



# Public-Private Partnerships in Correctional Health Care

By Lauren Galik and Leonard Gilroy

## Introduction

Over the past several decades, state prison populations have skyrocketed, and so too have corrections expenditures. According to U.S. Census Bureau statistics, states spent a combined \$32.2 billion (in 2011 dollars) on corrections expenditures in 1992; in 2011, states spent a combined \$47 billion.<sup>1</sup>

One of the driving factors behind these growing corrections budgets is the dramatic rise in correctional health care expenditures. According to a 2012 Bureau of Justice Statistics report, 42 of the 44 states it surveyed saw an increase in correctional medical expenditures between 2001 and 2008, with expenditures increasing by 50 percent or more in 21 states over that period.<sup>2</sup> Currently, health care spending accounts for an average of 10 to 20 percent of state corrections budgets. In 2011, states spent a combined \$7.7 billion on correctional health care, accounting for roughly 16 percent of all corrections expenditures that year, according to a 2014 report published by The Pew Charitable Trusts.<sup>3</sup>

In an attempt to control costs while maintaining high levels of service, a number of states have begun to form public-private partnerships (PPPs) in correctional health care by contracting out some or all of their prison health services—including medical, mental health and dental services—to private companies.

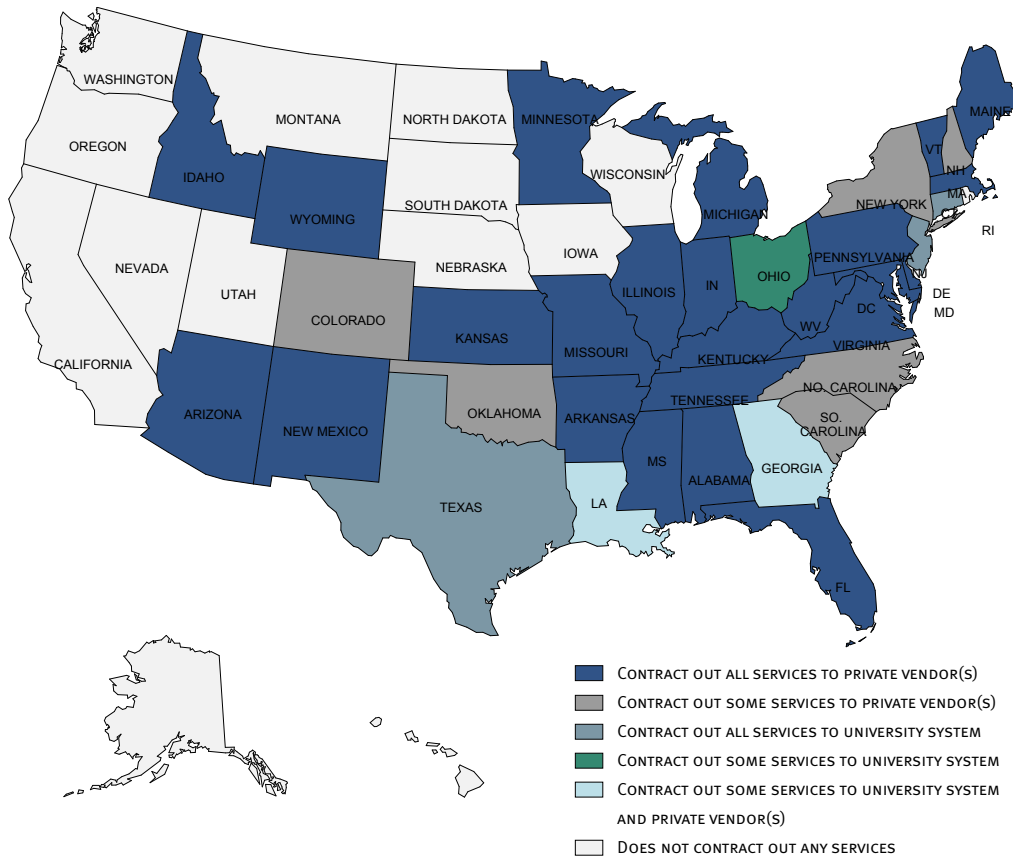
This paper gives a brief overview of what the current state correctional health care market looks like, and explores the various options states have pursued to provide their inmates with health care while incarcerated.

## Overview of the Correctional Health Care Market

Over the last several decades, many state corrections agencies have shifted the responsibility for inmate health care provision to outside third parties. Reasons vary, but include the pursuit of lower costs, a desire to improve the quality of health care services delivered, and an attempt to more squarely focus on the operation and administration of prisons themselves, as opposed to specialized services delivered within them.

Figure 1 below shows the variety of public, private and hybrid models of correctional health care provision by state. Currently, only 14 state correctional health care systems are completely self-operated by government correctional agencies, while 36 states contract out at least a portion of their correctional health care services to either a private company or their state university health system. Of these 36 states, 24 have their state correctional health care systems run completely by private companies through comprehensive, full-scope PPPs. Six other states have contracted out some health care services—but not all—to private firms. These contracted services range from comprehensive services, such as mental health care, to specialized services, such as dialysis or telemedicine services, for example.

Moreover, three states—Texas, Connecticut and New Jersey—have their state correctional health care systems run completely by their respective state university health systems. One state, Ohio, partners with its state university health system to provide some services, and two others—Georgia and Louisiana—contract out some services to private vendors and other services to their state university systems.

**Figure 1: State-by-State Correctional Health Care Provision, 2014**

Source: Author's Construct

According to a comprehensive review of current state correctional health care contracts and state budget data, **private correctional health care companies provided states an estimated \$1.9 billion in correctional health care services in 2013.**<sup>4</sup> Though inconsistency among states in budget reporting precluded the calculation of total spending on correctional health care across the states in 2013, given the previously cited figure of \$7.7 billion spent on correctional health care by all 50 states in 2011, it is reasonable to conclude that contracts with private health care providers account for a significant share of overall correctional health care spending.<sup>5</sup>

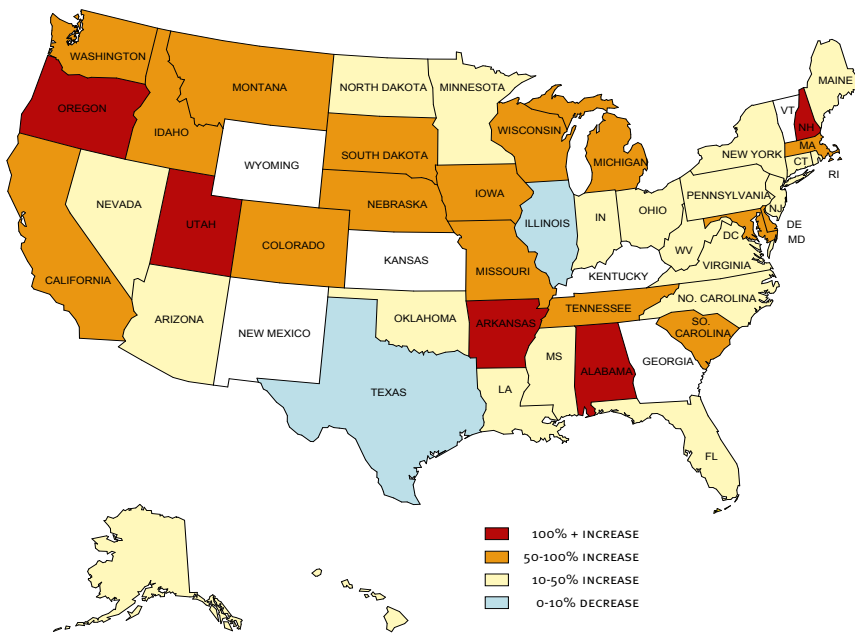
## The Rationale for Correctional Health Care Contracting

There are several potential advantages to forming PPPs in correctional health care, which include cost savings, improved performance and quality of services inmates receive, incentivizing innovation in care, and transferring risk of litigation away from the state.

### A. Cost Savings

Between 2001 and 2008, a majority of states saw a sharp increase in correctional medical expenditures. According to the Bureau of Justice Statistics, 42 out of the 44 states it surveyed saw an increase in correctional medical expenditures between 2001 and 2008. In 21 states, correctional medical expenditures increased by 50 percent or more, and in five of these 21 states, correctional medical expenditures increased by more than 100 percent. Only two states—Texas and Illinois—saw modest reductions in correctional medical expenditures between 2001 and 2008.<sup>6</sup>

**Figure 2: Percentage Difference in Correctional Medical Expenditures, 2001–2008**



Source: “State Corrections Expenditures, FY 1982–2010,” U.S. Department of Justice, Office of Justice Programs, Bureau of Justice Statistics. December 2012

According to the aforementioned 2014 report published by The Pew Charitable Trusts, total spending on correctional health care peaked in 34 states in 2009 and 2010, and many states significantly reduced the amount spent on correctional health care between then and 2011. Nevertheless, the majority of states spent more on correctional health care in 2011 than in 2007. Between 2007 and 2011, 32 states saw an increase in correctional health care expenditures, but only two states—Montana and Delaware—saw correctional health care expenditures increase by more than 30 percent. Eight states saw a modest reduction in correctional health care expenditures between 2007 and 2011. Oklahoma saw the largest percentage decrease in correctional health care expenditures between 2007 and 2011 (14 percent), although three other states experienced a decrease in correctional health care expenditures by 10 percent or more. All in all, the report found total state correctional health care spending increased by an average of 13 percent between 2007 and 2011 in all 50 states.

Increased spending on correctional health care is coming at the same time as a growing concern among correctional administrators about containing costs amid post-Recession budget challenges and future fiscal uncertainty. According to a 2011 survey of correctional professionals conducted by the National Institute of Corrections, cost containment was a critical or significant concern for 98.5 percent of respondents' organizations.<sup>7</sup> Moreover, 92 percent of respondents indicated that their corrections agency had been engaged in targeted cost containment efforts within the past five years as a result of budget constraints.

A 2013 report by The Pew Charitable Trusts demonstrates that outsourcing correctional health care services presents a promising opportunity for states to save taxpayer dollars and maintain or improve the quality of inmate care while protecting public safety.<sup>8</sup> The potential of cost-savings is particularly attractive to states that are struggling to balance their budgets, or are seeking to reduce corrections expenditures more generally. As such, more states have begun to contract out some or all of their correctional health care services to private vendors through PPPs.

Indeed, private vendors have fewer bureaucratic barriers and a greater incentive to employ cost-efficient measures than a state-run system has, and states that have used public-private partnerships in correctional health care have seen enormous savings. In 2000, the National Institute of Corrections (NIC) found that states that contracted out their health care services saved \$2.22 per inmate per day on average compared to states that did not contract out correctional health services.<sup>9</sup>

Forming public-private partnerships in correctional health care gives states the opportunity to set the vendor's rate of compensation, which in turn brings more predictability for state budgets. Moreover, many states that have contracted out their correctional health care services have built cost-savings in to the contract. For example, states have either set the per diem payment rate, or set an amount vendor payments may not exceed in their contracts.

#### **Containing Costs through Correctional Health Care Contracting: Some State Examples**

*Florida:* Florida recently signed contracts with two vendors to provide comprehensive correctional health care services to all of its state prisoners. One vendor provides services to inmates in the northern and central part of the state; the other vendor provides services to inmates in the southern part of the state. The language stated in both contracts requires the Florida Department of Corrections to compensate one vendor at a rate of \$8.42 per inmate per day, and the other vendor at \$8.48 per inmate, per day.<sup>10</sup> According to the Bureau of Justice Statistics, Florida spent \$12.93 per inmate per day in 2008, which would amount to \$14.05 in 2014 dollars (adjusted for inflation).<sup>11</sup> These built-in, contractually binding compensation requirements will allow Florida to save between \$5.57 and \$5.63 per inmate per day, or an average of \$2,044 per inmate per year as compared to what it spent in 2008. At the time the contracts were signed, officials at the Florida Department of Corrections estimated that annual savings from the two contracts would total approximately \$50 million per year.<sup>12</sup> The savings achieved from these contracts will significantly benefit Florida taxpayers immediately and in the long run.

*Kansas:* As of January 2014, Corizon is responsible for providing correctional health care services for the Kansas Department of Corrections. Instead of setting a per diem compensation rate, the department outlined figures that are not to be exceeded for each potential fiscal year. While this may not necessarily allow Kansas to achieve as significant of cost-savings as compared to setting a per diem price, this method brings predictability and certainty in future corrections budgets that would not come from keeping services in-house.

By setting a per diem rate or a price limit within the contract, states shift the financial risk to the provider and create a strong incentive for the vendor to become more efficient in managing care and controlling costs.<sup>13</sup>

## **B. Performance**

Another benefit of switching from a government-run correctional health care system to a public-private partnership is that the level and quality of care will likely improve.

When states outsource their correctional health care services to private vendors, they do so only for a limited time, and are free to contract with other companies if they're not satisfied with a particular vendor's performance, among other things. This in turn creates a competitive marketplace that incentivizes these private companies to provide better quality care than their competitor in order to obtain a contract renewal, or enter into a new state contract. To a vendor, the threat of a failed contract renewal serves as an incentive to provide the highest quality care at the lowest cost over the duration of the company's contract. If the company doesn't offer the level or quality of services that the state finds acceptable, it may choose to contract services out to another vendor that has offered to provide better quality services.

### **Using Contracting to Drive Performance in Prison Health Care**

*Pennsylvania:* In December 2013, the Pennsylvania Department of Corrections awarded a five-year mental health services contract to incumbent provider MHM Services that was updated to significantly ratchet up performance standards. The contract contains financial incentives to reduce the number of misconducts for mentally ill offenders, the number of inmates recommitted to prison mental health units, and the number of commitments to prison residential treatment units. Conversely, MHM will face financial penalties if it fails to achieve targeted baseline results for those same metrics. Also, MHM will be required to monitor and maintain or exceed an established baseline medication compliance rate. "No longer are we issuing contracts for just a service," Pennsylvania Corrections Secretary John Wetzel noted in a press release. "From this point on, our contracts will focus on results. The new contract includes performance measures that will ensure taxpayers are getting what they pay for, including inmates who leave our system better than when they entered it."

*Delaware:* The Delaware Department of Corrections has performance-based compensation built in to its contract with the company that provides comprehensive health care services to its inmates. These payments may only be made when the vendor's performance goes beyond what the contract specifies.<sup>14</sup> In 2012, the Delaware Department of Corrections was released from its Amended Memorandum of Agreement (AMOA) on inmate medical and mental health care services with the United States Department of Justice, an agreement that lasted for six years.<sup>15</sup>

*Kansas:* The Kansas Department of Corrections requires its correctional health care providers to meet certain performance measures, and imposes penalties when standards are not met. For example, providers must pay a \$100 fine if an inmate fails to receive a physical exam within seven days of admission to prison.<sup>16</sup> These contractual performance measures have helped to improve the quality of care inmates receive. Viola Riggan, director of health care services for the Kansas prison system, claims that there has been a dramatic decline in inmate grievances and lawsuits over the quality of care as a direct result of these measures.<sup>17</sup>

Indeed, a number of states have failed to provide adequate care to their institutional populations on their own, and as a result, have been required by the courts to improve the quality of their inmate health care or face further repercussions. As such, some states have opted to contract out all or some of their correctional health care with the sole purpose of improving the quality of care to the level that satisfies the courts.

### C. Accountability

Public-private partnerships are beneficial because they create options for corrections officials to determine the optimal means of delivering services, with the potential for substantial cost savings. Additionally, they bring accountability that isn't possible with government-provided services. For example, the terms of the contract, government monitoring, policymaker oversight, internal audits and compliance reviews, and obligations to corporate shareholders all ensure PPPs are held accountable.<sup>18</sup> With PPPs, states also have the ability to terminate contracts with companies whose performance is less than adequate, which is sometimes the case. This type of accountability is not possible when services are kept in-house.

Contracts with private providers specifically outline the responsibilities and expectations the provider must meet. For example, states may require that private providers provide a specific percentage in savings over the term of the contract as a necessary condition for approval.<sup>19</sup>

To ensure that the contracted health services meet national standards, states may require providers to have their health services accredited by a national certification organization, such as the National Commission on Correctional Health Care (NCCHC) or the American Correctional Association (ACA), to ensure that facilities are meeting national health standards.<sup>20</sup> However, private providers also have the incentive to voluntarily acquire these accreditations in order to be competitive in the market for PPPs.

### D. Risk Transfer

One of the major risks corrections departments face is litigation from inmates, especially when it comes to grievances over the conditions of their confinement. Though inmate lawsuits concerning conditions such as health care represent a small portion of litigation by inmates, these lawsuits can be extremely expensive



to states. In addition to individual lawsuits, an entire inmate population can challenge the correctional health care system in a class action lawsuit. These types of lawsuits have the potential to last for years or even decades, and can cost states millions of dollars.<sup>21</sup>

When states contract with private companies, the risk of litigation is shifted away from the state and on to the provider. This not only protects the state from potentially costly lawsuits, but creates an incentive for companies to provide excellent care in order to avoid having to bear the costs of litigation as well.

### **Recent High-Profile Class Action Lawsuits Over State Prison Health Care**

*California:* In California, a federal class-action lawsuit was filed in 2001 that alleged the state of medical care in California’s prisons violated the Eighth Amendment of the United States Constitution. In 2002, California settled the lawsuit by agreeing to reform its prisoner medical health care system.<sup>22</sup> In 2006, after years of little progress, the court placed control of the prison medical care program in the hands of a federal Receiver to oversee the reform process.<sup>23</sup> Since then, California has continually failed to demonstrate to federal courts that it is fully capable of meeting its obligation of delivering adequate health services independent of federal oversight, the original class action lawsuit has still not been settled, and taxpayers have been left to bear the burden of these litigation costs.

*South Carolina:* In January 2014, a judge ruled that the treatment of inmates suffering serious mental illness by the South Carolina Department of Corrections is unconstitutional and threatens the mental health of inmates. The ruling was a result of a class action lawsuit that was originally filed by inmates in 2005. Judge Michael Baxley wrote in his order, “Evidence in this case has proved that inmates have died in the S.C. Department of Corrections for lack of basic mental health care.” Evidence showed that the South Carolina Department of Corrections has known “its mental health program is systemically deficient and exposes seriously mentally ill inmates to a substantial risk of serious harm,” for more than 10 years. Baxley gave the South Carolina Department of Corrections 180 days to prepare a plan to remedy the situation.<sup>24</sup>

## **E. A More Businesslike Approach**

Public-private partnerships can bring a more businesslike, flexible approach to the delivery of public services, offering a range of benefits that include enhanced personnel management and reduced long-term liabilities for governments. Because they exist outside of the traditional civil service system, private contractors often have more flexibility—and far less red tape—in

recruiting personnel than governments, allowing them to be more competitive in offering market-rate compensation packages, granting performance bonuses and similar incentives, and creating more opportunities for upward professional mobility. On the latter point, a private firm operating on a regional or national basis may offer much more to an employee in terms of professional advancement—with more room to move up the corporate ladder or to similar positions in other cities or states—than a typical government, which is geographically constrained. Private contractors also have much more flexibility in terms of laying off underperforming employees as compared to a typical government where civil service laws and regulations can make this process lengthy or virtually impossible, in some cases.

Further, many states and local governments are facing a looming crisis in terms of unfunded liabilities for retiree pension and health care benefits. States and local governments have unfunded retiree pension liabilities ranging between \$1 trillion and \$4 trillion, according to various estimates, and unfunded retiree health care liabilities at the state level are estimated at \$530 billion.<sup>25</sup> While the scale of this problem strongly suggests the need for major reforms to retiree benefits for many governments, contracting out public services—and thus shifting from a reliance on in-house government employees to outside private contractors—can be one way for governments to avoid creating similar unfunded liabilities in the future.

Future retiree pension and health care benefits for the *current* workforce typically represent a long-term cost to taxpayers. By contrast, service contracts with private providers include all salaries and benefits in the contracted rates, so there is no outstanding obligation for taxpayers to cover benefits once the contract is over. Instead, private operators typically provide 401(k)-style defined contribution accounts and group health care coverage for their employees, and responsibility for paying these benefits belongs to the company alone, not future taxpayers.

## Conclusion

The twin challenges of the rapid rise in state spending on corrections in recent decades and the lingering fiscal challenges facing state governments—particularly in the wake of the Great Recession—have prompted corrections officials to seek ways to better control costs while maintaining high levels of service. This helps to explain why nearly half the states (24 total) contract with

private providers to deliver all of their correctional health care services and why nearly two-thirds of states (30 total) have some form of privatization in the service delivery mix, creating a \$1.9 billion market in privatized correctional health care in 2013. Not only do public-private partnerships in correctional health care offer the opportunity to lower or better control costs, but they also offer a powerful means of improving performance, increasing accountability and reducing taxpayer risks in prison health care service delivery.

## About the Authors

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## Endnotes

- 1 Total corrections expenditures for 1992 taken from United States Census Bureau’s Annual Survey of State Government Finances, 1992. Available at: [www2.census.gov/govs/state/92statess.xls](http://www2.census.gov/govs/state/92statess.xls). Inflation adjustments calculated with United States Department of Labor, Bureau of Labor Statistics CPI (Consumer Price Index) Calculator. Available at: [http://www.bls.gov/data/inflation\\_calculator.htm](http://www.bls.gov/data/inflation_calculator.htm). Total corrections expenditures from 2011 taken from United States Census Bureau’s Annual Survey of State Government Finances, 2011. Available at: [www2.census.gov/govs/state/11statess.xls](http://www2.census.gov/govs/state/11statess.xls).
- 2 “State Corrections Expenditures, 1982–2010,” U.S. Department of Justice, Office of Justice Programs, Bureau of Justice Statistics, December 2012, revised October 22, 2013, p. 6–7. Available at: <http://www.bjs.gov/content/pub/pdf/scefy8210.pdf>
- 3 “State Prison Health Care Spending: An Examination,” The Pew Charitable Trusts, MacArthur Foundation, July 2014. Available at: <http://www.pewtrusts.org/~media/Assets/2014/07/StatePrisonHealthCareSpendingReport.pdf>
- 4 Sources for the dollar estimation are individual vendor contracts obtained by Reason Foundation or spending listed on state transparency websites. Estimation of private health care spending does not include figures for correctional health care spending on services provided by universities. The estimation includes figures from the following states: Alabama, Arizona, Arkansas, Delaware, Florida, Georgia (only includes amount spent on private health care services, not services provided by the university), Idaho, Illinois, Indiana, Kansas, Kentucky, Massachusetts, Maryland, Maine, Michigan, Minnesota, Missouri, Mississippi, New Hampshire, New Mexico, Pennsylvania, Tennessee, Virginia, Vermont, West Virginia and Wyoming. Figures from Colorado, Louisiana, North Carolina, Oklahoma and South Carolina are not included in this estimation.
- 5 “State Prison Health Care Spending,” The Pew Charitable Trusts, 2014.
- 6 Note: Government expenditures for fiscal years preceding 2010 were inflation-adjusted to 2010 dollars in the report. “State Corrections Expenditures, FY 1982–2010,” U.S. Department of Justice, Office of Justice Programs, Bureau of Justice Statistics, December 2012, revised October 23, 2013, p. 7. Available at: <http://www.bjs.gov/content/pub/pdf/scefy8210.pdf>
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- 8 “Managing Prison Health Care Spending,” The Pew Charitable Trusts, MacArthur Foundation, State Health Care Spending Project, October 2013, p. 26. Available at: [http://www.pewtrusts.org/uploadedFiles/wwwpewtrustsorg/Reports/State\\_policy/SHCS\\_Pew-Managing\\_Prison\\_Health\\_Care\\_Spending\\_Report.pdf](http://www.pewtrusts.org/uploadedFiles/wwwpewtrustsorg/Reports/State_policy/SHCS_Pew-Managing_Prison_Health_Care_Spending_Report.pdf)
- 9 U.S. Department of Justice, Federal Bureau of Prisons, National Institute of Corrections, *Prison Health Care Survey: An Analysis of Factors Influencing Per Capita Costs, 2000*, <http://static.nicic.gov/Library/015999.pdf>, p. 22.
- 10 “The Department will compensate the Contractor on a monthly basis, for the provision of comprehensive healthcare services as specified in Section II., Scope of Service, at the Single Capitation Rate of **\$8.4242** Per-Inmate, Per Day (Unit Price) times the average monthly number of inmates, times the number of days in the month”—Contract Amendment Between the Florida Department of Corrections and Wexford Health Sources, Inc. Contract #C2758, Amendment #2, p. 105. Available at:

<http://www.dc.state.fl.us/business/contracts/C2758.pdf>; “The Department will compensate the Contractor on a monthly basis, for the provision of comprehensive healthcare services as specified in Section II., Scope of Service, at the Single Capitation Rate of **\$8.4760** Per-Inmate, Per Day (Unit Price) times the average monthly number of inmates, times the number of days in the month”—Contract Amendment Between the Florida Department of Corrections and Corizon, Inc. Contract #C2757, Amendment #1, p. 104. Available at: <http://www.dc.state.fl.us/business/contracts/C2757.pdf>

- <sup>11</sup> The Bureau of Justice Statistics report states that in 2008, Florida’s medical expenditures per capita were \$4,721 in 2010 dollars (adjusted for inflation). Per inmate per day cost (\$12.93) was calculated by dividing the 2008 per capita cost by 365. According to the report, “State medical expenditures for correctional institutions were compiled using state government accounting spreadsheets. The Bureau of Justice Statistics (BJS) categorized all costs associated with medical care, including mental health and dental costs. Medical expenditures included medical personnel costs, contract medical services, operational costs associated with medical units, and capital outlay and supply expenditures related to providing medical care. The categorized expense data were sent to state budget officers twice for verification: once after the initial categorization and again for confirmation before publication.” “State Corrections Expenditures, FY 1982–2010,” U.S. Department of Justice, Office of Justice Programs, Bureau of Justice Statistics, December 2012, revised October 23, 2013, p. 7. Available at: <http://www.bjs.gov/content/pub/pdf/scefy8210.pdf>; The \$14.05 figure was calculated with the CPI Inflation Calculator, Bureau of Labor Statistics, United States Department of Labor (calculating what \$12.93 in 2010 dollars would be valued at in 2014). Available at: [http://www.bls.gov/data/inflation\\_calculator.htm](http://www.bls.gov/data/inflation_calculator.htm)
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- <sup>16</sup> “Managing Prison Health Care Spending,” The Pew Charitable Trusts, 2013.
- <sup>17</sup> Ibid.
- <sup>18</sup> Leonard Gilroy et al, “Public-Private Partnerships for Corrections in California: Bridging the Gap Between Crisis and Reform,” Reason Foundation and Howard Jarvis Taxpayers Foundation. Policy Brief of Policy Study No. 381, April 2010 (revised April 2011). Available at: [http://reason.org/files/private\\_prisons\\_california\\_policy\\_summary.pdf](http://reason.org/files/private_prisons_california_policy_summary.pdf)
- <sup>19</sup> Example: Florida mandates that a contract for prison privatization must save taxpayers seven percent over the term of the contract as a necessary condition for approval. Florida Statute § 957.07 (2013), <http://www.flsenate.gov/Laws/Statutes/2013/957.07>

- <sup>20</sup> Description of National Commission on Correctional Health Care’s (NCCH) health services accreditation available here: [http://www.ncchc.org/filebin/Accreditation/2013\\_Brochure.pdf](http://www.ncchc.org/filebin/Accreditation/2013_Brochure.pdf); Description of American Correctional Association’s (ACA) Performance Based Standards for Correctional Health Care available here: <https://www.aca.org/standards/healthcare/>
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- <sup>25</sup> For the low end of the range, see The Pew Charitable Trusts, *The Fiscal Health of State Pension Plans: Funding Gap Continues to Grow*, March 2014, Available at: [http://www.pewstates.org/uploadedFiles/PCS\\_Assets/2014/WideningTheGap\\_Factsheet.pdf](http://www.pewstates.org/uploadedFiles/PCS_Assets/2014/WideningTheGap_Factsheet.pdf). For the high end of the range, see Cory Eucalitto, *Promises Made, Promises Broken—The Betrayal of Pensioners and Taxpayers*, State Budget Solutions, September 2013, Available at: <http://www.statebudgetsolutions.org/publications/detail/promises-made-promises-broken-the-betrayal-of-pensioners-and-taxpayers>. The \$530 billion estimate on unfunded liabilities in retiree health care was reported in Moody’s Investors Service, *US Municipal Governments Can Leverage Federal Medicare to Lower OPEB Costs*, March 2014. Available at: <http://media.navigatore.com/documents/Medicare+Helping+Muni+Governments+Lower+OPEB+Costs2.pdf>.