015).

188 H.R. 3227; H.R. 3543.

189 *See* First Step Act of 2018, Pub. L. No. 115-391, 132 Stat. 5194-5249 (2018).

achievement in an era of political party polarization.[190] Congress crafted the First Step Act with an eye toward sentencing reform and enhancing reentry programs; however, the law includes a few provisions that address conditions of confinement and health care in prisons. For example, Section 301 of the Act restricts the use of restraints on prisoners during pregnancy, labor, and postpartum recovery,[191] and Section 611 requires prisons to make tampons and sanitary napkins available free of charge.[192] The Act also directed the Bureau of Justice Statistics to expand its data collection efforts to include certain prison health and medical services data.[193] For example, the National Prisoner Statistics Program now must annually collect and report on medical and health care staff vacancy rates and the average length of a vacancy, and the number of facilities that operate at any time without an on-site clinical nurse, certified paramedic, or licensed physician.[194]

By including health care provisions in the First Step Act, Congress acknowledged that the harms of overincarceration extend to conditions of confinement and medical services. In response, Congress directed the Department of Justice to make a few modest, but concrete, changes to address prisoner health services and to officially monitor health care staffing levels.

V. INNOVATION IN HEALTH CARE PAYMENT MODELS

A. *Aligning Incentives Through New Payment Models*

Beyond prison health care, public and private health insurance plans are continuously exploring new health care service payment models to change health care providers' economic incentives to value quality of care over volume.[195] The traditional fee-for-service model is

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190 *See, e.g.*, President Donald Trump, Remarks by President Trump at Signing Ceremony for S. 756, the "FIRST STEP Act of 2018" and H.R. 6964, the "Juvenile Justice Reform Act of 2018" (Dec. 21, 2018) (transcript available at https://www.whitehouse.gov/briefings-statements/remarks-president-trump-signing-ceremony-s-756-first-step-act-2018-h-r-6964-juvenile-justice-reform-act-2018/).

191 First Step Act of 2018, § 301, 132 Stat. at 5217-5220.

192 First Step Act of 2018, § 611, 132 Stat. at 5247.

193 First Step Act of 2018, § 610, 132 Stat. at 5245-46.

194 First Step Act of 2018, § 610, 132 Stat. at 5246.

195 Darshak Sanghavi et al., *The beginner's guide to new health care payment models*, BROOKINGS (July 23, 2014), https://www.brookings.edu/blog/usc-brookings-schaeffer-on-health-policy/2014/07/23/the-beginners-guide-to-new-health-care-payment-models/.

viewed by health policy experts as "draining the entire health care system. When paying for volume, a sick patient is worth more than a healthy patient, and this status quo results in uncoordinated care, duplication of services, and fragmentation. After all, the more doctors and providers do, the more they get paid."[196]

Payment withholds are one such payment arrangement gaining popularity, even within traditional fee-for-service models.[197] Withholds allow the insurer or payer—in this context, the government— to withhold a percentage of the fee owed to the provider at the time of service.[198] Then, quarterly or annually, the government will disperse the pool of withheld funds to providers based on predetermined performance measures, such as the total cost of care or the quality of services.[199] If the provider satisfies each measure, she will be fully compensated.[200] If the provider falls short, she will not receive all the money withheld during the period.[201]

Health care bundles are another new payment arrangement.[202] Instead of compensating providers for each service rendered, the bundle model addresses services based on each "episode of care" by estimating the total cost of all services a patient might require for a specific ailment over a period of time.[203] For example, an insurer would estimate the total cost of treating a wrist fracture, then reduce that cost by 2%, and pay that amount (98%) to the provider, who then is responsible for all costs of treatment for the wrist fracture.[204] In this scenario, the insurer saves the 2% and shifts the risk of complications to the provider. If the provider is economical, she will keep any leftover money from the bundle.[205]

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196 *Id.*

197 *See* AM. MED. ASS'N, NEW PAYMENT MODELS: WITHHOLDS 1 (2018), https://www.ama-assn.org/sites/ama-assn.org/files/corp/media-browser/public/arc/pay-withholds.pdf.

198 *Id.*

199 *Id.*

200 *Id.*

201 *Id.*

202 Sanghavi et al., *supra* note 195.

203 *Id.*

204 *Id.*

205 *Id.*

B. *Affordable Care Act of 2010*

As rising health care costs and a greater emphasis on quality drive the development of new payment models, private plans and public officials are also devising methods of coordinating patient care across providers.[206] Federal government leadership is critical to innovation in provider payment reform because private insurers and Medicaid programs closely follow Medicare physician payment methods.[207] The Patient Protection and Affordable Care Act of 2010 (ACA) significantly reformed the health insurance industry by creating new programs to expand access to and reduce the cost of health insurance, and fostering innovative delivery models to lower the cost of health care services.[208]

The ACA created the Centers for Medicare and Medicaid Innovation Center, which is charged with testing "innovative payment and service delivery models that have the potential to reduce . . . [plan] expenditures while preserving or enhancing the quality of care for beneficiaries."[209] In an effort to deviate from Medicare's traditional fee-for-service payment system, the Innovation Center developed the Bundled Payments for Care Improvement (BPCI) initiative, which links private provider compensation to the treatment of an episode of care, rather than a single service or a patient.[210] An October 2018 BCPI report found that, after five years of the voluntary program, "Medicare payments declined for most clinical episodes and over half of the relative payment reductions were statistically significant;" however, "[q]uality of care, measured as emergency department visits,

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206 AM. MED. ASS'N, EVALUATING PAY-FOR-PERFORMANCE CONTRACTS 3 (2018), https://www.ama-assn.org/sites/ama-assn.org/files/corp/media-browser/member/about-ama/pay-performance-contracts.pdf.

207 Ginsburg, *supra* note 79, at 1978.

208 *See Affordable Care Act (ACA)*, HEALTHCARE.GOV, https://www.healthcare.gov/glossary/affordable-care-act/ (last visited Jan. 4, 2019); *see generally* Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010) (codified as amended in scattered sections of 26 and 42 U.S.C.).

209 *About the CMS Innovation Center*, U.S. CTRS. FOR MEDICARE & MEDICAID SERVS., https://innovation.cms.gov/About/index.html (last updated Jan. 2, 2019).

210 *See Bundled Payments for Care Improvement (BPCI) Initiative: General Information*, U.S. CTRS. FOR MEDICARE & MEDICAID SERVS., https://innovation.cms.gov/initiatives/bundled-payments/ (last updated Dec. 11, 2018).

mortality, and readmissions, was not affected in the vast majority of clinical episodes."[211]

The ACA also created a requirement that a baseline of health care benefits must be included in Medicaid plans and private plans within the individual and small group markets.[212] The ACA requires these plans to cover essential health benefits, which include health care services and items across ten benefit categories:

> (1) ambulatory patient services; (2) emergency services; (3) hospitalization; (4) maternity and newborn care; (5) mental health and substance use disorder services including behavioral health treatment; (6) prescription drugs; (7) rehabilitative and habilitative services and devices; (8) laboratory services; (9) preventive and wellness services and chronic disease management; and (10) pediatric services, including oral and vision care.[213]

Several ACA measures directly affect the health of the U.S. prison population.[214] The ACA expanded the use of electronic medical records in order to better coordinate patient care across providers.[215] This enables personal health records to follow patients when they change providers.[216] So when an individual leaves prison, her medical records can be transferred from the prison physician to her new physician, seamlessly continuing a treatment regimen.

The ACA also established the Community-Based Care Transitions Program.[217] This program "tested models for improving care transitions from the hospital to other settings and reducing readmissions for high-risk Medicare beneficiaries."[218] While this program was

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211 THE LEWIN GROUP, CMS BUNDLED PAYMENTS FOR CARE IMPROVEMENT INITIATIVE MODELS 2-4: YEAR 5 EVALUATION & MONITORING ANNUAL REPORT 2 (2018), https://downloads.cms.gov/files/cmmi/bpci-models2-4-yr5evalrpt.pdf.

212 *Information on Essential Health Benefits (EHB) Benchmark Plans*, CTR. FOR CONSUMER INFO. & INS. OVERSIGHT, U.S. CTRS. FOR MEDICARE & MEDICAID SERVS., https://www.cms.gov/cciio/resources/data-resources/ehb.html (last visited Jan. 4, 2019).

213 *Id.*

214 *See* Joel Teitelbaum & Laura Hoffman, *Health Reform and Correctional Health Care: How the Affordable Care Act Can Improve the Health of Ex-Offenders and Their Communities*, 40 FORDHAM URB. L.J. 1323, 1346-56 (2013).

215 *See* 42 U.S.C. § 17901 (2012).

216 *See id.*

217 Patient Protection and Affordable Care Act, 195 Pub. L. No. 111-148, § 3026, 124 Stat. 413 (2010).

218 *Community-based Care Transitions Program*, U.S. CTRS. FOR MEDICARE & MEDICAID SERVS., https://innovation.cms.gov/initiatives/CCTP/ (last updated Nov. 26, 2018).

not specifically directed at individuals transitioning from prison back into their communities, the mission is the same: "to improve transitions . . . from [a contained environment] to other care settings, to improve quality of care, to reduce readmissions for high-risk beneficiaries, and to document measurable savings[.]"[219]

One of the central objectives of the ACA—perhaps the most important to the long-term health of the prison population and the communities they return to—was to expand Medicaid eligibility.[220] Medicaid is a public health plan governed by federal and state law that covers—as of the July 2019 Enrollment Report—65.5 million people, including "low-income adults, children, pregnant women, elderly adults and people with disabilities."[221] The ACA authorized states to expand Medicaid eligibility to adults under 65 with an income up to 138% of the federal poverty level[222]—$16,753.20 in 2018.[223] The U.S. population now eligible for Medicaid in states that chose to expand the program "is remarkably reflective of the incarcerated population and one that has long struggled to gain access to any insurance coverage and, as a result, to health care services."[224] As of August 2019, thirty-six states and Washington, D.C., have expanded Medicaid eligibility under the ACA.[225]

While the federal government allows inmates to maintain Medicaid eligibility throughout their incarceration, there are significant limits on what Medicaid will cover while a beneficiary is incarcerated.[226] States may provide Medicaid coverage only "for care delivered outside the institution, such as at a hospital or nursing home, when the person has been admitted for 24 hours or more."[227] In such circumstances, the federal government will reimburse states for at

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219 *Id.*

220 Teitelbaum & Hoffman, *supra* note 214, at 1327.

221 *Medicaid*, MEDICAID.GOV, https://www.medicaid.gov/medicaid/index.html (last visited Oct. 28, 2019).

222 Olena Mazurenko et. al., *The Effects Of Medicaid Expansion Under The ACA: A Systematic Review*, 37 HEALTH AFFAIRS 944, 944 (2018).

223 *Prior HHS Poverty Guidelines and Federal Register References*, DEP'T OF HEALTH AND HUMAN SERVS., https://aspe.hhs.gov/prior-hhs-poverty-guidelines-and-federal-register-references (last visited Oct. 2, 2019).

224 Teitelbaum & Hoffman, *supra* note 214, at 1327 (citations omitted).

225 *Status of State Action on the Medicaid Expansion Decision*, KAISER FAM. FOUND., https://www.kff.org/health-reform/state-indicator/state-activity-around-expanding-medicaid-under-the-affordable-care-act/ (last updated Jan. 4, 2019).

226 PEW CHARITABLE TR., *supra* note 16, at 2.

227 42 U.S.C. § 1396d(a) (2012); *see also* PEW CHARITABLE TR., *supra* note 16, at 2.

least 50% of the cost of off-site care when the individual is enrolled in Medicaid, and up to 90% if the individual is eligible only because of the ACA Medicaid expansion.[228]

Because inmates can be enrolled in Medicaid throughout their incarceration, prison health providers must carefully ensure that Medicaid is not charged for care beyond this narrow, in-patient coverage.[229] Therefore, states that outsource prison health services must decide whether to suspend Medicaid eligibility for inmates—to make clear that the contractor is responsible for all care—or write provisions into the contract that clearly define how the vendor will coordinate care with Medicaid.[230] Nevertheless, in states with expanded Medicaid programs, states benefit from federal reimbursement of inpatient care, and inmates benefit from the availability of Medicaid benefits upon release, which "improves individuals' prospects for successful reintegration and benefits the public's health and safety."[231]

ANALYSIS

Since the Supreme Court's decision in *Estelle*, prisons have struggled to provide adequate health care services to incarcerated men and women across the United States. In part, this is symptomatic of the U.S. prison population growing faster than state and federal governments can accommodate.[232] Another part of the equation, however, is that governments have privatized the operation of correctional services—and, in some instances, prisons—in an effort to cut costs.[233] In the health care context, as illustrated in *Scott v. Clarke* and *Parsons v. Ryan*, these corporations often profit from taxpayer funds while providing constitutionally deficient services to prisoners in violation of the Eight Amendment's prohibition against cruel and unusual punishment.[234] A prohibition on the for-profit contractors that provide correctional health care may improve conditions of confinement for incarcerated Americans; however, these companies are currently

228 PEW CHARITABLE TR., *supra* note 16, at 2.

229 *Id.*

230 *Id.* at 3.

231 *Id.* at 9.

232 *Phasing Out Our Use of Private Prisons*, OFF. OF PUB. AFF., U.S. DEP'T OF JUST. (Aug. 18, 2016), https://www.justice.gov/archives/opa/blog/phasing-out-our-use-private-prisons.

233 *Id.*

234 *See supra* Part I.

firmly intrenched in federal and state prison systems across the country. Still, in the absence of reform that limits or phases out private contractors, lawmakers and public officials can take steps to effectively protect prisoners' constitutional rights while for-profit contractors remain in place.

I. REFORM THROUGH LITIGATION

The Supreme Court has developed parameters for identifying when prison health care providers have failed to provide adequate care.[235] Identifying the extent of this constitutional right is critically important; however, litigation has proven to be too cumbersome and inefficient to serve as an effective tool for enforcing those parameters and ensuring that private contractors are providing adequate health care to prisoners.

Litigation under the Eighth Amendment effectively addresses poor health care conditions only when "deliberate indifference to serious medical needs of prisoners constitutes the 'unnecessary and wanton infliction of pain,'"[236] which rises to the level of cruel and unusual punishment. "Deliberate indifference" exists when a prison official "knows of and disregards an excessive risk to inmate health or safety."[237] If prisoners are suffering under inadequate care, but cannot show deliberate indifference, or cannot find appropriate legal representation to help them make their case, litigation to improve conditions will likely be unsuccessful. Therefore, any successful Eighth Amendment claim under current Supreme Court standards requires prisoners to suffer through "unnecessary and wanton infliction of pain" before a court will take any action to begin rectifying constitutionally deficient health care services.[238]

Litigating prisoner conditions of confinement cases are labor-intensive and may be quite expensive. Plaintiffs in *Parsons* filed their complaint in March 2012 and reached a settlement in October 2014, but litigation to enforce the settlement agreement endures.[239] Plaintiffs in *Scott* brought their lawsuit in July 2012 and agreed to settle in

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235 *See, e.g.*, Farmer v. Brennan, 511 U.S. 825, 837 (1994); Estelle v. Gamble, 429 U.S. 97, 104 (1976).

236 *Estelle*, 429 U.S. at 104.

237 *Farmer*, 511 U.S. at 837.

238 *See, e.g.*, Scott v. Clark, 64 F. Supp. 3d 813 (W.D. Va. 2014).

239 *See supra* Part I.

November 2014, but litigation to enforce the settlement agreement endures.[240] Tax payers in Arizona and Virginia are funding both the inadequate for-profit prison medical care systems, as well as the legal fees of both parties.[241]

Settlement agreements often include provisions for the appointment of some form of court-ordered compliance monitor, and the court before which the case is pending retains supervisory jurisdiction. However, defendant-providers are generally afforded a significant period of time within which to raise the quality of their services to the constitutional floor.[242] Thus, private providers operate with relative impunity and little incentive to allocate the enhanced resources necessary to significantly improve the quality of the care they provide. While litigation persists and providers stall, men and women are suffering and dying as for-profit prison medical care systems survive.[243]

Litigation has largely driven significant improvements in prison health care to more closely align with health care services outside of the correctional system.[244] However, successful reliance on the courts has generally required years of litigation attended by years of human suffering in each individual case. Still, the courts have not specifically defined what medical services must be provided to prisoners.[245] Ultimately, additional meaningful reform must come from beyond the judiciary.

II. REFORM THROUGH LEGISLATION

To comprehensively address systemic problems in correctional health care services nationwide, Congress must take the lead. Federal lawmakers have the power to pass a legislative package that would immediately address current endemic failures of correctional health

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240 *See supra* Part I.

241 For example, plaintiffs' attorneys in *Scott* calculated attorneys' fees and litigation costs through settlement to be $2,063,298.82, but ultimately settled with the Defendants for a payment of $1,500,000.00. This sum does not include fees accrued in the years of litigation following the settlement agreement. Scott v. Clarke, No. 3:12-CV-00036, 2016 WL 452164, at *1, *34 (W.D. Va. Feb. 5, 2016).

242 *See, e.g.*, HUMAN RTS. WATCH, ILL-EQUIPPED: U.S. PRISONS AND OFFENDERS WITH MENTAL ILLNESS (2003), https://www.hrw.org/reports/2003/usa1003/usa1003.pdf; *see also, e.g.*, Campbell, *supra* note 147.

243 *See supra* Part I.

244 PEW CHARITABLE TR., *supra* note 22, at 3.

245 McDonald, *supra* note 25, at 437.

care services across the country—constitutional and otherwise. They also have the power to establish programs to address the more challenging problems associated with quality and cost of care. They should do so.

Legislators can look to the ACA for opportunities and inspiration. First, Congress must set a baseline of health care benefits that must be included in all correctional health systems. The items and services included in the essential health benefits package that the ACA requires of Medicaid and private individual and small group plans may not be suitable in the prison setting; however, the concept of an essential benefits package is perfectly appropriate for the prison medical care space. This concept addresses Justice Stevens' concerns in his dissent in *Estelle*. He argued for an objective standard for assessing the adequacy of prisoner medical care, and such an essential benefits package would finally establish a clear baseline for reasonably adequate health care services for prisoners.[246] Lawmakers can look to settlement agreements like those in *Scott* and *Parsons* to learn which services and resources are most important and most inadequate.

Congress need not rest once it has established a set of prisoner health care benefits that only meets a level of care that is minimally adequate under the Eighth Amendment. Considering the overall poor health of the U.S. prison population, Congress should take the opportunity to transform prison medical care through innovative payment models and coordinated care. A healthier prison population would lead to, over time, a healthier national population because at least 95% of prisoners return to their communities.[247]

Congress should also create programs to fund innovative coordinated care and payment models within the prison setting. It is simpler for providers to coordinate care in prisons because most care is delivered on site; therefore, it may be easier to measure the impact of coordinated care programs. Policymakers can draw on lessons learned from analogous ACA programs, such as the Community-Based Care Transitions Program,[248] a program designed to reduce the number of

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246 Estelle v. Gamble, 429 U.S. 97, 109 (1976) (Stevens, J., dissenting).

247 Timothy Hughes & Doris James Wilson, *Reentry Trends In The U.S.*, U.S. DEP'T OF JUST., BUREAU OF JUST. STATS., https://www.bjs.gov/content/reentry/reentry.cfm (last updated Jan. 4, 2019) ("At least 95% of all state prisoners will be released from prison at some point").

248 *Community-based Care Transitions Program*, U.S. CTRS. FOR MEDICARE & MEDICAID SERVS., https://innovation.cms.gov/initiatives/CCTP/ (last updated Nov. 26, 2018).

hospital readmissions for high-risk individuals.[249] Using that as inspiration, new prison programs can similarly work towards reducing recidivism by coordinating health care through the individual's initial community reentry period. Prison programs that successfully lower costs and utilization while improving outcomes can be duplicated and implemented in other settings.

Congress should also address how government contracts with private providers are designed and how they function. Legislation should encourage the development of innovative payment models and build upon those being tested and implemented in the private insurance market—such as bundled payments—that address episodes of care rather than individual treatments and services, and withholds that incentivize providers to meet quality and cost performance measures.[250]

The failure of the U.S. Supreme Court to establish a definitive baseline for constitutionally required health care has led to endless litigation and uncertainty among prisoners, providers, and public officials as to the adequate level of care the Constitution requires. Regardless of confusion about the current baseline, these recommendations for legislative activity, if implemented, would elevate prison care beyond that floor. In the absence of a clear floor set by the courts, the legislature should step in to set a constitutionally viable one, as well as exercise its constitutional prerogative to go beyond that and set it at the level that is mindful of public health overall. Chief Justice Warren observed that "The [Eighth] Amendment must draw its meaning for the evolving standards of decency that mark the progress of a maturing society."[251] The type of legislative package contemplated here would clearly mark societal progress. It would also provide much needed clarity for the courts, which would foster judicial efficiency and decrease the volume of prisoner litigation focused on conditions of confinement. Moreover, judicial interpretation of the reform legislation, once enacted, could reduce the frequency of future litigation by applying decisions to situations beyond the isolated facts of a case, unlike the current situation in which litigation is very fact-specific. This would provide additional clarity as to where the constitutional floor is.

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249 *Id.*

250 *See supra* Part I.

251 Trop v. Dulles, 356 U.S. 86, 101 (1958).

While litigation provides some protection of prisoners' Eighth Amendment rights, legislation establishing a baseline of essential services and resources with respect to prisoner health care would better protect prisoners' rights and would ease the judiciary's burden. The First Step Act offers optimism.

Enactment of the First Step Act shows that prison reform is popular and is on the minds of federal lawmakers. Moreover, the Act's provisions addressing confinement conditions indicate a consensus in Congress that something must be done to address medical and health care services in prisons. The Act's provisions directing the collection of prison health care data will further inform Congress of the critical need for fundamental prison health care reform. Therefore, legislation that includes—or even centers on—conditions of confinement reform is politically feasible and is becoming increasingly so. Prison reform advocates can look to the process surrounding the drafting and enactment of the First Step Act to identify the key lawmakers and interest groups that are serious about prison reform and have proven capable of successfully enacting prison reform law.

CONCLUSION

Correctional health care in the United States is fatally inadequate. Since the 1970s, the United States has been in an era of mass incarceration while substance abuse, mental illness, poverty, and associated criminal conduct have taken millions of Americans from our communities and placed them behind bars. Privatizing prisons and correctional services have deteriorated conditions of confinement while creating a commercial industry dependent on occupied cells. The judiciary has limited power to remedy conditions of confinement or impose limitations on the conduct of the for-profit prison industry, so Congress must act. Federal lawmakers must ensure that the government is meeting its "obligation to provide medical care for those whom it is punishing by incarceration."[252] To do so, Congress should pass legislation that establishes a baseline of constitutionally adequate health benefits for prisoners and saves lives. This legislative package should also include longer term reforms that will create programs to foster innovation in care delivery and payment structures in order to

[252] Estelle v. Gamble, 429 U.S. 97, 103-04 (1976) (quotations omitted).

improve public health and draw down health care costs. Americans are dying for a remedy to the pervasive constitutionally deficient medical care in prisons nationwide. Congress must respond.