NOTES

MISMANAGED CARE: EXPLORING THE COSTS AND BENEFITS OF PRIVATE VS. PUBLIC HEALTHCARE IN CORRECTIONAL FACILITIES

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Administering healthcare in prisons and jails has been an exceptionally difficult task for state, county, and city governments for decades. Facing the unprecedented rise in the correctional population, governments began contracting with private correctional healthcare companies in the 1980s for cheaper, higher-quality care. However, in practice, private correctional healthcare companies have been disastrous for inmate-patients and their families. This Note examines the structural deficiencies in the privatization of correctional healthcare, and argues that the market factors required for successful privatization, including choice, competition, and responsiveness to consumer preferences, are absent in the correctional healthcare sector. In addition, the lack of meaningful oversight, protective contractual provisions, and legal hurdles facing prospective litigants compound these structural problems and leave the companies unaccountable for their misconduct. This Note proposes switching from these private companies to publicly-run options, such as government health agencies, partnerships with universities, and private non-profit organizations. These public models increase democratic accountability and transparency, lower costs, and more appropriately treat correctional health as the public health issue that it is. While administering healthcare services in correctional settings will always be challenging, switching to public models is the first step in improving care and treating inmate-patients with dignity.

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Introduction

Corizon Health Services prescribed Rachel Wood "Claritin or Ibuprofen" to treat her lupus.[1] Convicted of dealing in a controlled substance in June 2010, twenty-two-year-old Wood detailed her history of lupus, bleeding disorders, and kidney trouble to Corizon doctors when she arrived to prison.[2] A Corizon nurse initially prescribed

1 Williams v. Ind. Dep't of Corr., 142 N.E.3d 986, 995 (Ind. Ct. App. 2020).

2 Corizon, a private correctional healthcare company, was under a contract to provide healthcare services in the Indiana prisons where Ms. Wood was incarcerated. The facts of

Ms. Wood hydroxychloroquine to manage her illnesses.[3] But, when Ms. Wood stopped taking the treatment because she had not had any lupus "flare-ups," her Corizon doctor discontinued her hydroxychloroquine prescription instead of educating her on the importance of compliance.[4] Over the next few months, Ms. Wood had numerous blood tests that showed abnormal and dangerous clotting levels; yet, her medical records "failed to show any consistent provider response."[5] When Ms. Wood was transferred to another facility, Corizon doctors failed to re-prescribe her hydroxychloroquine or "establish a long-term plan of care for [Ms.] Wood's lupus."[6]

Ms. Wood's health began deteriorating rapidly: Other prisoners had to help her write medical requests and bring her food, and her friends noted that she could not get out of bed, had "blood . . . coming out of [her] ears," and was covered in rashes.[7] In response, Corizon doctors merely gave her "Claritin or Ibuprofen."[8] In March 2012, a wheelchair-bound Ms. Wood was sent to a facility with an infirmary, but was almost immediately transferred to a hospital.[9] After a three-week stay, Ms. Wood was returning to prison when Corizon decided to change course—ordering Ms. Wood's transfer to another hospital seventy-one miles away—when she began coughing up blood.[10] Ms. Wood died while shackled to her ambulance bed.[11]

Unfortunately, Ms. Wood's tragic experience under Corizon's care is not unique. Since the 1980s, many states, counties, and municipalities across the country have contracted with private corporations like Corizon to provide inmate-patients with healthcare services.[12] With prison populations increasing exponentially and federal courts imposing new legal standards for correctional healthcare, corrections

Ms. Wood's decline are taken from the Indiana Court of Appeals decision in her family's lawsuit against Corizon and the State, *id.* at 991.

[3] *Id.* at 992.

[4] *Id.* at 992–93.

[5] *Id.* at 993.

[6] *Id.*

[7] *Id.* at 994–95.

[8] *Id.* at 995.

[9] *Id.* at 996–97.

[10] *Id.* at 998, 1005.

[11] *Id.* at 998–99.

[12] *See infra* Section I.A.2. The examples explored in this Note come from a limited number of states, due to the opacity surrounding much of private correctional healthcare administration. This will be discussed *infra*. Additionally, due to space constraints, this Note does not include a discussion of the Federal Bureau of Prisons' healthcare administration, which also partially contracts with private healthcare providers. *See, e.g.*, *Seven Corners—the Customer Service Leader in Correctional Healthcare*, SEVEN CORNERS, https://www.sevencorners.com/gov/bop (last visited June 6, 2020) ("Seven Corners was awarded 13 Federal Bureau of Prisons (BOP) contracts in 2019.").

departments turned to private providers for a more cost-efficient and effective method of providing healthcare services to their incarcerated populations.[13] Despite private companies' exciting potential to improve prisoner care for a lower price, inmate-patients, advocates, and public health experts have noted for years the structural problems within privatized prison care, including inadequate care for the prisoners and few repercussions for the companies.

Despite these concerns, the private correctional healthcare market has developed into an extremely profitable industry. A 2016 assessment valued the private correctional healthcare industry at three billion dollars and "estimate[d] that more than half of all state and local prisons and jails have outsourced their healthcare."[14] A 2014 report from the Reason Foundation revealed that thirty states have contracted with for-profit correctional healthcare companies: twenty-four states completely contracting out services and six partially.[15] With states and municipalities extending these contracts and negotiating new ones, this practice is not fading anytime soon.[16]

The proliferation of private companies, despite major lawsuits and allegations of misconduct, continues because of failures in the correctional healthcare market. Specifically, the market lacks the factors necessary for successful privatization: choice, competition, and responsiveness to consumer preferences.[17] Only a few major players dominate the market,[18] and governments are incentivized to stick with

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13 *See infra* Section I.A.

14 Rupert Neate, *Welcome to Jail Inc: How Private Companies Make Money off US Prisons*, GUARDIAN (June 16, 2016, 6:00 PM), https://www.theguardian.com/us-news/2016/jun/16/us-prisons-jail-private-healthcare-companies-profit (reporting opinion by Dr. Marc Stern, a former head doctor of Washington state's prisons).

15 LAUREN GALIK & LEONARD GILROY, REASON FOUND., PUBLIC-PRIVATE PARTNERSHIPS IN CORRECTIONAL HEALTH CARE 2 (2014). That number has been relatively constant since 2004, when it was reported that thirty-two states contracted with correctional healthcare companies either partially or totally. Alexandria Macmadu & Josiah D. Rich, *Correctional Health Is Community Health*, 32 ISSUES IN SCI. & TECH. 64, 67 (2015).

16 For example, Maryland signed a new contract with Corizon in 2018 to provide health services in the state's prisons. Pamela Wood, *Maryland Awards Big Contract for Inmate Health Care as Prior Contractor Sues*, BALT. SUN (Dec. 19, 2018, 7:20 PM), https://www.baltimoresun.com/news/maryland/politics/bs-md-board-prison-20181219-story.html. The City of St. Louis also recently renewed its contract with Corizon through 2022. *City of St. Louis Renews Corizon Health Partnership*, STREETINSIDER (Feb. 17, 2020, 2:43 PM), https://www.streetinsider.com/Globe+Newswire/City+of+St.+Louis+Renews+Corizon+Health+Partnership/16484007.html.

17 These arguments can be and have been made against private prisons generally. *See generally* MEGAN MUMFORD, DIANE WHITMORE SCHANZENBACH & RYAN NUNN, THE HAMILTON PROJECT, THE ECONOMICS OF PRIVATE PRISONS (2016). A critique of private prisons is, however, outside the scope of this Note.

18 *See infra* Section I.A.3.

their providers, or contract with another private provider, even when quality is low. Additionally, the "customer" is divided into two distinct roles: the government, which pays for healthcare, and the inmate-patients, who receive the services. The result is a gap between the preferences and needs of the inmate-patients and those of the governments paying for these services.

Some states and municipalities have begun to recognize the undue risks and abuses resulting from privatized correctional healthcare and have turned toward public sector alternatives. In 2015, New York City dropped Corizon as the city's long-standing healthcare provider at Rikers Island, and entered into a contract with the government agency that runs the city's public hospitals.[19] New Jersey and Texas both partner with state universities to provide correctional health services.[20] Other governments, like Delaware, have partnered with community-based health organizations.[21] Unlike private correctional health companies, these publicly-focused alternatives employ doctors, nurses, and other medical staff who treat both incarcerated and non-incarcerated populations. This holds the potential to raise the quality of care to non-correctional standards. Additionally, these systems provide greater accountability and transparency to both the public and the governments that contract with them.

With over two million people incarcerated in prisons and jails across the United States,[22] correctional healthcare administration has a monumental effect not only on those incarcerated, but also on the nation's public health more broadly. Prisoners are an "inherently unhealthy population," often suffering from multiple conditions at once.[23] An estimated 40% of those incarcerated suffer from at least one chronic condition,[24] and one estimate reports that "nearly 80% of inmates with chronic illnesses have never received routine medical care."[25] States collectively spend $8 billion on correctional healthcare, an average of about $5720 per inmate-patient per year.[26] And, since

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[19] Michael Winerip & Michael Schwirtz, *New York City to End Contract With Rikers Health Care Provider*, N.Y. TIMES (June 10, 2015), https://www.nytimes.com/2015/06/11/nyregion/report-details-failings-of-corizon-rikers-island-health-provider.html.

[20] *See infra* Section III.A; *infra* note 240 and accompanying text.

[21] *See infra* Section III.A.

[22] WENDY SAWYER & PETER WAGNER, PRISON POLICY INITIATIVE, MASS INCARCERATION: THE WHOLE PIE 2020, at 1 (2020), https://www.prisonpolicy.org/reports/pie2020.html.

[23] Norra MacReady, *Cruel and Unusual*, 373 LANCET 708, 708 (2009); *see also infra* Part III.

[24] Macmadu & Rich, *supra* note 15, at 66.

[25] MacReady, *supra* note 23, at 709.

[26] PEW CHARITABLE TRS., PRISON HEALTH CARE: COSTS AND QUALITY 90, 94 (2017) (reporting costs and averages over the fiscal years 2010–2015).

most prisoners are eventually released,[27] health problems that go untreated in prison will perpetuate once they reenter society.

This Note explores the implications of both private and public correctional healthcare models and argues that public models are preferable, as they provide greater oversight, are not driven by shareholder interests, and more appropriately treat correctional health as a public health issue. This Note will proceed in three parts. Part I describes the rise of privatized prison healthcare, mapping the history of correctional care and explaining in further detail the market failures that result from privatizing correctional healthcare. Part II addresses the barriers to improving privatized correctional healthcare, including cost-cutting incentives, dubious contract provisions, lack of oversight and accountability, and legal hurdles to filing suit. Part II concludes with a discussion of the negligence and misconduct that result from the privatized relationship. Finally, Part III evaluates the risks and benefits of three public-run models for correctional healthcare: private nonprofit healthcare organizations, university medical school partnerships, and government health agencies. This Note concludes by arguing that the current system of private healthcare is inadequate in treating the millions of people incarcerated across the country and that governments should instead turn to publicly-run models that better serve the incarcerated community and the public at large.[28]

I
Administering Healthcare in Correctional Facilities

Beginning in the 1970s, due to shifts in sentencing policy across the country, the United States prison population began a forty-year increase to unprecedented levels.[29] This Part surveys that history and the current state of private correctional healthcare. Section A examines the history of correctional healthcare privatization and the shift away from correctional departments administering healthcare themselves. Section B provides a deeper analysis of the theory of privatiza-

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[27] *See* Macmadu & Rich, *supra* note 15, at 64 ("[O]ver 95% of incarcerated individuals will eventually return to their communities, and their health problems and needs will often follow along.").

[28] This Note was finalized amidst the 2020 Coronavirus (COVID-19) pandemic, which has shone a harsh light on the inadequacy of correctional healthcare generally. It is too early to tell what effects public versus private healthcare systems have on the treatment of prisoners during the pandemic, but research on the topic would be fascinating and important for a future publication.

[29] The Sentencing Project, Trends in U.S. Corrections 2 (2019), https://sentencingproject.org/wp-content/uploads/2016/01/Trends-in-US-Corrections.pdf.

tion and the reasons it fails in the prison healthcare market. That Section further argues that because of the lack of competition and responsiveness to inmate-patients' needs, correctional healthcare companies face few repercussions for the issues outlined in Part II, including abuse and mismanagement.

A. History of the Modern Privatization of Correctional Care

Administering healthcare in prison requires balancing the interests of correctional facilities and prisoners' legitimate need for healthcare. In both private and public systems, these competing forces make the administration of healthcare necessarily complex. The primary function of jails and prisons is not the administration of healthcare, but housing those convicted of crimes.[30] Thus, all other functions, such as healthcare, vocational programming, and education, are secondary to "[t]he institutional goal of internal security."[31]

Those working in prisons, whether they are direct correctional employees or contracted doctors, must always consider institutional security. Indeed, "[c]ourts have recognized the legitimacy of penological and security interests," even when those interests infringe on other rights.[32] Over the last few decades, state and local governments have tried various healthcare systems to balance these competing interests.

1. Direct Service Period

In the 1970s, prior to the spike in the incarcerated population, correctional facilities were largely administering their own healthcare in what has been termed the "direct service" period.[33] Rather than contract with private companies or even other government agencies,

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[30] *See* David L. Thomas, Anthony J. Silvagni & James Howell, *Developing a Correctional Medicine Rotation for Medical Students*, 10 J. CORRECTIONAL HEALTH CARE 557, 559 (2004) ("Prisons are designed primarily to confine and control, not to diagnose and cure.").

[31] Michael Cameron Friedman, *Cruel and Unusual Punishment in the Provision of Prison Medical Care: Challenging the Deliberate Indifference Standard*, 45 VAND. L. REV. 921, 943 (1992) (citing Pell v. Procunier, 417 U.S. 817, 823 (1974)).

[32] *Id.* at 944 (citing cases upholding the constitutionality of prisoner package restrictions, unannounced cell searches, and body cavity inspections, in light of institutional security concerns); *see also* Wolff v. McDonnell, 418 U.S. 539, 556 (1974) ("[T]here must be mutual accommodation between institutional needs and objectives and the provisions of the Constitution that are of general application.").

[33] *See* Noga Shalev, *From Public to Private Care: The Historical Trajectory of Medical Services in a New York City Jail*, 99 AM. J. PUB. HEALTH 988, 989 (2009) (naming the 1932–1973 period the "direct service" era).

correctional departments employed their own doctors and nurses.[34] These healthcare professionals suffered from limited professional autonomy because they reported to the corrections department rather than an independent medical board.[35] Providers often practiced with restricted medical licenses or no licenses at all.[36] In New York City's jails, "staffing, medical records, and oversight of medical care" were all deficient.[37] As a result, inmate-patients suffered.[38]

These problems were compounded by the federal courts' hands-off approach to correctional operations. Before a series of federal cases in 1963, courts largely refused to interfere with states' operation of their prisons.[39] Inmate-patients therefore had little opportunity to challenge their inadequate care. With *Jones v. Cunningham*,[40] *Cooper v. Pate*,[41] and *Newman v. Alabama*,[42] federal courts began to recognize their responsibility to intervene when state prisoners were denied federal rights.[43] The landmark case *Estelle v. Gamble*[44] raised the stakes further by introducing the current standard of care for correc-

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[34] *See* Pew Charitable Trs., *supra* note 26, at 11 ("Until the late 1970s, every state provided prison health care directly.").

[35] *See* Lambert N. King, *Doctors, Patients, and the History of Correctional Medicine*, *in* Clinical Practice in Correctional Medicine 3, 9 (Rolla Couchman ed., 2d ed. 2006) (noting that the shift from direct service to contracted services "perceptibly enlarged" providers' autonomy and more closely resembles providers' autonomy in the non-correctional setting).

[36] B. Jaye Anno, *Prison Health Services: An Overview*, 10 J. Correctional Health Care 287, 288 (2004) (describing how medical care "most often was provided by unlicensed former military corpsmen who were assisted by untrained inmate 'nurses'"); *see also* Douglas C. McDonald, *Medical Care in Prisons*, 26 Crime & Just. 427, 441–42 (1999) (describing a 1979 study that compared full-time prison doctors to doctors treating the general population, and found that "[a]mong full-time prison physicians, there was a higher percentage having restricted licenses, limited postgraduate medical training, no area of specialization, and no board certification").

[37] Shalev, *supra* note 33, at 990.

[38] *See* King, *supra* note 35, at 8 (characterizing problems in New York City's jail system as "egregious" when the system provided its own healthcare); Shalev, *supra* note 33, at 990 (describing a report that suggested "routine medical services at the city jails were so inadequate that imprisonment produced more social damage than did the original crime"); *id.* at 991 (noting that a prisoner protest in the former Manhattan House of Detention jail was in part based on inadequate access to medical care).

[39] King, *supra* note 35, at 7; *see also* Anno, *supra* note 36, at 287.

[40] 371 U.S. 236 (1963) (holding that a state parolee could file a writ of habeas corpus to challenge his sentence).

[41] 378 U.S. 546 (1964) (reversing the district court's dismissal of state inmate's case that alleged religious discrimination in prison).

[42] 503 F.2d 1320 (5th Cir. 1974) (acknowledging that "deference which shields [prison] officials engaging in intemperate action and which excuses judicial myopia is incompatible with our role as arbiters of the Constitution and hence cannot be countenanced").

[43] *See* King, *supra* note 35, at 7 (documenting the end of the "hands-off" doctrine following these three cases).

[44] 429 U.S. 97 (1976). For further discussion of *Gamble*, see *infra* Section II.C.1.

tional healthcare. In *Gamble*, the Court held that "deliberate indifference to serious medical needs of prisoners constitutes the 'unnecessary and wanton infliction of pain'" in violation of the Eighth Amendment.[45] While in practice the deliberate indifference standard is a high bar to meet,[46] the imposition of any standard at all marked a shift from the Court's initial refusal to get involved.

2. Contracting Out Services

With the apparent failure of the direct service model, the growing correctional population, and correctional facilities' newfound responsibility to provide adequate medical care, corrections departments turned to alternate solutions around 1973.[47] "Contracting out" services to outside providers became popular because it allegedly drove down costs, improved care, increased provider autonomy, and transferred risk from governments to contracting private entities.[48] During this period, some prisons and jails contracted with government healthcare agencies.[49] New York City's Rikers Island contracted with New York medical schools and hospitals.[50] Switching to a private, yet nonprofit, model improved healthcare at Rikers: Outside providers were still required to "collaborate with security personnel and adhere to institutional policies,"[51] but inmate-patients felt that they could trust them more than corrections doctors and that they were more effective advocates.[52] As a result, quality of care improved and Rikers was the first jail in the country to have its medical program accredited by the Joint Commission on Accreditation of Healthcare Organizations.[53] Around the same time, Delaware become the first state to completely contract out its prison healthcare to an outside provider.[54] Delaware partnered with Sacred Heart General Hospital in Pennsylvania to

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45 *Gamble*, 429 U.S. at 104 (citing Gregg v. Georgia, 428 U.S. 153, 173 (1976)).

46 Even Gamble's claims were not found to rise to this standard. *See id.* at 105 ("This conclusion does not mean, however, that every claim by a prisoner that he has not received adequate medical treatment states a violation of the Eighth Amendment.").

47 *See, e.g.*, Shalev, *supra* note 33, at 991 (discussing New York City's decision to contract with Montefiore Hospital in order to provide healthcare at Rikers Island).

48 Galik & Gilroy, *supra* note 15, at 4–10.

49 *See, e.g.*, King, *supra* note 35, at 9 (indicating that Cook County Jail received healthcare services through the Health and Hospitals Governing Commission of Cook County).

50 *See* Shalev, *supra* note 33, at 991.

51 King, *supra* note 35, at 9.

52 Shalev, *supra* note 33, at 991.

53 *Id.* at 991–92.

54 McDonald, *supra* note 36, at 470; *see also* Correctional Health Care: An Annotated Bibliography 41 (Phillip Glassanos ed., 2d ed. 1979) (summarizing a study conducted by Doyle Moore that analyzed the efficacy of Delaware's contract with hospitals in Pennsylvania).

"provid[e] health care services to approximately 1500 prisoners in 11 Delaware penal institutions."[55]

3. Proliferation of Privatization

As the prison population continued to rise and began aging, administering healthcare became even more expensive for states and concerns over the quality of existing healthcare regimes grew.[56] States turned to a new alternative: contracting with *private* companies, which promised to provide an even cheaper alternative for states looking to improve correctional healthcare.[57]

This privatization complemented the national and global rise of neoliberal policies in the provision of public services. Neoliberalism "can be defined as a social and economic system" under which "[g]overnments are less willing to interfere with the free operation of market forces."[58] Neoliberal policies are typified by government deregulation and increased privatization.[59] In the United States, the Reagan Administration began slashing budgets for public services in late 1981.[60] In healthcare specifically, the Administration's budget included "[a] 25% reduction . . . in federal aid to the states for preventative health programs" and drastic cuts to the Centers for Disease Control, Medicaid, Medicare, the National Health Service Corps, and education for health professions.[61] These reductions embodied the neoliberal mantra: "[C]ut public budgets and privatize services."[62] In addition to the potential benefits of contracting out services mentioned above, privatization had another purported benefit: competi-

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[55] Correctional Health Care: An Annotated Bibliography, *supra* note 54.

[56] McDonald, *supra* note 36, at 429 (noting the "[d]emands on the health care systems" in American prisons since the 1970s); Pew Charitable Trs., Managing Prison Health Care Spending 2 (2013) (explaining that the increasing incarcerated population has contributed to ballooning prison healthcare costs).

[57] *See* McDonald, *supra* note 36, at 469–70 (describing the states' shifts towards privatization as a method of controlling costs).

[58] Callum Williams & Mahiben Maruthappu, *"Healthconomic Crises": Public Health and Neoliberal Economic Crises*, 103 Am. J. Pub. Health 7, 7 (2013).

[59] *See id.*; Chik Collins, Gerry McCartney & Lisa Garnham, *Neoliberalism and Health Inequalities*, *in* Health Inequalities: Critical Perspectives 124, 124 (Katherine E. Smith, Clare Bambra & Sarah E. Hill eds., 2015) (stating that neoliberalism involves "promoting privatization of public goods and services, together with deregulation of banking and finance").

[60] Thomas B. Edsall, *Oct. 1, 1981: That Day Is Finally Here—Reagan's Budget Cuts Begin: Federal Benefits Being Withdrawn*, Wash. Post, Oct. 1, 1981, at A1 (describing Reagan's thirty-five billion dollars in cuts across government benefits); *see also* Milton Terris, *The Neoliberal Triad of Anti-Health Reforms: Government Budget Cutting, Deregulation, and Privatization*, 20 J. Pub. Health Pol'y 149, 149 (1999) (describing the gutting effect of Reagan's budget cuts on public health program funding).

[61] Terris, *supra* note 60, at 149–50.

[62] *Id.* at 154.

tion, which promised to drive down costs while promoting quality service.[63]

Following these legal and political changes, for-profit companies rushed to fill the need for improved, cheaper care. In 1999, a survey of twenty-seven state prison systems discovered that about thirty-two percent partnered with a private healthcare provider.[64] While precise data describing the prevalence of these companies is scarce, a 2007 estimate revealed that forty percent of total expenditures on correctional health belonged to the private sector.[65] In 2014, the Reason Foundation reported that thirty states had contracted with private correctional health providers in some capacity—twenty-four completely contracting out services and six partially.[66] One estimate in 2016 valued the private correctional healthcare industry at three billion dollars and stated that "more than half of all state and local prisons and jails have outsourced their healthcare."[67] Conducting research into correctional healthcare reveals only a few strong players, with Corizon and Wellpath leading the market.[68] Until 2018, experts considered Corizon the industry's largest correctional healthcare company, bringing in around one billion dollars in revenue in 2017.[69] A new company emerged in 2018 when private equity firm H.I.G. Capital purchased and merged two existing companies, Correct Care Solutions and Correctional Medical Group Companies.[70] The resulting conglomerate, Wellpath, is now the country's largest private correctional healthcare provider that serves "nearly 40 states" across

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63 Practically, however, the application of neoliberal policies and privatization in healthcare generally have created a health inequality chasm between wealthy and lower-income people. *See* Collins et al., *supra* note 59, at 130. Wealthier people can afford private insurance and private services, but lower-income people are relegated to cheaper, lower-quality options or underfunded public services. Even when people do qualify for public services, they may require participation fees, which some people will not be able to afford at all. Under Reagan's neoliberal budget cuts, health inequalities soared. *Id.* at 130.

64 Anno, *supra* note 36, at 292.

65 *See* Shalev, *supra* note 33, at 993.

66 *See* Galik & Gilroy, *supra* note 15, at 2. That number has been relatively constant since 2005, when it was reported that thirty-two states contracted with private correctional healthcare companies either partially or totally. *See* Macmadu & Rich, *supra* note 15, at 67.

67 *See* Neate, *supra* note 14 (reporting opinion by Dr. Marc Stern, a former head doctor of Washington state's prisons).

68 *See* Marsha McLeod, *The Private Option*, Atlantic (Sept. 12, 2019), https://www.theatlantic.com/politics/archive/2019/09/private-equitys-grip-on-jail-health-care/597871.

69 *Id.*

70 *Correct Care Solutions and Correctional Medical Group Companies Join Forces to Deliver Best-in-Class Healthcare*, H.I.G. Capital (Oct. 1, 2018), https://higcapital.com/news/release/1128 (announcing the acquisition and merger of the two companies).

"550 health clinics and hospitals."[71] Other companies have also started growing in market share.[72]

While the landscape of private correctional healthcare is in a state of constant flux, it is clear that a substantial number of incarcerated individuals receive healthcare through a private provider. Moreover, while some states have abandoned the private model altogether, others continue to cycle through repeat players and hop from one company to another.[73]

B. Market Failure: Why Privatized Prison Healthcare Fails

Based on the data above, it is unlikely the private model for administering correctional healthcare will fade anytime soon. As discussed in the preceding Section, the privatization of prison healthcare tracked the rise of neoliberal policies across the globe. Proponents of neoliberalism argue that in the absence of government regulation, free market principles drive down costs and improve the quality of goods and services.[74] They further claim that government regulation unnecessarily interferes with such processes.[75] However, this Section will discuss why these principles fail in the correctional healthcare industry: first, because the correctional healthcare market is not a traditional "market," and, second, because specific contractual provisions incentivize governments to stick with private healthcare providers.

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71 *Id.*; *see also* McLeod, *supra* note 68.

72 For example, Centurion works in over 300 facilities across 17 states, *About Us*, Centurion, https://www.centurionmanagedcare.com/about-us.html (last visited Aug. 25, 2020), and picked up a new contract with Arizona in 2019. Jimmy Jenkins, *Corizon Health Loses Arizona Prison Health Care Contract*, KJZZ (Jan. 19, 2019, 7:59 PM), https://kjzz.org/content/750863/corizon-health-loses-arizona-prison-health-care-contract. Another company, Wexford Health, was founded in 1992 and "deliver[s] health care services to more than 270 correctional and other institutions" in thirteen states. *About Us: History*, Wexford Health, http://www.wexfordhealth.com/About-Us/History (last visited Aug. 25, 2020). NaphCare, founded in 1989, operates a variety of correctional healthcare services in 27 states, and also provides "off-site management services to the Federal Bureau of Prisons." *About NaphCare*, NaphCare, https://www.naphcare.com/about-naphcare (last visited Sept. 3, 2020).

73 *See, e.g.*, N.M. H. Memorial 106 (describing New Mexico's switch from Wexford to Centurion); Wood, *supra* note 16 (describing Maryland's history with private companies).

74 *See supra* notes 58–63 and accompanying text.

75 *See supra* notes 58–63 and accompanying text.

1. *Traditional Market Failure: Lack of Competition and Responsiveness*

For privatization to be successful, several market factors must be present. First, markets require competition.[76] If a sector has only one provider, that provider has little incentive to provide high-quality goods and services. For example, if a town has only one restaurant, the restaurant can provide low-quality food and service without repercussion: Diners will return to the restaurant despite the poor quality, unless they choose to expend extra time and energy to travel outside of town.[77] Those who lack the means to travel out of town are effectively forced to return to the same low-quality restaurant. However, when additional restaurants open, the original restaurant must improve its quality in order to compete.[78] In addition to competition, a functioning market requires firms that are responsive to consumer preference.[79] If the town suddenly has an onslaught of restaurants open but all provide the same low-quality service, then the availability of alternatives fails to improve quality. Yet, if one restaurant begins to provide superior quality, the others will take notice of losing diners and be forced to do the same. All of the actors must respond accordingly; otherwise, everyone will have to flock to that single higher-quality provider.[80] Such a result would resemble a monopoly or collusion,[81] neither of which resembles the type of market suitable for privatization.

The prison healthcare market suffers from "market failure" in that the conditions necessary for successful privatization do not exist.[82] First, competition is minimal. As demonstrated in the previous Section, only a few companies exist for the governments to choose from.[83] Even when there are successful lawsuits or large settlements against one provider, governments may choose another provider rather than exit the private provider market. Moreover, states become

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[76] *See* JULIAN LE GRAND, THE OTHER INVISIBLE HAND 1–2 (2007) (proposing a model for delivering public services that requires "choice and competition").

[77] *See id.* at 42–43 (describing a similar example with schools and hospitals).

[78] *See id.* at 43 ("If providers face adverse consequences from not being chosen—if, for instance, they will lose resources if they cannot attract users—then they will want to improve the quality of the service they provide.").

[79] *See id.* at 45.

[80] *See id.* at 112.

[81] *See id.* at 106.

[82] *See* COLIN CROUCH, MAKING CAPITALISM FIT FOR SOCIETY 26 (2013). This is also largely true of the healthcare market more generally. *See, e.g.*, William M. Sage, *Fracking Health Care: How to Safely De-Medicalize America and Recover Trapped Value for Its People*, 11 N.Y.U. J.L. & LIBERTY 635, 640 (2017) ("Notably, 'free markets' in American medicine have been anything but . . . .").

[83] *See supra* Section I.A.3.

dependent on these companies, electing to extend their contracts and eliminating competition altogether.[84]

The second problem is that the firm-customer relationship does not exist in the correctional healthcare market in the same way that it does in other sectors. The "customer," unlike the restaurant patrons in the hypothetical, is divided into two distinct roles: the payor of services—the government—and the recipients of those services—the inmate-patients.[85] This division results in a market that is not "responsive to the needs and wants of its users," an essential ingredient for a "good public service."[86] The government, motivated by keeping costs low and political pressures to avoid appearing "soft" on crime by providing prisoners with expensive healthcare, has little incentive to listen to inmate-patients who complain of inadequate care.[87] And since lawsuits over inadequate care do not occur very frequently,[88] and governments are often contractually insulated from the lawsuits that do occur,[89] states and municipalities face few legal or financial incentives to switch providers. Thus, as long as the companies promise low costs, the governments tend to be satisfied. The result of these two failures, lack of competition and responsiveness, is "just a series of deals between public officials and corporate representatives," rather than a true market.[90]

This is not to say that private organizations can never provide public services. Indeed, other public sectors have privatized options, such as private courier companies as alternatives to the postal service and private schools as alternatives to public schools. The key to successful privatization of public services, however, is *choice and competition*.[91] For "real" competition, Julian Le Grand has identified several key requirements:

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[84] Crouch, *supra* note 82, at 9.

[85] Colin Crouch defines the two roles as "customer" and "user" of services. *Id.* This too can be said of non-correctional healthcare generally. The division is starker in the correctional context, however, due to insufficient legal protections for inmate-patients compared to the general population. *Compare, e.g.*, Rush Prudential HMO v. Moran, 536 U.S. 355 (2002) (providing an example of how people outside of the correctional context are afforded certain legal protections) *with infra* Section II.C (describing the unique legal barriers faced by incarcerated individuals, including the Prison Litigation Reform Act).

[86] Le Grand, *supra* note 76, at 10.

[87] *See generally* Rachel Elise Barkow, Prisoners of Politics: Breaking the Cycle of Mass Incarceration 8 (2019) (noting that "[e]lected leaders fear being labeled as soft on crime, so they aim to appear as tough as possible, even if there is no empirical grounding for the approaches they endorse").

[88] *See infra* Section II.C.

[89] *See infra* Section I.B.2.

[90] Crouch, *supra* note 82, at 9.

[91] Le Grand, *supra* note 76, at 38–39.

> [T]here have to be alternative providers from which to choose; there have to be easy ways for new providers to enter the market, and, correspondingly, for failing providers to leave or exit from it; and there have to be ways of preventing existing providers [from] engaging in anti-competitive behaviour, such as colluding with one another against the interests of others, or trying to create local (or even national) monopolies.[92]

One solution for the current inadequacies of privately administered correctional care would be more companies competing for contracts, thereby solving the choice deficit. However, more options alone would not fix the current structure of privatized healthcare. As described in the restaurant example, the new options must provide better care for the entire market's output to improve. The division between user and payor would still inhibit responsiveness, so higher quality is not guaranteed. In addition, the inherent structural problems outlined in Part II would also persist, including lack of transparency and accountability and anti-competitive contract provisions.

2. *Contractual Incentives in Private Prison Healthcare*

These market failures force governments to continue contracting with the same few private providers unless they choose an alternate method of providing healthcare. These failures are only exacerbated by contract provisions that insulate state and local governments from legal liability and allow for contract extensions without a new round of public bidding.

First, contractual protection from legal liability via insulation provisions[93] incentivizes governments to renew contracts even when claims of abuse are well-publicized.[94] This cause-and-effect is not a fortunate coincidence that befalls the companies, but rather a deliberate mechanism to keep governments coming back. Todd Murphy, the former director of business development for Correctional Medical Group Companies, has explained that the company "indemnif[ies] the county against risk and reliability, [and does] everything [it] can to

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[92] *Id.* at 106.

[93] *See* Andy Marso, *What Is $2 Billion Buying Kansas and Missouri in Prison Health Care? Few People Know*, KAN. CITY STAR (Jan. 21, 2018, 7:00 AM), https://www.kansascity.com/news/politics-government/article195673934.html (acknowledging that state leaders continually ignore Corizon's "checkered past" because of the promise of legal insulation); Neate, *supra* note 14 (describing how insulation provisions are "the main reason counties are choosing to outsource their jail healthcare"). *But see* Dan Weiss, Comment, *Privatization and Its Discontents: The Troubling Record of Privatized Prison Health Care*, 86 U. COLO. L. REV. 725, 762–63 (2015) (noting that the government cannot be fully insulated from liability).

[94] *See infra* Section II.D.

keep them out of trouble."[95] Indeed, because litigating prisoner medical care and death cases can become so expensive, such indemnification has the potential to save municipalities millions of dollars over time.[96]

These insulation provisions not only benefit the contracting states and municipalities, but also protect the companies by keeping their legal liability hidden from the governments. Since governments are not party to these lawsuits, they are not entitled to partake in settlements that the companies pay out.[97] Michigan's contract with Corizon requires monthly statements of insurance claims, but this protection is essentially useless because Michigan does not consistently audit Corizon's performance.[98] Some departments do not even track the lawsuits against their private providers at all.[99] And since these cases very rarely go to court,[100] governments may lack details about abuse concerns that would otherwise prompt them to demand better service.[101]

The contracts also make it easier for governments to renew deals rather than open them to competitive bidding. Changing contractors is disruptive for both the patients and the government, so governments tend to prefer extending contracts or setting the contracts for long intervals.[102] Contracts often include automatic renewal provisions without laying down standards for renewal. In Kansas, the state's con-

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95 Neate, *supra* note 14.

96 Pew Charitable Trs., Jails: Inadvertent Health Care Providers 9 (2018) (noting the high risk of litigation for local governments that fail to provide adequate care).

97 Justin Horwath, *State Mum on Inmate Health Care Oversight*, Santa Fe New Mexican (Apr. 18, 2016), https://www.santafenewmexican.com/news/local_news/state-mum-on-inmate-health-care-%20oversight/article_f887fe6c-a1e2-59f2-b8b3-81332c7bfb2f.html.

98 *See* Change Notice No. 14 to Contract Between the State of Mich. & Corizon (Apr. 1, 2015) (on file with author) ("Contractor must provide to MDOC monthly statements that provide information regarding paid claims, aging of unpaid claims, and denied claims . . . ."); *Michigan: Corizon Audit Finds Deficiencies, State Extends and Expands Contract Anyway*, Prison Legal News (Jan. 10, 2017), https://www.prisonlegalnews.org/news/2017/jan/10/michigan-corizon-audit-finds-deficiencies-state-extends-and-expands-contract-anyway (noting that Michigan completed fifty percent of its required audits of Corizon's contractual performance).

99 *See* Edward Lyon, *New Mexico Prisoners Suffer and Die Under Privatized Health Care*, Prison Legal News (Nov. 6, 2018), https://www.prisonlegalnews.org/news/2018/nov/6/new-mexico-prisoners-suffer-and-die-under-privatized-health-care (reporting that New Mexico does not track lawsuits against Centurion, which won a contract with New Mexico after it dropped Corizon).

100 See *infra* Section II.C for a discussion of the legal challenges facing prisoners looking to sue healthcare companies.

101 While such information should be available under freedom of information laws, private companies protest the applicability of such laws against them. *See infra* Section III.C.2.

102 *See* Crouch, *supra* note 82, at 9.

tract with Corizon allows for renewal for up to eight years, upon approval of the Procurement Negotiating Committee.[103] The state, indeed, renewed its contract in 2015[104] and 2016.[105] Similarly, in Cumberland County, Maine, in 2007, the county extended its existing contract with Corizon for another ten years.[106] In Alameda County, California, there had been no competitive bidding for the jails' health-care contract in the eight years since Corizon won a three-year deal in 2008.[107] Until 2016, the Board of Supervisors extended the contract every year with no formalized evaluation process,[108] despite the county's Civil Grand Jury's concerns and its recommendations to begin "evidence-based" evaluations before renewing contracts.[109] In other cases, bidding has not even been required for the initial contract.[110]

Investigations have also uncovered private companies' campaign donations to local officials, which further incentivize municipalities to continue their partnerships. In Alameda County, Corizon was the largest campaign donor to Sheriff Gregory Ahern between 2006 and 2013.[111] Correspondingly, Sheriff Ahern personally recommended extending the Corizon contract to the county's Board of Supervisors when the contract expired in 2011.[112] In both 2011 and 2012 the Board granted a one-year extension, and in 2013 it extended the contract

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103 Agreement Between Kan. Dep't of Corr. & Corizon for Comprehensive Health Care Servs. (Oct. 3, 2013) (on file with author).

104 Amendment No. 2 to Agreement Between the Kan. Dep't of Corr. & Corizon Health, Inc. for Comprehensive Health Care Servs. (May 26, 2015) (on file with author).

105 Amendment No. 4 to Agreement Between the Kan. Dep't of Corr. & Corizon, LLC for Comprehensive Health Care Servs. (Oct. 14, 2016) (on file with author).

106 *See Cumberland County Jail Extends Contract with Controversial For-Profit Health Care Provider*, CONWAY DAILY SUN (Nov. 14, 2017), https://www.conwaydailysun.com/portland_phoenix/columns/cumberland-county-jail-extends-contract-with-controversial-for-profit-health/article_865da095-e244-5f0f-b45b-00170a748154.html [hereinafter *Cumberland County Jail*].

107 Simone Aponte, *2 Investigates: Questions Surround Jail Contractor's Donations to Sheriff's Campaign*, KTVU FOX 2 (Sept. 4, 2015), https://www.ktvu.com/news/2-investigates-questions-surround-jail-contractors-donations-to-sheriffs-campaign.

108 *Id.*

109 ALAMEDA CTY. GRAND JURY, 2011-2012 ALAMEDA COUNTY GRAND JURY FINAL REPORT 60–61 (2012). The Civil Grand Jury conducts inspections and audits of divisions of the county's government "to ensure that public agencies are working in the best interests of the public." ALAMEDA COUNTY GRAND JURY, http://grandjury.acgov.org (last visited May 29, 2020).

110 Dara Kam, *Prison Health Contract Under Scrutiny*, BALT. SUN (Feb. 13, 2016, 10:32 AM), https://www.baltimoresun.com/health/os-florida-prison-health-contract-scrutiny-20160213-story.html (describing a Florida protocol by which, if an emergency is declared, the Department of Corrections Services may enter a contract with no bidding process).

111 Aponte, *supra* note 107.

112 *Id.*

until 2016.[113] While targeted campaign donations are not per se illegal, Prison Health Services founder Doyle Moore admitted at a 1993 trial that paying a Florida official to maintain his company's contracts was "basically extortion."[114] Despite publicly recognizing this fact at trial, Prison Health, now Corizon, and other companies have continued this practice in the two decades since.[115]

II
Barriers to Improving Private Correctional Healthcare

Contracting out services in general, and to private entities specifically, began as an exciting development that promised to improve correctional care.[116] As mentioned, the companies would be autonomous and independent of correctional supervisors.[117] Further, privatization was meant to allow for market principles to drive down costs while

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[113] *Id.* The Board did so without implementing any official evaluation protocol, despite the Civil Grand Jury's recommendations. Alameda Cty. Grand Jury, *supra* note 109, at 61 (laying out the Civil Grand Jury's recommendations for obtaining and renewing contracts).

[114] *See* Paul von Zielbauer, *As Health Care in Jails Goes Private, 10 Days Can Be a Death Sentence*, N.Y. Times (Feb. 27, 2005), https://www.nytimes.com/2005/02/27/nyregion/as-health-care-in-jails-goes-private-10-days-can-be-a-death.html. Prison Health was the predecessor to the current Corizon Health, which was formed in 2011 after the merger between Prison Health Services and Correctional Health Services. At that time, Corizon became the nation's largest private correctional healthcare company. *See* David Reutter, *Merger Creates Largest Private Prison Medical Provider in U.S.*, Prison Legal News (Aug. 15, 2011), https://www.prisonlegalnews.org/news/2011/aug/15/merger-creates-largest-private-prison-medical-provider-in-us; Will Tucker, *Profits vs. Prisoners: How the Largest U.S. Prison Health Care Provider Puts Lives in Danger*, S. Poverty L. Ctr. (Oct. 27, 2016), https://www.splcenter.org/20161027/profits-vs-prisoners-how-largest-us-prison-health-care-provider-puts-lives-danger.

[115] A similar phenomenon was uncovered in Maine, where Governor Paul LePage had consistently advocated for the overall privatization of the state's jails and prisons while receiving campaign contributions from Corrections Corporation of America, a private prison company. *See* Dan Neumann, *Four Fired Nurses Raise the Alarm About Maine's For-Profit Prison Contractor*, Beacon (Dec. 13, 2018), https://mainebeacon.com/four-fired-nurses-raise-the-alarm-about-maines-for-profit-prison-contractor (reporting on LePage's advocacy on the behalf of private prison companies, as well as the resulting subpar standards of care); Lance Tapley, *Maine Governor Rakes in Private Prison Money, Shows Appreciation*, Prison Legal News (Apr. 15, 2011), https://www.prisonlegalnews.org/news/2011/apr/15/maine-governor-rakes-in-private-prison-money-shows-appreciation (reporting on Corrections Corporation of America's expenditure of twenty-five thousand dollars toward LePage's campaign).

[116] *See* Galik & Gilroy, *supra* note 15, at 4–10 (exploring several "potential advantages" to contracting out correctional health care to private entities, including cost savings, accountability, and performance improvements).

[117] *See supra* Section I.A (contrasting the amount of autonomy afforded in direct service correctional care, *supra* Section I.A.1, with that afforded to contractor providers, *supra* Section I.A.2)

promoting high-quality care.[118] Despite these purported benefits, the lack of incentives for private correctional healthcare companies to improve has rendered the quality of output disastrously low for decades.[119] This Part will describe barriers to improving correctional healthcare that stem from the positioning of privatized care providers: perverse cost-cutting incentives and a lack of oversight and accountability. Furthermore, because inmate-patients looking to sue private providers face unique legal hurdles, the lack of judicial or public oversight exacerbates these structural problems. Finally, this Part will address the resulting purposeful and incidental denials of care.

A. Pay Structures and Cost-Cutting Incentives

As private, for-profit corporations, correctional medical care companies must prioritize their bottom lines. While all methods of healthcare provision include some calculation of cost efficiency, for-profit companies have a primary duty to shareholders to increase shareholder value.[120] Thus, both the companies and the contracting municipalities seek contract provisions that will keep operating costs low.

There are generally two forms of contracts: cost-plus contracts and managed-care capitation contracts. In the cost-plus model, the state reimburses the company for all actual expenses incurred and pays an additional fee for "arranging and managing care."[121] In the managed-care system, the state pays a flat rate per inmate-patient.[122] While cost-plus systems tend to encourage transparency,[123] Corizon

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118 *See supra* Section I.A.3; *see also supra* Section I.B.1 (illustrating the logic behind these market principles and laying out real-world conditions for their application).

119 *See infra* Section II.D.

120 *See* D. Gordon Smith, *The Shareholder Primacy Norm*, 23 J. CORP. L. 277, 278 (1998) ("Corporate directors have a fiduciary duty to make decisions that are in the best interests of the shareholders."). Recently, the traditional view that monetary objectives *must* be the corporation's main focus has been challenged. *See* Burwell v. Hobby Lobby Stores, Inc., 573 U.S. 682, 711–12 (2014) (communicating the view that "modern corporate law does not require for-profit companies to pursue profits at the expense of everything else"). Although this view recognizes that companies should "advance the interests of all stakeholders," including those of "clients, customers, suppliers, and the general public," the benefits gained from such advancements "often . . . lead[ ] to improved corporate financial performance." Nien-hê Hsieh, *Can For-Profit Corporations Be Good Citizens?: Perspectives from Four Business Leaders*, *in* CORPORATIONS AND CITIZENSHIP 289, 290–91 (Greg Urban ed. 2014).

121 PEW CHARITABLE TRS., *supra* note 26, at 12.

122 *Id.*

123 *Id.* (contrasting the "basket of health care services" under managed-care systems with the spending transparency of cost-plus systems).

and other companies typically employ the managed-care model.[124] In the latter format, the company is incentivized to keep costs low, as every dollar the state pays that does *not* go towards providing care becomes profit. The cost-plus model also carries the risk that companies will use low-quality services to drive up their costs, since they are paid "based on the *quantity* of care they provide, not the outcomes they achieve for patients."[125]

The easiest way to keep costs down is to deny care.[126] Some municipalities have even commended measures that reduce costs despite clear quality implications. For example, in 2012, Maine Department of Corrections Commissioner Joseph Ponte described reducing the number of inmate-patient prescriptions as "progress" in his effort to reduce costs.[127] Ponte also planned to eliminate "certain medical procedures . . . such as knee replacement surger[ies]."[128] A county jail in Maine similarly denied prescriptions—including psychiatric prescriptions—regularly to inmate-patients to save money in 2016.[129] Critics claim that eliminating prescriptions has been a policy of Correctional Medical Services, Corizon's predecessor, since the 1990s.[130] Another cost-cutting method is to avoid sending inmate-patients to emergency rooms, even when they need life-saving emergency treatment.[131] In a Southern Poverty Law Center publication, a Corizon physician described institutional pressures to avoid sending

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124 *Id.* (reporting that the most prevalent model for states that contracted for care in 2015 was the managed-care capitation model). Indeed, Wexford President Daniel Conn has acknowledged that "[n]early all corrections agencies and managed health care plans have stopped using cost-plus contracts because of the risk involved." *See* Kam, *supra* note 110.

125 Jason Furman & Matt Fiedler, *Continuing the Affordable Care Act's Progress on Delivery System Reform Is an Economic Imperative*, White House: President Barack Obama (Mar. 24, 2015, 4:35 PM) (emphasis added), https://obamawhitehouse.archives.gov/blog/2015/03/24/continuing-affordable-care-act-s-progress-delivery-system-reform-economic-imperative (describing a drawback of "fee-for-service" healthcare payment systems, which are functionally identical to the cost-plus model); Pew Charitable Trs., *supra* note 26, at 13 ("Because cost-plus systems pay contractors based on the volume of care provided, and not on the outcomes achieved, they can inadvertently incentivize excessive use of low-value services.").

126 *See* McDonald, *supra* note 36, at 461 ("Common to all managed care strategies are procedures to limit patients' use of services.").

127 Eric Russell, *Report Finds Deficiencies in Health Care Services for Maine Inmates*, Bangor Daily News (Jan. 6, 2012, 4:25 PM), https://bangordailynews.com/2012/01/06/politics/report-finds-deficiencies-in-health-care-services-for-maine-inmates.

128 *Id.*

129 *Cumberland County Jail*, *supra* note 106.

130 *See* Ira P. Robbins, *Managed Health Care in Prisons as Cruel and Unusual Punishment*, 90 J. Crim. L. & Criminology 195, 195 (1999) (reporting the policy and resulting death of inmate-patient Billy Roberts).

131 *See* von Zielbauer, *supra* note 114 (reporting a Corizon nurse's 1994 statement, "We save money because we skip the ambulance . . . ."); Weiss, *supra* note 93, at 751–53 (describing contract provisions that incentivize companies to not seek offsite care).

patients to the hospital.[132] He told the Center, "[t]here was a constant demand to monitor all hospitalizations, to avoid hospitalizations, to request prompt hospital discharges and minimize hospital stays."[133] Rather than shy away from these policies, Corizon embraces them: In 2014, Corizon used "decreased emergency room visits" as a negotiation point in a proposal to the Missouri Department of Corrections.[134]

B. Lack of Oversight and Failure of Accreditation Bodies

Another barrier to improving privatized correctional care is the lack of oversight by the contracting government partner and independent auditing organizations. To ensure that the companies follow the provisions of their contracts, including, for example, maintaining adequate staffing and equipment levels, governments should audit and monitor the companies' performance. However, this Section will show that both independent and government auditing are never, or very infrequently, done. Some states do not even have sufficient mechanisms for monitoring these contracts. Even when audits are conducted, the ability of private companies to conceal information, including settlements for allegations of misconduct, can render the audits ineffective.

This lack of government oversight is compounded by the illusion of monitoring by independent organizations, like the National Commission on Correctional Health Care (NCCHC). Although such organizations promulgate corrections standards and reward those departments and companies that comply with them, this Section will show they actually do little to ensure high quality care. As a result, many companies operate completely unmonitored and unaccountable for their failures.

As investigations have shown, many governments fail to adequately audit companies' compliance with their contracts, and others lack such mechanisms for auditing altogether. Regarding performance, an audit of Corizon in Michigan revealed that the state's Department of Corrections performed only half of the mandated evaluations of Corizon's performance.[135] In Maine, the Legislature's Office of Program Evaluation and Government Accountability (OPEGA) noted that the Department of Corrections lacked "a strong and effective system for monitoring contractor performance" and had

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[132] Tucker, *supra* note 114 (describing the "constant pressure . . . to save money by limiting emergency room visits").

[133] *Id.*

[134] *Id.*

[135] *Michigan: Corizon Audit Finds Deficiencies, State Extends and Expands Contract Anyway*, *supra* note 98.

not "held the contractor sufficiently accountable for resolving issues when the[y] were identified."[136] Similar concerns have been raised in New Mexico,[137] Kansas,[138] and New York City.[139] In other states, governments do not even have an effective system for monitoring. For example, in the midst of Corizon's struggles in Alameda, the Civil Grand Jury of Alameda raised concerns about the county's "systemic problem . . . involving a lack of contract oversight and evaluation."[140] The significance of these failures was uncovered following the death of a county prisoner, Martin Harrison, when investigations finally discovered that Corizon was inappropriately staffing licensed vocational nurses instead of registered nurses in the county jails.[141] In Maine, OPEGA, faced with similar concerns, made recommendations encouraging the state to implement a better contract monitoring system.[142]

Even if the government wanted to audit these companies' provision of care, certain legal protections, unique to privatized healthcare systems, insulate the companies from oversight. As mentioned, companies are often not required to share settlement details with departments of corrections, per indemnification clauses in their contracts.[143] Private companies are also generally not obligated to release information to the public under freedom of information laws.[144] Additionally, since these companies are privately held,[145] there is no need for them to make public settlement disclosures per Security and Exchange Commission regulations.[146] As a result, governments who do audit

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136 Russell, *supra* note 127.

137 *See* H. Memorial 106, 53d Leg., 2d Sess., at 2–3 (N.M. 2018) (requesting the Secretary of Corrections consider a return to a direct services model due to a wide array of concerns, including "a terrible lack of oversight").

138 *See* Marso, *supra* note 93 (describing the lack of transparency about Corizon's performance in Kansas despite the presence of a Kansas Department of Corrections oversight team).

139 N.Y.C. Dep't of Investigation, DOI Report Finds Significant Breakdowns by Corizon Health Inc.: Failures in Employee Screening and Mental Health Treatment of Inmates in City Jails (2015) (finding a lack of proper oversight by N.Y.C. government entities, including the failure to conduct background checks and to adequately screen the hiring of Corizon staff).

140 Alameda Cty. Grand Jury, *supra* note 109, at 57.

141 For a further discussion of the improper staffing issue, see *infra* text accompanying notes 199–203.

142 Russell, *supra* note 127.

143 *See supra* notes 97–99 and accompanying text.

144 For a fuller discussion of freedom of information laws, see *infra* Section III.C.2.

145 *See, e.g.*, Wexford Health Sources, Inc., Proposal for: Inmate Medical Services for Oakland County, Michigan 184, 193 (2009) (characterizing Wexford Health Sources, Inc. as a privately held corporation).

146 *See* Securities Exchange Act of 1934 § 13(a), 15 U.S.C. § 78m(a) (2018) (requiring publicly traded companies to make disclosures of significant events and financial

company performance may be blocked from discovering important information.

Some municipalities claim that the existence of independent accrediting organizations means that governments need not perform their own audits.[147] However, independent accreditors also fail to provide the necessary oversight. Organizations such as the NCCHC, the American Correctional Association, and the American Jail Association evaluate healthcare companies against certain criteria that the organization creates. For example, the NCCHC sets standards for "health care services and support, patient care and treatment, special needs and services, governance and administration, personnel and training, safety, health records, health promotion and medical-legal issues."[148] While companies like Corizon tout their accreditation as a symbol of quality,[149] these accrediting organizations do little to promote standards of care. First, the organizations do not actually audit *performance*, but rather determine whether the companies' *policies* meet the organizations' self-proclaimed standards.[150] This explains how Corizon and others can maintain their accreditation despite short staffing levels, high-profile lawsuits, and other misconduct. Additionally, the standards define the bare minimum required to comply with

information). Securities and Exchange Commission (SEC) Rule 10b-5 provides a private remedy in the case that a corporation misstates or omits a "material fact." 17 C.F.R. § 240.10b-5(b) (2019). However, in practice, plaintiffs usually do not have much luck with private companies, since the truth-on-the-market presumption—which satisfies the "in connection with" requirement of SEC Rule 10b-5—requires a robust secondary trading market. Basic Inc. v. Levinson, 485 U.S. 224 (1988).

147 *See Cumberland County Jail*, *supra* note 106 ("[T]he [Cumberland County Board of Visitors] does not oversee health care at the jail. Instead, oversight is conducted by accreditors like the National Commission on Correctional Health Care, and through an outside consultant.").

148 *Jails and Prisons*, NAT'L COMMISSION ON CORRECTIONAL HEALTH CARE, https://www.ncchc.org/jail-prison-standards (last visited May 24, 2020).

149 For example, Corizon notes on its website that the company "has a 100% success rate in obtaining and maintaining accreditation in every facility of [theirs] in which accreditation is required." *About Corizon Health: Accreditations and Industry Partners*, CORIZON HEALTH, https://www.corizonhealth.com/about-corizon/accreditations-and-industry-partners (last visited May 24, 2020).

150 Alex Friedmann, *How the Courts View ACA Accreditation*, PRISON LEGAL NEWS (Oct. 10, 2014), https://www.prisonlegalnews.org/news/2014/oct/10/how-courts-view-aca-accreditation (noting that "the accreditation process is basically a paper review," where no "oversight or ongoing monitoring" is provided); Phaedra Haywood & Justin Horwath, *As Inmate Lawsuits and Other Warnings Poured In, State Officials Allowed Corizon Health to Deliver Care with Minimal Oversight*, SANTA FE NEW MEXICAN (Apr. 17, 2016), https://www.santafenewmexican.com/news/local_news/as-inmate-lawsuits-and-other-warnings-poured-in-state-officials/article_67255d2a-0428-11e6-b39c-135026d92a71.html.

constitutional requirements.[151] Finally, while accreditation is based on a variety of sources, such as review of policies and procedures, interviews with staff, and hearings,[152] the accreditation reports are unavailable to the public.[153] Thus, while these accreditation organizations aim to "champion[ ] the cause of corrections and correctional effectiveness,"[154] the practical effect of such accreditations seems dubious at best. In fact, these accrediting agencies may actually be harmful to quality assurance, as they create the appearance of accountability and monitoring without guaranteeing quality care.

C. Legal Hurdles to Challenging Correctional Healthcare

The absence of any true threat of legal action exacerbates this environment of unaccountability. Whenever an inmate-patient wishes to sue a medical provider, whether a government entity or a private company, the prospective plaintiff must first overcome judicially and legislatively imposed obstacles. This Section will walk through these hurdles: First, plaintiffs looking to sue under the Eighth Amendment must show that the care they received rises to the level of deliberate indifference.[155] To bring that Eighth Amendment claim, prisoners sue under 42 U.S.C. § 1983, the statute for filing a cause of action against state actors, and must show that the care they received was part of either the municipality's or the company's policies of administering care; otherwise, the *Monell* doctrine bars vicarious liability.[156] Finally, even if the prisoner can satisfy the requirements of the Eighth Amendment and § 1983, the Prison Litigation Reform Act may still bar relief.[157] Particularly since most incarcerated plaintiffs proceed pro se,[158] mounting a successful legal challenge is exceptionally difficult.

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[151] *See* Josiah D. Rich, Scott A. Allen & Brie A. Williams, *The Need for Higher Standards in Correctional Healthcare to Improve Public Health*, 30 J. Gen. Internal Med. 503, 503 (2014).

[152] Friedmann, *supra* note 150.

[153] *Cumberland County Jail*, *supra* note 106 ("While the jail is fully accredited, there are no publicly available independent reports on health care conditions at the facility.").

[154] *Legacy of Care: The History of the American Correctional Association*, Am. Correctional Ass'n, https://www.aca.org/ACA_Prod_IMIS/ACA_Member/About_Us/Our_History/ACA_Member/AboutUs/AboutUs_Home.aspx (last visited May 24, 2020).

[155] *See infra* Section II.C.1.

[156] *See infra* Section II.C.2.

[157] *See infra* Section II.C.3.

[158] Margo Schlanger, *Trends in Prisoner Litigation, as the PLRA Enters Adulthood*, 5 U.C. Irvine L. Rev. 153, 167 (2015) (showing that prisoners have proceeded pro se in civil rights litigation in district courts in around 95% of cases in 2000, 2006, and 2012, and 83% of cases in 1996); *see also U.S. Courts of Appeals - Judicial Business 2017*, U.S. Cts., https://www.uscourts.gov/statistics-reports/us-courts-appeals-judicial-business-2017 (last visited May 24, 2020) (reporting in 2017 that "[e]ighty-three percent of the 14,317 prisoner

Yet, even when a plaintiff has a viable claim, the procedural hurdles and high costs of litigation incentivize litigants to settle instead of enduring trial. For example, Martin Harrison's family sued Corizon after Mr. Harrison died in a California jail.[159] The trial court denied Corizon's motion for summary judgment on Mr. Harrison's deliberate indifference claim.[160] However, instead of enduring trial, the family accepted an $8.3 million settlement with Corizon and the county, the largest wrongful death settlement in California history.[161] Settlement means companies face few repercussions, and the details of those cases that do resolve in payout may remain hidden from the public.[162]

1. *Eighth Amendment and Deliberate Indifference*

For a prisoner to bring a lawsuit against a medical provider, they must first demonstrate that the healthcare they received was constitutionally deficient under the Eighth Amendment's prohibition against cruel and unusual punishment. Courts evaluate the constitutional adequacy of medical care under the framework set forth in *Estelle v. Gamble*.[163] In 1974, prisoner J.W. Gamble sued the Director of the Texas Department of Corrections, the prison warden, and the medical director of the Department and chief medical officer of the prison hospital under 42 U.S.C. § 1983.[164] Gamble alleged that the defendants violated his Eighth Amendment right against cruel and unusual punishment by denying him adequate medical care after he was injured during prison work.[165] Gamble had seen multiple doctors over the course of three months and received a variety of medication.[166] In evaluating Gamble's claim, the Supreme Court recognized that the

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petitions received [by federal appellate courts] were filed pro se, as were 85 percent of the 5,486 original proceedings and miscellaneous applications"). The data also show that pro se cases occur "at a much higher rate than prior to the PLRA, which drastically limited attorneys' fees." Schlanger, *supra*, at 166.

159 M.H. v. Cty. of Alameda, 62 F. Supp. 3d 1049 (N.D. Cal. 2014). Martin Harrison was an alcoholic, but the Corizon nurse who screened him did not initiate any treatment for alcohol withdrawal. *Id.* at 1057, 1059. Mr. Harrison developed severe withdrawal known as delirium tremens, but no medical or mental health providers came to treat him. *Id.* at 1060–64. As a result of withdrawal, Mr. Harrison began acting erratically and got into an altercation with numerous guards, who beat and tased him until he was unresponsive. *Id.* at 1065–70. Mr. Harrison died five days after he had been arrested. *Id.* at 1056, 1070.

160 *Id.* at 1076–80, 1100.

161 *See* Dan Levine, *Prison Health Provider Agrees to Changes in California*, REUTERS (Feb. 10, 2015, 2:25 PM), https://www.reuters.com/article/us-usa-prison-settlement/prison-health-provider-agrees-to-changes-in-california-idUSKBN0LE2KT20150210.

162 *See supra* Section II.B.

163 429 U.S. 97 (1976).

164 *Id.* at 98.

165 *Id.* at 101.

166 *Id.* at 107.

Eighth Amendment "proscribes more than physically barbarous punishments," and can include denying medical care that results in "unnecessary suffering."[167] The Court held that "deliberate indifference to a prisoner's serious illness or injury states a cause of action under § 1983."[168] However, the Court also found that Gamble failed to show such deliberate indifference from the prison doctor and Department medical director.[169] The Court characterized Gamble's claims as disagreements over medical strategy, not cruel and unusual punishment.[170]

A plaintiff who wants to sue under *Gamble* must demonstrate certain facts to satisfy the deliberate indifference standard. First, the action taken or not taken must be *deliberate*; a doctor's mere negligence "in diagnosing or treating a medical condition" is not enough to violate the Eighth Amendment.[171] In *Farmer v. Brennan*,[172] the Court rejected an objective test for deliberate indifference and instead adopted a subjective one: whether the prison official or medical provider "knows of and disregards an excessive risk to inmate health or safety."[173] The official must actually "draw the inference" that "a substantial risk of serious harm exists" from facts known to the official.[174] Furthermore, if the official reasonably attempts to solve the problem, they do not violate the Eighth Amendment regardless of the actual outcome.[175] Finally, the plaintiff must show that the medical problem they face is an objectively "serious" one.[176]

2. 42 U.S.C. § 1983

Prisoners who want to allege violations of the Eighth Amendment for inadequate medical care typically bring a 42 U.S.C. § 1983 claim for actions by state officers and private medical per-

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[167] *Id.* at 102–03.

[168] *Id.* at 104.

[169] The Court dismissed the claims against the doctor/Department medical director but remanded the case to the Court of Appeals to evaluate the claims against the other defendants. *Id.* at 108.

[170] *Id.*

[171] *Id.* at 106.

[172] 511 U.S. 825 (1994).

[173] *Id.* at 837.

[174] *Id.*

[175] *Id.* at 844.

[176] *Compare, e.g.*, Rhinehart v. Scutt, 894 F.3d 721, 737 (6th Cir. 2018) (noting that a "serious medical condition" qualifies as a serious medical need), *with* Peralta v. Dillard, 744 F.3d 1076, 1086 (9th Cir. 2014) (holding that routine tooth cleaning is not a serious medical need).

sonnel.[177] Section 1983 allows plaintiffs who believe their federal rights have been violated to sue a state official who was acting "under color of any statute, ordinance, regulation, custom, or usage, of any State" when the alleged violation occurred.[178] In *West v. Atkins*, the Supreme Court extended § 1983's application and held that *private* doctors providing medical services in state prisons act under the color of state law and can be sued under § 1983.[179]

However, under the *Monell* doctrine, to prove § 1983 liability against a municipality or local corrections department, inmate-patients must not only show that the officer was acting under the color of state law, but also that the officer was acting pursuant to an official policy or custom.[180] The *Monell* doctrine also poses this same legal hurdle for plaintiffs looking to sue private medical corporations working in correctional facilities: Correctional health care companies cannot be held liable for the unconstitutional actions of their employees unless the violations occur as part of the company's official policy.[181] Allegations that employees are acting in accordance with an official policy or custom are difficult to prove and cannot be conclusory.[182] For example, an allegation that medical providers are purposefully denying care to save money is insufficient to satisfy *Monell* without evidence of such policies' existence.[183]

While both private healthcare companies and municipal agencies are subject to the *Monell* doctrine, suing a government administration has one major advantage: transparency. As will be explained *infra*, private companies are not obligated to release information under freedom of information laws.[184] Therefore, the only avenue for a plaintiff suing private correctional health providers is to request discovery, which is even more difficult for pro se prisoners. As a result, an inmate-patient who wants to uncover evidence of a policy or practice faces the nearly insurmountable challenge of going up against an opaque private company.

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[177] Inmate-patients in federal facilities can bring a *Bivens* action against federal officers. *See* Bivens v. Six Unknown Named Agents, 403 U.S. 388 (1971).

[178] 42 U.S.C. § 1983 (2018).

[179] West v. Atkins, 487 U.S. 42 (1988).

[180] Monell v. Dep't of Soc. Servs., 436 U.S. 658 (1978); *see also* Robbins, *supra* note 130, at 209.

[181] *See Monell*, 436 U.S. at 694 (describing the general *Monell* doctrine for local governments); Sims v. Wexford Health Sources, No. 14-108, 2015 WL 4041771, at *5 (W.D. Pa. July 1, 2015) (noting that the *Monell* doctrine has been "extended to private corporations that are under contract with the state").

[182] *Sims*, 2015 WL 4041771, at *10.

[183] *Id.* (citing similar cases); *see also supra* Section II.A.

[184] *See infra* Section III.C.2.

3. Prison Litigation Reform Act

In 1996, Congress enacted the Prison Litigation Reform Act (PLRA), a law meant to curtail the number of frivolous lawsuits brought by prisoners in federal courts.[185] Codified at 42 U.S.C. § 1997e, the PLRA imposed an exhaustion requirement on prisoners seeking relief: If prisoners do not first exhaust all administrative remedies provided by the facility, their claims will be dismissed.[186] Additionally, the PLRA amended the *in forma pauperis*[187] proceedings provision, 28 U.S.C. § 1915, to create a "three strikes" rule for prospective litigants.[188] Prisoners are barred from bringing civil claims related to their incarceration if they have "on 3 or more prior occasions, while incarcerated or detained in any facility, brought an action or appeal in a court of the United States that was dismissed on the grounds that it is frivolous, malicious, or fails to state a claim upon which relief may be granted . . . ."[189] The only exception is if the prisoner is under "imminent danger of serious physical injury."[190]

Although the number of allegedly frivolous claims by prisoners has decreased since the PLRA's passage, data suggests that *all* claims have been stifled. In 2009, Human Rights Watch reported that the number of lawsuits brought by prisoners per thousand prisoners has decreased by sixty percent since the statute's passing.[191] This decrease was accompanied by a steady increase in the prison population, which suggests that "rather than filtering out meritless lawsuits, the PLRA has simply tilted the playing field against prisoners across the board."[192] And although inmates could still bring their federal constitutional claims in state courts,[193] many states have passed their own

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[185] David Fathi, Human Rights Watch, No Equal Justice: The Prison Litigation Reform Act in the United States (2009) [hereinafter No Equal Justice], https://www.hrw.org/report/2009/06/16/no-equal-justice/prison-litigation-reform-act-united-states.

[186] 42 U.S.C. § 1997e(a) (2018).

[187] *In forma pauperis* is Latin for "in the manner of a pauper." *In Forma Pauperis*, Black's Law Dictionary (11th ed. 2019) (defining the term to mean "[i]n the manner of an indigent who is permitted to disregard filing fees and court costs").

[188] 28 U.S.C.A. § 1915 (West 1996).

[189] *Id.*

[190] *Id.*

[191] No Equal Justice, *supra* note 185, at 3; *see also* Sasha Volokh, *Suing Public and Private Prisons: The Role of the Prison Litigation Reform Act*, Wash. Post (Feb. 20, 2014, 9:27 AM), https://www.washingtonpost.com/news/volokh-conspiracy/wp/2014/02/20/suing-public-and-private-prisons-the-role-of-the-prison-litigation-reform-act (describing the role of state PLRAs in litigation).

[192] No Equal Justice, *supra* note 185, at 35.

[193] *See* Tafflin v. Levitt, 493 U.S. 455 (1990) (holding that state courts have concurrent jurisdiction with federal courts to hear federal claims, unless Congress says otherwise).

PLRAs similar to the federal version.[194] Both the state and federal statutes add another "burden[ ] and restriction[ ] that apply to no other persons" seeking relief for alleged wrongdoing.[195] Finally, the PLRA applies equally to public and private forms of healthcare administration.[196] While the statute gives no definition outlining who may *be sued* under the PLRA, it is "well established" judicial practice "that the PLRA applies to prison contractors," including private healthcare companies.[197]

D. Results: Negligence and Abuse

Because of this legal insulation, limited oversight, and little competition in the market, private correctional health companies can cut corners to cut costs. The problems outlined in this Section, however, are not limited to private correctional healthcare companies. Understaffing in particular has consistently been an issue in both public and private correctional healthcare.[198] However, due to the lack of monitoring and other structural problems highlighted in this Part, this Section argues that the foregoing problems are particularly problematic in the privatized space. As Part III will argue, these problems are mitigated by structural protections inherent to the publicly-run healthcare model.

1. Unqualified Staff

To cut costs, companies may hire poorly trained and unqualified staff instead of fully trained, and more expensive, medical professionals. For example, investigations following the death of Martin Harrison in a California jail uncovered that Corizon had been staffing licensed vocational nurses (LVN) instead of registered nurses (RN) in its jails.[199] LVNs perform tasks like "transcribing orders, administering medications, [and] health screening."[200] RNs, however, supervise LVNs and "provide direct care to patients."[201] In the lawsuit filed against Corizon and Alameda County by Mr. Harrison's family, the plaintiffs alleged that Mr. Harrison's death would not have occurred

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194 No Equal Justice, *supra* note 185, at 9.

195 *Id.* at 1.

196 *See* Volokh, *supra* note 191 (explaining that the PLRA does not apply differently to public and private prisons).

197 Chandler v. C.C.S. Med. Servs., No. 2:16-cv-22-cr-jmc, 2016 WL 8453025, at *2 (D. Vt. July 11, 2016).

198 *See supra* Section I.A.1; *infra* Section III.B.

199 Levine, *supra* note 161.

200 Madeleine LaMarre, *Nursing Role and Practice in Correctional Facilities*, *in* Clinical Practice in Correctional Medicine, *supra* note 35, at 417, 419.

201 *Id.*

had Corizon appropriately staffed RNs.[202] Following an eight million dollar settlement, an expert physician reviewed the jail's healthcare system and found that, in addition to staffing LVNs instead of RNs, Corizon was permitting nurses to perform jobs that they should not have been performing.[203] Corizon subsequently committed to switching over to RNs in its facilities.[204] A similar contractual requirement to staff RNs over LVNs was included in a 2016 amendment to Corizon's contract with Kansas.[205]

The same findings were made in upstate New York facilities, where Prison Health Services operated for decades.[206] A year-long investigation into PHS's operation in New York found "doctors underqualified . . . [and] nurses doing tasks beyond their training."[207] Nurses were making medical decisions meant for doctors, such as "pronouncing patients dead."[208] The investigation also discovered that one influential doctor, who held positions in multiple New York jails, was not legally licensed to practice in New York. Instead, the doctor had been making his medical orders and recommendations by phone from out of state.[209]

While hiring licensed medical professionals would appear to be a base-level constitutional requirement, companies seem to skimp on this frequently. In 1999, the NCCHC took the position that hiring medical professionals with limited or revoked licenses was anathema

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202 Alex Emslie, *Alameda County, Jail Health Care Company Settle Suit over Inmate Beating Death*, KQED (Feb. 10, 2015), https://www.kqed.org/news/10429458/alameda-county-jail-health-care-company-settle-suit-over-inmate-beating-death; *see also* Levine, *supra* note 161.

203 Letter from Calvin B. Benton, M.D., Quality Assurance Officer, ACSO, to Dr. Orr (June 22, 2013), https://media.ktvu.com/media.ktvu.com/document_dev/2015/09/01/Merged%20Extracted%20highlights_Benton%20redacted_144369_ver1.0.pdf ("If the inmate is scheduled for sick call he may not be seen by the physician. . . . The nurse frequently does not have the ability or knowledge to evaluate the inmate disease process. . . . From my experience we have a majority of inexperienced nursing staff.").

204 Levine, *supra* note 161.

205 *See* Amendment No. 4 to Agreement Between the Kan. Dep't of Corr. & Corizon, *supra* note 105, ¶ 9 (transitioning from 4.00 FTE LPNs to 4.00 FTE RNs).

206 Corizon still operates in one upstate New York facility: Coxsackie. *See Corizon Health Selected to Continue Services at the Coxsackie Regional Medical Unit*, CORIZON HEALTH (Mar. 9, 2017), http://www.corizonhealth.com/index.php/S=0/Corizon-News/corizon-health-selected-to-continue-services-at-the-coxsackie-regional-medi ("The New York State Department of Corrections and Community Supervision (DOCCS) awarded its recent RFP for operating a skilled nursing facility within the Coxsackie Regional Medical Unit to Corizon Health, continuing [a] 19-year partnership.").

207 von Zielbauer, *supra* note 114.

208 *Id.*; *see also* LaMarre, *supra* note 200, at 422 (warning that although "physician presence may be minimal or absent in some correctional facilities . . . [i]t is important that correctional nurses remain within their scope of practice, as determined by their respective state law and Board of Nursing regulations").

209 von Zielbauer, *supra* note 114.

to the practice of correctional medicine and the practice of medicine overall.[210] The Commission's Position Statement on the subject warned that correctional healthcare departments should only hire fully licensed physicians, who "may freely work in a community setting as well as in a jail, prison, or juvenile confinement facility."[211] The Commission also warned against the practice of state licensing boards granting restricted licenses, which allow practitioners to work in prisons and jails, but not in the outside community.[212] Despite these warnings, physicians continue working in prisons with license restrictions and histories checkered with allegations of abuse and criminal convictions.[213]

2. *Understaffing*

Despite many correctional health contracts including minimum staffing levels requirements and high penalties for understaffing,[214] complaints of understaffing facilities have been rampant. In both 2016 and 2017, Corizon faced massive penalties from Kansas for understaffing its prisons.[215] Staffing did not improve in 2018 despite the fines, and Kansas fined the company another $2.82 million.[216] Between 2007 and 2011, Corizon faced $1 million in penalties for understaffing facilities in New Mexico, which included $230,000 for doctor shortages

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[210] Nat'l Comm'n on Corr. Health Care & Soc'y of Corr. Physicians, Joint Position Statement, *Licensed Health Care Providers in Correctional Institutions*, 7 J. CORRECTIONAL HEALTH CARE 157, 159 (2000).

[211] *Id.*

[212] *Id.* at 160.

[213] Robert L. Cohen, *Health and Public Health Advocacy for Prisoners*, *in* CLINICAL PRACTICE IN CORRECTIONAL MEDICINE, *supra* note 35, at 28, 32; *see also* Caroline Lewis, *Restructuring Health Care Delivery at New York City Jails*, CRAIN'S N.Y. BUS. (May 26, 2016, 12:00 AM), https://www.crainsnewyork.com/article/20160526/HEALTH_CARE/160529894/restructuring-health-care-delivery-at-rikers-island-new-york-city-jails (reporting that after Rikers dropped Corizon, New York City's HHC let go about fifteen percent of the correctional health staff after background checks and interviews, and "didn't keep anyone who presented a potential risk to patient safety").

[214] *See, e.g.*, Amendment No. 2 to Agreement Between the Kan. Dep't of Corr. & Corizon Heath, *supra* note 104 (outlining staffing requirements for each facility); Health Services Agreement Between Cty. Comm'rs for Cumberland Cty. & Corr. Med. Servs., Inc. (Jan. 1, 2007) (on file with author) ("The number of full time equivalents as used for staffing of positions as more specifically set forth in [the appendix] and assigned to each post are necessary requirements of this Agreement.").

[215] Jonathan Shorman, *Kansas Prison Contractor's Negligence Forced Removal of Woman's Colon, Suit Alleges*, WICHITA EAGLE (May 25, 2018, 5:39 PM), https://www.kansas.com/news/politics-government/article211762544.html (noting that Corizon owed Kansas over $3.4 million in penalties, mostly related to falling below minimum staffing levels).

[216] *See Kansas Reduces Payments to Prison Health Care Company*, ASSOCIATED PRESS (Feb. 27, 2019), https://apnews.com/98c0a37931c24fad89f31ed9d1d9cc47.

alone.[217] After New Mexico switched to Centurion, it fined that company $2.1 million for staffing shortages between 2016 and 2018.[218] Similar complaints of understaffing against Corizon have occurred in Georgia, Alabama, and Maine.[219]

The implications of understaffing, particularly alongside a mushrooming correctional population, are severe. Following Martin Harrison's death in Alameda and the county's pledge to shift from LVNs to RNs, Corizon operated the county at only sixty percent of required nurses.[220] As a result, the nurses were working back-to-back shifts and others refused to come to work entirely.[221] In another case, Brian Tetrault, an inmate with Parkinson's disease, never saw the single Corizon doctor who staffed an upstate New York facility before dying ten days later because medical staff cut off his medications.[222] In Baltimore jails, PHS could only provide psychiatrists for sixty-four percent of the required hours each week in 2004.[223] And considering the wealth of inmate-patients with mental health issues, subpar staffing of mental health professionals can be the difference between a stable patient and a patient experiencing a psychotic breakdown.

3. *Staff Misconduct*

Records, investigations, and lawsuits have also uncovered claims of staff misconduct that jeopardizes patients' lives. Pressured by institutional policies to deny care, providers may report patients as malingerers rather than treat them. Lawsuits in Missouri and Kansas against Corizon alleged that "Corizon employees classified medical conditions as 'cosmetic' in order to avoid providing care," even using that term to describe a patient's shoulder tumor.[224] In New York, Brian Tetrault was deemed a "faker" and "manipulative" as his struggle with Parkinson's disease worsened.[225] The Corizon doctor had never given him a physical examination and he died after only eleven days in

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[217] Haywood & Horwath, *supra* note 150.

[218] Lyon, *supra* note 99.

[219] von Zielbauer, *supra* note 114.

[220] *See* Jenna Lyons, *Alameda County Jail Nurse Says Layoffs Have Led to 'a Mad House,'* SFGATE (Jan. 8, 2016, 5:54 AM), https://www.sfgate.com/crime/article/Alameda-County-jail-health-care-provider-lays-off-6742234.php.

[221] *See id.*

[222] von Zielbauer, *supra* note 114.

[223] Gus G. Sentementes & Greg Garland, *Ailing System Struggles with Inmate Care*, BALT. SUN (June 10, 2005, 3:00 AM), https://www.baltimoresun.com/maryland/bal-te.md.prisons10jun10-story.html (noting that PHS only staffed psychiatrists for 100 of the 156 required hours every week).

[224] Marso, *supra* note 93.

[225] von Zielbauer, *supra* note 114.

jail.[226] According to a *New York Times* article about the scandal, "sheriff's officials altered records to change the time of his release from custody," in order to make it appear as though he had not died while in custody.[227] An investigation into PHS's operations in Baltimore discovered that staff members were also altering records to "falsely indicate that they had conducted required checks on suicidal inmates every 15 minutes."[228] The family of Tricia Cooper, who hanged herself in her cell after two weeks in jail, raised a similar allegation in their lawsuit against Correct Care Solutions. In addition to allegations that the company failed to provide Ms. Cooper with adequate mental health treatment, the family alleged that certain reports were not completed until after Ms. Cooper had already killed herself.[229] Prisoners in New Mexico alleged sexual assault by a Corizon doctor who worked in multiple facilities.[230] After New Mexico transitioned to Centurion, issues persisted: Inmate-patient George Parra reported "hateful" employees who denied care for his muscular dystrophy.[231] Finally, as described in Section II.A, emergency room avoidance and denial of prescriptions are regularly practiced as cost-cutting initiatives. The sum of these behaviors, and lack of legal or political incentive to implement changes, leads to dangerous, ineffective healthcare that is shielded from constitutional challenge.

III
Examining Public-Run Care

As has been explored in Part II, the dangers of private prison healthcare administration have been demonstrated for decades. Inmate-patients have suffered as a result of companies' malpractice and government apathy. While some states and municipalities continue to partner with private companies, others have turned to contracting with existing public-health and public-focused alternatives. This Part will examine the benefits and risks of public alternatives. Section A will present three models of publicly-administered healthcare. Section B will discuss critiques, both theoretical and actual, of switching to a public-run system. Finally, Section C will describe the benefits of a public system and the reasons such systems can provide superior care: promotion of continuity of care, treatment

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[226] *Id.*
[227] *Id.*
[228] Sentementes & Garland, *supra* note 223.
[229] Cooper *ex rel.* Estate of Cooper v. Correct Care Sols., No. 18-4358, 2019 WL 1227713, at *2 (E.D. Pa. Mar. 15, 2019).
[230] Lyon, *supra* note 99.
[231] *Id.*

of correctional health as a public health issue, and increased accountability and transparency.

A. Three Models of Public-Run Care

This Section examines three types of public health structures: nonprofit organizations, university programs, and government health agencies. A note on terminology: This Note characterizes private, nonprofit organizations as a "public" model even though they are private organizations. Similarly, this Note discusses Rutgers University, a public university, as an example of a university partnership, but the arguments and analysis apply equally to private university-run programs. This Note uses "public" not only to signify that actors working in the system are typical "public" government employees, as in the health agency context, but also to characterize these models as public-service- and community-oriented rather than profit-driven.

1. Community Health Nonprofits

One alternative to partnering with a private company is contracting with an existing nonprofit that already provides inmate-patients with care prior to incarceration. These nonprofits, alternatively called "social enterprises," balance making money with their "socially motivated goals and intentions."[232] One example of this system is Connections Community Support Programs ("Connections"), who ran Delaware's correctional healthcare until 2020.[233] Connections' mission is to "collaborat[e] with government, community, corporate, and other philanthropic partners to maximize services for [Delaware's] most vulnerable citizens."[234] In addition to community health services, the organization provides drug treatment services, family therapy, mental health services, and housing services, among others.[235] Connections took over Delaware's entire correctional population in 2014 and continued operating in Delaware until April 2020.[236] Additionally, Unity Health Care in Washington, D.C. is a nonprofit community health organization that has provided health-

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[232] Marge Berer, *Who Has Responsibility for Health in a Privatised Health System?*, 18 Reprod. Health Matters 4, 8 (2010).

[233] Esteban Parra & Brittany Horn, *Connections Community Support Programs to Exit Delaware Prisons amid Controversies*, Del. News J. (Mar. 2, 2020, 9:41 AM), https://www.delawareonline.com/story/news/crime/2020/03/02/connections-leaving-delaware-prison-health-care/4927423002; *see also* Connections Community Support Programs, https://www.connectionscsp.org/about-us (last visited Sept. 14, 2020).

[234] Connections Community Support Programs, *supra* note 233.

[235] *Id.*

[236] Parra & Horn, *supra* note 233 (describing the termination of Connections' contract).

care for D.C.'s jails since 2006.[237] Unity also provides health services to people around D.C. "through a network of over 20 traditional and non-traditional health sites,"[238] and runs specialized programs for teens and young adults, the homeless, and deaf adults and children, among others.[239]

2. University Partnerships

Partnerships with university medical schools are another way to provide prison healthcare. This model can take a variety of forms. First, a university can directly oversee and staff corrections departments. For example, Rutgers University's University Correctional Health Care division staffs correctional facilities across New Jersey.[240] The University's commitment to providing top quality prisoner care has resulted in significantly reduced medical complaints since the University began providing health services in 2005.[241] The University also reports improved health outcomes for inmate-patients on a variety of metrics.[242]

Universities can also create rotational programs for medical students in correctional facilities. This practice has been implemented in multiple states for decades. A university in Florida implemented a prison rotation for upcoming osteopaths in 1998.[243] The students took an "extremely active yet closely supervised role in patient care" and

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237 Andrea Noble, *D.C. Jail Medical Contract Sparks City Council Criticism*, WASH. TIMES (Mar. 18, 2015), https://www.washingtontimes.com/news/2015/mar/18/dc-jail-medical-contract-sparks-city-council-criti.

238 *About Unity Health Care*, UNITY HEALTH CARE, https://www.unityhealthcare.org/about (last visited June 6, 2020).

239 *Services*, UNITY HEALTH CARE, https://www.unityhealthcare.org/services (last visited June 6, 2020).

240 Mary Ann Littell, *Health Care Behind Bars*, RUTGERS MAG., Winter 2016, at 66. Other states have developed similar programs. The University of Texas Medical Branch and Texas Tech University Health Sciences Center have been providing eighty percent of the medical, dental, nursing, and mental health services to Texas's inmate-patients since 1994. Alexandra Becker, *Health Care Behind Bars*, TMC NEWS (Apr. 5, 2017), https://www.tmc.edu/news/2017/04/health-care-behind-bars. Additionally, the Southern Illinois School of Medicine will provide healthcare services to two of the state's prisons starting summer 2020. John O'Connor, *SIU Medical School to Pilot State Prison Health Care*, ST. J.-REG. (Feb. 17, 2020, 8:07 PM), https://www.sj-r.com/news/20200217/siu-medical-school-to-pilot-state-prison-health-care.

241 *University Correctional Health Care: Accomplishments*, RUTGERS U. BEHAV. HEALTHCARE, https://ubhc.rutgers.edu/uchc/accomplishments.html (last visited June 6, 2020).

242 For example, the program's website reports "[r]educed inpatient psychiatric commitments by 90%" between 2004 and 2018, and "[r]educed mental health complaints by 94%, medical complaints by 67% and dental complaints by 74% from 2004 to 2014." *Id.*

243 *See* Thomas et al., *supra* note 30.

the rotation became "the most desirable elective in the system."[244] Rutgers medical and nursing students can also do a rotation in New Jersey prisons.[245] In either method—direct staffing or student rotations—university partnerships present a promising option as "the interest of an academic institution is . . . more aligned with the interests of their patients" than that of a for-profit company.[246] The rotation's popularity also means that the programs will be fully staffed and will hopefully inspire future doctors to pursue correctional healthcare careers.

To further incentivize medical students to pursue such careers, state and local governments could follow the federal government's lead and institute loan repayment programs for working in prisons. The federal government currently offers such an incentive for doctors, pharmacists, and nurses who work for the Bureau of Prisons.[247] Some states have begun contributing to loan repayment in other sectors, such as nursing[248] and teaching.[249] To combat medical students' reluctance to work in prisons,[250] the government could take such affirmative steps to normalize the occupation and incentivize new, qualified doctors to pursue prison work.

3. Government Health Agencies

Finally, some governments are partnering with their public health agencies to administer correctional healthcare. Following New York City's split with Corizon in 2015, New York City Health and Hospitals Corporation (HHC), which runs the city's public hospitals, began pro-

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[244] *Id.* at 561.

[245] Littell, *supra* note 240, at 96.

[246] Haywood & Horwath, *supra* note 150 (quoting Carl Takei, a staff attorney with the ACLU National Prison Project).

[247] *Program Statement*, FED. BUREAU PRISONS (Oct. 28, 2016), https://www.bop.gov/policy/progstat/3530.02.pdf.

[248] Illinois's Nurse Educator Loan Repayment Program contributes up to five thousand dollars a year for four years to applicants with eligible loans. The program exists to "address the shortage of nurses and the lack of instructors to staff courses teaching nurses in Illinois." *Nurse Educator Loan Repayment Program*, ILL. STUDENT ASSISTANCE COMMISSION, https://www.isac.org/students/after-college/forgiveness-programs/nurse-educator-loan-repayment-program.html (last visited May 21, 2020).

[249] The Teach for Texas Loan Repayment Assistance Program offers up to $2500 a year to "recruit and retain certified classroom teachers in fields and communities that have a shortage of teachers in Texas." *Teach for Texas Loan Repayment Assistance Program*, TEX. HIGHER EDUC. COORDINATING BOARD, http://www.hhloans.com/index.cfm?ObjectID=A85B6795-9731-B000-C93CA1848B604DB8 (last visited May 21, 2020).

[250] *See* Thomas et al., *supra* note 30, at 560 (noting that when the rotational program was designed, "[s]ome students expressed concerns that their placement in a correctional setting might expose them to risk" and "[t]here was clearly some wariness on the part of many students").

viding healthcare for Rikers Island.[251] HHC also focuses on community health and runs nursing homes and rehabilitation clinics.[252] The corporation is run by a Board of Directors, many of whom are appointed by the mayor.[253] These directors are not paid for their service on the Board,[254] unlike directors of a private company who are directly reimbursed for their work. This can help ensure that directors' motives are to promote the welfare of patients, not profits.[255] Additionally, the Mayor's and Board's supervision of HHC's work further enhances accountability.[256]

Since 2015, the Los Angeles County Department of Health Services (DHS) has been running the county's jail healthcare.[257] Like the New York City administration, DHS serves individuals throughout the county and not only those incarcerated. DHS runs clinics and hospitals throughout Los Angeles and has a unit focused on community

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251 *Health and Hospitals Corporation to Run City Correctional Health Service*, N.Y.C. OFF. MAYOR (June 10, 2015), https://www1.nyc.gov/office-of-the-mayor/news/383-15/health-hospitals-corporation-run-city-correctional-health-service. In 2019, the New York City Council voted to close Rikers Island and build new jails in each of the boroughs, excluding Staten Island. HHC will continue to run medical and mental health services in the new facilities. *See* Samar Khurshid, *How the City's New Jails Plan Accounts for Those with Serious Mental Illness*, GOTHAM GAZETTE (Nov. 8, 2019), https://www.gothamgazette.com/city/8910-how-city-close-rikers-jails-plan-serious-mental-illness. How this change affects the healthcare quality is something to monitor.

252 *About*, NYC HEALTH + HOSPITALS, https://www.nychealthandhospitals.org/about-nyc-health-hospitals (last visited June 11, 2020).

253 *See* N.Y. UNCONSOL. LAW § 7384 (McKinney 2020).

254 *Id.*

255 These Board members are dedicated public servants who have devoted their lives to public health. For example, HHC's CEO is a medical doctor who was previously the Director of the Los Angeles County Health Agency and the Los Angeles County Department of Health Services. *See Leadership: Dr. Mitchell Katz*, NYC HEALTH + HOSPITALS, https://www.nychealthandhospitals.org/leadership/dr-mitchell-katz/#leaders (last visited June 9, 2020). Four of the Board's fourteen members are medical doctors and two have Ph.D. degrees. *Leadership*, NYC HEALTH + HOSPITALS, https://www.nychealthandhospitals.org/leadership_roles/board-of-directors/#leaders (last visited June 9, 2020). In contrast, the Corizon CEO's experience is almost exclusively in business leadership, and Corizon's Executive Board has only two doctors: the Chief Medical Officer and the Chief Psychiatric Officer. *About Corizon Health: Executive Team*, CORIZON HEALTH, http://www.corizonhealth.com/About-Corizon/Executive-Team (last visited June 9, 2020); *see also Executive Management Team*, NAPHCARE, https://www.naphcare.com/about-naphcare/our-team (last visited June 9, 2020) (listing Executive Officers, with the only two M.D.s being the two Chief Medical Officers); *Management Team*, WEXFORD HEALTH SOURCES INC., http://www.wexfordhealth.com/About-Us/Management-Team (last visited June 9, 2020) (listing three members of Management Team, none of whom is a doctor).

256 *Health and Hospitals Corporation to Run City Correctional Health Service*, *supra* note 251.

257 Anna Gorman, *Health Care Revamped at L.A. County Jails*, KAISER HEALTH NEWS (Mar. 8, 2018), https://khn.org/news/health-care-revamped-at-l-a-county-jails.

health, Community Health and Integrated Programs (CHIP).[258] CHIP administers the jail's healthcare and serves other populations such as the homeless and foster children.[259] Because the agency addresses the needs of the population at large, people are hopeful that the "clinics inside the jails [will become] more like ones on the outside."[260]

B. Critiques of Public Models: In Theory and Practice

While these models promise exciting opportunities for correctional healthcare, public administration is not flawless. Indeed, not all public employees are "knights," in that not all public interest actors work to promote the public interest.[261] Instead, public choice theorists argue that public employees, like corporate employees, are motivated by rational self-interest and not necessarily the public good. Legislators, bureaucrats, and other government employees "are assumed to maximize their own welfare," and "not presumed to seek to maximize the welfare of society."[262] Legislators, for example, might prioritize their own reelection over public welfare and may engage in "certain unproductive activities" that merely appear beneficial.[263] Other government employees may face similar pressures to prioritize their own job security.[264] And public administration also carries other stereotypes about government employees: "lazy, security-seeking bureaucrats who are insensitive to the needs of the publics they serve."[265]

Public sector actors are similarly constrained by budgetary limitations in the same way that private companies must work within their contractual budgets. Generally, "public budgeting is much more constrained than private sector . . . budgeting."[266] While private companies may face pressures to cut costs to maximize profits, public agencies may also feel pressured to limit expenditures to remain

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[258] *Community Health and Integrated Programs*, L.A. County Health Services, https://dhs.lacounty.gov/more-dhs/departments/chip (last visited June 9, 2020).

[259] *Id.*

[260] Gorman, *supra* note 257.

[261] Julian Le Grand uses the term "knight" to apply to the assumption that public service workers' "principal concern is with the welfare of others." In contrast, "knaves" are those "whose only concern is with his or her private self-interest." Le Grand, *supra* note 76, at 18.

[262] Mark Gallagher, *A Public Choice Theory of Budgets: Implications for Education in Less Developed Countries*, 37 Comp. Educ. Rev. 90, 94 (1993).

[263] *Id.*

[264] Jody Freedman, *The Private Role in the Public Governance*, 75 N.Y.U. L. Rev. 543, 561 (2000) (describing bureaucrats' potential to "pursue their own interests when exercising administrative discretion").

[265] J. Norman Baldwin, *Public Versus Private Employees: Debunking Stereotypes*, 11 Rev. Pub. Personnel Admin. 1, 1 (1990).

[266] Irene S. Rubin, The Politics of Public Budgeting 23 (9th ed. 2019).

within budget. This is especially true when agencies face budget cuts. Rather than ensure the basics are still covered when budgets are restrained, "supplies and infrastructure tend to be the first to be reduced."[267] For healthcare agencies trying to administer care to inmate-patients, cutting supplies can have disastrous results.[268]

Indeed, certain public-run systems have faced similar criticisms to the private models. Specifically, allegations of understaffing and negligence have plagued Connections in Delaware in recent years. The *Delaware News Journal* has reported on serious medical deficiencies in Connections' care, including a settlement with the estate of former prisoner Steven Sipple, who died from cancer after his requests for medical attention during his incarceration were ignored.[269] Another lawsuit alleged that Connections workers "treated [an inmate-patient] like he was faking his injuries," which caused him permanent damage to his spinal cord and brain damage.[270] According to an independent review of the healthcare at one Delaware facility, "an 'inadequate electronic health record system' and understaffing led to delayed care and missed appointments."[271] The Delaware Department of Justice launched an investigation into the company after a counselor at a substance abuse program for drug offenders, also administered by Connections, admitted to falsifying records to indicate that the

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[267] Gallagher, *supra* note 262, at 96.

[268] For example, a 1991 survey of health officials' views on budget cuts found that "[h]aving to cut budgets or staff . . . significantly exacerbat[ed] the problem" of increased demand and pressure on local healthcare systems to meet national health care goals. Martin P. Wasserman, Nancy Rawding & John M. Aberle-Grasse, *A Survey of Local Health Officials' Views on Current Resources for Public Health Services*, 13 J. PUB. HEALTH POL'Y 261, 264 (1992). Especially in this unprecedented public health moment of the COVID-19 pandemic, public health agencies constrained by tight budgets must make difficult choices in how they administer healthcare. *See, e.g.*, Derek Hawkins & William Wan, *Health Agencies' Funding Cuts Challenge Coronavirus Response*, WASH. POST (Mar. 8, 2020, 5:57 PM), https://www.washingtonpost.com/health/health-agencies-funding-cuts-challenge-coronavirus-response/2020/03/08/73953314-5f0a-11ea-b014-4fafa866bb81_story.html ("[D]ecades of budget cuts have left many local [health] departments without the staff, equipment or plans to mount an adequate response [to the coronavirus]. Local health departments say they're already pulling employees from critical efforts such as opioid abuse prevention."); *see also* Shannon Firth, *Trump's Budget: A Body Blow to Healthcare and Science*, MEDPAGE TODAY (May 23, 2017), https://www.medpagetoday.com/publichealthpolicy/healthpolicy/65531 (describing concerns that the 2018 federal budget's "slashing funds for the critical federal agencies that oversee the healthcare industry . . . destabilizes the foundation of services on which patients depend" (quoting John Meigs Jr., M.D., President of the American Academy of Family Physicians)).

[269] Christina Jedra, *Critics Call for Probe of Health Care Contractor*, DEL. NEWS J., Mar. 3, 2019, at A1.

[270] *Id.*

[271] *Id.*

patients had received counselling.[272] Following these controversies, the Connections Chief Medical Officer resigned in June 2019.[273]

Additionally, the Connecticut Department of Correction has faced criticisms of its handling of its contract with the University of Connecticut Health Center (UCHC), a university-run system. Correctional Managed Healthcare, a division of UCHC, provided healthcare services to the Connecticut correctional population for twenty years until Connecticut terminated that contract in 2018.[274] Connecticut auditors had discovered that the contract terms lacked "measurable performance standards . . . recognized standards of care, and . . . an effective quality control system."[275] The audit also discovered lack of oversight in employee evaluations, among other areas. The state examined forty employees and, for about half of the employees, "evaluations were either incomplete, untimely, or not on file."[276] Additionally, the Department of Correction had been sued by prisoners and their families for poor healthcare, and the state had paid a $1.3 million settlement to a prisoner who alleged that "inadequate medical care led to a late diagnosis of cancer."[277] After terminating the contract, the Department took over health administration directly, but results have not improved. Understaffing has worsened, and current staff say they often work sixteen-hour days.[278] With fewer employees, more employees work overtime, which contributed to the Department being seventeen million dollars over budget halfway through the 2020 budget year.[279] The fact that the Department of Correction had "no chief medical officer and no plan for moving for-

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[272] Christina Jedra, *State DOJ Probing Connections over Reports of Falsified Records*, Del. News J., May 14, 2019, at A9.

[273] Ian Gronau, *DOC Contractor's Chief Medical Officer to Resign*, Del. St. News (May 8, 2019), https://delawarestatenews.net/news/doc-medical-contractors-chief-medical-officer-to-resign.

[274] Will Healey, *DOC Didn't Properly Administer Inmate Health Contract: Auditors*, J. Inquirer (Sept. 6, 2018), https://www.journalinquirer.com/politics_and_government/doc-didn-t-properly-administer-inmate-health-contract-auditors/article_23356e68-b1e9-11e8-b285-4768b3d10fc8.html.

[275] John C. Geragosian & Robert J. Kane, State of Conn. Auditors of Pub. Accounts, Auditors' Report: Department of Correction Fiscal Years Ended June 30, 2014 and 2015, at 21 (2018), https://wp.cga.ct.gov/apa/wp-content/cgacustom/reports/Correction,%20Department%20of_20180904_FY2014,2015.pdf.

[276] *Id.* at 10, 30.

[277] Healey, *supra* note 274.

[278] Lisa Backus, *Staffing Shortage Creates 'Dangerous' Situation in CT Prisons*, Conn. Post (Feb. 3, 2020, 6:32 PM), https://www.ctpost.com/local/article/Staffing-shortage-creates-dangerous-15027264.php.

[279] *Id.*

ward" upon terminating the UCHC contract may have contributed to these challenges.[280]

C. Benefits of Public Models

As the preceding incidents show, the problems in prison healthcare will not be resolved by simply eliminating private correctional healthcare companies and switching to public providers. Public providers are also subjected to budgetary constraints that result in compromising care, and advocates and inmate-patients struggle to hold these providers accountable for their misconduct. However, the structural benefits and protections of public providers make them preferable to private models.

Calls for integration of prison health into community health are not new. In fact, the benefits have been recognized for decades.[281] First, integrating correctional health into government agencies, community programs, or university health systems has the potential to provide continuity of care. This integration into community health not only promotes the inmate-patient's health during incarceration, but also helps facilitate the patient's release into society. Additionally, public models resolve one of the biggest problems plaguing private companies discussed above: lack of accountability. Finally, contrary to neoliberal policy proponents' beliefs, public models can be cheaper than private options by lowering emergency and litigation costs.

1. Continuity of Care and Public Health

First, connecting correctional health to community health promotes inmate-patients' health upon release. Inmate-patients may have been seen by community or public health clinics before their incarceration, so using one of these systems during incarceration allows for a smooth transition in and out of confinement. Medical files can take substantial amounts of time to be transferred to the prison healthcare administrator if they come from a different provider.[282] A short stay,

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[280] *See id.*

[281] *See* Nat'l Comm'n on Corr. Health Care, Position Statement, *Continuity of Care*, 3 J. CORRECTIONAL HEALTH CARE 85, 87 (1996) [hereinafter *Continuity of Care*] ("Accordingly, NCCHC believes that inmate health care is a part of a public health continuum; that health care, before, during, and after incarceration is a necessary societal responsibility . . . ."); Nat'l Comm'n on Corr. Health Care, Position Statement, *Third Party Reimbursement for Correctional Health Care*, 2 J. CORRECTIONAL HEALTH CARE 93, 93 (1995) ("As a vital component of . . . community public health . . . , the financing of correctional health care is a responsibility that all in society must share.").

[282] *See, e.g.*, Melissa M. Goldstein, *Health Information Privacy and Health Information Technology in the US Correctional Setting*, 104 AM. J. PUB. HEALTH 803, 803 (2014) (explaining that few correctional facilities use electronic health records, and "there is very

particularly in jails, means the provider may not even be able to access files before the patient is released or transferred.[283] Considering the importance of a prisoner's health screening upon entry, the gap in provider information access is problematic.[284] However, with a system that envelopes pre-custody, in-custody, and post-incarceration care, individuals' files can be accessed more quickly upon arriving to prison or jail.

Additionally, having a unified provider system facilitates the transition out of incarceration. Again, files do not need to be transferred, but instead are already available to the same provider.[285] Depending on the type of model, the doctors may even be the same doctors treating these patients inside and outside of the correctional system. This can strengthen the important doctor-patient relationship and thereby improve care, particularly for patients who have brief stays in county jails. In New York City, HHC's takeover should improve continuity of care, since HHC already has access to hospital records in its system and can continue providing care upon release.[286]

The quality of care those incarcerated receive inside prisons and jails also has major public health implications. Over ninety-five percent of people incarcerated, whether in prison or jail, are released into the community.[287] Those incarcerated are generally among society's most vulnerable patients health-wise even before they are incarcer-

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little electronic exchange of health information within correctional systems or between systems and community providers"); Robert B. Greifinger, *Thirty Years Since* Estelle v. Gamble*: Looking Forward, Not Wayward*, *in* PUBLIC HEALTH BEHIND BARS: FROM PRISONS TO COMMUNITIES 1, 6 (Robert B. Greifinger, Joseph Bick & Joe Goldenson eds., 2007) (describing the "challenge of transfer of medical information between community and correctional providers" as a "cumbersome process," which "happens infrequently").

283 *See Continuity of Care*, *supra* note 281, at 86 (noting that jail prisoners are usually incarcerated for "relatively brief" periods of time, "from a day or two to a usual maximum of one year"); Ingrid A. Binswanger, Nicole Redmond, John F. Steiner & LeRoi S. Hicks, *Health Disparities and the Criminal Justice System: An Agenda for Further Research and Action*, 89 J. OF URBAN HEALTH 98, 99 (2011) (describing that facility transfers and release pose risks for inmate-patients "due to poor transfer of medical laboratory and pharmacy records [and] poor communication among providers").

284 *See generally* John M. Raba, *Intake Screening and Periodic Health Evaluations*, *in* CLINICAL PRACTICE IN CORRECTIONAL MEDICINE, *supra* note 35, at 41, 43–45 (describing the importance of health screening for people newly admitted to correctional facilities).

285 *See* Christy A. Visher & Kamala Mallik-Kane, *Reentry Experiences of Men with Health Problems*, *in* PUBLIC HEALTH BEHIND BARS: FROM PRISONS TO COMMUNITIES, *supra* note 282, at 434, 457 ("Coordination between the prison and community providers can be improved by making prison health records easily available to community health care providers.").

286 *See Health and Hospitals Corporation to Run City Correctional Health Service*, *supra* note 251 (noting that HHC's management of correctional health services allows for "better coordination of care between hospital and jail-based health services").

287 Macmadu & Rich, *supra* note 15, at 70.

ated. Rates of tuberculosis, HIV, and AIDS are disproportionately high among the incarcerated.[288] Mental illness and substance abuse are also disproportionately high, with jails and prisons commonly considered "warehouses for the mentally ill."[289] These health implications also have broader social consequences for certain populations. First, "the communities to which inmates return tend overwhelmingly to be low-income communities of color, and they often lack adequate health care resources."[290] Failing to manage diseases while incarcerated only exacerbates the existing racial disparities in healthcare upon release.[291] Additionally, although women are only a small fraction of the incarcerated population, incarcerated women "have a greater burden of disease than their male counterparts."[292] Incarcerated women may also carry a history of PTSD and physical and sexual abuse.[293]

Without proper treatment while incarcerated and continued care upon release, formerly incarcerated people will likely return to society with mismanaged illnesses. Since people on the outside have historically ignored correctional health concerns,[294] the result is an underappreciation of the serious public health risks that subpar correctional health poses to both the inmate-patients and the community at large. Normalizing and connecting treatment outside and inside prison walls is necessary in reducing these risks.

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288 *See Continuity of Care*, *supra* note 281, at 86; David Cloud, Vera Inst. of Justice, On Life Support: Public Health in the Age of Mass Incarceration 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 (noting that HIV/AIDS is two to seven times more prevalent and tuberculosis is four times more prevalent amongst prisoners than amongst the general population).

289 *E.g.*, Cohen, *supra* note 213, at 33.

290 Macmadu & Rich, *supra* note 15, at 64.

291 *See generally* Khiara M. Bridges, *Implicit Bias and Racial Disparities in Health Care*, Hum. Rts. Mag. (Aug. 1, 2018), https://www.americanbar.org/groups/crsj/publications/human_rights_magazine_home/the-state-of-healthcare-in-the-united-states/racial-disparities-in-health-care (describing the causes of racial discrimination in healthcare treatment).

292 Macmadu & Rich, *supra* note 15, at 66 (noting that even though women only comprise about ten percent of those incarcerated, they have unique healthcare needs).

293 *Id.* (reporting that PTSD is "particularly common among incarcerated women, about a third of whom experienced physical abuse and a third of whom experienced sexual abuse prior to incarceration").

294 Am. Soc'y of Internal Medicine, Am. College of Physicians, Correctional Medicine 1–6 (2001) (recognizing that correctional healthcare has been "long ignored" by "[p]ublic health officials, practicing physicians, and society," but has started to "emerg[e] as a unique discipline").

2. *Democratic Accountability and Public Oversight*

In addition, transferring obligations from private providers to public organizations has the potential to increase democratic accountability and public oversight. As mentioned, much of what the private companies do can remain secret, whether settlements pay-out or details of the care provided.[295] Public agencies, however, have certain disclosure requirements that allow for more stringent oversight by the public.[296] For example, public agency budget documents are publicly accessible, unlike private company budgets.[297] These budgets "may be the focus of public controversy if citizens do not like what they see or do not fully understand it."[298] Additionally, unlike government agencies, private companies are not subject to freedom of information laws. The federal version of this law, known as the Federal Freedom of Information Act (FOIA), "provides that any person has the right to request access to federal agency records or information," subject to certain exceptions.[299] Every state and Washington, D.C. has some version of freedom of information laws (FOIL).[300] These laws can increase accountability by exposing lawsuits, among other records.

Freedom of information laws can also provide information needed for a *Monell* claim, as discussed in Section II.C. To hold a municipality or private healthcare company liable under 42 U.S.C. § 1983, a plaintiff must show that the defendants' actions were part of an organizational policy or custom.[301] As mentioned, conclusory allegations that the organization acted according to a policy are insufficient; instead, potential plaintiffs must have some evidence of such a policy. Without access to public records, discovering such evidence might be extremely difficult for an incarcerated patient trying to pursue a claim.

In New Mexico, efforts to hold private prison healthcare companies to the same standard of accountability as public agencies have

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[295] *See* discussion *supra* Section I.B.2.

[296] *See* Marie Gottschalk, Caught: The Prison State and the Lockdown of American Politics 72 (2015) (describing how private prisons and correctional services are not typically subject to federal and state statutes designed to increase accountability of public agencies, such as the Administrative Procedure Act or freedom of information acts).

[297] *See* Rubin, *supra* note 266, at 6 (discussing the importance of accountability in public budgets).

[298] *Id.*

[299] *Freedom of Information Act*, U.S. Dep't St., https://foia.state.gov/Learn/FOIA.aspx (last visited July 4, 2020). Medical files, for example, are excluded from FOIA disclosures. *Id.*

[300] *See State Freedom of Information Laws*, Nat'l Freedom Info. Coalition, https://www.nfoic.org/coalitions/state-foi-resources/state-freedom-of-information-laws (last visited July 4, 2020).

[301] *See supra* Section II.C.

failed. In 2019, a New Mexico judge ruled that Corizon settlement documents should be disclosed under the state's public records law.[302] The Court noted that there was "no distinction between [Corizon] and a public entity" concerning the disclosure of the documents.[303] Although the appellate court affirmed the trial court's writ of mandamus instructing Corizon to release the documents,[304] Corizon has failed to comply. Even after the New Mexico Supreme Court declined to hear Corizon's appeal in the case,[305] Corizon refused to release the records.[306] According to a Corizon spokesperson, "[i]t continues to be Corizon's position that [they] are not subject" to the public records laws.[307] As of this writing, Corizon has released sixty-two settlement agreements, but has refused to make another thirty-five public.[308]

On the contrary, when government agencies refuse to comply with disclosure requirements, public oversight puts pressure on the government to either comply or change their policies. For example, New York State's Article 78 proceedings allow for challenges to an agency's refusal to provide information sought in a FOIL request.[309] If an agency denies disclosure pursuant to New York's FOIL process, an individual can bring the issue in front of a judge to decide, among

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[302] N.M. Found. for Open Gov't v. Corizon Health, 460 P.3d 43, 47–48 (N.M. Ct. App. 2019) (denying certiorari in a case where Corizon Health sought to appeal a writ of mandamus issued by a district court judge that ordered the company to disclose settlement agreements of improper care and sexual assault against prisoners); Katy Barnitz, *Court Affirms that Prison Settlements Are Public Records*, ALBUQUERQUE J. (Sept. 18, 2019, 12:05 AM), https://www.abqjournal.com/1367510/court-says-prison-settlements-public.html.

[303] *N.M. Found. for Open Gov't*, 460 P.3d at 51.

[304] *Id.* at 54.

[305] Phaedra Haywood, *New Mexico Supreme Court Declines to Hear Corizon Appeal in Open Records Case*, SANTA FE NEW MEXICAN (Dec. 20, 2019), https://www.santafenewmexican.com/news/local_news/new-mexico-supreme-court-declines-to-hear-corizon-appeal-in/article_7ecfad7a-228a-11ea-9eda-2b5a1a2a01d4.html.

[306] Phaedra Haywood, *Ex-prison Health Contractor Won't Release Records Despite Court Rulings*, SANTA FE NEW MEXICAN (Jan. 25, 2020), https://www.santafenewmexican.com/news/local_news/ex-prison-health-contractor-won-t-release-records-despite-court-rulings/article_fa8c2a42-3b99-11ea-b90b-c37d243df965.html.

[307] *Id.*

[308] Phaedra Haywood, *Inmate Medical Care Vendor Produces Some Records*, SANTA FE NEW MEXICAN (Feb. 17, 2020), https://www.santafenewmexican.com/news/local_news/inmate-medical-care-vendor-produces-some-records/article_11c8b718-51f0-11ea-8c12-b3d5be9f36ba.html.

[309] N.Y. C.P.L.R. art. 78 (McKinney 2003); N.Y. Pub. Off. Law § 89(4)(b) (McKinney 2020) ("[A] person denied access to a record in an appeal determination . . . may bring a proceeding for review of such denial pursuant to article seventy-eight of the civil practice law and rules."); *see also FAQ–Freedom of Information Law (FOIL)*, NY.GOV, https://www.dos.ny.gov/coog/freedomfaq.html (last visited Aug. 19, 2020) (explaining that an individual seeking information from an agency can challenge the agency's denial under Article 78).

other questions, "whether the body or officer failed to perform a duty enjoined upon it by law[,] . . . whether a determination was made in violation of lawful procedure, . . . or was arbitrary and capricious or an abuse of discretion."[310] This procedure brings the decision into the courts for review and into public discourse for scrutiny.

Such disclosures, whether voluntary or court-ordered, can expose deficiencies in service and lead to much-needed improvements. After taking over from Corizon, New York City's HHC started publicly publishing monthly reports describing facility-level data.[311] The reports track data such as how many medical, mental health, and social work appointments were completed, the reasons such appointments were not completed, and the number of referrals to mental health specialists that were seen within seventy-two hours.[312] The reports also break down these metrics for Rikers's ten individual facilities.[313] The reports allow the city's Board of Correction, Department of Correction (DOC), and HHC to monitor quality and "intervene where necessary."[314] The Board did intervene in 2019, when it was discovered that HHC and DOC had discrepancies in the number of "serious injuries" that each department reported in 2017.[315] DOC had reported eighty-one percent fewer serious injuries than HHC, and the Board audited both sets of records and both departments' procedures to understand the error.[316] The Board discovered that HHC and DOC used different standards to classify these injuries, with HHC defining a wider variety of problems as "serious."[317] DOC also used paper

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310 N.Y. C.P.L.R. 7803 (McKinney 2003).

311 *See generally Correctional Health Services Reports*, N.Y.C. Board Correction, https://www1.nyc.gov/site/boc/reports/correctional-health-authority-reports.page (last visited July 1, 2020) [hereinafter *Services Reports*].

312 *See, e.g.*, Corr. Health Servs., NYC Health + Hospitals, CHS Access Report: June 2019, at 3 (2019), https://www1.nyc.gov/assets/boc/downloads/pdf/chs_access_report_june2019.pdf (summarizing all scheduled visits and service outcomes across all jail facilities in New York City).

313 *Id.* at 1.

314 *Services Reports*, *supra* note 311.

315 N.Y.C. Bd. of Corr., Serious Injury Reports in NYC Jails 11, 23 (2019), https://www1.nyc.gov/assets/boc/downloads/pdf/Reports/BOC-Reports/2019.01.07%20-%20BOC%20Serious%20Injury%20Report%20-%20Final.pdf (reporting that in 2017 the New York City Department of Correction divulged eighty-one percent fewer serious injuries than Correctional Health Services and making a number of recommendations to prevent these discrepancies in the future).

316 *See id.* at 8 (describing the Board of Correction's audit methodology).

317 The DOC defines such an injury as "a physical injury that creates a substantial risk of death or disfigurement; is a loss or impairment of a bodily organ; is a fracture or break to a bone, excluding fingers and toes; or is an injury defined as serious by a physician." *Id.* at 7 (quoting N.Y.C. Dep't of Corr., Directive 5000R-A, Reporting Unusual Incidents (2004)). HHC, however, includes "lacerations requiring suturing or stapling, fractures (excluding fingers and toes), dislocations requiring clinical reduction, permanent or

reports to track injuries, while HHC used an electronic medical reporting system.[318] According to Homer Venters, the former Chief Medical Officer of New York City's jails, this allowed HHC to more easily change the status of an injury from benign to serious, while DOC would need to "track down the original paper report" to make such a change.[319] As a result of the audits, the Board made a series of recommendations, including developing a comprehensive electronic injury-tracking system, requiring DOC to become compliant with its own policy for reporting injuries, and having the Board conduct yearly audits of the prisoner injury reports.

3. *Cost-Saving Potential*

Finally, although proponents of neoliberalism highlight the cost-cutting potential of privatization, public health models can also lower costs. Jeffrey Dickert, the Chief Operating Officer of Rutgers's university correctional healthcare program, argues that providing adequate care brings down litigation and emergency costs.[320] By catching problems before they develop into emergency situations, providers can prevent expensive hospitalization.[321] The system lowers costs by providing more treatment in the facilities and by "using evidence-based treatment guidelines and formulary controls."[322] New Jersey's correctional health costs were ten million dollars *under* budget in 2008, which was returned to the state instead of kept as profit.[323] Roland Zullo of the Economic Growth Institute has stated that "the cost-saving side of privatization is 'one of the great myths that's been debunked by recent literature.'"[324] Typical cost-saving analyses do not consider the *value* of service provided by the companies.[325] Govern-

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temporary disabling of an organ, foreign body ingestion requiring removal . . . in a hospital, any blow to the head resulting in post-concussive syndrome diagnosis, and any injury judged to be serious by medical professionals." *Id.*

318 Cindy Rodriguez, *Report: Serious Injuries to Inmates Are Vastly Under-Reported in NYC Jails*, GOTHAMIST (Jan. 8, 2019, 12:49 PM), https://gothamist.com/news/report-serious-injuries-to-inmates-are-vastly-under-reported-in-nyc-jails.

319 *Id.*

320 Littell, *supra* note 240, at 66.

321 *Id.*

322 PEW CHARITABLE TRS., *supra* note 56, at 15 (describing how the Rutgers University partnership with the New Jersey Department of Corrections was able to contain costs, resulting in a six-year low in prescription drug costs).

323 *Id.*

324 Sarah Leeson, *Despite Increased State Supervision, Expert Says Private Prison Health Care Comes at a Cost*, MICH. RADIO (May 25, 2018), https://www.michiganradio.org/post/despite-increased-state-supervision-expert-says-private-prison-health-care-comes-cost.

325 *See id.* (noting that while initial studies seemed to indicate privatization led to cost-savings, more recent studies that take into account the value of the services received suggest that the public sector is better at "providing public value").

ments may be paying hundreds of millions of dollars to private companies, but the quality of service rendered may fall below that of public models. And, considering the market failure described earlier in this Note, the dearth of competition thwarts the cost-saving function that competition in markets usually provides.[326]

Conclusion

The calls for comprehensive criminal justice reform have surged in recent years, with more people starting to rethink the country's tough-on-crime attitude to sentencing and incarceration. Important bipartisan changes have already been made across the country, from the passage of the First Step Act[327] to multiple 2020 presidential candidates recognizing the need for criminal justice reform in their campaigns.[328] Improving correctional healthcare is another critical way to address the injustices in the criminal justice process while also addressing broader public health goals.

To improve care, governments and corrections departments must seriously consider whether contracting with private healthcare companies is the best way to provide prisoner healthcare. As this Note and the past few decades of private correctional healthcare administration have shown, the private correctional healthcare industry is rampant with egregious mismanagement, abuse, and in some cases, corruption. The companies' incentives to cut costs and deny care are exacerbated by a lack of oversight and contract provisions that make the governments' sticking with private providers almost inevitable. In addition, the lack of legal pressures the companies face to improve care, and that the governments face to switch providers, compounds these structural problems and leaves providers unaccountable for their actions. As a result, inmate-patients receive poor healthcare and cannot access the necessary information to vindicate their rights to adequate services. These problems are inherent in the correctional healthcare market: Due to the lack of competition and the division between payor and user, correctional healthcare is simply not something that can or should be privatized.

As discussed throughout this Note, all healthcare administration systems require some calculation of cost efficiency and budgetary bal-

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326 Crouch, *supra* note 82, at 10.

327 *An Overview of the First Step Act*, Fed. Bureau Prisons, https://www.bop.gov/inmates/fsa/overview.jsp (last visited July 4, 2020) (noting the bipartisan passage of criminal justice reform legislation in December 2018).

328 *See generally* Katie Park & Jamiles Lartey, *2020: The Democrats on Criminal Justice*, Marshall Project (Apr. 8, 2020, 6:00 PM), https://www.themarshallproject.org/2019/10/10/2020-the-democrats-on-criminal-justice.

ancing. However, the role of an agency official versus that of a private corporation head are clearly distinct. Whereas corporate officers have duties to their shareholders, public servants have a duty to the public. While public models alone cannot guarantee quality improvements, they do allow for the increased oversight necessary to pressure governments into improving care.

Moving forward, governments should consider alternatives to private companies and turn to the public-driven models outlined in this Note. Continuity of care will improve inmate-patients' health not only during incarceration, but also upon release. This should help mitigate the disparate health effects formerly incarcerated people face compared to the rest of society,[329] and should help manage the spread of illnesses that people may bring back from incarceration. This improved care can also lower litigation costs, a promise that could counter private companies' attractive offers to insulate governments from liability. Even when care quality issues persist, public administrations have stronger mechanisms in place through which to challenge that care, like increased accountability and fewer barriers to legal repercussions. Therefore, switching to a public health model and dropping private companies is an important first step in providing inmate-patients with quality healthcare, treating them with dignity, and treating correctional healthcare like the public health issue it is.

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[329] *See Incarceration and Health: A Family Medicine Perspective (Position Paper)*, AM. ACAD. FAM. PHYSICIANS, https://www.aafp.org/about/policies/all/incarcerationandhealth.html (last visited July 4, 2020) (noting the American Academy of Family Physicians' position in favor of criminal justice reform as incarceration is detrimental to health).