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Committee on Criminal Justice

PRIVATIZATION OF PRISON HEALTH CARE SERVICES

Statement of the Issue

The Department of Corrections (department) is responsible for providing health care services for Florida inmates. In Fiscal Year 2008-09, the department spent approximately $400 million for health services, almost double the expenditure in Fiscal Year 1998-99 and an increase of nearly 3 percentage points in the share of total department expenditures. These numbers reflect both rising medical costs and increasing inmate population throughout the decade. However, the trend of rising expenditures was reversed in Fiscal Year 2008-2009 when spending for health care fell by $20.8 million from the previous fiscal year. This reduction can largely be attributed to new legislation limiting the billing rate for non-contract health services and more effective implementation of managed care practices by the department. Nearly two-thirds of the total expenditures for inmate health care services are incurred for services provided by the department, with the remaining one-third expended for services performed by providers in the community. Currently, all management functions are performed by the department. This was not the case from 2001 to 2006 when the department contracted with private health care management companies for delivery of comprehensive health care services to inmates in Region IV. This report focuses on the history of that privatization effort and lessons that might be learned from it if a new initiative is made to further reduce costs by entering into a contract for comprehensive inmate health care with one or more private companies.

Discussion

General

The inmate population is typically not as healthy as the general American population. Many inmates have not exercised preventative medicine habits prior to entering prison, and this along with the stress and lack of stimulation of prison life tends to cause them to age quicker. These factors have led Florida and many other states to consider an inmate who is over 50 years old to be elderly. Aging inmates, and those with communicable diseases or other special medical conditions, require more extensive and expensive medical treatment. Florida has a higher percentage of elderly inmates than many other states, in part because there is no possibility of parole for crimes committed after 1983. Adding to the burden is the fact that even though many inmates meet the indigency standards for Medicaid, states cannot receive federal reimbursement for expenses to provide health care and services for an "inmate of a public institution."[1]

Correctional health care includes physical, dental, mental health, and pharmacy services. Health care staff at each major institution provide primary health care services to inmates. Some reception centers are staffed and equipped to provide specialty procedures such as kidney dialysis. Inmates who require consultations with medical specialists or care not available within the department are transported to community physicians or hospitals for treatment. In some cases, the department has contracted with specialists to provide services within the facility. Emergency care beyond the capability of the institution is provided by the closest hospital emergency room.

[1] 42 U.S.C. §1396d(a). The American Bar Association Criminal Justice Section Report to the Delegates, August 2007, *www.abanet.org/crimjust/policy/corrections.doc*, last viewed on September 20, 2010, includes a thorough discussion of the impact of the "inmate exception" on the states and urges its repeal by Congress.

Legal Requirement for Inmate Health Care

The United States Supreme Court has established that prisoners have a constitutional right to adequate medical care.[2] The Court determined that it is a violation of the Eighth Amendment prohibition against cruel and unusual punishment for the state to deny a prisoner necessary medical care, or to display "deliberate indifference" to an inmate's serious medical needs.

The development of correctional health care in Florida has been influenced by a class action lawsuit filed by inmates in 1972. The plaintiffs in *Costello v. Wainwright*[3] alleged that prison overcrowding and inadequate medical care were so severe that the resulting conditions amounted to cruel and unusual punishment. The overcrowding aspect of the case was settled in 1979, but the medical care issue continued to be litigated for 21 years. In 1985, a court-appointed survey team observed that the department exhibited "systematic indifference" to inmate medical needs, and a Special Master and a Monitor were appointed to oversee inmate health services.

The *Costello* litigation brought about two major changes in Florida's inmate health care system that resulted in termination of the federal court's oversight of inmate health services in 1993. First, the health care delivery system was revised to ensure that security staff would not make health care decisions and that prisoners were not involved in providing health care services. Second, the Correctional Medical Authority (CMA) was created in 1986 to provide independent evaluation of the department's provision of health care services. The CMA is required to conduct a survey of health services at each major institution at least once every three years. In addition to individual institutional surveys, the CMA annual report often includes recommendations for systemic changes.

Region IV Comprehensive Health Care Contracts

One of the first recommendations made by the CMA after it was established was that the department contract with a single vendor for HMO type health care delivery in Region IV.[4] The recommendation was for a vendor to take responsibility for total health care, including hospitalization. The CMA withdrew the recommendation in its November 1991 report, but in 1996 indicated that it was worth reconsidering.[5] The Office of Program Policy Analysis and Government Accountability (OPPAGA) also recommended in 1996 that the department privatize health services for an entire region, but did not specify which region should be privatized.[6]

The department did not act upon the CMA and OPPAGA recommendations, but did have privatized health services at some individual institutions. In 2000, the Legislature directed the department to issue a Request for Proposals (RFP) for inmate health care services at all department-run facilities in Region IV no later than September 1, 2000.[7] The legislation stated that the purpose was "to secure one or more private vendors to provide the minimal constitutionally adequate level of health care to inmates at a cost savings when compared to the department's actual FY 1999-2000 health care expenditures." Vendors were to be requested to submit options to provide inmates with health care services "compatible to the current standard Medicaid service level of health care, but include a requirement to provide an enhanced Medicaid service level of care that includes dental, mental health and pharmacy programs." The appropriation specifically stated that the RFP was not to require specific staffing standards and that it should encourage innovation in providing health care to inmates in the department's custody.

The RFP grouped the 12 major institutions in Region IV into an East cluster of 7 institutions (Broward, Dade, Everglades, Glades, Indian River, Martin, and South Florida Reception Center) and a West cluster of 5 institutions (Charlotte, DeSoto, Hardee, Hendry, and Okeechobee). Prospective vendors could bid on providing comprehensive medical services for either one or both clusters. Four companies submitted proposals: Corrections Medical Services, Inc., Physicians Healthcare Plans, Inc., Prison Health Services, Inc., and Wexford Health Sources, Inc. After resolution of bid protests, the department entered into a 5-year contract with Wexford on

[2] *Estelle v. Gamble*, 420 U.S. 97, 97 S.Ct. 285, 50 L.Ed.2d 251(1978)
[3] 430 U.S. 3425, 51 L.Ed.2d 372, 97 S.Ct. 1191 (1977)
[4] Corrections Medical Authority December 1987 Annual Report.
[5] Corrections Medical Authority 1995-1996 Annual Report.
[6] OPPAGA Report No. 96-22, "Review of Inmate Health Services Within the Department of Corrections" (November 1996)
[7] Chapter 2000-166, Laws of Florida.

July 13, 2001. The contract provided for payment of a per diem rate times the monthly average inmate population, and provided for a 3 percent annual increase in the per diem rate.

Interestingly, health services staffing costs rose significantly prior to the start of the contract. One factor was a general shortage of medical professionals that resulted in high wages. In addition, the CMA reported that the department relied significantly on agency and temporary staffing in Region IV for several years prior to the start of the contract due to uncertainty about the status of privatization efforts. These temporary measures to maintain vital health care functions resulted in significantly increased staffing costs in the short term.[8] Delays in the Region IV contract reportedly resulted in $8 million expended for temporary agency employees.[9] This phenomenon was similar to that experienced by the department in 2001 when it submitted a budget request to privatize Region 3. Staffing was impacted immediately by employees requesting lateral transfers to Regions I and II in order to retain their state employee status and benefits.

Initial 45-day monitoring reports of the contract revealed numerous start-up difficulties. These included findings that there did not appear to be a system of internal controls, poor or nonexistent tracking mechanisms, inadequate control and/or tracking of specialty consultations, and unacceptable pharmacy systems. Concerns with the pharmacy prompted Wexford to change pharmacy vendors that eliminated the major problems. Continued improvement was noted during subsequent monitoring visits during the first year of the contract. The CMA noted in its report that the complex missions of many of the institutions in the eastern grouping of the contract may have caused problems in providing the level of services specified in the contract.

In its 2003-2004 Annual Report, the CMA expressed concern that Wexford was not meeting the terms of the contract in certain areas. Because of some repetitive deficiencies, the CMA encouraged the Department to consider invoking contract provisions relating to non-compliance. The primary concern was the CMA's finding that Wexford had not corrected issues found in its May 2002 survey of the South Florida Reception Center. Wexford contended that the medical and psychological classifications of the inmate population exceeded contractual specifications and that it was therefore required to perform services in excess of its contractual obligations.[10] Wexford's position was that although the inmate population remained relatively constant, it included a higher percentage of inmates who were prone to medical or psychological issues than was specified in the contract.

In February 2003, Wexford requested a 10 percent increase in the per diem payment. The department denied the request, and notified Wexford in July 2003 that the Legislature had not appropriated funds for even the 3 percent annual per diem increase provided for in the contract. The department contended that it could not give the automatic increase because the contract included standard language providing that subsequent year payments were subject to appropriation by the Legislature. Wexford filed suit in August 2003 after the parties were unable to resolve the issue. Wexford maintained that it could not meet the constitutional standard of care without the increase, and that the "no appropriation" clause in the contract could not be invoked because the General Appropriations Act (GAA) did not include a specific statement of non-appropriation for the rate increase. The department's defense was that the appropriations committees had expressed the intent not to fund the increase in committee meetings, but there was no dispute that the GAA did not expressly provide for non-appropriation. Wexford won the lawsuit and was ultimately paid the increased rate, offset in part by liquidated damages claimed by the department for noncompliance with the contract.[11]

In April 2005, the department invoked the liquidated damages provisions of the contract for a variety of issues. Wexford agreed that improvements were needed in some areas, but asserted that it was correcting deficiencies and did not agree that it was appropriate to assess liquidated damages. In mid-May the Office of Health Services recommended termination of the contract. During this same time frame, the GAA for Fiscal Year 2005-2006 was

[8] Corrections Medical Authority 2000-2001 Annual Report.
[9] Attorney General Report No. 02-096, "Improvements Needed in Cost Management For Corrections Health Services and Overtime," November 2001.
[10] Wexford letter dated April 3, 2003 (referring to earlier letter dated March 5, 2003, which was not available).
[11] The lawsuit was limited to the issue of enforcement of the per diem rate increase. The liquidated damages assessment was not litigated.

passed and signed by the Governor. The GAA prohibited expenditure of funds for the existing contract after December 31, 2006, and directed that the contract be rebid with a new contract to begin no later than January 1, 2006.[12]

A new Invitation to Bid (ITB) for comprehensive health services in Region IV called for bids to provide comprehensive health services to all institutions in the region, with no cap on the amount expended by the contractor.[13] Three companies provided bids: Wexford, Correctional Medical Services, Inc., and Prison Health Services, Inc. (PHS). The department determined that PHS was the only bidder that both met the financial requirements and whose bid did not contain material deviations from the specifications. In addition, the PHS bid of approximately $645 million for the 5-year contract was more than $80 million less than the next lowest bidder.

The new 5-year contract commenced on schedule on January 1, 2006, but PHS soon began to request a modification of the reimbursement rate due to unexpected costs. The department did not agree to modify the contract, and on August 21, 2006, PHS gave formal ninety-day notice that it was terminating the contract. The notice stated that PHS had an unanticipated level of costs due to inaccurate and incomplete data on hospital utilization and costs that was provided during the ITB process. A PHS press release more plainly stated that the reason for the termination was a higher than anticipated volume of off-site hospitalization services. The company did not attribute the allegedly inaccurate information to purposeful misleading by the department, stating that it may have been the only information available to the department at the time. PHS also indicated that it would bid on a new contract if an ITB with complete cost information was issued.

A new bid solicitation for comprehensive health care services was made, but none of the bidders met the bid's financial responsibility requirements. In order to continue providing health services without interruption, the department began procuring 1-year contracts and issuing purchase orders to PHS sub-contractors. During the early phases of this transition there were some problems with contract management and medical oversight, but the department corrected the situation.[14] Since that time, it has consolidated a number of contracts with outside providers both in Region 4 and throughout the state, converted contract staff positions to state employees in Region IV and Taylor Correctional Institution, and improved the quality of its utilization management effort while expanding it throughout the state. Significant cost savings resulted from proviso language in 2008 that capped non-contract payments to health care providers at 110 percent of the Medicare rate.[15] The cap on non-contract payments for health services and the department's new management practices were the primary reasons that health care expenditures of $400.5 million in Fiscal Year 2008-2009 were $20.8 million less than in the previous fiscal year, a reduction of nearly 5 percent.[16]

In addition to other cost-saving measures that it has implemented in recent years, the department is also looking into the possibility of obtaining Medicaid reimbursement for certain health services. Federal law defines an inmate as an "institutionalized individual" for whom federal Medicaid reimbursement is generally not available. However, an inmate is not considered to be an "institutionalized individual" while he or she is an inpatient in a hospital outside of the correctional system for 24 hours or longer.[17] The department should take aggressive steps to make use of this exception for inmates who would be Medicaid-eligible but for their inmate status, including determining whether any state statutes or administrative rules need to be amended.

Private Contracting

The primary goal of the inmate health care system must be to provide a constitutionally acceptable level of health care for inmates. This goal does not change whether the service is provided by a government employee or a private contractor. Beyond that goal, the government is responsible to the taxpayers for ensuring that the care is

[12] Chapter 2005-70, Laws of Florida.
[13] Comprehensive health services includes medical, dental, psychological, and pharmaceutical services and supplies.
[14] OPPAGA Report No. 09-07, "Steps to Control Prison Inmate Health Care Costs Have Begun to Show Savings" (January 2009).
[15] The proviso language was codified as s. 945.6041, F.S., in 2009.
[16] Corrections Medical Authority 2008-2009 Annual Report.
[17] 42 C.F.R. 1009-1010. Also see footnote 1.

provided in a cost-effective manner. A fair assessment of whether public or private provision of services is more cost-effective would require a complex and imperfect evaluation that is beyond the scope of this brief.

Once it is decided that a private contractor will be used to provide health services, the government must take steps to ensure that it receives the necessary level of services without stifling the private entity's ability to innovate. Unnecessary restrictions may prevent the private entity from utilizing other effective methods to perform the service. An example is a requirement for a specific number of staff. The provider may have a plan to maximize the use of technology to provide an acceptable level of care, resulting in the need for less staffing and reduction of costs. If the contract requires a fixed level of staffing, there may be no incentive for the provider to innovate in this area. The converse would be a requirement that the provider use telemedicine and hire fewer staff, which might not be the provider's model.

On the other hand, the nature of providing services to a correctional population makes it necessary to have certain requirements. The department has been increasing the number of contracts by which local specialists and services, such as mobile radiology platforms, are brought into the prison. This may or may not be as cost effective as off-site examinations, but it eliminates the security risk of transporting the inmate into the community and the need for escort officers. Choices have to be made about acceptable levels of risk, and the department will be held responsible for any mistakes regardless of who is providing health services.

Health Care Systems in Other Large State Correctional Systems

Florida is the third largest state correctional system with 103,915 inmates as of January 1, 2010.[18] The department operates a hybrid system in which the Office of Health Services essentially acts as the administrator of a managed care system. In general, primary health care for inmates is provided by department medical employees, and specialty care and many other services are provided by private health care professionals. The inmate health care systems of the other state correctional systems that are among the top ten inmate populations can be briefly described as follows:

- In Texas (171,249 inmates), inmate health care is provided through a partnership between the Texas Department of Criminal Justice and the state's two major medical schools. Telemedicine is used extensively in providing services to remote locations.[19] In May 2010, the University of Texas Medical Branch – Galveston, which provides 80 percent of inmate health services, indicated that it might cancel the long-standing contract after being informed that it would have to absorb $32 million of an $82 million shortfall.[20]
- California (169,413 inmates) has faced upheaval in its inmate health care system since the filing of federal lawsuits due to extremely poor conditions. Medical care is under a federal Receiver as the result of a lawsuit filed in 2001, and dental, mental health, and disability services are under federal Special Masters appointed as the result of separate lawsuits. The various judges have ordered their representatives to coordinate plans of action as much as possible. On June 30, 2010, it was announced that health services for inmates at the 33 adult prisons would be provided by Health Net, a Preferred Provider Organization with a statewide network of providers.[21]
- New York (58,648 inmates) and Arizona (40,523 inmates) use state employees in their inmate health care system, both of which appear to be similar to the Florida system.[22] Ohio (51,606 inmates) also provides

[18] The inmate population figures in this section are taken from "Prison Count 2010: State Population Declines for the First Time in 38 Years," p. 17, The Pew Center on the States (April 2010).
[19] "Health Care in the Texas Prison System, A Looming Fiscal Crisis", http://www.utmb.edu/CMC-May-2010/WhitePaper_82nd_Legislature_Summary.pdf , May 18, 2010, last viewed on September 16, 2010.
[20] "Prison Health Care Could Be Cut With Budget", May 13, 2010, http://www.statesman.com/news/texas-politics/prison-health-care-could-be-cut-with-budget-685519.html last viewed on September 16, 2010.
[21] California Prison Health Care Services press release dated June 30, 2010, last viewed on September 16, 2010 at http://www.cphcs.ca.gov/docs/press/PRESS_20100630_HealthNet.pdf.
[22] "Healthcare in New York Prisons 2004-2007", The Correctional Association of New York, February 2009; also Arizona Department of Corrections website: http://www.azcorrections.gov/adc/divisions/health/Hema_Health_Medical.aspx, last viewed on September 16, 2010, and telephone conference between Senate staff and Arizona Department of Corrections staff on September 16, 2010.

health services through department employees, but it makes extensive use of telemedicine consults with the Ohio State University Medical Center. Approximately 5,000 specialty consults are performed each year.

- Georgia (53,562 inmates) provides inmate health care through the Medical College of Georgia.
- Pennsylvania (51,429 inmates) contracts with PHS for comprehensive health services at all of its correctional facilities.
- Michigan (45,478 inmates) entered into a contract with PHS for primary medical services beginning April 1, 2009. Prior to that time, it contracted with Corrections Medical Services, Inc., to provide physician and physician assistant services, but nurses, dentists and support staff were department employees.[23]
- Illinois (45,161 inmates) uses private contractors that are obtained through competitive bidding. The bids cover comprehensive health care (except that some facilities have state employee nurses or a combination of state and vendor employees). Hospitalization, dialysis care, HIV medications, and hepatitis C medications are carved out from the contract and paid by the state. Wexford successfully bid on a new contract that began in December 2005 to provide services at a majority of the facilities after its previous contract was cancelled in July 2005 due to labor problems. Five correctional facilities in northern Illinois receive services from the University of Illinois at Chicago.

Traditional Contracts

The typical comprehensive health care contract used by state correctional systems in recent years is a long-term capitated contract. In this type of contract, the government entity pays the contractor a fixed amount for a fixed period of time for each person who is to be served by the contractor. In return, the contractor is responsible for providing the contracted service at the agreed price, regardless of whether it actually costs more or less than that amount. This is basically a health insurance contract, and some states require that the provider be licensed as a health maintenance organization (HMO).

Accurately determining a price in a capitation contract depends primarily upon the contractor's ability to correctly assess the health status of the served population. The government entity is responsible for providing accurate information about the population. With that information, it is the contractor's responsibility to predict the health care needs of that population. Once the contractor has predicted the health care needs, it must forecast the future cost of providing the estimated services for the term of the contract. The first of these factors is controllable and the second factor is reasonably predictable given a large-enough population and accurate information. However, predicting the future cost of health care in the current market is much less certain.

The department's contracts with Wexford and PHS in Region IV were capitated contracts for comprehensive health care and their premature termination illustrates the impact of errors or perceived errors in each of the three decision-making factors:

- Wexford asserted that the department changed the mix of the inmate population by increasing the number of inmates who were more prone to health problems. It maintained that as a consequence of inaccurate information about the population, its assessment of the health status and prediction of health care needs was too optimistic. In addition, it faced the unexpected nonappropriation of the annual rate increase, which had the same effect as an unanticipated increase in prices.
- PHS asserted that it was given erroneous or incomplete information with which to predict the health care needs of the served population, and that there were also significant unanticipated increases in health care costs. As noted previously, it recognized that the information may have been all that was available to the department at the time of the bid solicitation. For its part, the department maintained that it provided available information that was sufficient for the bidders to assess future health care costs.

[23] A Comprehensive Assessment of the Michigan Department of Corrections Health Care System, National Commission on Correctional Health Care, January 2008; also Michigan Department of Corrections website: http://www.michigan.gov/corrections/0,1607,7-119-9741_11776---,00.html last viewed on September 16, 2010. The MDOC's website indicates that it is currently redesigning its contracts and reorganizing its system of health care administration, but it is likely that this has not been updated since the PHS contract began.

Once the contractor assesses the future health care needs and future costs, it must decide on a premium amount to cover the risk that its assessment is wrong. The ability to accurately forecast future health care needs and particularly future costs diminishes as the contract lengthens. Consequently, the risk premium increases. This is not beneficial for either the government or the contractor. The more conservative and responsible contractor may price itself out of competition, even though it is the most capable of performing the service. The less cautious contractor may underbid and later request modifications in price or scope, underperform, or terminate the contract because of inadequate financial return. It is possible for even the most conscientious contractor to underbid, but lowering the risk lessens this possibility.

A fixed-term contract with no out and no caps for excessive expenditures is essentially an insurance contract, with the premium set by the vendor and paid by the government. Facing volatile increases in the cost of health care services, the vendor will choose to either: (1) build in enough profit to mitigate the risk, without bidding so low that it will be forced to terminate the contract or risk significant financial loss; or (2) bid with less regard for risk while maintaining a fall-back position of terminating the contract if it becomes untenable. In the first case, the public entity will likely pay more than necessary for health services. In the second case, the public entity will likely face inflated costs to obtain services to bridge the gap between the terminated contract and any new contract, or will be forced into quickly entering a new contract or contracts without adequate competition.

Alternative Approaches if Privatization of Prison Health is Expanded

There are several variations of the traditional fixed-price, long term contract that may be considered if there is a fresh attempt at contracting for comprehensive health care services.

- Many long-term contracts for comprehensive health care, including Florida's Region IV contracts, have a fixed annual percentage increase. This is fundamentally no different than a contract without automatic price increases. Although the baseline is raised, the same assessment of risk and prediction of future costs is required by the contractor.
- Contracting for shorter terms would reduce the risk and, theoretically, the risk premium that is charged by the contractor. However, short term contracts are generally undesirable in contracting for comprehensive health care services for a number of reasons inherent to the type of service provided and the restrictions of state contracting. Chief among these are frequent start up costs and the prospect of bid protests that may delay implementation of subsequent contracts, requiring expensive short term solutions to bridge the gap between contracts.
- Providing for renegotiation of prices at specified intervals or upon the occurrence of specified or unanticipated events could also reduce risk and lower overall costs. To the extent allowed by state purchasing laws, the contract could provide for annual or biennial renewal upon negotiated terms. Renegotiation could also be triggered by events such as an increase in the cost of physician's services beyond a certain amount. This would allow increases or decreases in the contract price based upon current conditions and have a similar effect to shorter term contracts, while reducing the potential for bid protests.
- The contract could reduce the risk of the contractor having to absorb the costs of expensive and infrequent types of care, such as bone marrow transplant, by excepting such expenses from the contract. The care could either be separately contracted for by the entity, or the contractor could arrange for or provide the care and pass-through the costs to the entity. Another similar approach is to cap the contractor's liability for treatment of catastrophic illnesses or accidents. Removing the contractor's risk of exposure to high cost care would allow for a more accurate prediction of costs for normal treatment. Of course, it also removes certainty of costs for the government entity, one of the benefits of contracting.
- The contract could specify a threshold of the anticipated level of care for appropriate categories or expenses, such as the number of days of inpatient hospitalization in a community facility. Alternatively, the threshold could be a set amount of expenditures. A mechanism should be included to share any savings achieved if the threshold is not met, and to share costs if the threshold is exceeded.

In conclusion, the private operation of prisons is a contentious issue on ideological grounds because some view restricting liberty as a purely governmental function. However, the use of private providers for inmate health care does not raise such philosophical questions. In fact, the failure to use private providers on at least a limited basis – such as obtaining necessary care from a private specialist – may be unconstitutional. Whether inmate health care

services are provided by government employees or by private individuals or companies, the focus should be on ensuring that constitutionally acceptable health care is provided to inmates in a cost-effective manner. With proper planning and monitoring, there is no reason that this standard cannot be met by either a public, private, or mixed method of delivery.