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Ira P. Robbins

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MANAGED HEALTH CARE IN PRISONS AS CRUEL AND UNUSUAL PUNISHMENT

IRA P. ROBBINS*

I. INTRODUCTION

Billy Roberts, a prisoner in an Alabama state prison, had a history of severe psychiatric disorders.¹ He was often put on suicide watch, and received large doses of psychotropic drugs.² A managed health care company, Correctional Medical Services (CMS), was responsible for the health care at the prison.³ After Roberts had a suicidal episode, CMS's statewide mental health care director reportedly put Roberts in an isolation cell rather than a psychiatric care unit.⁴ The mental health care director also ordered that Roberts' medication be discontinued pursuant to an alleged policy of CMS to get as many prisoners off psychotropic drugs as possible in order to keep costs down.⁵ Six days later, Billy Roberts hanged himself.⁶

This is not an isolated case. In an effort to cut costs or to provide constitutionally adequate health care to inmates, an increasing number of prisons have been using managed care sys-

* Barnard T. Welsh Scholar and Professor of Law and Justice, American University, Washington College of Law. A.B. 1970, University of Pennsylvania; J.D. 1973, Harvard University. Author, *HABEAS CORPUS CHECKLISTS* (West Group, 2000); Editor, *PRISONERS AND THE LAW* (four vols., West Group, 1999). I am grateful to Catherine Ng, Benjamin Olson, Adrienne Turner, Sara Young, and Susan Zentay for their excellent research assistance, and to the American University Law School Research Fund for providing financial support.

¹ See *McDuffie v. Hopper*, 982 F. Supp. 817, 821 (M.D. Ala. 1997).

² See *id.*

³ See *id.* at 820-21.

⁴ See *id.* at 821.

⁵ See *id.*

⁶ See *id.*

tems to provide health care.⁷ Although the use of managed care has saved states money, the quality of health care arguably has decreased. Inadequate care has been a recurring problem in prisons run by private managed health care firms. Consequently, prisoners and staff continue to complain, and prisoners are filing suits asserting that their constitutional rights have been violated.⁸

Courts have evaluated claims of constitutional violations in cases in which prisoners have challenged the adequacy of their medical treatment under the "deliberate indifference" standard, first announced by the Supreme Court in 1976, in *Estelle v. Gamble*.⁹ In *Estelle*, the Supreme Court established that, when prison officials are deliberately indifferent to the serious medical needs of prisoners, the prisoners' Eighth Amendment right to be free from cruel and unusual punishment has been violated.¹⁰ In *Ankata v. Prison Health Services*,¹¹ for example, the United States Court of Appeals for the Eleventh Circuit held that, "if necessary medical treatment has been delayed for non-medical reasons, a case of deliberate indifference has been made out."¹² Financial considerations constitute "non-medical reasons."¹³ Thus, the use of managed care in prisons with the intent of cutting costs may constitute an institutional deliberate indifference on the part of the prisons.

⁷ See *infra* note 174 and accompanying text (discussing the role of cost-cutting in prison health care contracting); DOUGLAS C. McDONALD, NATIONAL INSTITUTE OF JUSTICE, MANAGING PRISON HEALTH CARE AND COSTS 61-72 (1995) (discussing privatization of health care by prisons in an attempt to comply with constitutional standards for adequate care); see, e.g., *Nobles v. Duncil*, 505 S.E.2d 442, 446, 451 (W. Va. 1998) (addressing privatization of health care services by a state prison in an effort to comply with a court order to remedy inadequate level of health care).

⁸ See *infra* Part III.G (discussing suits brought by prisoners); *Fifteen Tips for Contracting Out Correctional Health Care*, CORRECTIONS ALERT, Nov. 9, 1998, at 1 [hereinafter *Fifteen Tips*] (reporting complaints by prison staff).

⁹ 429 U.S. 97 (1976).

¹⁰ See *infra* Part III.A (discussing *Estelle* and the history of the "deliberate indifference" standard).

¹¹ 769 F.2d 700 (11th Cir. 1985); see also *Archer v. Dutcher*, 733 F.2d 14 (2d Cir. 1984).

¹² 769 F.2d at 704.

¹³ See *id.*

This Article examines the use of managed care in prisons and discusses some of the legal issues surrounding managed care practices. The Article argues that the use of managed care may result in an overemphasis on costs that in certain instances rises to the level of deliberate indifference, thereby violating the Eighth Amendment.

II. MANAGED HEALTH CARE IN PRISONS

The goal of managed health care is to have a health care system that operates more cost-effectively than the traditional fee-for-service system.¹⁴ In managed health care systems, however, this goal is often achieved through cost-cutting measures.¹⁵ Thus, managed health care can result in inadequate treatment for patients. Concerns regarding inadequate health care are magnified in a prison setting, in which inmates have no choice about health care and cannot seek outside advice. They are left to the discretion of the health care provider chosen by the county or state.¹⁶ In addition, since prisoners themselves are not usually paying customers,¹⁷ health care providers have even less of an incentive to provide quality care.

¹⁴ See Sharon L. Davies & Timothy Stoltzfus Jost, *Managed Care: Placebo or Wonder Drug for Health Care Fraud and Abuse*, 31 GA. L. REV. 373, 373 (1997) (stating that managed care alters the incentive structure in health care provision).

¹⁵ See *id.* at 385-87.

¹⁶ See *West v. Atkins*, 487 U.S. 42, 54-55 (1988) ("It is only those physicians authorized by the State to whom the inmate may turn."); *Estelle v. Gamble*, 429 U.S. 97, 103 (1976) ("An inmate must rely on prison authorities to treat his medical needs; if the authorities fail to do so, those needs will not be met."). Furthermore, prison officials may have a conflict of interest because they must consider both financial and medical issues. Thus, prison health care may be compromised. See, e.g., *One-Third of Texas Inmates May Have Hepatitis C, Officials Say*, DALLAS MORNING NEWS, May 29, 1999, at 39A (reporting that prison officials were undecided about whether to administer a costly but effective drug to inmates).

¹⁷ Some prison health care schemes use co-payments in providing managed health care. These systems require the inmate to pay a small fee for certain types of services. See *Reynolds v. Wagner*, 128 F.3d 166 (3d Cir. 1997) (holding that co-payment statutes as implemented are constitutional). Co-payment statutes have come under attack, but have thus far been held constitutional as long as they require payment only from inmates who have the resources to pay. See *id.* The plaintiffs in *Reynolds* challenged the co-payments under the deliberate indifference standard. See *id.* at 172. They argued, first, that the co-payments were *per se* unconstitutional, and second, that the co-payment system as implemented was unconstitutional. See *id.* The court held that the co-payment scheme was not *per se* unconstitutional: "[i]f a prisoner is able to

To understand how managed health care works in prisons, it is first necessary to consider why counties or states would choose managed health care for their prisons. While some of the reasons are logistical, the primary concern is always financial.¹⁸

A. MANAGED CARE

There are three major components of a managed care system: (1) the managed care organization (MCO), which acts as an insurer and finances the health care of the members of its health care plans;¹⁹ (2) the health care provider, which can be a physician, a group of physicians, a hospital, or a physician-hospital association;²⁰ and (3) the health plan member or patient.²¹

Managed health care evolved as a reaction by health care consumers and the federal government to rapidly escalating health care costs under the traditional fee-for-service system.²²

pay for medical care, requiring such payment is not 'deliberate indifference to serious medical needs.'" *Id.* at 174 (quoting *Helling v. McKinney*, 509 U.S. 25, 32 (1993)). The court also held that the co-payment scheme as implemented did not rise to the level of deliberate indifference. *See id.* at 178-79; *see also City of Revere v. Massachusetts Gen. Hosp.*, 463 U.S. 239, 245 n.7 (1983) ("Nothing we say here affects any right a hospital or government entity may have to recover from a detainee the cost of medical services provided to him.").

¹⁸ As inmate populations and prison health care costs have continued to increase, federal, state, and local governments have sought to cut costs by contracting with private managed care organizations. *See* Chuck Appleby, *Going Private to Capture Savings*, HOSPS. & HEALTH NETWORKS, May 20, 1997, at 70; *U.S. Medical Group Acquires American Mobile Surgical Services, Inc.*, PR NEWswire, June 7, 1999, at *1.

¹⁹ *See* LEIYU SHI & DOUGLAS A. SINGH, *DELIVERING HEALTH CARE IN AMERICA* 303-06 (1998). In an attempt to cater to varying consumer demands, MCOs take on a wide variety of forms. *See infra* note 25 (discussing the rationale behind different forms of MCOs).

²⁰ *See* SHI & SINGH, *supra* note 19, at 303-06.

²¹ *See id.*

²² From 1962 to 1975, the Consumer Price Index reported that medical costs rose 59%, more than any other major category of personal expenses. *See* ROBERT G. SHOULDICE, *INTRODUCTION TO MANAGED CARE* 28 (1991). This dramatic increase rendered the fee-for-service system, in which patients or their health insurance programs paid health care providers a fee for each service performed, unworkable because the patients or their employers could not continue to pay the escalating insurance premiums. *See id.* at 17-29. Congress responded by passing the Health Maintenance Act of 1973, 42 U.S.C. § 300(e) (1994), which encouraged the expansion of MCOs through federal assistance. *See id.* at 36. Since 1973, the number of MCOs has grown

The term "managed care" generally refers to a variety of administrative and treatment practices that attempt to improve the quality, efficiency, and cost-effectiveness of the health care system.²³ Although virtually all forms of health insurance now incorporate managed care to some degree,²⁴ for-profit MCOs are at the forefront in the application of managed care practices.²⁵ Because MCOs compete with one another to offer the lowest monthly fees to consumers, they must control health care costs through policies designed to reduce both the cost and the amount of care provided.²⁶

Because MCOs contract with employers for a fixed per-patient or per-incident fee, the MCO assumes the financial risk that costs will exceed that fixed amount.²⁷ For this reason, MCOs have a great incentive to minimize high-cost treatments, particularly those that require hospitalization or the consultation of specialists.²⁸ Because many MCOs pass the risk along to health care providers through fixed fees, doctors and other health care professionals face similar incentives to provide less treatment at a lower cost.²⁹ However, the risk that the provision

rapidly and, as of 1997, an estimated 85% of employees from firms with 10 or more employees were covered by some form of managed care. See Craig Copeland, *Issues of Quality and Consumer Rights in the Health Care Market*, EBRI ISSUE BRIEF, Apr. 1998, at 1, 5.

²³ See Vicki Yates Brown & Barbara Reid, *Managed Care at the Crossroads: Can Managed Care Organizations Survive Government Regulation?*, 7 ANNALS HEALTH L. 25, 25-26 (1998).

²⁴ See Marsha Gold, *The Changing U.S. Health Care System*, 77 MILBANK Q. 3, 8-9 (1999).

²⁵ In response to demands for health care plans that provide a choice of providers at a low cost, MCOs have taken on a range of forms and implemented a variety of managed care policies in an attempt to attract the most health care plan enrollees. See SHI & SINGH, *supra* note 19, at 313-21. For example, the two largest types of MCOs—health maintenance organizations (HMOs) and preferred provider organizations (PPOs)—compete for consumers by striking different balances between provider choice and cost-containment. See *id.* HMOs generally maintain the lowest fees by limiting enrollees to an approved group of providers. See *id.* At a higher fee, PPOs allow enrollees to choose any provider, but encourage use of approved providers by covering their treatment at a higher rate. See *id.*

²⁶ See *id.* at 303-12.

²⁷ See *id.* at 303-04; Kenneth E. Thorpe, *The Health System in Transition*, 22 J. HEALTH POL'Y & L. 339, 342 (1997).

²⁸ See Davies & Jost, *supra* note 14, at 379-93.

²⁹ See *id.*

of a low quality of care will cause the MCO to lose its contract with the consumer, or the provider to lose its contract with the MCO, acts as a counter-balance to incentives to cut costs to a point at which the quality of care becomes unsatisfactory to consumers.³⁰ Nevertheless, there is a strong concern that, left to its own devices, the market will not strike an acceptable balance between cost and quality in the provision of health care.³¹

One way that managed care controls costs is through a utilization review strategy.³² MCOs oversee the decisions made by health care providers in order to ensure that the providers are conforming to the standards set by the MCO.³³ If the providers do not conform to these standards, they can suffer financial penalties.³⁴

While there may be some debate whether managed care provides better or worse care for the patient,³⁵ it is clear that

³⁰ See *supra* note 25 (describing the competition between MCOs to provide the most service at the lowest cost); Walter A. Zelman, *Consumer Protection in Managed Care*, HEALTH AFF., Jan.-Feb. 1997, at 158, 163-64 (discussing consumer choice of managed care plans as a vehicle for consumer protection).

³¹ See Zelman, *supra* note 30, at 158 (discussing consumer fears about health care quality in managed care systems).

³² See SHI & SINGH, *supra* note 19, at 310-12.

³³ See *id.*

³⁴ See *id.*

³⁵ On the one hand, MCOs argue that reduced quantity does not mean reduced quality:

Advocates of managed care challenge conventional wisdom when they claim that doing less produces a greater outcome for the patient than taking action Managed care is a unique form of health-care delivery because it is premised on the idea that often, in medical care, less is more. What produces value in managed care is a good health outcome rather than medical intervention.

ARNOLD BIRENBAUM, *MANAGED CARE: MADE IN AMERICA* 13-14 (1997). On the other hand, the effects of managed care on health care quality have not been proven one way or the other:

One of the current realities of health policy making is that anecdotes far outweigh solid evidence when it comes to shaping the attitudes of people in relation to the performance of managed care. . . . Quality-of-care evidence from fifteen studies showed an equal number of significantly better and worse HMO results, compared with non-HMO plans. However, in several instances, Medicare HMO enrollees with chronic conditions showed worse quality of care. . . . Fears that HMOs uniformly lead to worse quality of care are not supported by the evidence Hopes that HMOs would improve overall quality also are not supported, in part because of slow clinical practice change, lack of risk-adjusted [fixed] rates, and inadequate quality measurement and reporting.

Robert H. Miller & Harold S. Luft, *Does Managed Care Lead to Better or Worse Quality of Care?*, HEALTH AFF., Sept.-Oct. 1997, at 7, 7-8. But see STATE AUDITOR OF TEXAS, AN

managed care provides less care to patients and prevents health care providers from using additional treatments and unproven medical intervention.³⁶ One of the positive aspects of managed care is that the application of business principles can reduce health care expenditures and thus allow a greater number of individuals to receive health insurance by keeping premiums low.³⁷ In addition, unnecessary treatments and unnecessary hospitalization are sharply reduced.³⁸ Managed care also encourages the use of preventive care, as patients are forced to rely more on primary care physicians.³⁹

On the other hand, doctors make less money than they do under the fee-for-service system.⁴⁰ Moreover, as described above, MCOs second-guess doctors' judgments, as doctors need to get approval from MCOs for tests and surgical procedures.⁴¹ In this way, managed care can undermine the role played by doctors in treatment decisions by compromising medical considerations with financial concerns, thereby lowering the standard of care.

B. MANAGED HEALTH CARE IN PRISONS

Managed health care in prisons is conspicuously different from managed health care on the outside. First, the general prison population is usually less healthy than the general population.⁴² Second, the quality of health care in prisons is usually

AUDIT REPORT ON MANAGED HEALTH CARE AT THE TEXAS DEPARTMENT OF CRIMINAL JUSTICE 49 (1998) [hereinafter TEXAS AUDIT] (statement of David R. Smith, M.D., President of the Correctional Managed Health Care Advisory Committee: "Texas offenders are being provided increased access to a higher quality health care at a lower cost than by pre-managed care practices.").

³⁶ See Miller & Luft, *supra* note 35, at 20-21.

³⁷ See SHI & SINGH, *supra* note 19, at 308-13.

³⁸ See *id.*

³⁹ See BIRENBAUM, *supra* note 35, at 86.

⁴⁰ See *id.* at 156-57.

⁴¹ See Thaddeus J. Nodzenski, *Regulating Managed Care Coverage*, 7 ANNALS HEALTH L. 1, 7 (1998).

⁴² See McDONALD, *supra* note 7, at 3; see, e.g., Laura Beil, *Prisons Draft Treatment Plans for Inmates With Hepatitis C; Almost 30% Have Infection; Care Will Cost State Millions*, DALLAS MORNING NEWS, June 18, 1999, at 35A (reporting that in Texas prisons more than 40,000 inmates, nearly one-third of prison population, are infected with Hepatitis C, a highly communicable and life-threatening liver disease).

lower than the quality of health care provided to the portion of the outside population covered by managed care.⁴³ Third, the patients in a prison setting have no choice regarding health plans; they must take the plan provided for them.⁴⁴ Fourth, if the health care provider in the prison refuses to provide treatment, it is difficult, if not impossible, for the prisoner to get treatment elsewhere.⁴⁵

In its structure, however, prison managed care is the same as general managed care. MCOs hire health care providers and supervise their provision of health care the same way in prisons as they do in general managed care.⁴⁶ Ultimately, the focus is on efficiency and cutting costs, since the primary goal of MCOs is enhancing the financial bottom line.⁴⁷ This goal often results

⁴³ See generally McDONALD, *supra* note 7; Michael Cameron Friedman, Special Project, *Cruel and Unusual Punishment in the Provision of Prison Medical Care: Challenging The Deliberate Indifference Standard*, 45 VAND. L. REV. 921, 932 (1992).

⁴⁴ See *Estelle v. Gamble*, 429 U.S. 97, 103 (1976).

⁴⁵ See *id.* Also, a prisoner's inability to seek treatment elsewhere could become problematic if an MCO provides hospice care in addition to curative care. Because hospice or non-curative care is significantly less expensive than curative care, an MCO may have a conflict of interest in determining whether to abandon curative care for the prisoner. See NAT'L INST. OF CORRECTIONS INFORMATION CENTER, U.S. DEP'T OF JUSTICE, *HOSPICE AND PALLIATIVE CARE IN PRISONS 2* (1998) (stating that hospice care is less expensive than traditional treatment). This issue is beyond the scope of this Article, however. For information regarding hospice care and other alternatives, see, e.g., 2 PRISONERS AND THE LAW ch. 14B (Ira P. Robbins ed., 1999) ("Compassionate Release"); Ronald H. Aday, *Golden Years Behind Bars: Special Programs and Facilities for Elderly Inmates*, 58 FED. PROBATION 47 (June 1994); William B. Aldenberg, Note, *Bursting at the Seams: An Analysis of Compassionate Release Statutes and the Current Problem of HIV and AIDS in U.S. Prisons and Jails*, 24 NEW ENG. J. ON CRIM. & CIV. CONFINEMENT 541 (1998); Nancy Neveloff Dubler, *The Collision of Confinement and Care: End-of-Life Care in Prisons and Jails*, 26 J.L. MED. & ETHICS 149, 149-56 (1998); Marjorie P. Russell, *Too Little, Too Late, Too Slow: Compassionate Release of Terminally Ill Prisoners—Is the Cure Worse Than the Disease?*, 3 WIDENER J. PUB. L. 799 (1994); Susan Lundstrom, Comment, *Dying to Get Out: A Study on the Necessity, Importance, and Effectiveness of Prison Early Release Programs for Elderly Inmates Suffering From HIV Disease and Other Terminal-Centered Illnesses*, 9 BYU J. PUB. L. 155 (1994). See also Laurie Smith Anderson, *Inmates Helping Inmates; Louisiana State Penitentiary's Hospice Program Receives National Recognition*, BATON ROUGE ADVOC., Apr. 17, 1998, at 1; Jeff Barnard, *Killers Provide Comfort to Dying Inmates in Oregon; Hospice Program Brings Solace to the Ailing, Humanity to the Caregivers*, TACOMA NEWS TRIB., July 18, 1999, at 1.

⁴⁶ See McDONALD, *supra* note 7, at 61-66.

⁴⁷ See *supra* Part II.A (discussing the motivations of MCOs).

in treatment decisions that are based less on the inmates' needs and more on saving money.⁴⁸

1. *The Different Companies*

To date, there are fourteen private sector firms that provide inmate health care.⁴⁹ Approximately twenty-nine states have managed care in all or part of their prison health care systems.⁵⁰ The two main companies that provide correctional managed health care are American Service Group, Inc. (ASG)⁵¹ and CMS.⁵² CMS has contracts that provide care "to more than 268,600 inmates at 348 correctional facilities in 30 states."⁵³ ASG, the parent company of Prison Health Services, Inc. (PHS) and EMSA Correctional Care, Inc. (EMSA),⁵⁴ manages health care for more than "134,000 inmates in 25 states."⁵⁵ Prior to ASG's acquisition of EMSA in 1999, EMSA claimed to "cover" 71,000 inmates in 19 states.⁵⁶ PHS has been providing health care in prisons since 1978, and claims to be "the founder of the managed correctional healthcare industry."⁵⁷

⁴⁸ See TEXAS AUDIT, *supra* note 35, at 49.

⁴⁹ See *Fifteen Tips*, *supra* note 8, at 1.

⁵⁰ See *id.*

⁵¹ ASG's website can be found at <<http://www.asgr.com>> [hereinafter AGS website].

⁵² CMS's website can be found at <<http://www.cmsstl.com>> [hereinafter CMS Website].

⁵³ CMS Website, *supra* note 52, at <<http://www.cmsstl.com/about.html>>.

⁵⁴ PHS's website can be found at <<http://www.prisonhealth.com>> [hereinafter PHS Website]. EMSA's website can be found at <<http://www.corrections.com/emsa>> [hereinafter EMSA Website].

⁵⁵ ASG Website, *supra* note 51, <<http://www.asgr.com/phs.htm>>. For commentary on ASG's purchase of EMSA, see Rick Rousos, *Inmate Care Provider Bought; A Parent Company Regains Jail Health Services in Polk Through Buyout*, LAKELAND LEDGER, Feb. 10, 1999, at A1; *America Service Group Announces First Quarter Gains*, CORRECTIONS PROF., May 21, 1999, at 19.

⁵⁶ See EMSA Website, *supra* note 54. In several instances, EMSA was fired due to inadequate provision of health care. Westchester County, in New York, terminated its contract with EMSA after the suicide of a teenage girl under its care. See *Health Care Firm Dropped*, N.Y. DAILY NEWS, Dec. 14, 1998, at 1. In 1996 and 1997, Polk and Pinellas Counties in Florida terminated their contracts with EMSA because of inadequate care. See *Down the Same Path?*, LAKELAND LEDGER, Aug. 31, 1996, at A8.

⁵⁷ PHS Website, *supra* note 54, <<http://www.prisonhealth.com/toppage1.htm>>.

2. *Contracts for Services*

Prisons may contract out a variety of health services. For example, the contract for Texas Correctional Managed Health Care demonstrates the typical arrangement in a prison managed care system.⁵⁸ In this contract, Texas state universities provide complete medical services to the prisons.⁵⁹ The contract contains a fee-per-offender provision that limits the amount the health care provider must spend on each inmate.⁶⁰ The fee-per-offender varies with respect to "the services provided and the differences in demographics and health status of the inmates."⁶¹ Other forms of service contracts are more limited and provide only specific off-site services, such as dental care or psychological care.⁶²

3. *Accreditation Standards*

There are some non-governmental means of ensuring the quality of care provided by a correctional managed care entity. One such means is accreditation. Accreditation of prison managed care systems is governed by the National Commission on Correctional Health Care (NCCHC). Accreditation is by no means mandatory; it merely provides companies with a seal of approval to help them attract business.⁶³ NCCHC encourages

⁵⁸ See Abstract, Texas Correctional Managed Health Care (visited Nov. 9, 1999) <<http://www.lcc.net/~cmhc/bestprac.txt>>. The Texas System, however, has an additional component that is not typical of prison managed care systems: a legislatively mandated Correctional Managed Health Care Advisory Committee (Committee) that oversees the entire system. See TEXAS AUDIT, *supra* note 35, at 6. The Texas Department of Criminal Justice (Department) contracts with the Committee, which contracts with the universities for correctional health care state-wide. See *id.* at 6-7. The six-member Committee includes two members from the Department and two from each of the universities. See *id.* A recent report by the Texas State Auditor criticized the multi-layered system. See *id.* at 7-8. The audit reported that the objectivity of the health care procurement could be compromised because two-thirds of the Committee members are employees of the universities providing health care. See *id.* In addition, the multi-layered contracting tends to obscure which parties are responsible for which aspects of the system. See *id.* at 11-12.

⁵⁹ See TEXAS AUDIT, *supra* note 35, at 11-12.

⁶⁰ See *id.*

⁶¹ *Id.*

⁶² See McDONALD, *supra* note 7, at 62.

⁶³ See National Commission on Correctional Health Care Health Services Accreditation (visited Nov. 9, 1999) <<http://www.corrections.com/ncchc/accreditation.html>>

correctional facilities to have their health care provision systems accredited whether they are operated by the state or by a private MCO.⁶⁴

The process for receiving NCCHC accreditation is not stringent. It consists of completing a Self-Survey Questionnaire and having an accreditation site visit.⁶⁵ The NCCHC assures prospective accreditees that the site visit will be "scheduled only when you feel you are ready."⁶⁶ The NCCHC examines the following areas: "facility governance and administration, managing a safe and healthy environment, personnel and training, health care services support, inmate care and treatment, health promotion and disease prevention, special [inmates'] needs and services, health records, and medical legal issues."⁶⁷ Thus, the accreditation provides for external peer review to ensure that correctional health care systems meet certain standards for the provision of health services.⁶⁸

NCCHC accreditation may be beneficial to the companies, but it ensures only a basic level of care in prisons.⁶⁹ However, judicial standards on health care in prisons impose more rigorous requirements on MCOs. The United States Supreme Court, through a series of cases, has specified "deliberate indifference" as the threshold for prison health care.⁷⁰ MCOs that are deliberately indifferent to prisoners' serious medical needs will be held to have violated the Eighth Amendment.

[hereinafter NCCHC Website]. According to the NCCHC, the benefits of this optional accreditation are adding prestige to facilities, improving employee morale, aiding recruiting efforts, obtaining increased budgets, and improving community support. *See id.* NCCHC also states that accreditation can reduce "liability premiums and [can protect] facilities from lawsuits related to health care." *Id.*

⁶⁴ *See id.*

⁶⁵ *See id.*

⁶⁶ *Id.*

⁶⁷ *Id.*

⁶⁸ *See id.*

⁶⁹ *See* William Allen & Kim Bell, *Watchdog Without Teeth*, ST. LOUIS POST-DISPATCH, Sept. 27, 1998, at G3 (stating that NCCHC accreditation only ensures a basic level of care and is not the "watchdog" organization that it is perceived to be). On the debate concerning the merits of prison accreditation generally, see 3 PRISONERS AND THE LAW ch. 18 (Ira P. Robbins ed., 1999).

⁷⁰ *See infra* Part III.A (discussing the deliberate indifference standard).

III. THE "DELIBERATE INDIFFERENCE" STANDARD

A. HISTORY OF THE STANDARD

In 1976, the Supreme Court established the "deliberate indifference" standard for Eighth Amendment claims of unconstitutional prison health care in *Estelle v. Gamble*.⁷¹ In *Estelle*, the respondent, J.W. Gamble, was injured while performing a prison work project.⁷² He complained that the treatment he received after the injury was inadequate and filed a civil rights action under 42 U.S.C. § 1983.⁷³ One month after Gamble received his injury, the treating doctor certified him as capable of light work.⁷⁴ Over the next two months, Gamble was brought before the prison disciplinary committee for failure to work, even though he continued to complain about back and chest pains.⁷⁵ On a constitutional challenge to the health care that had been provided to Gamble, the Supreme Court held that § 1983 and Eighth Amendment principles required the government to provide medical care for those whom it incarcerates, and announced that "deliberate indifference to serious medical needs of prisoners" was the standard for § 1983 claims.⁷⁶ The Court ruled that deliberate indifference can be committed either by prison doctors or by prison guards.⁷⁷

In 1991, in *Wilson v. Seiter*,⁷⁸ the Supreme Court extended the deliberate indifference standard to conditions of confinement.⁷⁹ In so doing, the Court developed a two-part test for de-

⁷¹ 429 U.S. 97 (1976). See also Friedman, *supra* note 43, at 929-35 (describing the history of the deliberate indifference standard and examining the level of health care to which prisoners are entitled). Friedman believes that the deliberate indifference standard is not an appropriate standard by which to evaluate prison medical care. See *id.* at 946-48. He asserts that the standard places too high a burden of proof of "intent" on the inmate, is difficult to apply, and is outdated since the overall quality of health care has greatly improved. *Id.* Friedman proposes a gross negligence standard instead, arguing that a higher standard of care is necessary. See *id.* at 948-49.

⁷² See *Estelle*, 429 U.S. at 98.

⁷³ See *id.*

⁷⁴ See *id.* at 100.

⁷⁵ See *id.* at 100-01.

⁷⁶ See *id.* at 104.

⁷⁷ See *id.* at 104-05.

⁷⁸ 501 U.S. 294 (1991).

⁷⁹ See *id.* at 302-03.

termining deliberate indifference:⁸⁰ the prisoner must demonstrate an objective component —“sufficiently serious” deprivation—and a subjective component—that the prison official had a “sufficiently culpable state of mind” that demonstrated deliberate indifference to the prisoner’s safety.⁸¹

Three years later, in *Farmer v. Brennan*,⁸² the Court further developed *Wilson*’s test, holding that the second part of that test created a subjective standard of deliberate indifference.⁸³ The Court stated that liability of the prison official cannot be established unless: (1) “the official knows of and disregards an excessive risk to inmate health or safety”; (2) “the official [is] aware of facts from which the inference could be drawn that a substantial risk of serious harm exists”; and (3) “[the official draws] the in-

⁸⁰ See *id.*

⁸¹ See *id.* In adding the second element, the subjective culpable state of mind requirement, *Wilson* represented a retreat from previous jurisprudence. In an earlier case, *Rhodes v. Chapman*, 452 U.S. 337 (1981), the Supreme Court had held that, in determining cruel and unusual punishment violations, courts should look to objective standards. See *id.* at 346; see also David J. Gottlieb, *Wilson v. Seiter: Less Than Meets the Eye*, in 1 PRISONERS AND THE LAW 2-35 (Ira P. Robbins ed., 1999) (stating that, in *Rhodes*, Justice Powell emphasized that any cruel and unusual punishment test should rely on objective elements). Professor Gottlieb argues that the addition of a subjective component incorrectly allocates the responsibility for the cruel and unusual punishment. See *id.* at 2-37. The subjective component overlooks the fact that it is often governmental policy that is responsible for the abhorrent prison conditions, and not the fault of the individual prison officials. See *id.* Thus, *Wilson*’s holding creates a problem in establishing systemic deliberate indifference violations. See *id.* However, Gottlieb states that, in institutional cases involving medical care, courts have focused more on the objective component in *Wilson*. See *id.* at 2-41.

⁸² 511 U.S. 825 (1994). See John Boston et al., *Farmer v. Brennan: Defining Deliberate Indifference Under the Eighth Amendment*, 14 ST. LOUIS U. PUB. L. REV. 83 (1994) (discussing the decision in *Farmer* and arguing that the decision is neither a victory nor a defeat for prisoners’ rights).

The facts of *Farmer* are as follows: Dee Farmer was incarcerated for credit card fraud. See *id.* at 84-85. She was diagnosed as a transsexual, and was housed in various prisons, sometimes in the general male population. See *id.* She was segregated on at least one occasion because of concerns for her safety. See *id.* In 1989, she was raped by a fellow prisoner, and filed a suit based on deliberate indifference to her safety. See *id.* at 85. The Supreme Court affirmed the lower court’s definition of deliberate indifference, but held that Farmer’s failure to notify prison officials of the danger she faced was not dispositive of their lack of knowledge. See *id.* at 96. The Court remanded for a determination of whether prison officials knew of the risk to Farmer. See *Farmer*, 511 U.S. at 848-49.

⁸³ See *Farmer*, 511 U.S. at 838-39.

ference.”⁸⁴ The Court also held that a prison official can be found to have been aware if the substantial risk is obvious.⁸⁵ The Court stated, for example, that a plaintiff could present evidence that the risk of an attack was “longstanding, pervasive, or expressly noted by prison officials in the past.”⁸⁶

In applying the subjective component to determine whether medical care violates the deliberate indifference standard, courts focus on the obviousness of the risk.⁸⁷ A court needs to ascertain whether the prison official had a “sufficiently culpable state of mind”;⁸⁸ the court must look at the events as the prison official may have seen them. Courts should examine whether the prisoner’s medical condition was noted by other prison officials or doctors.⁸⁹ Courts should also consider factors such as “the severity of the medical problem, the potential for harm if medical care is denied or delayed and whether any such harm actually resulted from the lack of medical attention.”⁹⁰

In *McNally v. Prison Health Services, Inc.*,⁹¹ for example, the Federal District Court in Maine denied a prison’s motion to dismiss. The prisoner alleged a § 1983 violation for inadequate medical care when he was denied HIV medication while a pre-trial detainee.⁹² The court stated that “deliberate indifference is more than negligence.”⁹³ The court also stated that “when a supervisory official is placed on actual notice of a prisoner’s

⁸⁴ *Id.* at 837.

⁸⁵ *See id.* at 842.

⁸⁶ *Id.* at 843 (quoting Brief for Respondents at 22).

⁸⁷ *See id.*

⁸⁸ *Wilson*, 501 U.S. at 302-03.

⁸⁹ *See Farmer*, 511 U.S. at 842.

⁹⁰ *McNally v. Prison Health Servs., Inc.*, 28 F. Supp. 2d 671, 673 (D. Me. 1998) (quoting *Burns v. Head Jailer of La Salle County Jail*, 576 F. Supp. 618, 620 (N.D. Ill. 1984)).

⁹¹ 28 F. Supp. 2d 671 (D. Me. 1998).

⁹² *See id.* at 672. The court in *McNally* stated that, even though the Supreme Court has not specifically articulated standards for medical care of pretrial detainees, they “are at least as great as the Eighth Amendment protections available to a convicted prisoner.” *Id.* at 673 (citing *City of Revere v. Massachusetts Gen. Hosp.*, 463 U.S. 239, 244 (1983)); *see also Gaudreault v. Municipality of Salem*, 923 F.2d 203, 208 (1st Cir. 1990). *See generally Bell v. Wolfish*, 441 U.S. 520 (1979) (addressing rights of pretrial detainees).

⁹³ *McNally*, 28 F. Supp. 2d at 673.

need for . . . medical care, administrative negligence can rise to the level of deliberate indifference.”⁹⁴ In this instance, where the prisoner told PHS of his need to take medication immediately, his doctor confirmed his HIV diagnosis, and the prisoner was suffering from obvious physical symptoms, the court held that it could be inferred that PHS was subjectively aware that the prisoner required medical care.⁹⁵

There have been many challenges to the adequacy of prison medical care under the deliberate indifference standard.⁹⁶ The plaintiff in a § 1983 claim must show that the injury in question was inflicted by state actors and that the injury involved a deprivation of rights secured by the Constitution and the laws of the United States.⁹⁷

B. LIABILITY OF INSTITUTIONAL DEFENDANTS

Municipalities can be found liable for their official policies and customs. The liability of a municipality under § 1983 may not be based on the doctrine of respondeat superior.⁹⁸ Municipalities can be held liable only for acts that constitute a government custom or policy.⁹⁹ Liability is not limited to official policies, however, and may be based on the prevailing customs of the municipality.¹⁰⁰ In *Nelson v. Prison Health Services, Inc.*,¹⁰¹ for example, the Federal District Court in Florida stated: “In order to prove the county’s liability based on custom, ‘[the Plaintiff] must establish a widespread practice that, although not authorized by written law or express municipal policy, is so permanent and well-settled as to constitute a custom or usage with the force of law.’”¹⁰²

⁹⁴ *Id.* (quoting *Elliot v. Cheshire County*, 940 F.2d 7, 10 (1st Cir. 1991)).

⁹⁵ *See id.*

⁹⁶ *See infra* Part III.G (discussing deliberate indifference claims by inmates).

⁹⁷ *See, e.g., Nelson v. Prison Health Servs., Inc.*, 991 F. Supp. 1452, 1460 (M.D. Fla. 1997).

⁹⁸ *See Monell v. Department of Soc. Servs.*, 436 U.S. 658, 694 (1978).

⁹⁹ *See id.*

¹⁰⁰ *See Nelson*, 991 F. Supp. at 1464.

¹⁰¹ 991 F. Supp. 1452 (M.D. Fla. 1997).

¹⁰² *Id.* at 1465 (quoting *Brown v. City of Ft. Lauderdale*, 923 F.2d 1474, 1481 (11th Cir. 1991)).

The court in *Nelson* examined the issue of how to determine when a "custom or policy" rises to the level of deliberate indifference.¹⁰³ The court stated that "a county must be held accountable for more than its officially-codified policies."¹⁰⁴ The plaintiff can base his or her case on customs or policies of the institution. However, the custom or policy must be "longstanding and widespread" and considered to be "authorized by the policymaking officials because they must have known about it but failed to stop it."¹⁰⁵ The *Nelson* court held that the liability imposed on PHS "mirrors that of the test for the County."¹⁰⁶

In addition, a plaintiff must prove that the custom or policy caused the violation of the prisoner's rights. In *City of Canton v. Harris*,¹⁰⁷ the United States Supreme Court held that there must be a causal connection between the policy or custom and the constitutional violation. Similarly, in *McDuffie v. Hopper*,¹⁰⁸ the Federal District Court in Alabama stated that a finding of § 1983 liability requires "an affirmative causal connection between the alleged constitutional violation and an official policy or custom of the institutional defendant."¹⁰⁹

¹⁰³ See *id.* at 1464-65. The *Nelson* court also addressed the issue of qualified immunity for private health care providers. See *id.* at 1461. The court cited *Richardson v. McKnight* to deny qualified immunity to private companies, and their employees, that provide health care services to correctional facilities. *Id.* at 1463 (citing *Richardson v. McKnight*, 521 U.S. 399 (1997)). *Richardson* stated that the decision (denying qualified immunity to prison guards) applies "where a private firm, systematically organized to assume a major lengthy administrative task . . . with limited direct supervision by the government, undertakes that task for profit and potentially in competition with other firms." *Richardson*, 521 U.S. at 413. The *Nelson* court added: "The provision of medical treatment to an entire institution . . . with little or no supervision by the Sheriff, is clearly the sort of 'major lengthy administrative task' contemplated by the Court in *Richardson*." *Nelson*, 991 F. Supp. at 1462. Thus, there is strong precedent that private health care companies can be held liable under the deliberate indifference standard for systemic violations of prisoner rights by providing inadequate medical care.

¹⁰⁴ *Nelson*, 991 F. Supp. at 1465 (quoting *Van Ooteghem v. Gray*, 628 F.2d 488, 494 (5th Cir. 1980), *vacated on other grounds*, 640 F.2d 12 (1981)).

¹⁰⁵ *Id.*

¹⁰⁶ *Id.*

¹⁰⁷ 489 U.S. 378, 388-90 (1989).

¹⁰⁸ 982 F. Supp. 817 (M.D. Ala. 1997).

¹⁰⁹ *Id.* at 826 n.8.

In *City of Canton*, the Supreme Court confronted a civil rights action in which the respondent claimed that she had received inadequate medical attention while in police custody.¹¹⁰ The Court refused to adopt the petitioner's proposed standard that there could be § 1983 liability only if "the policy in question is itself unconstitutional."¹¹¹ The Court held that a municipality's failure to train its employees can be a policy for which the city may be held liable if the failure to train causes a constitutional violation.¹¹²

C. LIABILITY OF PRIVATE HEALTH CARE PROVIDERS

Using the deliberate indifference standard, courts have examined the liability of private health care providers who have contracted to provide services for the government. These providers can be found liable for a § 1983 violation if, *inter alia*, the court finds that state action is present. When a corporation contracts with a state to provide medical services at a correctional facility, the obligations of the Eighth Amendment attach to the provider. Thus, the private company becomes a state actor for purposes of § 1983 liability.

In *West v. Atkins*,¹¹³ the Supreme Court found that there was state action when a private physician had contracted with a North Carolina prison to provide medical services to inmates.¹¹⁴ The Court stated:

We now make explicit what was implicit in our holding in *Estelle*: Respondent, as a physician employed by North Carolina to provide medical services to state prison inmates, acted under color of state law for purposes of § 1983 when undertaking his duties in treating petitioner's injury. Such conduct is fairly attributable to the State.¹¹⁵

Similarly, in *Ancata v. Prison Health Services, Inc.*,¹¹⁶ the United States Court of Appeals for the Eleventh Circuit reversed a lower court's dismissal of a § 1983 claim in which the prisoner's representatives filed suit claiming inadequate medical

¹¹⁰ See *City of Canton*, 489 U.S. at 381-82.

¹¹¹ *Id.* at 386.

¹¹² See *id.* at 388-90.

¹¹³ 487 U.S. 42 (1988).

¹¹⁴ See *id.* at 54.

¹¹⁵ *Id.*

¹¹⁶ 769 F.2d 700 (11th Cir. 1985).

treatment after the prisoner had died of leukemia.¹¹⁷ The court found that state action was present where PHS provided medical care to the inmates in the Broward County Jail.¹¹⁸ The court stated that, "[a]lthough Prison Health Services and its employees are not strictly speaking public employees, state action is clearly present."¹¹⁹ The court in *Ancata* also cited several cases to support the proposition that private health care companies are state actors.¹²⁰

D. MUNICIPAL LIABILITY BASED ON ACQUIESCENCE IN ACTS OF PRIVATE HEALTH CARE PROVIDERS

Municipalities can be found liable for the unconstitutional acts of contract private health care providers. In *Covington v. Westchester County Jail*,¹²¹ for example, in the United States District Court for the Southern District of New York, the plaintiff alleged that Westchester County manifested a policy of deliberate indifference by entrusting inmates' medical care to EMSA after being put on notice that EMSA provided constitutionally inadequate medical care.¹²² The plaintiff slipped and fell while incarcerated in Westchester County Jail.¹²³ He alleged that he felt incredible pain and heard something snap in his ankle.¹²⁴

¹¹⁷ See *id.* at 704.

¹¹⁸ See *id.* at 703.

¹¹⁹ *Id.* The court went on to say that, "[w]here a function which is traditionally the exclusive prerogative of the state (or here county) is performed by a private entity, state action is present." *Id.*

¹²⁰ See *id.* (citing *Lawyer v. Kernodle*, 721 F.2d 632 (8th Cir. 1983); *Morrison v. Washington County, Ala.*, 700 F.2d 678 (11th Cir. 1983); and *Perez v. Sugarman*, 499 F.2d 761 (2d Cir. 1974)). See generally IRA P. ROBBINS, *THE LEGAL DIMENSIONS OF PRIVATE INCARCERATION* 70-119 (1988); Ira P. Robbins, *Privatization of Prisons: An Analysis of the State Action Requirement of the Fourteenth Amendment and 42 U.S.C. § 1983*, 20 CONN. L. REV. 835 (1988).

¹²¹ No. 96-Civ.-7551, 1998 WL 26190 (S.D.N.Y. Jan. 26, 1998). In January 1998, the United States District Court for the Southern District of New York granted the defendant's motion for a jury trial. See *Covington v. Westchester County Jail*, No. 96-Civ.-7551, 1998 WL 642798, at *3 (S.D.N.Y. Sept. 17, 1998). In a footnote, the court stated that "[t]he earliest date that this case will be reached for trial will be February 1999." *Id.* at *3 n.4.

¹²² See *Covington*, 1998 WL 26190, at *1.

¹²³ See *Covington v. Westchester County Jail*, No. 96-Civ.-7551, 1997 WL 580697, at *1 (S.D.N.Y. Sept. 18, 1997).

¹²⁴ See *id.*

He requested to see a doctor but was denied treatment until two-and-one-half months later, when he was diagnosed with a fractured ankle.¹²⁵ The court found that municipal liability need not be based on any particular action, as long as the municipality "promoted a policy which sanctioned the type of action which caused the violations."¹²⁶ The plaintiff alleged that Westchester County demonstrated such a policy by allowing EMSA to provide medical care to inmates even after being put on notice that EMSA provided deficient care.¹²⁷ To support his theory of deliberate indifference, the plaintiff introduced evidence that the county publicly announced its intention to end its contract with EMSA when a female inmate committed suicide after EMSA took her off antidepressants without consultation and a newspaper article recounted several inmates' complaints about EMSA's care in Westchester County.¹²⁸ In denying defendant's motion to dismiss, the court relied on the Eleventh Circuit's decision in *Ancata* to find that the Westchester County Jail may be "directly liable for any constitutional violations committed by EMSA."¹²⁹ The court stated that the case should proceed in order to determine if EMSA had violated the deliberate indifference standard.¹³⁰

In addition to *Ancata*, the *Covington* court cited *Williams v. Ward*¹³¹ to support the proposition that municipal liability can be based on acquiescence in a health care provider's negligence.¹³² Williams alleged that an unlicensed physician's gross negligence caused his leg to require amputation.¹³³ The court denied the defendant's motion to dismiss where the plaintiff alleged that, "in hiring . . . an unlicensed physician and delegating the medical care of inmates at Attica Correctional Facility to him, defen-

¹²⁵ See *id.*

¹²⁶ *Covington*, 1998 WL 26190, at *3 (quoting *Williams v. Ward*, 553 F. Supp. 1024, 1027 (W.D.N.Y. 1983)) (citation omitted).

¹²⁷ See *id.* at *1.

¹²⁸ See *id.*

¹²⁹ *Id.* at *4.

¹³⁰ See *id.* at *4-5.

¹³¹ 553 F. Supp. 1024 (W.D.N.Y. 1983).

¹³² See *Covington*, 1998 WL 26190, at *4.

¹³³ See *Williams*, 553 F. Supp. at 1027.

dant . . . 'evinced a deliberate indifference to the adequacy of the medical care they would receive.'"¹³⁴

E. FINANCIAL CONSIDERATIONS AS DELIBERATE INDIFFERENCE

Under the deliberate indifference standard, prison health care providers may not place financial considerations ahead of the medical needs of prisoners. Courts have firmly established that a lack of funds does not justify constitutionally inadequate treatment of inmates,¹³⁵ particularly in the case of medical care.¹³⁶ The United States Court of Appeals for the Second Circuit held that prison health care providers may not place non-medical considerations ahead of the medical requirements of prisoners under the deliberate indifference standard.¹³⁷ Moreover, in *Ancata*, the Eleventh Circuit held that an MCO providing health care to prisoners would violate the deliberate indifference standard by placing financial considerations ahead of inmate medical needs.¹³⁸

¹³⁴ *Id.* (quoting Plaintiff's Reply Memorandum of Law to Defendant Ward's Motion to Dismiss or for Summary Judgment at 14).

¹³⁵ See *Finney v. Arkansas Bd. of Correction*, 505 F.2d 194, 201 (8th Cir. 1974) ("Lack of funds is not an acceptable excuse for unconstitutional conditions of incarceration."); see also *Ruiz v. Estelle*, 679 F.2d 1115, 1146 (5th Cir. 1982), *amended in part on other grounds, vacated in part on other grounds*, 688 F.2d 266 (5th Cir. 1983); *Battle v. Anderson*, 594 F.2d 786, 792 (10th Cir. 1979); *Campbell v. McGruder*, 580 F.2d 521, 540 (D.C. Cir. 1978); *Welsch v. Likins*, 550 F.2d 1122, 1128 (8th Cir. 1977); *Sweet v. South Carolina Dep't of Corrections*, 529 F.2d 854, 869 (4th Cir. 1975); *Benjamin v. Malcolm*, 495 F. Supp. 1357, 1363 (S.D.N.Y. 1980); *Owens-El v. Robinson*, 442 F. Supp. 1368, 1373 (W.D. Pa. 1978).

¹³⁶ See *Howell v. Burden*, 12 F.3d 190, 191 (11th Cir. 1994) (refusing to excuse prison for failing to administer costly medication to asthmatic because of insufficient funds); *Durmer v. O'Carroll*, 991 F.2d 64, 68-69 (3d Cir. 1993) (rejecting argument that budgetary constraints could excuse a failure to adequately treat inmates, despite a showing that the prison lacked the funds to provide treatment that would prevent paralysis of inmate); *Finney*, 505 F.2d at 202 ("[W]e . . . cannot agree that lack of funds or facilities justify lack of competent medical care."); *Morales Felciano v. Ros-sello Gonzalez*, 13 F. Supp. 2d 151, 210 (D.P.R. 1998) ("Budgetary limitations or inadequate resources . . . can never be a valid justification for constitutional violations."); see also *Battle*, 594 F.2d at 792; *Pugh v. Locke*, 406 F. Supp. 318, 331 (M.D. Ala. 1976), *aff'd*, 559 F.2d 283 (5th Cir. 1977).

¹³⁷ See *Archer v. Dutcher*, 733 F.2d 14, 15 (2d Cir. 1984).

¹³⁸ See *Ancata v. Prison Health Servs., Inc.*, 769 F.2d 700, 704 (11th Cir. 1985).

In the Second Circuit case, *Archer v. Dutcher*,¹³⁹ the court addressed the situation in which a pregnant female prisoner alleged that her constitutional rights had been violated by inadequate prison medical treatment that resulted in the loss of her baby.¹⁴⁰ The court held that the facts presented were sufficient to constitute a claim that medical treatment had been denied to the prisoner "as punishment for past breaches of the disciplinary code, or for other invalid reasons."¹⁴¹ The court specifically stated that the failure to provide medical care to the prisoner "in order to make [her] suffer" would undoubtedly satisfy the requirements for a claim under *Estelle*.¹⁴² Thus, *Archer* stands for the proposition that a treatment decision based on non-medical considerations constitutes deliberate indifference.

Similarly, the court in *Ancata*, citing *Archer*, held that placing financial considerations ahead of the medical needs of the prisoner can rise to the level of deliberate indifference.¹⁴³ The Eleventh Circuit wrote that, "if necessary medical treatment has been delayed for non-medical reasons, a case of deliberate indifference has been made out."¹⁴⁴ The court held that the plaintiff's allegations that the defendants put the financial interests of PHS ahead of her medical needs were sufficient to state a constitutional claim.¹⁴⁵

F. INSTITUTIONAL LIABILITY OF PRIVATE HEALTH CARE PROVIDERS

The foregoing standards provide a basis for private health care providers who have contracted with the government to be found liable on an institutional basis for constitutional violations. Private health care providers can clearly be held liable under the state action doctrine for constitutional violations of prisoners under their care.¹⁴⁶ Thus, a managed care organiza-

¹³⁹ 733 F.2d 14 (2d Cir. 1984).

¹⁴⁰ See *id.* at 15.

¹⁴¹ *Id.* at 17.

¹⁴² *Id.* at 16.

¹⁴³ See *Ancata*, 769 F.2d at 704.

¹⁴⁴ *Id.*

¹⁴⁵ See *id.*

¹⁴⁶ See *supra* Part III.C (explaining the liability of private health care providers).

tion that has contracted with a municipality to provide health care services to inmates could be found liable for unconstitutional care. The prisoner must allege that a longstanding custom or policy of the MCO caused a constitutional violation. Under *City of Canton*, this policy can be a failure to train its employees adequately.¹⁴⁷ Under *Archer* and *Ancata*, placing financial considerations ahead of the needs of the prisoner can also amount to deliberate indifference.¹⁴⁸

G. CHALLENGES UNDER THE STANDARD

This section summarizes the facts from some of the challenges to prison medical care under the Eighth Amendment's deliberate indifference standard. As is evident from these examples, that standard is most often discussed in rulings on motions to dismiss and motions for summary judgment. If the plaintiff succeeds on these motions, the medical care company typically will settle to avoid going to trial.¹⁴⁹ This practice leaves a lack of articulated standards on the subject, and a less developed deliberate indifference standard for purposes of determining liability of managed health care providers.

Hartman v. Correctional Medical Services, Inc.,¹⁵⁰ for example, a federal case from Florida, involved a § 1983 claim of cruel and unusual punishment arising from the suicide of an inmate, Mark Douglas.¹⁵¹ Jeff Schultz, who had primary responsibility

¹⁴⁷ See *supra* notes 110-12 and accompanying text.

¹⁴⁸ See *supra* notes 143-45 and accompanying text.

¹⁴⁹ For example, in Polk County, Florida, PHS lost on motions to dismiss in two cases involving allegations of inadequate medical treatment. See *Meade v. Prison Health Servs., Inc.*, No. 94-854-CIV-T-17-B, 1994 WL 654509, at *2 (M.D. Fla. Nov. 10, 1994) (denying motion to dismiss because sufficient evidence existed of deliberate indifference to suicidal mental state of inmate); *Cherry v. Crow*, 845 F. Supp. 1520, 1524-25 (M.D. Fla. 1994) (denying motion to dismiss because sufficient evidence existed of custom or policy of deficient medical care). After its motions to dismiss were denied, PHS settled these cases. See Rousos, *supra* note 55, at A1. Moreover, PHS refused to disclose settlement information until required to do so by court order. See *Prison Health Servs., Inc. v. Lakeland Ledger Publ'g Co.*, 718 So. 2d 204, 205 (Fla. Dist. Ct. App. 1998). It is a general practice of MCOs to refuse to disclose information regarding settlement, compensation of doctors, health care spending, and revenues generated by capitated fees. See BIRENBAUM, *supra* note 35, at 32.

¹⁵⁰ 960 F. Supp. 1577 (M.D. Fla. 1996).

¹⁵¹ See *id.* at 1578-79.

for all aspects of treating inmates with serious mental disorders, ordered Douglas to be taken off suicide watch.¹⁵² Schultz's title was clinical psychologist, although he was not licensed as such in Florida.¹⁵³ The plaintiff alleged that CMS had policies of allowing unlicensed persons to have full discretionary control over inmates' mental health and of taking "inmates off suicide watch as early as possible to avoid use of extra manpower and to avoid using the contract psychiatrist unless absolutely necessary."¹⁵⁴ On these facts, the court, denying summary judgment, found sufficient evidence that the policies amounted to deliberate indifference: "Schultz was motivated in several respects concerning his . . . mishandling of Mr. Douglas' case. . . . '[W]hen a private corporation is hired to operate a prison, there is an obvious temptation to skimp on civil rights whenever it would help to maximize shareholder[s'] profits."¹⁵⁵

Kelly v. Delaware County Board of Prison Inspectors,¹⁵⁶ from Pennsylvania, arose out of the death of an inmate, Kevin Kelly, after significant delay in receiving medication for his seizures.¹⁵⁷ The plaintiff alleged that PHS had a custom of inadequately staffing the infirmary, "permitting its on call physician to employ a covering doctor who was unfamiliar with prison protocols, and delegating treatment decisions to nurses and physician assistants," thus causing the delay.¹⁵⁸ The court denied the defendant's motion for summary judgment, finding sufficient evidence of deliberate indifference to Kelly's serious medical needs.¹⁵⁹

In *McDuffie v. Hopper*,¹⁶⁰ the son of Billy Roberts, a prisoner who committed suicide while incarcerated in an Alabama state prison, sued CMS and others under § 1983 for cruel and un-

¹⁵² See *id.*

¹⁵³ See *id.*

¹⁵⁴ *Id.* at 1581.

¹⁵⁵ *Id.* (quoting *Manis v. Corrections Corp. of Am.*, 859 F. Supp. 302, 305 (M.D. Tenn. 1994)).

¹⁵⁶ No. 91-5497, 1996 WL 685433 (E.D. Pa. Nov. 21, 1996).

¹⁵⁷ See *id.* at *1-*2.

¹⁵⁸ *Id.* at *2.

¹⁵⁹ See *id.* at *3.

¹⁶⁰ 982 F. Supp. 817 (M.D. Ala. 1997).

usual punishment and under various state laws.¹⁶¹ Roberts had a history of severe psychiatric disorders, had often been put on suicide watch, and had received large doses of a psychotropic drug.¹⁶² CMS's statewide mental health director allegedly ordered Roberts to be placed in an isolation cell rather than a psychiatric care unit and ordered that his drugs be discontinued.¹⁶³ Six days after Roberts stopped receiving medication, he hanged himself.¹⁶⁴ The court found sufficient evidence of deliberate indifference to Roberts' serious medical needs to deny CMS's motion for summary judgment.¹⁶⁵

In these three cases, the courts found that there was sufficient evidence of deliberate indifference. However, because the MCOs settled out of court after these rulings, the courts did not get a chance to decide whether the facts of these cases actually constituted deliberate indifference. Other cases are currently pending. On June 23, 1998, a group of prisoners at East Jersey State Prison brought a class action suit against government entities responsible for their medical care, and against employees of CMS, who had been contracted to provide the medical care at the prison.¹⁶⁶

The complaint alleges that the governmental entities and CMS failed to provide constitutionally adequate medical care.¹⁶⁷ The complaint further alleges deliberate indifference by CMS because CMS utilized cost-cutting measures that resulted in the injury and death of several inmates.¹⁶⁸ Specifically, the plaintiffs allege that CMS withdrew psychotropic drugs from inmates who needed them, canceled scheduled surgeries, and had inadequate staffing at all of the Department of Corrections facili-

¹⁶¹ See *id.* at 819.

¹⁶² See *id.* at 820-21.

¹⁶³ See *id.*

¹⁶⁴ See *id.*

¹⁶⁵ See *id.* at 829.

¹⁶⁶ See Complaint, *Jackson v. Fauver* (D.N.J. June 23, 1998) (No. 98-2890).

¹⁶⁷ See *id.*

¹⁶⁸ See *id.* at ¶¶ 23-28. The complaint also alleges that CMS misrepresented itself when it bid for the contract. See *id.* at ¶¶ 20-22. CMS allegedly gave false information about pending litigation, and stated that they had a "good track record." *Id.*

ties.¹⁶⁹ The complaint also describes the unsanitary and overcrowded conditions of the medical facilities at the prison.¹⁷⁰ This case is particularly significant because it alleges that the cost-cutting measures used by CMS, a managed care organization, are deliberately indifferent to the constitutional rights of the prisoners.

IV. CAN THE USE OF MANAGED CARE CONSTITUTE "DELIBERATE INDIFFERENCE"?

This Article examines whether the use of managed care alone can constitute deliberate indifference. As discussed previously, managed health care companies can be found liable for constitutional violations through state action and institutional liability.¹⁷¹ A municipality that enters into a contract with a private corporation for the provision of inmate health care creates an official policy regarding the health and welfare of those persons for whom it is responsible and should be held liable for injuries resulting from that policy.¹⁷² Managed health care contracts, whether or not in a correctional setting, are generally entered into as a means of cutting costs.¹⁷³ Although managed

¹⁶⁹ See *id.* at ¶¶ 24-28. The complaint states: "Strangely enough, it appears that CMS's strategy for cutting costs of medical services is not to provide them." *Id.* at ¶ 26.

¹⁷⁰ See *id.* at ¶¶ 23-33.

¹⁷¹ See *supra* Parts III.A-B.

¹⁷² See *Board of County Comm'rs v. Brown*, 520 U.S. 397, 407 (1997) ("[C]ontinued adherence to an approach that [officials] know or should know has failed to prevent tortuous conduct by employees may establish . . . deliberate indifference."); *City of Canton v. Harris*, 489 U.S. 378, 388-89 (1989) (finding that municipal liability should be imposed only if a custom or policy of the municipality is deliberately indifferent and causes the alleged harm).

¹⁷³ See *Matters Relating to the Federal Bureau of Prisons: Hearing Before the Subcomm. on Crime of the House Comm. on the Judiciary*, 104th Cong. 121-32 (1995) (statement of Stuart H. Shapiro, M.D., President and CEO, Prison Health Services, Inc.) [hereinafter Shapiro]. According to Dr. Shapiro, privatizing health care in federal prisons will save the Federal Bureau of Prisons (BOP) one billion dollars over a five-year period. See *id.* at 123. Dr. Shapiro cited statistics indicating that PHS provided correctional health care to more than 100 facilities in 1993, at an average of \$1,987 per inmate annually, see *id.* at 127-28, compared to the approximately \$3,200 per inmate spent annually by the BOP in 1994, see *id.* at 121-23. Other benefits of privatized correctional health care cited by Dr. Shapiro include the predictability of a predetermined per-inmate fee for health care and a wider variety of on-site health services, thereby reducing transportation and security costs of off-site services. See *id.* at 122.

care has been successful at cutting costs in some cases,¹⁷⁴ critics worry that the quality of care has often suffered as a result.¹⁷⁵ Where the quality of care has diminished under managed care and resulted in serious injury to an inmate, a municipality should be held liable for having a custom or policy of putting financial considerations before the health and safety of inmates.¹⁷⁶ Although financial considerations cannot justify in-

¹⁷⁴ See *id.* at 121-22 (discussing lower cost of managed health care); *Privatizing Inmates' Health Care Saves Money But Causes Alarm*, CHI. TRIB., Dec. 27, 1996, § 1, at 13 (reporting that New Jersey's privatization of correctional medical care will save at least \$14 million over the first year). But see MCDONALD, *supra* note 7, at 14-16 (stating that managed health care's ability to cut costs is unproven).

¹⁷⁵ See, e.g., *Correctional Medical Services Under Fire*, CORRECTIONS DIG., Aug. 19, 1999, at 7 (reporting an increase in the number of complaints—which included pharmaceutical errors and substandard care for mentally ill inmates—from 118 to 200 in Minnesota's correctional care system since CMS took over in 1998); *Managed Care Under Fire in Passaic, N.J.*, CORRECTIONS DIG., Aug. 12, 1999, at 3 (describing a situation in Passaic, N.J., in which a county sheriff alleged that privatization of the health care services in his prison system is endangering the health of 18,000 inmates due to shortage of nurses, frequent staff turnover, and bureaucracy that makes it difficult to fill temporary vacancies); Michael Berryhill, *Critical Diagnosis: If You Think Your HMO is Bad, Check Out What Texas Has Created for its Prison Inmates*, HOUSTON PRESS, Jan. 22, 1998, at 6 ("When UTMB[, Texas's self created managed care system for correctional health care,] took over no one had any experience at a prison unit. The approach was typical of managed care: Cut costs, cut care.") (quoting former Texas prison health administrator Jim Cook); Joe Jackson, *Norfolk Jail Fires Medical Provider; Private Firm Neglected Sick Inmates, Sheriff Says*, NORFOLK VIRGINIAN-PILOT, June 28, 1994, at B1 (reporting that Norfolk City Jail ended their contract with CMS after a number of inmates died under CMS's care and that jail officials claim that the deaths were due, primarily, to a lack of patient follow-ups by CMS staff).

In particular, a deficiency in the treatment of HIV and AIDS has come under fire. See Joe Malinconico, *Inmates Say Prisons Skimp on Health Care, Officials Say They Must Protect the Taxpayers*, NEWARK STAR-LEDGER, Aug. 10, 1997, at 27 (noting that HIV positive inmates who receive medical treatment from CMS are generally treated with medications now considered outdated, such as AZT and the antibiotic Bactrim, rather than the more recently developed and highly effective protease inhibitors); David Nitkin, *HIV Care Called Neglectful*, FT. LAUDERDALE SUN-SENTINEL, Mar. 8, 1998, at 19A (reporting that inmates at Broward County Jail, where EMSA provides the medical care, claim that unqualified nurses dispense HIV medications haphazardly without knowing what they were for or how to pronounce the names of the medicines).

¹⁷⁶ See *Ancata v. Prison Health Servs., Inc.*, 769 F.2d 700, 704 (11th Cir. 1985) (finding that non-medical reasons for delaying necessary medical treatment constitute deliberate indifference); see also *Lancaster v. Monroe County*, 116 F.3d 1419, 1425 (11th Cir. 1997) (citing *Ancata* for the proposition that knowingly failing to provide needed medical care is firmly established as deliberate indifference); *Covington v. Westchester*, No. 96-Civ.-7551, 1998 WL 26190, at *2, *4 (S.D.N.Y. Jan. 26, 1998) (citing *Ancata* and denying county's motion to dismiss where plaintiff alleged that the

adequate treatment, it is also well established that liability will not be imposed if it is found that an inmate merely disagrees with the treatment or medication provided. Several courts have refused to find deliberate indifference where inmates objected to the types of medication or treatment prescribed, or to the dosage provided.¹⁷⁷ The ultimate difference between the two lines of cases is whether the prescribed treatment could be considered adequate, even if less costly than other available options.¹⁷⁸ Deliberate indifference, however, is the state of mind requirement. The "objectively sufficiently serious" requirement promises that liability will not be imposed where inmates are adequately treated.¹⁷⁹ The requirement that an alleged injury be serious *and* caused by the deliberate indifference of the defen-

county had a custom of denying adequate medical care by allowing EMSA to continue to provide medical care to inmates after county was on notice that EMSA had previously provided constitutionally deficient medical care). For other cases discussing a custom or policy of making medical decisions based on non-medical reasons, see *Moore v. Jackson*, 123 F.3d 1082 (8th Cir. 1997) (reversing the grant of CMS's motion for summary judgment where inmate alleged that CMS had a policy of destroying or ignoring inmates' requests for medical treatment, resulting in a nine-month delay before his tooth infection was treated); *Proffitt v. Prison Health Servs., Inc.*, No. 01A01-9604-CV-00144, 1996 WL 426779 (Tenn. Ct. App. July 31, 1996) (reversing lower court's grant of summary judgment in favor of PHS where plaintiff alleged that delay in receiving surgery was caused by policy of putting profits before medical needs).

¹⁷⁷ See, e.g., *Jolly v. Badgett*, 144 F.3d 573, 573 (8th Cir. 1998) (upholding lower court's grant of summary judgment in favor of prison where officials interfered with inmate's ability to take medication on recommended schedule); *Johnson v. Stephan*, 6 F.3d 691, 692 (10th Cir. 1993) (finding no deliberate indifference where inmate alleged that leg stocking provided for cramping was improper size); *Smith v. Marcantonio*, 910 F.2d 500, 502 (8th Cir. 1990) (rejecting inmate's deliberate indifference argument where doctor would not prescribe medications recommended by a different doctor); *Martin v. Sargent*, 780 F.2d 1334, 1339 (8th Cir. 1985) (holding that inmate's disagreement with physician over proper treatment for back pain did not constitute deliberate indifference); *Callaway v. Smith County*, 991 F. Supp. 801, 809 (E.D. Tex. 1998) (rejecting argument that an inmate receiving an improper dosage of medicine constitutes deliberate indifference).

¹⁷⁸ See *Hamm v. DeKalb County*, 774 F.2d 1567, 1575-76 (11th Cir. 1985) (finding no deliberate indifference and finding adequate medical treatment where jail nurse, doctor, and psychiatrist provided care and prescribed medications during numerous visits by Hamm to the infirmary); *Pinkney v. Davis*, 952 F. Supp. 1561, 1567 (M.D. Ala. 1997) (stating that, although a decision to treat an inmate with a less efficacious method can constitute deliberate indifference, the issue of whether deliberate indifference is present ultimately turns on whether the treatment was adequate).

¹⁷⁹ See *supra* Part III.A (discussing the requirement that alleged harm be objectively serious).

dant ensures the propriety of deciding the issue of deliberate indifference without regard to the gravity of the injury alone.¹⁸⁰

The use of managed care in the correctional setting creates a risk that medical decisions will be based on fiscal, rather than medical, considerations. Case law indicates that, "if necessary medical treatment [is] delayed for non-medical reasons, a case of deliberate indifference [is] made out."¹⁸¹ Furthermore, several courts have specifically rejected the argument that budgetary considerations can justify a decision to deny treatment or provide a less efficacious treatment.¹⁸² Certain practices used by MCOs in prisons and jails—such as financial incentives to avoid treating inmates—inherently ensure that medical decisions will be based on cost. Other practices of MCOs—such as authorizing less costly but unqualified staff to treat inmates—create an unjustifiable risk that cost is the determinative factor in medical decisions.¹⁸³ Because of the firmly established case law holding that medical decisions cannot be based on financial considerations,¹⁸⁴ financial incentives to delay or deny treatment should constitute *per se* deliberate indifference,¹⁸⁵ and practices giving rise to an unjustifiable risk that medical decisions have been based on financial considerations should warrant a rebuttable presumption of deliberate indifference.¹⁸⁶

¹⁸⁰ Cf. Barbara Kritchevsky, *Making Sense of State of Mind: Determining Responsibility in Section 1983 Municipal Liability Litigation*, 60 GEO. WASH. L. REV. 417, 454-59 (1992) (arguing that the culpability of individual defendants should not determine municipal liability because the presence or absence of a deliberately indifferent custom or policy is independent of an individual employee's acts in accordance with such a policy).

¹⁸¹ *Ancata v. Prison Health Servs., Inc.*, 769 F.2d 700, 704 (11th Cir. 1985) (citing *Archer v. Dutcher*, 733 F.2d 14, 17 (2d Cir. 1984)).

¹⁸² See *supra* notes 135-36 (listing cases).

¹⁸³ Although the negligent actions of an unqualified or undertrained health care provider would not be sufficient to meet the culpability requirement of the deliberate indifference standard, the MCO is deliberately indifferent because it has knowingly hired that provider. See Kritchevsky, *supra* note 180, at 454-60 (arguing that the culpability of individual defendants should not determine municipal liability because the presence or absence of a deliberately indifferent custom or policy is independent of an individual employee's acts in accordance with such a policy).

¹⁸⁴ See *supra* Part III.E (discussing the impropriety of basing medical decisions on non-medical factors, including finances).

¹⁸⁵ See *infra* Part IV.A (discussing *per se* liability).

¹⁸⁶ See *infra* Part IV.B (discussing rebuttable presumption of liability).

A. *PER SE* DELIBERATE INDIFFERENCE

Among the myriad provisions found in contracts between municipalities and MCOs, financial incentives to avoid treating inmates have generated the most controversy.¹⁸⁷ Contractual provisions that directly encourage health care providers to deny medical treatment or provide less efficacious treatment establish a policy of placing financial considerations above the health and safety of inmates. When an inmate is seriously harmed because of a decision to deny adequate treatment in favor of financial benefits, the policy should be considered *per se* deliberate indifference to the health of the inmate.

Direct financial incentives to avoid treating inmates, in the form of bonuses to individual health care providers, jeopardize the welfare of inmates. Pinellas County, Florida, for example, entered into a contract with EMSA for prison health care.¹⁸⁸ The contract provided a \$250 bonus to the medical director, Dr. David R. Webb, for every emergency 911 call that could be avoided.¹⁸⁹ In 1996, inmate Melony Bird died from a heart at-

¹⁸⁷ See *infra* notes 188-95 and accompanying text (discussing widespread criticism of bonuses given to prison doctors). In addition, some courts have recognized the problematic nature of financial incentives discouraging treatment by requiring MCOs and health care providers to disclose the existence of such incentives to plan members. See *Shea v. Esenstein*, 107 F.3d 625, 629 (8th Cir. 1997) (holding that the failure to disclose is a breach of the MCO's fiduciary duty to its enrollees). Several states have responded to the conflict of interest created by financial incentives by statutorily requiring disclosure. See ARIZ. REV. STAT. ANN. § 20-1076 (Supp. 1997); CAL. HEALTH & SAFETY CODE § 1367.10 (West 1990); MD. CODE ANN., INS. § 15-121 (1997); MINN. STAT. ANN. § 62J.72 (West Supp. 1998); N.M. STAT. ANN. § 59A-23B-5 (Michie 1995); R.I. GEN. LAWS § 23-17.13-3 (1996); VA. CODE ANN. § 38.2-3407.10(C)(4)(a) (Michie Supp. 1994); WYO. STAT. ANN. § 26-34-109 (Michie Supp. 1996).

¹⁸⁸ See David Nitkin & Mitch Lipka, *Inmates Are Lifeblood of Company, Series: Medical Care in Jail*, FT. LAUDERDALE SUN-SENTINEL, Mar. 8, 1998, at 1A.

¹⁸⁹ See *id.* Other correctional health care companies have offered similar bonuses. Dr. Kevin Martin, a former medical director for CMS, claims that he was unofficially offered a bonus in exchange for reducing the medical procedures he ordered. See Kim Bell & William Allen, *Former CMS Doctor Says Bottom Line Ruled*, ST. LOUIS POST-DISPATCH, Sept. 27, 1998, at G5. According to Dr. Martin, CMS offered him a \$30,000 bonus in his new contract if he was able to reduce medical expenditures at his site, stating, "You've got this \$30,000 hanging over your head if you'd maybe just order a few less surgeries.' They don't come out and say it but that's what they mean." *Id.* The Texas state correctional health care provider (two medical schools in the state operating under an HMO-type contract) has been attacked for awarding \$668,000 in bonuses to 60 prison doctors in 1997. See Michael Berryhill, *Following the Money*, HOUSTON PRESS, Jan. 12, 1998, at *2. The bonuses raise questions about whether the

tack after Dr. Webb vetoed a 911 call to get her help.¹⁹⁰ Although tests revealed the possibility that she was having a heart attack, thirteen hours elapsed before any help was summoned.¹⁹¹ Several weeks after Bird's death, Charles Henderson, another Pinellas County inmate, was allegedly injured as a result of EMSA preventing nurses from calling 911.¹⁹² Henderson filed suit against the county, EMSA, and Webb alleging that Webb vetoed a nurse's request to get emergency care for Henderson when he fell into a coma after EMSA staff injected him with fluids containing sugar, despite records indicating he was diabetic.¹⁹³ Henderson contended that EMSA's failure to summon help led to disabling nerve and heart damage.¹⁹⁴ In January 1997, Pinellas County revoked its contract with EMSA and entered into a contract with Correctional Physician Services (CPS), dropping the bonuses from the new contract.¹⁹⁵

Bonuses such as the ones provided in the Pinellas County contract represent a municipal policy of elevating cost-cutting measures above inmate health. Municipal liability is properly imposed only if the custom or policy of the municipality causes the harm.¹⁹⁶ Where, as here, the policy does not facially instruct employees to injure inmates, liability is proper where the policy evinces deliberate indifference to inmate health by placing individuals in a position where it is "all but inevitable" that an injury will ensue.¹⁹⁷ By providing direct financial incentives to avoid

money was available because of inadequate care and whether any surplus would have been better spent by returning it to the state. *See id.*

¹⁹⁰ *See* Nitkin & Lipka, *supra* note 188, at 1A.

¹⁹¹ *See id.*

¹⁹² *See* Jen Pilla, *Jail's Health Care Provider Liable for Emergency Costs*, ST. PETERSBURG TIMES, Feb. 6, 1997, at 3B.

¹⁹³ *See id.*

¹⁹⁴ *See id.*

¹⁹⁵ *See id.* Despite dropping the bonuses from the new contract, CPS retained most of the staff previously employed by EMSA and kept a contractual provision identical to the one found in EMSA's contract that provided for a \$25,000 per-incident threshold. *See id.*

¹⁹⁶ *See* City of Canton v. Harris, 489 U.S. 378, 388-89 (1989) (stating that municipal liability can be imposed where an official custom or policy caused individuals to violate the constitutional rights of the plaintiff).

¹⁹⁷ Kritchevsky, *supra* note 180, at 471; *see also* Canton, 489 U.S. at 387 (finding that a municipality can be liable for constitutional injuries where there was a custom of

treating inmates, a municipality virtually ensures that an inmate will suffer serious harm, thus demonstrating *per se* deliberate indifference to the health of the inmates.

B. REBUTTABLE PRESUMPTIONS OF DELIBERATE INDIFFERENCE

Other practices and policies of managed care in prisons give rise to a rebuttable presumption of deliberate indifference. A rebuttable presumption is a legal fiction that requires the existence of a fact (the presumed fact) to be accepted as true upon proof of other facts (the basic facts).¹⁹⁸ Once the basic facts establish the presumed fact, the party opposing the presumed fact bears the burden of producing evidence sufficient to justify finding that the presumed fact does not exist.¹⁹⁹ If the opponent fails to rebut the presumed fact, it is concluded to exist.²⁰⁰ If, however, the opponent introduces any evidence contradicting the presumed fact, the prevailing view holds that the presumption ceases to have any effect and the presumed fact will be accepted only if the trier believes it to exist.²⁰¹

failing to train guards adequately, thus evidencing deliberate indifference to the safety of inmates).

¹⁹⁸ See FLEMING JAMES, JR. ET AL., *CIVIL PROCEDURE* § 7.17 (4th ed. 1992); CHARLES T. MCCORMICK, *MCCORMICK ON EVIDENCE* § 342 (4th ed. 1992); 21 CHARLES ALAN WRIGHT & KENNETH W. GRAHAM, JR., *FEDERAL PRACTICE AND PROCEDURE* § 5122 (1978).

¹⁹⁹ See JAMES ET AL., *supra* note 198, at § 7.17 (explaining the effect of an un rebutted presumption).

²⁰⁰ See *id.*

²⁰¹ The theory that a presumption disappears once the opponent introduces evidence contradicting the presumed fact is attributed to James Thayer and John Wigmore and is often called the Thayer-Wigmore theory. See JAMES BRADLEY THAYER, *A PRELIMINARY TREATISE ON EVIDENCE AT THE COMMON LAW* 336 (1898); 9 JOHN HENRY WIGMORE, *WIGMORE ON EVIDENCE* § 2490 (James H. Chadbourne rev. 1981). The Thayer-Wigmore theory is used in the Federal Rules of Evidence. See FED. R. EVID. 301 ("[A] presumption imposes on the party against whom it is directed the burden of going forward with evidence to rebut or meet the presumption, but does not shift to such party the burden of proof in the sense of the risk of nonpersuasion. . . .") (emphasis added). In contrast, Morgan and McCormick's theory holds that the presumption continues to have effect even after the opponent introduces contrary evidence. The Morgan-McCormick theory states that a presumption should not only shift the burden of producing evidence, but also the burden of proof (or nonpersuasion), such that a presumed fact will be accepted unless the opponent introduces evidence sufficient to convince the trier of the nonexistence of the presumed fact. See MCCORMICK, *supra* note 198, § 342; Edmund M. Morgan, *Further Observations on Presumptions*, 16 S. CAL. L. REV. 245, 246, 249 (1943); see also The Evidence Project—Proposed Revisions to the Federal Rules of Evidence, 171 F.R.D. 330, 427-33 (comparing Thayer-

Courts and legislatures create presumptions "in accordance with a group of factors sometimes referred to as the Three P's: Policy, Probability, and Possession of Proof."²⁰² The social policy furthered by a presumption can justify its creation even absent a reliable inference leading from the basic facts to the presumed facts.²⁰³ Presumptions, however, generally reflect a logical inference and thus avoid expending time and energy on proving what is probable.²⁰⁴ In addition, presumptions are frequently designed to place the onus of producing evidence on the party in the best position to do so.²⁰⁵

The use of managed health care in prisons should give rise to a rebuttable presumption under all three justifications. First, because inmates are at the mercy of the state's or county's

Wigmore theory with Morgan-McCormick theory and recommending revision of Federal Rule of Evidence 301 to encompass Morgan-McCormick theory by providing that a presumption "imposes on the party against whom it is directed the burden of proving that the nonexistence of the presumed fact is more probable than its existence").

²⁰² WRIGHT & GRAHAM, *supra* note 198, § 5122.

²⁰³ The presumption of the legitimacy of a child born to a married woman cohabiting with her husband is given as an example of a presumption based, at least in part, on the policy favoring the legitimacy of a child. See JAMES ET AL., *supra* note 198, § 7.17 (giving presumption of legitimacy as example of presumption in which the presumed "would not even be a permissible inference from" the basic facts); see also MCCORMICK, *supra* note 198, § 343 ("[T]he presumption of ownership from possession . . . tends to favor the prior possessor and to make for the stability of estates.").

²⁰⁴ See WRIGHT & GRAHAM, *supra* note 198, § 5122 (stating that a decision to create a presumption requires asking: "what will be the probable state of facts in most cases?" so that the burden of showing an idiosyncratic course of events can be placed on the party asserting the unusual"). The presumption that a properly addressed and mailed letter reached the addressee is an often given example of a presumption rooted in a rational inference. See JAMES ET AL., *supra* note 198, § 7.17. Because presumptions are generally rooted in the probable, they frequently continue to have an effect on the finder of fact even after the opponent introduces some evidence of the nonexistence of the presumed fact regardless of whether the Thayer-Wigmore or the Morgan-McCormick theory is used. See *id.* ("[A]lthough countervailing evidence banishes the artificial procedural effect given by a presumption [of] the [basic facts] . . . it does not destroy the rational probative effect of [the basic facts].").

²⁰⁵ For example, because a bailee is in the best position to produce evidence showing what caused harm to property under his or her control, the bailee is often presumed to be negligent if property is damaged while in the bailee's possession. See JAMES ET AL., *supra* note 198, § 7.17 (citing *Frissell v. John W. Rogers, Inc.*, 106 A.2d 162 (Conn. 1954)).

choice of health care,²⁰⁶ it should be presumed that MCOs, as state actors, are executing their constitutional duty. Social policy dictates that, if an MCO is pursuing a policy of understaffing, hiring underqualified staff, delaying or denying necessary treatment, or maintaining any other policy that creates an unjustifiable risk that financial considerations are being placed over medical considerations, there should be a rebuttable presumption that the MCO is acting with deliberate indifference.

Second, a logical inference exists that, when a municipality decides to save money by contracting with a private company and an inmate is seriously injured in the face of the cost-cutting practices of managed care, the injury was caused by the deliberately indifferent policy of placing costs before inmates' health. In an effort to cut costs, several disturbing practices have emerged indicating that MCOs are compromising inmates' health in order to save money: staffing levels have decreased; underqualified staff are responsible for inmates' health;²⁰⁷ less expensive, but also less efficacious, treatments are provided;²⁰⁸ and treatments are frequently delayed or denied.²⁰⁹ These practices have developed primarily in prisons in which private companies are responsible for the health care of inmates and are a direct result of attempts to decrease the costs of inmate health care.²¹⁰ Because of the logical connection between cost-cutting

²⁰⁶ See *supra* notes 44-45 and accompanying text (discussing prisoners' lack of choice regarding health care).

²⁰⁷ See *infra* Part IV.B.2 (discussing staffing problems).

²⁰⁸ See *infra* Part IV.B.1.b (discussing inefficacious treatment).

²⁰⁹ See *infra* Parts IV.B.1.a & c (discussing delayed and denied treatment).

²¹⁰ See generally Stratton Shartel, *Nevada Fight Illustrates Need for Careful Evaluation of Privatized Medical Services*, CORRECTIONS ALERT, Feb. 15, 1999, at 2 (warning that municipalities should not act hastily in entering into private health care contracts in light of dramatic increase in the number of inmates alleging inadequate medical care coinciding with the rise of privatized correctional health care). These practices are similar to those employed by MCOs on the outside. See *supra* Part II.A (discussing managed care generally).

The case of *Jackson v. Fauver*, now pending before the United States District Court for the District of New Jersey, presents the wide range of allegations about managed care practices made by inmates. See Complaint, *Jackson v. Fauver* (D.N.J. June 23, 1998) (No. 98-2880). The plaintiffs in *Jackson* allege that the health care provided to them by CMS at East Jersey State Prison is constitutionally deficient for a variety of reasons. See *id.* A pro se complaint filed by a group of inmates alleges that CMS's cost-cutting measures have resulted in inmates being taken off needed psychotropic

measures and inadequate care for inmates, a rebuttable presumption that an injury was a result of a deliberately indifferent policy of placing costs before inmates' health is warranted.

Third, the managed health care company is in the best position to provide proof on the issue of deliberate indifference. The company is in possession of information concerning hiring practices, hiring records, records of treatment, and the policies of the company. It should not be the burden of the inmate to prove facts that the company clearly already knows.

A rebuttable presumption of deliberate indifference for certain aspects of managed care would place the burden of proof on the managed health care company. When an inmate has demonstrated serious injury while in the care of an MCO, a rebuttable presumption should attach where the inmate can show that the injury was the result of: (1) inadequate or denied treatment; (2) inadequate staffing; or (3) any other managed care practice that creates an unjustifiable risk that finances are being placed over medical considerations.

1. *Treatment-Based Controversies*

A common feature of inmate health care contracts is per-incident thresholds capping the financial responsibility of the MCO.²¹¹ Such thresholds provide that the company is responsible for the costs of an inmate's outside medical care only up to a certain dollar amount and that the municipality is responsible for all costs beyond that threshold.²¹² Because MCOs are always paid a per-inmate fee for providing medical care, thus being paid the same whether the inmate remains healthy or becomes

drugs, staffing shortages, canceled and delayed surgical procedures, delayed emergency care, and harassment of inmates who request medical care. *See id.*

²¹¹ *See* Mitch Lipka, *EMSA Criticized in Suit; Ex-Inmate: Staff Ignored Infection*, FT. LAUDERDALE SUN-SENTINEL, Mar. 8, 1998, at 19A (reporting that \$50,000 per-incident threshold at Palm Beach County Jail discouraged EMSA from sending inmates to the hospital); Nitkin & Lipka, *supra* note 187, at 1A (discussing EMSA's per-incident thresholds); *Down the Same Path?*, LAKELAND LEDGER, Aug. 31, 1996, at A8 (reporting controversy over per-incident provision in EMSA contract with Pinellas County, Florida, Sheriff's Office).

²¹² *See* Lipka, *supra* note 211, at 19A (describing role of thresholds).

ill,²¹³ higher thresholds increase the financial responsibility of the company when an inmate requires medical attention that is more costly than the contractually provided per-inmate payment.²¹⁴ As a result, high thresholds have come under attack because they provide MCOs with a disincentive to treat inmates adequately.²¹⁵

High per-incident thresholds create the risk that MCOs will restrict inmates' access to costly but necessary medical procedures in order to avoid higher out-of-pocket expenses.²¹⁶ In *Nobles v. Duncil*,²¹⁷ for example, the West Virginia Supreme Court of Appeals, in 1998, considered the possible implications of high per-incident thresholds. *Nobles* involved a petition for a writ of mandamus by five inmates at the Huttonsville Correctional Center, at which CMS provided the medical care, challenging certain conditions at the prison, including the prison's health care.²¹⁸ The Supreme Court of Appeals appointed Judge Larry Starcher as Special Judge. (Judge Starcher had maintained an active role in the operation of Huttonsville from 1985 through 1996.²¹⁹) Huttonsville's contract with CMS provided a

²¹³ See Shapiro, *supra* note 173, at 121 ("[W]e provide services at a predetermined price and assume all liability.").

²¹⁴ See Lipka, *supra* note 211, at 19A (describing role of thresholds).

²¹⁵ See *Nobles v. Duncil*, 505 S.E.2d 442, 451-53 (W. Va. 1998) (overruling the finding of a Special Judge that high thresholds discourage treatment); Nitkin & Lipka, *supra* note 188, at 1A (stating that \$50,000 threshold for outside medical care "gives the company a financial incentive to treat inmates at the jail for illnesses and injuries that would be traditionally be treated in an emergency room").

²¹⁶ It is unclear whether preventive treatment of inmates—a standard cost-cutting practice of MCOs outside of prisons—constitutes medically necessary treatment under the deliberate indifference standard. For example, if an inmate over 50 years of age with a family history of colon, prostate, or other cancer does not receive preventive screening, a court would likely rule that this lack of treatment does not constitute deliberate indifference because the inmate has not suffered harm as a result of the deprivation. However, because males over 50 face a substantial risk of developing cancer, the argument could be made that the risk to male inmates over 50 is sufficiently obvious to require preventive screening. See *What You Need to Know About Cancer* (visited Jan. 14, 2000) <http://cancernet.nci.nih.gov/wyntk_pubs/index.html> (National Cancer Institute website providing information about the risk factors associated with a variety of cancers).

²¹⁷ 505 S.E.2d 442 (W. Va. 1998).

²¹⁸ See *id.* at 446-47.

²¹⁹ See *id.*

per-incident threshold of \$5,000.²²⁰ Judge Starcher's final order included a provision limiting the per-incident threshold in any future contracts to \$500 because of the risk that the threshold "might be a fiscal incentive to the contractee [sic] to (1) discourage needed follow-up care from specialists, (2) refuse to use specialists who insist on quality care for their [patients], . . . [and] (3) delay needed rehabilitative medical care."²²¹

The prison officials challenged Judge Starcher's limit on thresholds, alleging that there was no evidence that the \$5,000 threshold created a systematic deficiency in the prison health care system.²²² The Supreme Court of Appeals agreed with the prison officials that there was insufficient evidence in the record that the threshold caused medical treatment to be denied.²²³ Despite the holding, however, the court went on to state that its decision was based solely on the lack of evidence in the record and that it was "not passing judgment on the logic or wisdom of [Judge Starcher's] reasoning or belief on this issue."²²⁴

The following sections illustrate how managed health care has resulted in the denial of necessary treatment, the use of less expensive but less efficacious treatments, and harmful delays in treatment.

a. Treatment Denied

Many inmates who receive their medical care from MCOs allege that they have been denied access to necessary medical procedures as a result of efforts to lower health care costs.²²⁵ In

²²⁰ See *id.*

²²¹ *Id.* at 446.

²²² See *id.* at 451-52.

²²³ See *id.* at 452-53.

²²⁴ *Id.* at 453.

²²⁵ See, e.g., William Allen, *Recommended Heart Surgery is Delayed Until It's Too Late*, ST. LOUIS POST-DISPATCH, Sept. 27, 1998, at 8 (reporting on the death of Roy Hilton at the New Mexico Penitentiary after CMS failed to schedule clearly needed heart surgery, which CMS claims was not performed because Hilton refused surgery until he could obtain medical clemency); Herbert Lass, *Massachusetts Inmates Use Legal Force to Get IFN Hepatitis C Therapy*, BIOTECHNOLOGY NEWSWATCH, Aug. 17, 1992, at 3 (discussing Hepatitis C sufferers' suit against Massachusetts Department of Corrections, alleging that they received no treatment since EMSA began its contract to provide health care to the inmates).

Broward County, Florida, for example, Walter Roszowski, an inmate under the care of EMSA physicians, was refused surgery to remove a tube that had been inserted to help him pass kidney stones.²²⁶ Approximately seven stones were lodged between the tube and his ureter, leading to a painful infection and blood in his urine.²²⁷ Roszowski stated that medical staff informed him that his surgery was denied because it was considered elective and would be too costly.²²⁸ Robert Washington, another Broward County inmate, was denied surgery on his hernia.²²⁹ According to Washington, two doctors warned him that without surgery his life was in danger because of the risk of the hernia bursting.²³⁰ Attorneys for EMSA stated that Washington did not receive surgery because he already had the hernia when he was incarcerated and because the surgery would be "costly and disruptive."²³¹

b. Inefficacious Treatment

Another disturbing trend among correctional health care companies is the use of inexpensive over-the-counter medications to treat serious illnesses.²³² The use of inferior medications to treat serious disorders has raised questions about the quality of health care in jails and prisons.²³³ An attorney with the Vol-

²²⁶ See Nitkin & Lipka, *supra* note 188.

²²⁷ See *id.*

²²⁸ See *id.*

²²⁹ See Noreen Marcus, *Prisoners Fight with an Outside Hand; Pro Bono Lawyers Handle Civil Rights Law Suits*, FT. LAUDERDALE SUN-SENTINEL, Apr. 29, 1998, at 1B (reporting on civil rights attorney representing Washington in a § 1983 suit against the Broward County Jail).

²³⁰ See *id.*

²³¹ *Id.*

²³² See, e.g., Laura Lafay, *Prison Deaths Put Focus on Health Contractor; Company Operates Medical Facilities in 184 Prisons and Jails in 27 States*, NORFOLK VIRGINIAN-PILOT, May 9, 1996, at A12 (mentioning inmate died of lung cancer after CMS treated his complaints of chest pain with ibuprofen); Nitkin & Lipka, *supra* note 188 (revealing that an inmate diagnosed with borderline emphysema was given an inhaler and sent back to his cell by an EMSA nurse after complaining of chest pains; he was found dead a few hours later).

²³³ See *Ancata v. Prison Health Servs., Inc.*, 769 F.2d 700, 704 (11th Cir. 1985) ("Although the plaintiff has been provided with aspirin, this may not constitute adequate medical care. If deliberate indifference caused an easier and less efficacious treatment to be provided, the defendants have violated the plaintiff's Eighth Amendment

unteer Lawyers Project (VLP) stated that, over the three years he has been with VLP, medical cases have surpassed excessive force cases as the most prevalent inmate complaint: "[T]hey are far more serious than we've ever seen before. . . . For excruciating pain, at best, they get ibuprofen when they should be seeing specialists."²³⁴ In a Georgia prison at which CMS provides the health care, an inmate complaining of chest pain was given ibuprofen after a cursory medical examination.²³⁵ A month later the inmate died of lung cancer.²³⁶

c. Treatment Delayed

Inmates have also alleged that prison officials delay administering approved treatments in order to save money.²³⁷ *Proffitt v. Prison Health Services, Inc.*²³⁸ involved an inmate's allegation that prison officials delayed a needed surgery because of a policy of putting profits before inmates' medical needs.²³⁹ When Proffitt became incarcerated, she had a broken leg and transfixing

rights . . .") (quoting *West v. Keve*, 571 F.2d 158, 162 (3d Cir. 1978) (internal quotation marks omitted)).

²³⁴ Marcus, *supra* note 229 (quoting attorney David Weintraub).

²³⁵ See Lafay, *supra* note 232 (reporting on controversy surrounding CMS, including inmates' deaths and Norfolk City's cancellation of health care contract after multiple deaths).

²³⁶ See *id.*

²³⁷ *Nelson v. Prison Health Servs., Inc.*, 991 F. Supp. 1452 (M.D. Fla. 1997), involved the death of Diane Nelson, from acute myocardial infarction, at Pinellas County Jail. When Nelson arrived at the jail, her initial medical exam indicated she was taking medications for a heart condition. See *id.* at 1457. She began asking for her medications and complaining of pain the morning after her arrival, but never received them during the three days of her detention prior to her death. See *id.* at 1458-59. In an affidavit, a PHS nurse "admitted to having joked that '[we] save money because we skip the ambulances and bring them right to the morgue.'" *Id.* at 1458 (quoting Jackson Deposition at 63). The court found sufficient evidence to deny PHS's motion for summary judgment. See *id.* at 1467-68.

Richard Kleinhans, a former CMS nurse, reports that CMS went to great lengths to increase profits, including delaying treatments until an inmate was released or transferred. See Kim Bell, *Inmate Got Cancer Treatment After a Judge and a Nurse Stepped In*, ST. LOUIS POST-DISPATCH, Sept. 27, 1998, at 5. For example, Kleinhans stated: "[I]f somebody needed oxygen, and they were in for a misdemeanor, the jail would call the judge up and say, 'Can we get his bond lowered?'" *Id.* In addition, pregnant inmates nearing their delivery would be released only to be re-arrested once the child was born. See *id.*

²³⁸ No. 01A01-9604-CV-00144, 1996 WL 426779 (Tenn. Ct. App. July 31, 1996).

²³⁹ See *id.* at *3.

screws in her knee.²⁴⁰ Her initial medical exam revealed that the screws needed to be removed and surgery was approved.²⁴¹ Despite approving the surgery, however, PHS never scheduled the surgery and the screws remained in Proffitt's knee until after she was paroled six months later.²⁴² PHS asserted that the delay was due to the relatively low priority level of the surgery, but presented no evidence of higher priority cases that actually rendered them unable to schedule the surgery.²⁴³ Based on this evidence and the affidavit of an internal medicine expert that the surgery was clearly necessary and must have been delayed for non-medical reasons,²⁴⁴ the Tennessee Court of Appeals reversed the lower court decision granting summary judgment in favor of PHS.²⁴⁵

In addition to delaying treatments until the inmate is released, MCOs have been accused of transferring inmates to other facilities and prematurely releasing inmates in order to avoid paying for necessary medical procedures. Between 1995 and 1997, despite its own policy dictating that medical procedures are to be performed before transferring inmates, EMSA reportedly transferred forty-three inmates to other facilities where different companies handled the inmates' health care.²⁴⁶ Among the transfers, at least two jeopardized the inmates' health, some occurred on the same day that treatment was

²⁴⁰ *See id.* at *1.

²⁴¹ *See id.*

²⁴² *See id.* Proffitt was recommended for parole to the Samaritan Recovery Center three months prior to her actual parole, but was denied release to the Center because her leg remained untreated. *See id.*

²⁴³ *See id.* at *5 ("Uncontradicted evidence that needs of higher priority actually did render defendant unable to supply the services sooner might suffice, but such specific and definitive evidence was not offered.").

²⁴⁴ *See id.* at *4 (citing affidavit of Charles A. Rosenberg, M.D., an internal medical specialist and consultant in the field of correctional medical care).

²⁴⁵ *See id.* at *7.

²⁴⁶ *See Nitkin & Lipka, supra* note 188 (discussing EMSA's transfer of inmates despite their own policy dictating that medical procedures are to be performed before transfers take place).

scheduled, and others involved complicated surgery, thus shifting considerable costs.²⁴⁷

2. *Inadequate Staffing*

In an effort to lower costs, MCOs often compromise the quality of inmate care by reducing staffing levels and employing unqualified medical personnel.²⁴⁸ Courts have already found that understaffing in state-run prison health care facilities constitutes deliberate indifference.²⁴⁹ Complaints by prisoners against MCOs are numerous and some have brought suit alleging that inadequate staffing caused constitutional injuries.²⁵⁰ In

²⁴⁷ See *id.* (citing an unidentified authority); see also Bell, *supra* note 237 (discussing allegations that CMS employed a similar delay tactic to avoid paying for costly medical care).

²⁴⁸ See generally BIRENBAUM, *supra* note 35, at 142 (stating that short-staffing by MCOs in order to cut costs has created a demand for "safe staffing" legislation); see, e.g., TEXAS AUDIT, *supra* note 35, at 93 ("The substitution of lower qualified staff is a common trend in managed care settings today among providers in the private sector as well as correctional health care corporations."); Christy Hoppe, *State Audit of Prison Health Care Questions Profits, Quality But Service Called Improving as Costs Drop*, DALLAS MORNING NEWS, Jan. 17, 1998, at 17A (stating that an audit of UTMB revealed that eight doctors had previously been disciplined by medical review boards and that UTMB failed to check employees' references, graduation records, or residency program completions); Jackson, *supra* note 175 (citing a report commissioned by the Norfolk City Jail that found CMS hired unqualified nurses to manage the majority of inmate health care); Lafay, *supra* note 232 (reporting that a Department of Justice investigation of CMS criticized the MCO for failing to train their staff appropriately).

²⁴⁹ See *Anderson v. City of Atlanta*, 778 F.2d 678, 686 (11th Cir. 1985) (holding that short-staffing may constitute deliberate indifference); *Ramos v. Lamm*, 639 F.2d 559, 578 (10th Cir. 1980) ("[B]ecause of staff shortages inmates are effectively denied access to diagnosis and treatment by qualified health care professionals. Such conditions endanger their health and well being, make unnecessary suffering inevitable, and evince on the part of the state a deliberate indifference to the serious health needs of the prison population.").

²⁵⁰ See *Chuffo v. Ramsey*, 55 F. Supp. 2d 860, 864-67 (N.D. Ill. 1999) (holding, *inter alia*, that the claim that CMS's failure to train nurses adequately led to the death of an inmate survived a motion for summary judgment); *Kelly v. Delaware County Bd. of Prison Inspectors*, No. 91-5497, 1996 WL 685433, at *2 (E.D. Pa. Nov. 21, 1996) (denying PHS's motion for summary judgment where plaintiff alleged that inmate's death was caused by PHS's policies of inadequately staffing the infirmary, permitting doctors to employ covering doctors who had not worked in prisons before, and delegating treatment decisions to nurses and physician assistants); *Hartman v. Correctional Med. Servs.*, 960 F. Supp. 1557, 1578-79 (M.D. Fla. 1996) (addressing inmate's allegations that CMS had a policy of employing unlicensed psychologists).

Hartman v. Correctional Medical Services,²⁵¹ for example, an inmate with psychological problems, being treated by an unlicensed psychologist, committed suicide after being taken off suicide watch.²⁵² The plaintiff in *Hartman* alleged that CMS's policies of allowing unqualified persons to treat mental patients and of prematurely taking patients off suicide watch in order to avoid using extra manpower caused the inmate's death.²⁵³

The introduction of the market rationale to prison health care in the form of managed care has created distinct patterns of cost-cutting practices that are deliberately indifferent to the medical needs of inmates. Municipal liability is properly imposed if an official custom or policy is deliberately indifferent to inmates' health.²⁵⁴ The use of MCOs, with their emphasis on cutting costs, has created a well-documented risk that medical decisions are being based on financial considerations that result in constitutionally inadequate treatment.²⁵⁵ The prevalence of problems associated with privatized correctional care is sufficient to put jail and prison officials on notice of the risk that managed care practices will result in constitutionally deficient medical care. Thus, when an inmate under the care of an MCO is seriously harmed and can demonstrate that this harm was the result of inadequate treatment or staffing, or any other managed care practice that creates an unjustifiable risk that financial concerns are being given priority over medical considerations, a rebuttable presumption that a policy or custom of deliberate indifference exists is warranted.²⁵⁶ Courts

²⁵¹ 960 F. Supp. 1557 (M.D. Fla. 1996).

²⁵² See *id.* at 1578. Jeff Shultz, clinical psychologist, was responsible for the inmate's mental health care, despite not being licensed in Florida. See *id.*

²⁵³ See *id.* at 1579. The court denied CMS's motion for summary judgment, finding a genuine issue of fact as to whether CMS's policies regarding inmates' mental health constituted deliberate indifference. See *id.* at 1582-83.

²⁵⁴ See *supra* Parts III.B & D (discussing requirements of municipal liability).

²⁵⁵ See *supra* Part IV.B (detailing widespread reports of the inadequacies of managed health care in prisons).

²⁵⁶ See *Board of County Comm'rs v. Brown*, 520 U.S. 397, 407 (1997) (finding that, in a limited number of circumstances, municipal liability is proper where prison officials fail to alleviate an obvious risk of serious harm); *Covington v. Westchester*, No. 96-Civ.-7551, 1998 WL 26190, at *2, *4 (S.D.N.Y. Jan. 26, 1998) (allowing plaintiff-inmate to proceed to discovery where plaintiff alleged that the county was deliberately indifferent in allowing EMSA to continue to provide medical care to inmates af-

must guard against systematic violations of inmates' Eighth Amendment rights by carefully scrutinizing managed care practices in prisons.

V. CONCLUSION

In an effort to cut costs, many state and county incarceration facilities have turned to private managed health care organizations to provide health care for their prisoners. Despite—or, perhaps, because of—the money saved by the government and the money made by managed care organizations, the level of health care in these facilities has decreased, and prisoner complaints and lawsuits are on the rise. Private managed health care in prisons has resulted in inmate injuries and deaths, many of which have been and are being challenged on Eighth Amendment grounds.

Constitutional violations in prison health care are determined under the deliberate indifference standard. The Supreme Court has held that government entities, or private companies carrying out governmental duties, can be held liable for systemic deliberate indifference violations where the entity promulgates an official custom or policy that violates prisoners' constitutional rights. Without question, some managed health care systems in prisons contain aspects that constitute an official custom or policy that violates prisoners' constitutional rights.

Some aspects of managed care, particularly direct financial incentives to avoid treating inmates, constitute *per se* deliberate indifference. Courts should find that the implementation of these policies always fails constitutional muster. Other aspects of managed care create a rebuttable presumption that deliberate indifference exists. Measures to save money—such as cutting staff, hiring less qualified staff, and denying, delaying or providing inefficacious treatment—can give rise to a rebuttable presumption that deliberate indifference has occurred.

Legislatures should consider banning private managed health care in prisons and jails. In the alternative, legislatures might consider enacting and departments of corrections might

ter county was on notice that EMSA provided substandard care that resulted in the death of an inmate).

consider contracting for provisions that ensure the adequate treatment of inmates. Absent these alternatives, the use of managed health care in incarceration facilities, and the decreased level of care that comes along with it, should remain under the constant vigilance of federal and state courts, whose obligation it is to enforce the Constitution of the United States.

