

A GRASSROOTS LEADERSHIP SOUTH CAROLINA FAIR SHARE
SPECIAL REPORT

PRESCRIPTION FOR DISASTER: COMMERCIALIZING PRISON HEALTH CARE
IN SOUTH CAROLINA

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Prescription for Disaster: Commercializing Prison Health Care in South Carolina

Executive Summary

South Carolina's Department of Corrections, despite a previous costly, inefficient and troubled experience with commercialized health care in a portion of its prison medical services system, has announced that it will soon be privatizing all of its prison health care services. This report documents the many problems—from seriously deficient services provided to prisoners to cost over-runs and unpredictable, unstable contracting arrangements—associated with privatized prison health services in South Carolina and the nation at large.

From 1986 to 2000, South Carolina contracted with Corrections Medical Services [hereafter, CMS], a private corporation with a checkered record of providing comprehensive health services—that is, medical and psychiatric care-- to prisons and jails around the country. CMS' contract with the Department of Corrections [hereafter, SCDC] initially provided services to three prisons (Coastal Pre-Release Center, Lieber, and MacDougall); by 1999, its contract covered ten facilities and it received \$31 million from the state in the two fiscal years ending in June, 1999.

As the South Carolina General Assembly's Legislative Audit Council's report, *A Review of the Medical Services at the SC Department of Corrections*¹, documents with great clarity, the experience of privatized health care in the S.C. prison system was rife with problems that ranged from medical care of very poor quality to failures of the Department to exercise its mandated oversight responsibilities to cost over-runs and substantial funds expended on services that were never provided.

The record of the CMS contract with the State of South Carolina is a dismal one, and though it is clear that the state failed in its monitoring responsibilities, CMS nevertheless

complained that monitoring was “excessive and disruptive” in citing its reasons for terminating its contract. This attitude is likely to prevail in any future privatized prison health system and bodes ill for both sick prisoners and for the state’s taxpayers.

South Carolina has already had a bad experience with commercial prison health care, and there is no doubt that it has wasted many thousands of dollars on shoddy care to the nearly 24,000 people in its prisons. Instead, this money could have been spent on better, state-provided health services and on vigilant monitoring to assure those services were, in fact, being given. The sorry experience that other states have had with privatized prison health care should be caution enough to halt the drive toward re-privatizing South Carolina’s system.

Indeed, we agree with a recent editorial in *The State* which cautioned: “...officials should not rush to privatize health care at prisons—or any other public function...out of desperation because of a tight budget.” South Carolina has the opportunity to learn from its own past mistakes and from the problems experienced elsewhere. It also has an opportunity to examine effective and humane improvements that it and other state governments have achieved that have modernized and made more efficient their prison medical services without sacrificing quality or cost.

Introduction

South Carolina’s Department of Corrections, despite a previous costly, inefficient and troubled experience with commercialized health care in a portion of its prison medical services system, has announced that it will soon be privatizing all of its prison health care services. This report documents the many problems—from seriously deficient services provided to prisoners to cost over-runs and unpredictable, unstable contracting arrangements—associated with privatized prison health services in South Carolina and the nation at large.

The South Carolina Experience: It Didn't Work Then, Why Would It Work Now?

From 1986 to 2000, South Carolina contracted with Corrections Medical Services [hereafter, CMS], a private corporation with a checkered record of providing comprehensive health services—that is, medical and psychiatric care-- to prisons and jails around the country. CMS’ contract with the Department of Corrections [hereafter, SCDC] initially provided services to three prisons (Coastal Pre-Release Center, Lieber, and MacDougall); by 1999, its contract covered ten facilities and it received \$31 million from the state in the two fiscal years ending in June, 1999.

As the South Carolina General Assembly’s Legislative Audit Council’s report, *A Review of the Medical Services at the SC Department of Corrections*¹, documents with great clarity, the experience of privatized health care in the S.C. prison system was rife with problems that ranged from medical care of very poor quality to failures of the Department to exercise its mandated oversight responsibilities to cost over-runs and substantial funds

expended on services that were never provided. Some of the many serious deficiencies documented in the audit were:

A comparison of medication provision to chronically mentally ill inmates at a SCDC operated prison and one run by CMS showed timely provision at a 92% rate at the state run facility but only 54% at the one where CMS was responsible. Further, CMS failed completely in its discharge planning responsibilities for the mentally ill leaving prison: either there was no discharge summary at all or summary documents were not sent to the agencies responsible for follow-up.²

Mental health staff at both CMS and SCDC-run institutions did not meet minimum requirements, but since CMS had contracted to employ appropriately credentialed staff, it violated its agreement.³

SCDC did not adequately monitor, with the result that CMS was not held accountable for the services it was contracted to provide. For instance, there were no behavioral health audits between July 1998 and May 1999, no medication audits of 7 of 8 institutions where they were supposed to be done, and no re-audits of the preponderance of institutions where a corrective plan was required. There were also virtually no audits of SCDC-provided health care during FY 97-98 and 98-99.⁴

SCDC did not monitor staffing levels at the facilities where medical services were contracted and failed, through inadequate auditing, to ensure that contracted health care was adequate.⁵

In those situations in which audits were done, compliance rates were very low (46% for medication delivery in one case).⁶

An improperly executed contract by SCDC and its lax monitoring health care delivery at levels far below contract specifications resulted not only in inferior services to the incarcerated but also in fiscal loss to the state, perhaps running to millions of dollars.⁷

The record of the CMS contract with the State of South Carolina is a dismal one, and though it is clear that the state failed in its monitoring responsibilities, CMS nevertheless complained that monitoring was “excessive and disruptive” in citing its reasons for terminating its contract.⁸ This attitude is likely to prevail in any future privatized prison health system and bodes ill for both sick prisoners and to the state’s taxpayers.

Paying More for Less

Privatized health care, despite being inadequate, is apparently also more expensive. As an example, when state health regulators forced the SCDC to close five prison infirmaries in January 2003, 20 prisoners were moved to the infirmary at Kirkland Correctional and 18 went to Columbia Care, run by a private health care corporation, Just Care Inc. of Alabama. SCDC’s chief accountant, Bruce Burnett, was quoted as estimating that private

care would cost the state \$20,000 more per prisoner per year. Two of Just Care's top officers were former employees of CMS, and the company had contributed \$3,500 to former Governor Jim Hodges' re-election campaign.⁹

As will be demonstrably documented below, South Carolina's bad experience with commercialized prison health care is not unique. On the basis of its own experience, the state and the SCDC should surely be extremely wary of repeating the experience. Indeed, we must ask: why would the State and the Department even be considering privatization again?

Experiences in Other States: A Costly Experiment That Has Failed

Bad Medicine

The U.S. Supreme Court has ruled that the 8th Amendment requires that the incarcerated receive adequate health care, including mental health and dental care, and that these requirements obtain whether the services are provided directly by the state or by contracted medical personnel.¹⁰

Commercialized—often called “privatized”—prison health care has become a popular development around the country. Companies have argued that it is a cost-saver for the states and localities that employ it. But an examination of the record shows that this method has been a disaster, not only for the incarcerated whose care has been precarious at best and too often injurious at worst, but also to the responsible governments that have been repeatedly sued, losing millions in damages awards and settlements. A review of published investigations, newspaper reports and academic literature reveals that commercialized prison health care is rife with abuse and malfeasance. There are numerous examples of defective privatized care; we cite only a few examples.

An exhaustive 1998 5-month study “Death, Neglect and the Bottom Line: Push to Cut Costs Poses Risks,” of the St. Louis-based, national corporation CMS revealed “a picture of an industry that, at best, is still trying to find its way through the complex problems posed by health care in a prison environment. At worst, it was a picture of an industry that takes advantage of the public's ill will toward people in prison to give poor care while making a profit.” More than 20 cases of deaths through “negligence, indifference, understaffing, inadequate training or overzealous cost-cutting” were cited.¹¹ This report also found that prison doctors include some who have been disciplined in the past, and some of them are not allowed to practice on the general population; distant managers make decisions based on the economic bottom line rather than on patients' needs; health personnel express attitudes that prisoners fake illnesses and consequently ignore legitimate complaints; and medical records are altered to look like doctors have issued orders when, in fact, nurses have.¹²

Hepatitis C is epidemic in the nation's prisons, yet, according to another investigation of CMS, which has responsibility for 214,000 prisoners throughout the country, “As a

matter of formal company policy, CMS discourages treatment for hepatitis, and the [onerous] protocol pathway [imposed on prisoners who request help] is just a way of making it harder for prisoners to demand it.”¹³ The same report cited examples of prisoner deaths resulting from medical neglect or malfeasance on the part of CMS doctors ranging from dehydration and starvation, discontinued insulin, and injection with wrong medication.¹⁴

Yet another investigation of CMS, this one done by a former editor of the Journal of the American Medical Association (JAMA) focused on the checkered backgrounds of some of the doctors the company has employed. For instance, the writer found that 9 CMS prison doctors in Missouri, or one in 4 of all CMS doctors in that state, had been disciplined by licensing boards. This figure compared to one in 40 of the nation’s total of 689,000 physicians.¹⁵ In Alabama, CMS hired two “key” doctors with shady pasts: one had had his license revoked in Michigan and the other had a history of sexual assault on a minor, mentally retarded boy in Tennessee.¹⁶

A 2003 investigation noted that CMS had been cited the New York State Commission of Correction’s Medical Review Board, as having “revealed numerous and significant quality care issues, including violations of nursing practice rules, severe understaffing... a resistance to oversight scrutiny and some severely problematic outcomes” (including 2 suicides) at the Broome County facilities where CMS had the contract. This news report also stated that “The Commission questions whether Correctional Medical Services, and other for-profit companies doing similar work in jails and prisons, can hire licensed medical professionals to provide services to jail inmates because state law does not authorize such activities.”¹⁷

CMS, as the nation’s largest prison health contractor, has logically been the subject of many investigations. But it is not alone. For instance (and there are examples too numerous to cite in this brief report), the August. 27, 2003 Decatur Daily (Ala) reported: “Dozens of HIV-infected inmates have died prematurely and miserably due to grossly negligent medical care at Limestone Correctional Facility.” The findings were in conjunction with a lawsuit against the provider, NaphCare, and the state.¹⁸ A three-part series on injurious health care provided by Prison Health Care [PHS] in Philadelphia’s jails criticized DePaul Health Care, the contracted monitor, and cited instances of suspicious deaths and failure to provide mental health care.¹⁹ PHS was also cited as bearing responsibility for deaths in several county facilities in Florida.²⁰

As for hiring practices, another company, ESMA Correctional Care, employed as a jail psychiatrist in Westchester County, NY, a doctor who had served a sentence for killing a college sophomore in a botched illegal abortion in the 1960s and then covering it up by “cutting her up and flushing her down his toilet.” This “doctor,” Lothringer, took a 17 year old incarcerated young woman off anti-depressants, and she subsequently killed herself. A lawsuit by the girl’s family resulted in a wrongful death settlement, the company paying \$700,000 and the employing county, \$745,000.²¹

Finally, an exhaustive study of medical practices at an unnamed county facility that

contracted with three different private medical companies from 1992-1997 found “a persistent pattern of medical ill-treatment...which extended over the entire five-year period.”²²

Law suits have remedied some medical abuses

Prisoners and their families have a hard time bringing lawsuits for medical malpractice and wrongful death. Not only are they burdened by isolation and stigma, they must also prove intention or “deliberate indifference.”²³ Nonetheless, there have been numerous successful lawsuits and judgments that have been costly to private prison health companies and governments alike. Two such cases have been mentioned above. In addition, North Carolina has prosecuted CMS for involuntary manslaughter stemming from short-staffing resulting in an inmate’s death.²⁴ In 1993, the U.S. Department of Justice’s Civil Rights Division cited CMS for providing “grossly inadequate” care at Virginia’s Norfolk County Jail; from 1981-1994, the company paid out \$4.1 million in indemnity claims, and in 1997, it had 500 suits pending against it throughout the country.²⁵ Prisoners in Youngstown, Ohio won a \$1.5 million judgment against CMS for a variety of medical care abuses, ²⁶ and other suits against CMS and NaphCare have been filed by the ACLU, the NAACP, the UAW representing public correctional officers in Michigan, the Southern Poverty Law Center, and lawyers hired privately by prisoners’ families. The ACLU has also notified several state correctional departments about gross deficiencies in privatized prison health care.²⁷

Prison Health Services has settled several lawsuits in Florida, including one for \$3 million bought by the family of an inmate who was beaten and then medically neglected and another by a nurse who sued after being fired for refusing to falsify medical records.²⁸ PHS and its purchased company, EMSA Correctional Care, are facing over 1,100 lawsuits.²⁹

Clearly, advocates for the incarcerated have recognized the many medical abuses they have suffered, and lawyers have sought to redress their injuries in court. These lawsuits have been costly not only to the medical corporations but also to the state, county, and municipal governments that have hired them.

The Problems with Commercialized Prison Medical Services The Bottom Line is What Counts

Contracted prison health care is just another form of HMOs, the increasingly dominant form of health care delivery that is widely criticized by both professionals and consumers. As one critic put it: “HMO systems have established a direct conflict between the interests of patients and medical servers.”³⁰ As in other aspects of privatized incarceration, commercial prison health care seeks to make the greatest profits it can for both its executives and its shareholders.³¹ Prison health care companies promise reduced health care costs; the many articles and reports reviewed for this paper show that they

attempt to cut their costs by creating obstacles to care, hiring too few staff, employing staff who are not licensed to practice on the general public (and thus will work for less money) or unqualified or inexperienced staff, and skimping on medication (including using expired medication). Prison health care in general is notoriously bad; it stands to reason that when the private sector becomes the provider at reduced costs, the quantity and quality of services decline. For example, the company hired to provide health services to the Miami-Dade County Detention Center employed one doctor and one nurse-practitioner for 1,800 inmates instead of the required staffing pattern of one doctor or nurse-practitioner for 500.³²

Hidden Costs of Privatized Prison Healthcare Are Substantial

Commercial prison health care also incurs additional costs to the state, including administrative costs associated with procuring and administering contracts, monitoring, and legal fees and settlements associated with litigation. For example, when Albany County (NY) privatized its jail's medical services, county officials asked for a doubling of insurance protection "in case the county is sued for improper medical care at the jail."³³

An additional problem is paying for overcharges, some of which are undoubtedly never uncovered because of lax monitoring. In Massachusetts the state auditor accused EMSA of \$1.5 million in overcharges by inflating the numbers of AIDS patients in an 18-month period in the early 1990s.³⁴ In Florida, PHS is currently under investigation by the Florida Attorney General's Office for \$3.25 million in Medicaid overcharges.³⁵

Finally, many press reports comment on the apparently common practice of switching providers, a practice that undoubtedly incurs additional administrative costs and wasted funds as health records and prescriptions are duplicated and medical personnel are changed.

When the Going Gets Tough: Commercial Providers Are Unreliable

Private prison health companies are known to renege on their contracts when costs exceed their contracted reimbursement rates. For instance, early this year, Corrections Corporation of America [CCA], which had a contract with the state of Nevada to run the Women's Correctional Facility, sought to get out of its contract unless the state took over the medical care that the company deemed too expensive. CCA claimed it couldn't find qualified staff locally, although it had claimed, when competing for the contract, that it would have less difficulty than the state in attracting medical personnel.³⁶ In Pennsylvania, Wexford Health Services, Inc. pulled out of its five-year contract with the state one year after its initiation, citing growing costs and hoping to negotiate a more lucrative contract.³⁷

In this regard, South Carolina's own previous experience is instructive. CMS had a 2 year

contract to provide medical and mental health services to prisoners in 10 of the state's facilities. In April, 1999, three months before the contract was up for renewal, CMS announced that it did not want to renew the contract. Until January 31, 2000, CMS continued, on a month-to-month basis, providing services while the state sought, unsuccessfully, for another provide vendor. The SCDC assumed all medical services in February 2000. 38

Some Governments Have Rejected Private Providers

Several jurisdictions are becoming disillusioned with commercialized prison health services, and they have found alternative ways to economize on prison health care. In 2003, Utah contracted with a prison privatization expert to evaluate whether or not to contract its health services. The consultant recommended against privatization, concluding that the state was already running its system comparatively efficiently.³⁹

In January 2004, a legislative panel in Alabama blocked three state contracts with medical contractors (providers and monitors). The reasons included that contracts are too costly in a time of budget problems; they were agreed to two months before being properly submitted to lawmakers for review; the contracts were struck without an open bid process; and contractors were from out of state.⁴⁰ In February of this year, the sheriff in Leon County, Florida threatened to discontinue PHS' contract for medical services because of persisting complaints about the quality of care.⁴¹

Hard Questions, Uneasy Answers

South Carolina has already had a bad experience with commercial prison health care, and there is no doubt that it has wasted many thousands of dollars on shoddy care to its prisoners. Instead, this money could have been spent on better, state-provided health services and on vigilant monitoring to assure those services were, in fact, being given. The sorry experience that other states have had with privatized prison health care should be caution enough to halt the drive toward re-privatizing South Carolina's system. Indeed, we agree with a recent editorial in *The State* which cautioned: "...officials should not rush to privatize health care at prisons—or any other public function...out of desperation because of a tight budget."⁴² South Carolina has the opportunity to learn from its own past mistakes and from the problems experienced elsewhere. It also has an opportunity to examine effective and humane improvements that it and other state governments have achieved that have modernized and made more efficient their prison medical services without sacrificing quality or cost.

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