September 2023 | Report 416

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The Lack of Data Impedes Cost-Effective Health Care in Michigan's Prisons

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The Lack of Data Impedes Cost-Effective Health Care in Michigan's Prisons

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The Lack of Data Impedes Cost-Effective Health Care in Michigan's Prisons

3 Key Takeaways

- Providing health care to prisoners is a costly endeavor, yet the state does not adequately assess whether it meets its legal obligations to prisoners in the most cost-effective way.
- Improving quality of care and maximizing cost-effectiveness of the prison health care system requires a significant amount of data to identify and understand potential cost-drivers.
- Since every resident in Michigan has a stake in the quality and efficiency of the prison health care system, the state should ensure that the relevant data regarding prisoner health and spending be made available to policymakers and the general public.

Summary

The prison system, like roads and schools, is a part of the government's core architecture that aims to benefit society. While every citizen has a stake in the quality and efficiency of this system, the needs of prisoners are often overlooked and rarely prioritized by state policymakers and the public. Prisoners are too often seen as a collection of undesirable individuals that burden the state, as opposed to a necessary component of the state's responsibility to its people.

The state has an obligation to operate prisons in a manner that meets the basic needs of prisoners. Health care is a primary component of those operations and accounts for a large portion of the corrections budget. To that end, the state also has a duty to maximize health care quality and efficiency for the benefit of prisoners and the public.

In recent years, the state has spent approximately $300 million per year – roughly two percent of all General Fund dollars – to provide care for more than 30,000 prisoners. These costs are increasing on a per prisoner basis, particularly over the last several years. Minimizing costs without sacrificing quality of care is a monumental goal that requires a great deal of analysis. There are many potential theories as to what primarily drives prison health care costs and, accordingly, many different policy solutions. In order to assess how to allocate funding, it is necessary to analyze the true cost of prison health care and break down the primary drivers of those costs.

Achieving this goal requires extensive data about prisoner health care that is largely unavailable to the public. Much of the raw data is tracked by the Michigan Department of Corrections (MDOC). However, MDOC is only required to share high-level data with the public and is not required to provide sufficiently detailed reports to the legislature about its fulfillment of its obligations. Identifying cost-drivers within the prison health care system and recommending policy solutions depends on the availability of this data. The first legislative step for improving prison health care services and efficiently managing the associated costs, therefore, is taking action to require the collection and public reporting of aggregated prisoner health care information for analysis. [A]

[A] Citizens Research Council's goal at the beginning of this project was to conduct the analysis proposed by this paper – studying whether the state is meeting its obligations related to prisoner health care and how efficiently it is doing so. The Research Council's requested summary statistics and aggregated health data from MDOC to carry out this analysis, but the department did not produce any data.

Legal Obligations

The obligation to provide health care to prisoners flows from legal standards set by the U.S. and state constitutions, as well as federal and state laws, regulations, and policy. In addition to the obligation *to prisoners* to provide health care, governments – to protect themselves against litigation and waste – have concurrent obligations *to the public* to carry out their legal and ethical obligations in an effective manner while being good stewards of public resources.

U.S. citizens have a constitutional protection against cruel and unusual punishment under the Eighth Amendment. A state's failure to provide adequate health care, including deliberate indifference to the medical needs of prisoners, violates the constitution. Michigan also has its own analogous constitutional provision related to punishments.

In addition to the constitutional baseline, states may also establish additional requirements and parameters around prison health care through statutes, rules, and policies. In Michigan, a variety of laws and policies regulate the structure and delivery system of prisoner health care and create additional legal obligations on the state. Failing to meet the standard of care set out in the Eighth Amendment, the Michigan Constitution, or self-imposed statutory and regulatory obligations not only opens the state up to legal challenges from prisoners and/or their families, but also threatens societal trust in the order and integrity of the legal system.

States must fulfill this prisoner health care obligation to serve and protect the public, and the public has a stake in whether this legal standard is met and how the state goes about meeting it. First, meeting these obligations helps to protect the state's financial interests from litigation brought by prisoners and/or their families, and the effects of this financial loss trickle down to individual taxpayers. In addition, meeting the health care needs of prisoners serves the state's interest in rehabilitation which directly impacts recidivism and public safety.

Prison Health Care Delivery in Michigan

In Michigan, the Department of Corrections (MDOC) is responsible for the general health, psychiatric health, and medication needs of prisoners in its jurisdiction, which includes state correctional facilities, reentry centers, and some county jails. The department delivers these services in conjunction with a contracted vendor who provides physicians and mid-level providers for prisoner general health, psychiatric, and addiction treatment needs. Standards for care are determined by MDOC policies, terms agreed to by the department and its contractor, and evidence-based medical guidelines.

The department shares the financial risk with the contractor by blending two different financial models: cost-plus and capitation. The cost for services starts from a base capitated rate for the care provided by the physicians and providers employed by the contractor, and any cost differential between the base rate and actual rate is shared between the state and the contractor. The cost sharing structure is intended to incentivize the contractor to manage prisoner healthcare on-site and minimize the use of off-site services. Michigan also requires prisoner co-payments which are intended to reduce costs associated with unnecessary medical visits by deterring prisoners from over utilizing health care services.

Spending on Prison Health Care

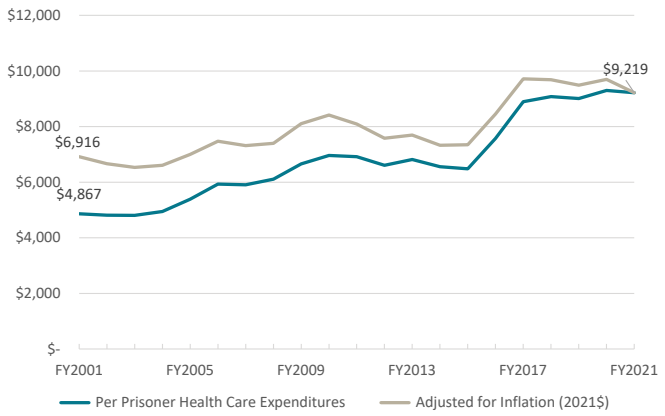
Prison health care is primarily funded by the states, with few avenues for federal support. Collectively, states spent about $8 billion on health care in state prisons in FY2015,[1] accounting for close to 20 percent of states' total corrections budgets for that year.[2] While national data on prison health care spending has not been compiled in the last several years, total corrections spending was more than $70 billion in FY2021.[3]

Michigan spends about $2 billion every year on MDOC operations, almost all of which is general fund money, and that figure has remained relatively consistent over the last two decades. Prison health care spending in particular accounts for nearly $300 million per year and has declined slightly as of FY2021 largely due to the declining prison population. The average per prisoner cost of health care has increased dramatically - 34 percent - over the last two decades, even after adjusting for inflation (see **Chart A**).

The significant increase in per prisoner health care spending over the last two decades is an important

Chart A

Per-Prisoner Health Care Expenditures in Michigan, FY2001 to FY2021



Source: Data compiled from MDOC Statistical Reports and U.S. Bureau of Labor Statistics Detroit CPI. Includes mental health expenditures by Department of Community Health in state prisons prior to FY2011 when that line-item was transferred to the MDOC budget.

matter of public policy. The limitations on using federal grants to offset state prisoner health care spending places the burden of this on the state's General Fund. It is important for policymakers to understand what the state is getting in exchange for this spending, why the cost of prisoner health care has risen, and what options the state has, if any, to meet its obligations in a way that better serves prisoners and the public alike.

Evaluation and Data Needs

Evaluating prison health care requires an analysis of whether health care in prisons is not only adequate, but also whether it is efficient. Allocating resources on potential policy solutions will depend largely on the answers to these questions – if prison health care is found to be neither adequate nor efficient, uncovering the reasons why will guide policymakers towards solutions.

Unfortunately, the state does not currently provide the data necessary to conduct this type of analysis. The MDOC provides limited data on the health of the prison population, health outcomes of incarcerated individuals, and prison health care spending. The available data is insufficient and leaves policymakers and the public in the dark on numerous important questions. The department tracks more data than it releases and uses that data to inform its decisions, but if MDOC does not provide the data to the legislature, stakeholders, and the public, there is no way to know whether the department is fulfilling its obligations.

Public data is needed that measures and tracks the health of individual prisoners and prison populations over time, including demographics, health conditions, and health outcomes. It is important to know what health issues prisoners have when they arrive, what issues they develop while in prison, and how well the department manages those issues. General information from MDOC and broader national survey data paint a consistent picture that the prison population is less healthy than the general population, particularly when it comes to mental health and substance abuse issues. However, more granular data is needed.

Presumably, MDOC has the underlying data necessary to generate the kind of metrics that would be helpful for analysis, as the department does a thorough health intake screening and documents health visits and treatments throughout a prisoner's time in custody.[4] In particular, the kind of health data that would be valuable for this analysis would include (for both existing prisoners and those entering the system):

- Percentage of prisoners with mental health issues broken down by severity and type/diagnosis
- Percentage of prisoners with substance abuse issues
- Percentage of prisoners with a chronic health condition (not just Hepatitis C) broken down by severity and type/diagnosis
- Percentage of prisoners considered overweight/obese

Potential Cost Drivers

Federal and state stakeholders – including MDOC – have theorized about the causes of increasing prison health care costs,[5] but there remains a limited understanding of exactly which factors actually drive the cost increases. Without a handle on the reasons

for the increases, policymakers and the public cannot evaluate whether the state is spending its resources as efficiently as possible, nor can they properly design policies and allocate resources in a manner that might allow the state to rein in the growing expenditures. Similarly, without better data, policymakers do not have a way to forecast whether a particular proposed policy change will move the needle on these expenditures or whether any changes would help prisoners avoid recidivating.

Potential cost drivers include:

- General increases in health care sector costs
- Mental health issues and the rising cost of mental health treatment
- Substance abuse issues
- Infectious disease control
- Preventative care costs
- Specialty/in-patient care utilization increases
- Increased demand for health services
- Prescription drugs costs
- Aging prisoners
- Staff shortages and retention issues

There are a wide variety of reform options available to the department and the legislature. If the data shows that the costs are coming from the health issues of the incoming prison population, policies should focus on social determinants of health to improve economically disadvantaged communities. If the data shows the health of prisoners deteriorates faster than those outside of prison, policies may need to focus on better preventative care. If the data shows that costs are being driven by the aging population, policymakers should look at shortening sentences or promoting early release for those deemed no longer a danger to society. If the problems seem to be associated with poor service delivery, the policy discussion may turn to system reform. Each solution has its own internal logic, but pushing on every available lever is rarely an option. The state has a finite set of resources and there is intense competition over those resources, even among stakeholders that agree ideologically.

The prison population is one of the more understudied societal groups, yet the state and the public maintain a substantial and often unrecognized stake in the well-being of prisoners. The health of prisoners has both economic and broader societal ramifications related to crime, recidivism, and public safety. Crafting policies that aim to improve the health of prisoners while reducing the financial burden on taxpayers could take on many different forms. These proposed policy solutions have been largely based on theoretical causes of poor quality of care and higher costs. Researchers who seek to develop policies for Michigan's prison population need the appropriate data to help tailor their recommendations for improved quality of care and cost-reduction.

The state needs to undertake a serious effort to study prison health care so that it can take targeted steps toward reining in growing costs. That effort starts with gathering, synthesizing, and releasing much more data than the department currently does. MDOC should welcome this effort, but if it does not,

Endnotes

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The Lack of Data Impedes Cost-Effective Health Care in Michigan's Prisons

Introduction

The needs of prisoners are often overlooked and rarely prioritized by state policymakers and the public. While other vulnerable populations frequently receive special attention, prisoners are not perceived as a sympathetic group that motivates legislative or political action. Somewhat understandably, it is difficult to convince policymakers faced with budget constraints to devote time, attention, and funding to this population. Prisoners are too often seen as a collection of undesirable individuals that burden the state, as opposed to a necessary component of the state's responsibility to its people.

State governments are responsible for multiple functions to ensure that their residents thrive. Providing systems of transportation, developing schools and education programs, and establishing and collecting taxes are a few widely recognized functions that allow people to meet their needs and contribute to society. Creating laws, and enforcing those laws, is an integral component to maintaining order. The prison system, like the roads and schools, is a part of the structural framework that aims to benefit society. And like roads and schools, every citizen has a stake in the quality and efficiency of this system.

Unlike other state responsibilities, establishing a prison system fundamentally alters the relationship between the state and the individuals that become incarcerated. Incarceration creates a substantial population of people who become dependent on the state to meet their basic needs. This population is separated from the usual government structures and private services that most people have access to and instead are completely dependent on the prison institution for basic services. The state is physically and financially responsible for not only the prison system as a whole, but also for each incarcerated individual.

Establishing a well-functioning prison system, therefore, requires attention to a variety of issues related to the provision of services to this population. First, the state must determine the types of services that are necessary for human beings. While prisoner rights advocates argue for a wide range of services to be available to incarcerated individuals, including job training, education, and recreational services, health care is one of the most basic of these services. At the very least, states are responsible for protecting the health and safety of prisoners. The United States Constitution, along with federal and state laws, establish minimum requirements that states must meet to provide basic health care services to prisoners. While the scope and quality of those services has remained in contention for years, the obligation of the state to provide health care to prisoners is set in stone.

The general public has an interest in a prison system that is undesirable but not unjust. First, while people can take steps to avoid going to prison, incarceration is a potential consequence for any citizen. In addition, most prisoners reenter society, and the public has an interest in their health and productivity upon release. Further, the state must demonstrate its capacity to house and care for individuals who are deemed to threaten the public. Those who rely on and support prisons to protect them from wrong-doers need to know that prisons are well-equipped for this task.

The public has a stake in not only the adequacy of the prison system, but also in its efficiency. Maintaining an effective and efficient health care system within prisons is essential to the functioning of the prison system. With limited funding to meet all the state's responsibilities, every component of the state budget should be analyzed for maximum efficiency. As health care accounts for a large portion of the prison budget, it is essential prison health care be evaluated to get the most bang for the buck – how can prisons fulfill their constitutional, legal, and ethical obligations to care for the health of incarcerated individuals in the most efficient and cost-effective way. The state has

a responsibility to those both in and out of prison to be good stewards of public money and create high-functioning institutions that serve society.

Prison health care is extremely costly. Today, the state spends approximately $300 million per year – roughly two percent of all general fund dollars – to provide care for more than 30,000 prisoners. And these costs are increasing, particularly over the last several years. Adjusted for inflation, per prisoner health care spending is up 34 percent over the last two decades, although that does not tell the entire story. Per prisoner health care costs were cut following the Great Recession, so between Fiscal Year (FY)2015 and FY2021 there has been a 25 percent increase in inflation-adjusted costs. Minimizing costs without sacrificing quality of care is a monumental goal that requires a great deal of analysis. There are many potential theories as to what primarily drives prison health care costs and, accordingly, many different policy solutions. In order to assess how to allocate funding, it is necessary to analyze the true cost of prison health care and break down the primary drivers of those costs.

Achieving this goal requires extensive data about prisoner health care that is largely unavailable to the public. Much of the raw data is tracked by the Michigan Department of Corrections (MDOC). However, MDOC is only required to share high-level data with the public and is not required to provide detailed reports to the legislature about its fulfillment of its obligations. Identifying the problems within the prison health care system and recommending policy solutions depends on the availability of this data. The first legislative step for improving prison health care services and efficiently managing the associated costs, therefore, is taking action to require the collection and public reporting of aggregated prisoner health care information for analysis.[A]

[A] The Citizens Research Council's goal at the beginning of this project was to conduct the analysis proposed by this paper – studying whether the state is meeting its obligations related to prisoner health care and how efficiently it is doing so. The Research Council requested summary statistics and aggregated prisoner health data from MDOC to carry out this analysis, but the department did not respond to our request.

State Obligation to Provide Health Care to Prisoners

An incarcerated person is essentially a ward of the state. Whether they are housed in public or private correctional facilities, the government is responsible for the care and well-being of prisoners, including providing health care. This obligation to provide health care flows from legal standards set by the U.S. and state constitutions, as well as federal and state laws, regulations, and policy. In addition to the obligation *to prisoners* to provide health care, governments – to protect themselves against litigation and waste – have concurrent obligations *to the public* to carry out their legal and ethical obligations in an effective manner while being good stewards of public resources.

In addition to the obligation to prisoners to provide health care, governments have concurrent obligations to the public to carry out their legal and ethical obligations in an effective manner while being good stewards of public resources.

Constitutional Obligations

The quality of and access to health care in prisons must be such that conditions do not constitute cruel and unusual punishment under the Eighth Amendment of the U.S. Constitution. Over time, the U.S. Supreme Court has established fundamental principles regarding the treatment of prisoners that obligate governments to provide medical care for prisoners. Deliberate indifference to the serious medical needs of prisoners has been held to constitute "unnecessary and wanton infliction of pain," which can establish cruel and unusual punishment.[6] In other words, because governments are responsible for the people they incarcerate, failure to provide health care for a prisoner's serious medical needs violates the Eighth Amendment.

There are two components to any Eighth Amendment violation: 1) *an objective component* – the demonstration of a serious medical need, and 2) *a subjective component* – the state of mind of prison personnel. To be a clear constitutional violation, the quality of health care must be so poor that it resulted in a serious medical condition, and it must be shown that those responsible for a prisoner's care deliberately ignored or failed to provide appropriate care. When determining whether an Eighth Amendment violation occurred because of insufficient health care, courts consider factors such as the amount of pain or distress experienced by the prisoner, the impact on the prisoner's ability to engage in normal activities, delays in providing care, and failure to provide treatment, among others.[7]

While the Eighth Amendment is a federal constitutional protection, it is one that the U.S. Supreme Court has incorporated onto the states through the Fourteenth Amendment's Due Process Clause. Therefore, states are obligated to care for their prisoners in a manner that is consistent with the Eighth Amendment.[8]

Michigan has its own analogous constitutional provision related to punishments. Article I, Section 16 of the 1963 Michigan Constitution provides that "…cruel or unusual punishment shall not be inflicted." This language has generally been interpreted more broadly[9] than its federal counterpart due to the use of the word "or" rather than "and," but claims of cruel and unusual punishment in the prison context have more commonly been brought in federal courts and there is limited state-level case law on the topic. In addition to broader federal cases on the parameters of the Eighth Amendment, Michigan has been party to several consent decrees over the years pertaining to several prisons that included requirements related to health care.[10]

Broadly, the Eighth Amendment sets a minimum level of care that states must provide to prisoners in their custody. Failing to meet the standard of care set out in the Eighth Amendment jurisprudence would open the state up to legal challenges from prisoners and/or their families that could burden the state with legal costs, damages, and/or court orders mandating certain types of care. In addition, the state's failure to uphold the constitution, regardless of the financial cost that comes from providing constitutionally deficient care, threatens societal trust in the order and integrity of the legal system.

State Laws, Regulations, and Policies

In addition to the constitutional baseline, states may also establish additional requirements and param-

eters around prison health care through statutes, rules, and policies. In Michigan, a variety of laws and policies regulate the structure and delivery system of prisoner health care and create additional legal obligations on the state.

Michigan does not have a comprehensive set of statutes regulating prisoner health care and has generally delegated that authority to MDOC to carry out via its power to set department policy, although there are statutes and annual appropriations boilerplate language pertaining to prisoner health care.

Specifically, MDOC has a Policy Directive regarding health care for prisoners which states, in part:[11]

> Prisoners shall be provided with a continuum of medically necessary health care services that are supported by evidence-based medical research.

The policy directive, and other related policy directives,[12] provide that all prisoners – which include parolees and probationers in MDOC operated facilities and contracted correctional facilities – must have access to health services, regardless of custody level or security or classification. Health services include intake services; annual health care screenings; chronic care services; cosmetic, corrective, and reconstructive surgery services; mental health care services; dental care; ancillary services, including pharmacy, radiology, and laboratory services; and any other additional services that are ordered by a medical provider.

The Bureau of Health Care Services (BHCS) is *responsible* for MDOC's health services program, including the coordination and monitoring of services, but health care services may be *delivered* by BHCS, under the direction of the BCHS Administrator, or by a contracted third-party provider. This type of delivery system is known as a "hybrid" system, as it utilizes both state employees and private vendors to provide care. While some services may be outsourced, the State of Michigan remains responsible for fulfilling legal requirements related to health services for prisoners.

While the core health care requirements are outlined in policy directives, there are some specific requirements that have been enacted into law. In particular:

- Prisoners are entitled to receive mental health services and maintain a right to confidentiality of medical information.[13]
- MDOC must establish and operate a corrections mental health program to provide mental health services for prisoners who are in need.[14]
- Anyone who is confined in a place of detention by the state who requests mental health services must be provided those services by the appropriate community mental health program.[15]
- MDOC maintains financial responsibility for any prisoner who is transferred to a separate mental health facility for treatment.[16]
- Prisoners are responsible for a co-payment fee to MDOC for nonemergency medical, dental, or optometric services received at the prisoner's request.[17]

Similarly, there is typically appropriations boilerplate language related to health care services, usually related to reporting (see box on **Page 5**).

While the statutory and regulatory obligations related to prisoner health care are self-imposed, the state is required to uphold its own laws and policies. Failing to provide health care consistent with the laws, rules, and policies enacted and adopted by the state could open the state up to litigation and other potential consequences.

Appropriations Boilerplate Language

It is common for annual appropriations acts to impose reporting requirements on state departments and agencies as a condition of receiving all or part of their yearly funding. Such reporting requirements are commonly included in the portion of the budget known as "boilerplate" language. Boilerplate language contains provisions that the department or agency must follow as a condition of receiving the associated appropriation and – unlike statutes – is not permanent law.

The Fiscal Year 2024 MDOC budget provides that:[18]

- The department shall provide reports on:
  - Physical and mental health care, pharmaceutical services, and durable medical equipment for prisoners. Reports must detail current and prior fiscal year expenditures itemized by vendor, allocations, status of payments from contractors to vendors, and projected year-end expenditures from accounts. Reports must include a breakdown of all payments to the integrated care provider and to other providers itemized by physical health care, mental health care, pharmaceutical services, and durable medical equipment expenditures.
  - Pharmaceutical prescribing practices, including a detailed accounting of expenditures on antipsychotic medications, and any changes that have been made to the prescription drug formularies.
  - A status report on efforts to develop measurable data and outcomes for physical and mental health care within the prisoner population. (This provision was first included in FY2023 and has not been completed)
  - Prisoner health care utilization that includes the number of inpatient hospital days, outpatient visits, emergency room visits, and prisoners receiving off-site inpatient medical care in the fiscal year, by facility. A new provision in FY2024 requires a listing of the 10 most common chronic care conditions.
  - The total amount spent on specialty medication for the treatment of Hepatitis C, the number of prisoners who were treated, the amount of any rebates that were received from the purchase of specialty medication, and what outstanding rebates are expected to be received. The report must include the Hepatitis C status of all incoming prisoners and the number of prisoners who are reinfected while incarcerated and require retreatment for Hepatitis C. The report must also include the number of those treated and released and then retreated upon reincarceration.
  - The number of prisoners who received medication assisted therapies, the length of time on therapies, and the number of prisoners who have discontinued treatment while incarcerated.
  - The utilization of Medicaid benefits for prisoners.
- The department shall assure that all prisoners, upon any health care treatment funded from appropriations, are given the opportunity to sign a release of information form designating a family member or other individual to whom the department shall release records information regarding a prisoner.
- Funds appropriated for Hepatitis C treatment shall be used only to purchase specialty medication for Hepatitis C treatment in the prison population. In addition to the above appropriation, any rebates received from the medications used shall be used only to purchase specialty medication for Hepatitis C treatment.
- The department must establish three medication assisted treatment clinics and submit quarterly reports on the selected locations, staffing levels, expenditures, the number of prisoners treated, and the number of prisoners requiring treatment who have not yet received it.

The State's Duty to Carry Out Legal Obligations

While states have an obligation to prisoners to provide them with health care, the state also has an obligation to the public to carry out that mandate in an effective manner while being good stewards of public resources. The public has a stake both in the fact that a legal mandate is met and how the state goes about meeting it.

States must fulfill this prisoner health care obligation to serve and protect the public. First, meeting these obligations helps to protect the state's financial interests from litigation brought by prisoners and/or their families. If the state fails to meet its constitutional and other legal obligations to prisoners, prisoners and/or their families may have legal standing to sue the state for damages caused by its failures and/or compel changes in health care services in state prisons. In addition to the direct costs associated with losing such lawsuits, these types of cases could lead to significant legal costs for the state. Paying expenses related to the state's legal defense or any settlements would come directly from the state's coffers and deplete funds that could be used for other state priorities.

In addition, the state's public safety goals are directly impacted by prisoner health. Ninety-five percent of those who enter the prison system are eventually released,[22] and evidence suggests that the physical and mental health of prisoners at the time of release

Human Rights Standards and Moral Obligations

In addition to constitutional and other legal obligations, states carry an ethical responsibility to provide services and treatment to individuals under their care. The state's ethical responsibilities, while not necessarily enforceable under law, are often established by public declaration, usually via international agreements. The United States has ratified various international treatises that either directly or indirectly concern the human rights of prisoners.

The Universal Declaration of Human Rights, established in 1948, commits nations to recognize certain fundamental rights and freedoms of all human beings.[19] While not legally binding on the state, the Declaration establishes a right to life, a prohibition on slavery and torture, and establishes an individual's economic, social, and cultural rights, including health care. The contents of the Declaration have been incorporated into treaties and standards, some of which have been signed or ratified by the U.S.

Similarly, the International Covenant on Civil and Political Rights (ICCPR) was ratified by the U.S. in 1992.[20] While the ICCPR does not expressly establish a right to health care, the United Nations Human Rights Committee has stated that the right to adequate and timely medical care is implied by the express right to life (Article 6), the prohibition on torture or cruel, inhuman, or degrading treatment and punishment (Article 7), and the right to humane treatment of prisoners (Article 10).

Another example is the United Nations Standard Minimum Rules for the Treatment of Prisoners.[21] It contains several rules related to prisoner health care. The Rules declare that the provision of health care for prisoners is the state's responsibility, and that prisoners should receive the same standards of health care that are available in the community. While not legally binding, the rules serve as widely recognized guiding principles for prisoner treatment and care.

Beyond formal international agreements and guidelines, states carry a general ethical obligation to treat people humanely and with dignity. Even when there is no formal legal requirement or structure in place to mandate a moral necessity, states carry an obligation to their citizens. While there is room for disagreement about what prison conditions are acceptable in a just society, denying prisoners essential medical services would certainly fall below the minimum ethical threshold.

can impact their likelihood to recidivate.[23] Focusing on the health care needs of prisoners serves the state's interest in rehabilitation. The state has a significant interest in releasing healthy, productive prisoners to their communities to fulfill its public safety obligations as well.

The state also has an obligation to try to fulfill these legal mandates in the most efficient and effective manner possible. All government endeavors require balance between costs and outcomes. Citizens have a right to expect that their government is using public resources in an appropriate manner and is striving to utilize limited funds in the best possible way, even in challenging circumstances.

In other words, the state faces a two-part obligation related to prisoner health care. The state must ensure that it is fulfilling its legal obligation to prisoners by providing a level of care that does not violate their constitutional and legal rights. The public has an interest in this part of the obligation because: 1) failing to fulfill it would open the state up to financial penalties, and 2) prisoner well-being upon release is important for public safety. In addition, the state must strive to fulfill its obligation to prisoners in a manner that does not waste public resources. Understanding the degree to which the state is meeting these obligations requires an understanding of how the state provides health care in prisons, what it costs, and the potential impact of that care.

Financial Structure and Delivery of Health Care to Prisoners

In order to fulfill the legal obligation of providing health care to prisoners, states must develop and implement health care delivery systems. In some cases, the delivery system is shaped by state law, but in others it is a product of department policy and contractual agreements. States make decisions about how to design their prison health care systems based on a variety of factors, but the policy deliberations are typically centered on cost-effectiveness given the state's legal obligation to prisoners and the expensive nature of health care services.

Prison Health Care Delivery Models

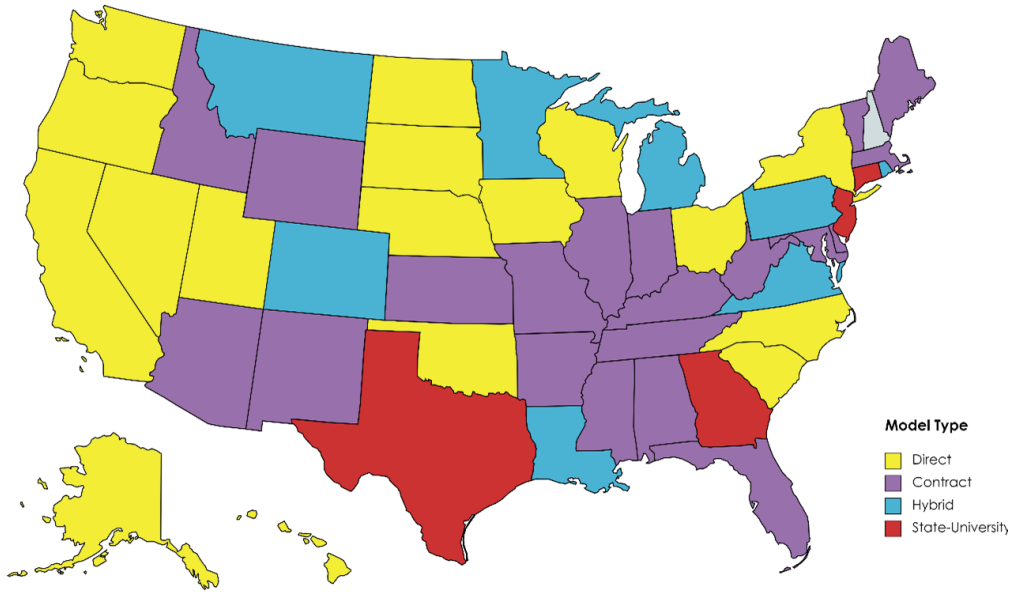
Until the 1970s, all states generally utilized the "direct" service model in which prisoner health care was provided by state-employed medical professionals.[24] However, due to budget crunches, geographically remote prison locations, and general worker shortages, state corrections departments struggled to attract a sufficient supply of health care professionals. In some cases, to respond to these challenges, states delegated some health care tasks to corrections officers, including administering medications, screening, and providing emergency care.[25] As the lack of adequate care and low-quality care in prisons ended up in the courts on Eighth Amendment grounds, states began to re-examine their health care delivery models.[26] Many states, including Michigan, began to look to outsourcing medical care for prisoners, primarily to improve quality of care.

Currently, states typically utilize one of four models for delivering health care services – direct, contract, hybrid, and state-university – with most states now relying on outside contractors or entities for at least some of their health care services (see **Map 1**). Seventeen states directly provide most health care by state-employed clinicians. Twenty states rely primarily on a contracted vendor to provide health care. In eight states, including Michigan, care is provided by a roughly even mix of state employees and contractors. In four states, most prisoner health care is provided in partnership with a public university medical school.[27] Among the states that utilize outside vendors, the scope of services provided by the contractor varies widely. States also vary as to whether they contract out solely for clinical services or also for managerial functions, and whether they provide services to all prisons in the state.[28]

Whether provided directly by state employees or through a contracted vendor, state prison systems typically provide both on-site and off-site health care services. Primary care and outpatient services are generally provided on-site in prison clinics. On-site care may also include specialized medical facilities operated by the state for prisoners with acute or chronic illnesses, prisoners who need recurrent care (such as kidney dialysis), or prisoners who are recuperating after a hospital stay.[29] Requests for non-emergency off-site care generally require authorization by the state corrections department.

Map 1

Prison Health Care Delivery System Organizational Structure, 2015



Source: Pew Charitable Trusts, "Prison Health Care: Costs and Quality," 2017. Note: New Hampshire did not provide data.

Some states' prison health care delivery systems include formal mechanisms for monitoring quality of care. Thirty-five states reported that they had a system in place for monitoring health care quality, most of which assign that responsibility to the state corrections department.[30] Most states track quality measures related to access and utilization (e.g., timely access to care and triage response time), screening or prevention services (e.g., examinations and vaccinations), and prevalence of various health conditions, including infectious disease, behavioral health, and chronic illness. Only a handful of states (Florida, Nevada, New Jersey, Newy York, and Texas) had legislation or regulations that govern quality improvement policies.[31] Almost every state that contracts out for health care services includes a provision in the contract related to quality metrics.[32]

Over the past decade, state prisons have started to provide continuity of care services for those transferring or leaving prison. Some prisons partner with other state agencies or community stakeholders to provide services related to insurance coverage, provider linkages, patient education, medication management, and records sharing.[33] Most states provide these services to individuals with specific medical conditions and do not make these resources available to every discharged individual.[34]

Financing Prisoner Health Care

Prison health care is primarily funded by the states, with few avenues for federal support. While many incarcerated individuals would otherwise be eligible for Medicare or Medicaid, federal law generally prohibits the use of Medicaid and Medicare funds to pay for the health care of an "inmate of a public institution," except for hospitalizations longer than 24 hours. This generally includes individuals detained in a local jail, state or federal prison, detention facility, or other setting that is organized for the primary purpose of involuntary confinement and the individual "is an inmate of a public institution."[35]

Collectively, states spent about $8 billion on health care in state prisons in FY2015,[36] accounting for close to 20 percent of states' total corrections budgets for that year.[37] While national data on prison health care spending has not been compiled in the last several years, total corrections spending grew to more than $70 billion in FY2021.[38] Given recent

trends, it is likely that current state prison health care costs nationally are in the neighborhood of $12 billion to $13 billion. In other words, approximately $1 out of every $250 spent by the states goes to prisoner health care. Michigan has generally been in the top five states for total spending on prisoner health care, although on a per prisoner basis the state is usually closer to ninth or tenth highest.[39]

Given that states generally cover prisoner health care costs directly from their general fund budgets with little federal assistance, system design is largely a question of cost-effectiveness. Some states believe a direct, state-employee model provides them with the most control, while others have shifted to relying on contractors as a method of controlling costs. For states that utilize contractors, they typically split into two funding models: 1) cost-plus, in which contracted vendors charge the department for services plus a fee for managing the program, and 2) capitation models, in which vendors receive a fixed per-person payment for all individuals under their care.[40]

Quality and Cost-Effectiveness in System Design

States' decisions between employing a direct service or a contractor-based model to provide prisoner health care are often framed as a balance between quality of care and efficiency, with direct service being more oriented toward quality and contractors being more oriented toward efficiency. But on both dimensions, the arguments are more complicated. Direct service employees and contractors simply have different structural incentives.

Direct service employees are not individually financially motivated to minimize costs and find efficiencies, so they may seek to provide direct care that is higher quality because the added expense is borne by the taxpayers rather than the decision makers. People on the ground may make decisions about the best way to allocate the resources provided to them, but there is no financial incentive to degrade care. On the other hand, there is no financial incentive to improve care or compete against other providers to provide better care or provide the same care in a cheaper manner.

Contractors are financially motivated to minimize costs, as long as they meet their contractual requirements for quality of care. This can lead contractors to provide the bare minimum required care to maximize their profit margins. On the other hand, their financial incentive should also push them to perform better to maintain their contract.

There have not been systematic evaluations of which model is most cost-effective,[41] but the variation in models places different requirements on policymakers seeking to ensure the quality of care and cost-effectiveness of prison health care. In direct service states, policymakers that oversee corrections departments need to take a more direct interest in health care protocol design, staff retention, and cost monitoring. Alternatively, in contract states, the policy focus needs to be on designing the proper contract incentives and performance monitoring.

The Michigan Model

In Michigan, the Department of Corrections (MDOC) is responsible for the general health, psychiatric health, and medication needs of prisoners in its jurisdiction, which includes state correctional facilities, reentry centers, and some county jails. The department delivers these services in conjunction with a contracted vendor (the current vendor is Grand Prairie Healthcare Services, although the state has used different contractors in the past). The contractor is required to provide physicians and mid-level providers for prisoner general health, psychiatric, and addiction treatment needs. Additionally, the contractor is responsible for providing dentists as requested by MDOC. Other staffing for ambulatory care at outpatient clinics is provided by MDOC.[42]

Cost-Sharing. The department shares the financial risk with the contractor by blending cost-plus and capitation models. The cost for services starts from a base capitated rate for the care provided by the physicians and providers employed by the contractor. The costs for on-site and off-site specialty services and pharmacy costs also start with a base capitated rate, but in cases where the actual costs for these services are higher than the base rate, the cost differential is shared between the state and the contractor. However, the formula sets a cap for the risk share, and costs that exceed the capped amount are entirely borne by the contractor. However, when the actual costs of these services are below the base capitated rate, the state and contractor share in the savings, with most of the savings (85 percent) accruing to the state. The cost sharing structure is intended to incentivize the contractor to manage prisoner healthcare on-site and minimize the use of off-site services.[43]

Additionally, health care services are partially funded by prisoner co-payments. Prisoners are responsible for a co-payment fee to MDOC for non-emergency medical, dental, or optometric services received at the prisoner's request.[44] The use of co-payments are intended to reduce costs associated with unnecessary medical visits by deterring prisoners from over utilizing health care services.

Health Care Services. Delivery of health services and standards for care are determined by MDOC policies, terms agreed to by the department and its contractor, and evidence-based medical guidelines. MDOC and its Bureau of Health Care Services (BHCS) are responsible for evaluating and modifying its service delivery system to incorporate management models that have been shown to be successful in improving outcomes and reducing costs, including preventative health and population health management.[45] A state-wide chief medical officer and a clinical leadership team oversee all

Health Care Co-Payments for Prisoners

Health insurance co-pays are a common cost sharing strategy in which covered individuals pay a designated out-of-pocket amount for certain types of services. Co-pays offset some of the insurer's costs and create an economic deterrent to prevent overutilization. Generally, higher co-pays are associated with lower plan premiums.

While the same general principles apply in prisons (i.e., prisoners bearing some cost decreases the overall cost to the state and having to pay for care decreases the odds prisoners seek care they do not need), some argue that requiring co-pays for prisoner health is not in the state's interest. For one, prisoners are not obtaining private insurance in a competitive market, so the tradeoff between co-pays and premiums is not a relevant consideration. Prisoners also have very limited financial resources and using co-pays to generate revenue has limited upside for the state. Additionally, while health services are a scarce resource in prison, deterring prisoners from seeking care – care that they likely did not have access to before they entered prison – is not consistent with the goal of rehabilitation, and may result in worse health outcomes.

health care operations, including those provided by the contractor. Health care teams at each prison are responsible for managing the prison population to achieve the expressed goals of improved health outcomes, patient experience, provider satisfaction, and cost-effectiveness. MDOC has established a Continuous Quality Improvement Team to develop and implement programs to improve quality of care, enhance general and behavioral health care operations, and assure responsible management of offsite services.[46]

Generally, individuals in MDOC custody receive medically necessary on-site services, including assessments of substance use disorders and management and prescribing of medications for addiction treatment. On-site clinics provide sick call referrals, ambulatory care, specialty units and care (including inpatient services, infectious disease units, and dialysis centers), withdrawal management, and palliative care services. Incoming prisoners receive a comprehensive health intake screening and assessment within 14 calendar days of arrival and their prisoner health record is established. Prisoners also receive an annual health care screening appointment within 30 days of their birthdays. Non-emergency care is also available by prisoner request and triaged depending on level of urgency.[47]

When prisoner needs cannot be met on-site, prisoners have access to a network of licensed and accredited providers. The services include acute care hospitals, mental health facilities, post-acute or skilled nursing facilities, therapy services (including physical therapy), physician specialists/consultants, emergency service providers, urgent/emergency dental services, durable medical equipment services, x-ray and interpretation, independent laboratories, and diagnostic testing centers.[48]

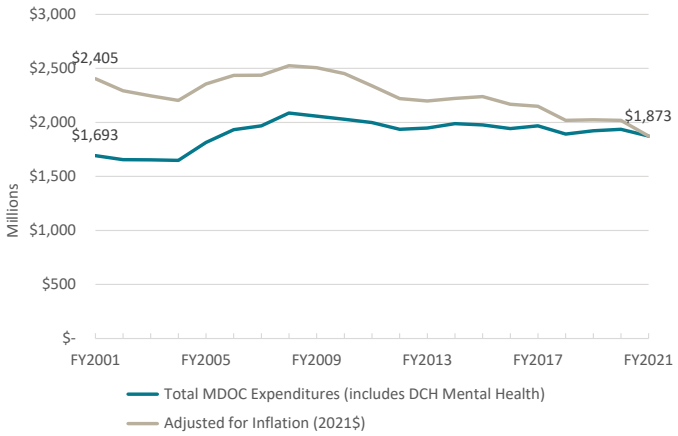
Mental health care can be provided to prisoners both on-site and off-site. All prisoners have access to a range of institutional services, including mental health intake evaluations, crisis intervention, suicide prevention services, specialized group therapies, parole board psychological evaluations, and aftercare planning. Certain qualifying individuals have access to additional in-patient services, residential treatment programs, outpatient mental health programs, and counseling services. Prisoners and/or staff can request an evaluation by a qualified mental health professional as defined by MDOC policy.[49]

Health Care Spending

Michigan spends about $2 billion every year on MDOC operations, almost all of which is general fund money. This figure has remained relatively consistent over the last two decades even as the prison population has declined, although total costs have come down after adjusting for inflation (see **Chart 1**). Inflation-adjusted total prison expenditures increased by about 15 percent from $2.2 billion in FY2004 to $2.5 billion in FY2008 (2021 dollars), but that amount gradually decreased by 35 percent to $1.8 billion in FY2021.

Chart 1

Total Prison Expenditures in Michigan, FY2001 to FY2021

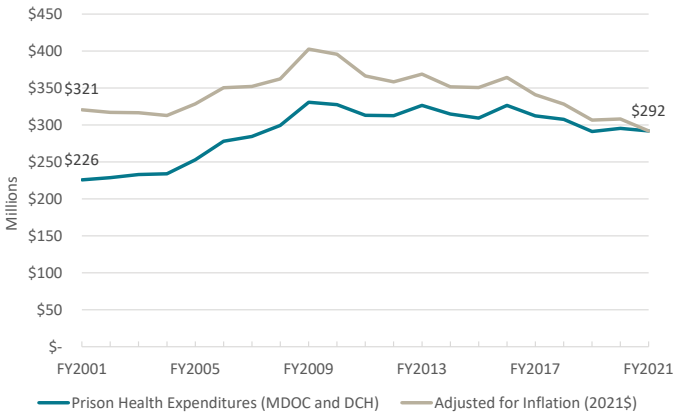


Source: Data compiled from MDOC Statistical Reports and U.S. Bureau of Labor Statistics Detroit CPI. Includes mental health expenditures by Department of Community Health in state prisons prior to FY 2011 when that line-item was transferred to the MDOC budget.

The same can largely be said about prison health care spending, which accounts for nearly $300 million per year (see **Chart 2**). Total inflation-adjusted prison health care spending increased by 28 percent from $312 million in FY2004 to $403 million in FY2009 but has decreased by 38 percent to $292 million in FY2021.

Chart 2

Total Prison Health Care Expenditures in Michigan, FY2001 to FY2021



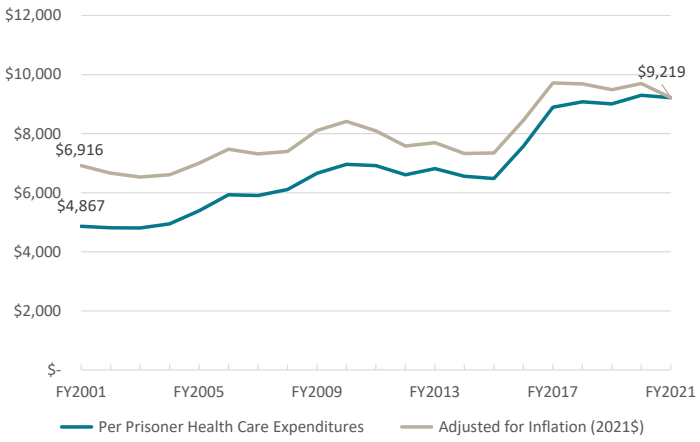
Source: Data compiled from MDOC Statistical Reports and U.S. Bureau of Labor Statistics Detroit CPI. Includes mental health expenditures by Department of Community Health in state prisons prior to FY2011 when that line-item was transferred to the MDOC budget.

While MDOC has trimmed the total health care budget from a high of $330 million in FY2009,[B] this drop is largely due to the decline in the number of prisoners. The average per prisoner cost of health care has increased dramatically during this period even after adjusting for inflation (see **Chart 3**). Between FY2001 and FY2021, inflation-adjusted per prisoner health care spending increased by 34 percent (from $6,916 to $9,219). Chart 3 shows a major increase from FY2015 to FY2017 (32 percent), but it is probably more accurate to view FY2017 as a return to the pre-Great Recession trend following several years of budget-tightening in which the department was likely underfunding health care. Inflation-adjusted costs leveled off in the last couple of fiscal years, although this is tied more closely to increased inflation than a change in nominal spending trends.

[B] Prior to FY2011, the Department of Community Health provided mental health services to prisoners. Funding for these services was part of the MDCH budget rather than MDOC. For appropriate context, all figures treat these MDCH expenditures as part of prison spending. In FY2011, these employees became MDOC employees and the MDCH appropriation was shifted to MDOC.

Chart 3

Per-Prisoner Health Care Expenditures in Michigan, FY2001 to FY2021



Source: Data compiled from MDOC Statistical Reports and U.S. Bureau of Labor Statistics Detroit CPI. Includes mental health expenditures by Department of Community Health in state prisons prior to FY2011 when that line-item was transferred to the MDOC budget.

The department breaks health care expenditures down into several categories (base personnel, hospital/specialty services, other operations, consent decrees, and mental health) and reports that the two factors driving this increase are "base personnel" and "hospital/specialty services," but provides no additional detail about which specific costs are associated with each category (see **Chart 4**).

The spending trends vary by category, although it is difficult to fully interpret the trends without knowing whether certain expenditures are shifted among the different categories over time. All figures are presented in 2021 dollars to account for inflation.

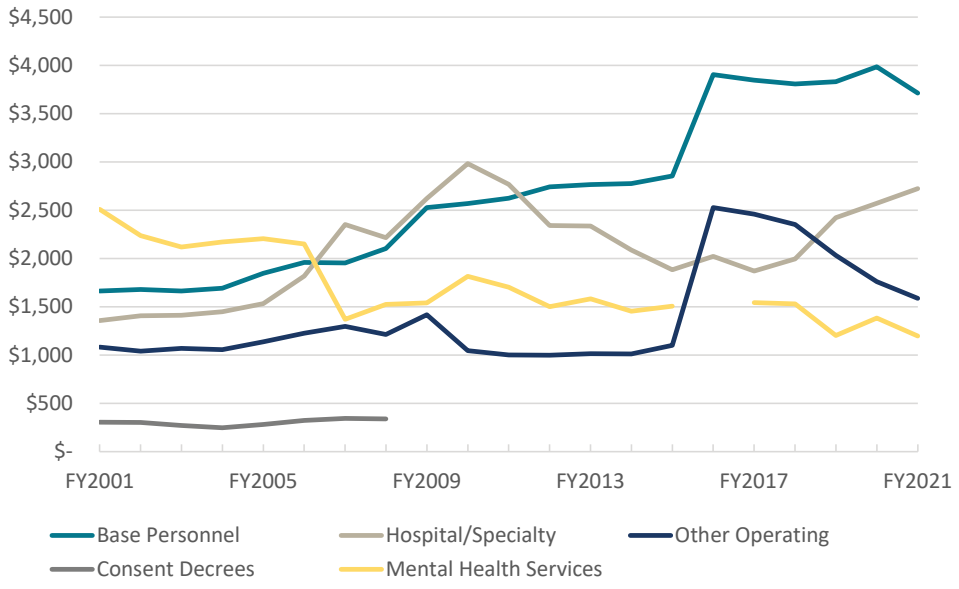
- **Base personnel** expenses climbed steadily – increasing by 72 percent between FY2001 and FY2015 – before a major 37 percent increase in FY2016 that has generally leveled out.

- **Hospital and specialty services** increased 120 percent between FY2001 and FY2010, declined 37 percent between FY2010 and FY2015, and then saw another 45 percent increase between FY2015 and FY2021.
- **Mental Health** spending has generally been trending downward with some ebbs and flows. Since FY2001, expenditures declined by 52 percent on a mostly consistent trajectory. There was a major dip in FY2007 followed by growth in FY2008 and FY2009 before the downward trend resumed.
- **Other Operations spending** grew steadily from FY2001 to FY2009, increasing by 31 percent. Between FY2009 and FY2015, these expenditures declined by 29 percent. FY2016 saw an annual increase of 129 percent, but spending declined 37 percent in the five years that followed.

The significant increase in per prisoner health care spending over the last two decades is an important matter of public policy. The state has a legal and ethical obligation to provide these services in a manner that is *at least* constitutionally adequate. But the state must also be a good steward of public resources and should be attempting to design a system that provides necessary services in a cost-effective way. General inflation in the health care sector is typically higher than the overall economy,[50] so it is not surprising to see inflation-adjusted prison health care costs increasing. The limitations on using federal grants to offset state prisoner health care spending places the burden of this on the state's general fund. It is important for policymakers to understand what the state is getting in exchange for this spending, why the cost of prisoner health care has risen, and what options the state has, if any, to meet its obligations in a way that better serves prisoners and the public alike.

Chart 4

Inflation-Adjusted Per Prisoner Health Expenditures in Michigan by Category, FY2001 to FY2021



Source: Data compiled from MDOC Statistical Reports and U.S. Bureau of Labor Statistics Detroit CPI. Includes mental health expenditures by Department of Community Health in state prisons prior to FY2011 when that line-item was transferred to the MDOC budget. In FY2016, mental health spending was not reported separately and is rolled into the other categories.

Note: MDOC was a party to three consent decrees related to conditions at specific facilities that required certain remedial action by the department. Health care was included as part of the decrees and the department allocated some of the money appropriated for consent decree compliance to health care, but MDOC did not specify if it supplemented existing expenditures or targeted specific issues at the facilities.

Evaluating Health Care in Michigan's Prisons

Policymakers and the public need to be able to evaluate whether the state is meeting its obligations related to prison health care, if there are any areas where the state should make changes, and what policy changes might lead to better outcomes. Evaluating prison health care requires an analysis of whether health care in prisons is not only adequate, but also whether it is efficient. Further, allocating resources on potential policy solutions will depend largely on the answers to these questions – if prison health care is found to be neither adequate nor efficient, uncovering the reasons why will guide policymakers towards solutions.

If prison health care is found to be neither adequate nor efficient, uncovering the reasons why will guide policymakers towards solutions.

Unfortunately, the state does not currently provide the data necessary to conduct this type of analysis. The Michigan Department of Corrections provides limited data on the health of the prison population, health outcomes of incarcerated individuals, and prison health care spending. Much of the existing data – which is presented in the following sections – comes from reports required by appropriations boilerplate which are limited in detail and may not be reauthorized in any given budget cycle. The available data is insufficient and leaves policymakers and the public in the dark on numerous important questions. The department tracks more data than it releases and uses that data to inform its decisions, but if MDOC does not provide the data to the legislature, stakeholders, and the public, there is no way to know whether the department is fulfilling its obligations. Robust oversight and effective policymaking require information – information that is currently not available.

While MDOC provides some information on these topics, it must expand the scope of its public reporting across a wide variety of metrics so that the public can understand whether the state's annual $300 million investment is going to good use. The department should welcome this request, as MDOC has a genuine interest in internal improvements, but has not prioritized this information sharing. If the department does not produce the kind of data that is needed to evaluate prison health care, the legislature should take action to require it.

In order to appropriately evaluate the state's prison health care system and develop policy solutions for improvement, access to a wide range of data is needed. Public data is needed that measures and tracks the health of individual prisoners and prison populations over time, including demographics, health conditions, and health outcomes is necessary. While some of this information is available, it is not available with the level of detail necessary to determine where resources are most needed. Without this information, any analysis of potential cost-drivers and discussions of policy solutions will be unnecessarily limited.

Measuring the Health of the Prison Population

The Michigan Department of Corrections has no control over who walks through its doors in the first place: the incoming population of prisoners is a product of state and local criminal justice policy. This includes policies dealing with local policing, prosecutorial discretion, state sentencing guidelines, and more. The department is handed a cohort of prisoners who bring with it an existing set of health issues that the department is obligated to manage and treat during its time in custody. It is important to know what health issues prisoners have when they arrive, what issues they develop while in prison, and how well the department manages those issues. Without knowing this underlying health data, it is extremely challenging to evaluate how the health of prisoners change while in custody, whether the state is providing adequate care, and if there are ways in which the state could achieve adequate (or better) outcomes in a more efficient way.

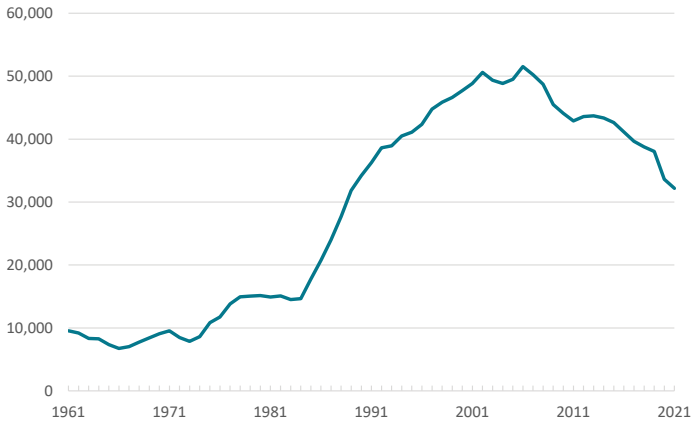
Prisoner Population and Demographics

The first step in measuring the health of the prisoner population is gathering data on the makeup of that population. The department provides relatively good data on this topic, but there are a few areas where more data would be helpful.

The department's data on new prisoners and total population is extensive. This provides an understanding of the total population over time, as well as the number of people entering and exiting prison each year. Michigan's prison population ballooned in the 1980s, 1990s, and early 2000s, growing from around 15,000 prisoners to a peak of 51,515 prisoners in 2006, but it has been declining over the last two decades, dropping to 41,000 prisoners by 2016 and 32,000 prisoners by 2021 (See **Chart 5**).[51]

Chart 5

State Prison Population in Michigan, 1961 to 2021



Source: 2021 MDOC Statistical Report

The number of people sent to prison in Michigan has been on the decline for more than a decade, but the COVID-19 pandemic drove the number of new prisoners down ever further. In 2021, there were over 5,000 people sent to prison, down from about 8,100 in 2019 and down from more than 10,000 as recently as 2014.[52]

The department also provides solid data on the gender, age, and race of the prison population. More than 90 percent of new prisoners in 2021 were men and about 60 percent were white.[53] By age, the population of new prisoners was split roughly evenly among prisoners 29 years old and under (32 percent), prisoners 30 to 39 years old (35 percent), and prisoners 40 years old and over (33 percent).[54] While these percentages have varied from year to year, the relative rates have been largely consistent even as the overall number of new prisoners has declined. The only significant change in recent years has been that the share of new prisoners who are white has grown slightly.[55]

The incoming prison population is:

- **More male** than Michigan as a whole (~90 percent vs ~50 percent)
- **Less white** than Michigan as a whole (~60 percent vs ~80 percent)[C]
- **Younger** than Michigan as a whole (~two-thirds of incoming prisoners are under 40 years old vs ~one-third of adults in Michigan are under 40 years old).[56]

Due to sentence length, the age of the overall prison population has increased even as the incoming cohorts have remained reasonably similar, as ~50 percent of prisoners are under 40 years old. Additionally, the total existing prison population is even less white than the incoming population (46 percent).

While the age, sex, and race/ethnicity of the population are important variables for any population comparisons, MDOC does not publicly report data on the educational attainment or socioeconomic status of incoming prisoners, so it is not possible to place the incoming prison population into context on those dimensions even though they are important correlates of individual health.[57] It would be useful for the department to provide metrics associated with education level and poverty to help properly contextualize the health of the prisoner population.

Prisoner Health Data

The Michigan Department of Corrections publishes no data on the incoming health profile of its population and has only publicly provided very general data on the health of its prisoners overall.[58, 59] Two recent

[C] MDOC reports race using white/non-white, while U.S. Census data has white/partial white vs. non-white, so the comparison is not identical.

presentations to legislative committees contain surface-level data on the state of prisoner health in Michigan.

Broadly, the department reported that "individuals in prison are more likely to have chronic health concerns, such as diabetes, high blood pressure and substance use disorder"[60] and that "most prisoners did not receive regular medical, mental health, optometry, or dental care" prior to incarceration and that "prisoners are 10 years older than their chronological age" when their health status is considered.[61] On specific topics, MDOC has reported the following:

Mental Health: Thirty-three percent of the prison population is being treated for mental health issues,[62] with 10 percent of the population having what MDOC defines as a serious mental illness (e.g., schizophrenia, bipolar disorder, major depressive disorder, psychosis, etc.).[63]

Aging Prisoners: MDOC is "faced with a rapidly expanding older prisoner population with all the challenges involved in caring for a frail medical or frail elderly prisoner." Prisoners over 50 years old, who account for about 25 percent of the population, "have earlier onset and higher prevalence of chronic medical conditions than noninstitutionalized adults of the same age" and "many prisoners have issues with Activities of Daily Living (ADL), dementia, and [are] wheelchair bound." In 2019, there were about 800 prisoners with "life limiting medical issues" and 172 enrolled in MDOC's version of hospice.[64]

Hepatitis C: Ten percent of prisoners have Hepatitis C, with about one-third of those having received direct treatment while in custody. About 50 to 100 prisoners are treated at any giving time with about 11 new prisoners diagnosed each month at intake.[65]

Pregnancy: About 9-12 prisoners are pregnant at any given time.[66]

Medication: Roughly half of prisoners take at least one medication.[67]

Cancer: There were 225 active oncology patients in 2019.[68]

Presumably, MDOC has the underlying data necessary to generate the kind of metrics that would be helpful for analysis, as the department does a thorough health intake screening and documents health visits and treatments throughout a prisoner's time in custody.[69] In particular, the kind of health data that would be valuable for this analysis would include (for both existing prisoners and those entering the system):

- Percentage of prisoners with mental health issues broken down by severity and type/diagnosis
- Percentage of prisoners with substance abuse issues
- Percentage of prisoners with a chronic health condition (not just Hepatitis C) broken down by severity and type/diagnosis
- Percentage of prisoners considered overweight/obese

None of the requested data would require the department to publish personal identifiable information or protected health information. This analysis can be done by producing summary statistics and aggregate information, and the department would be able to establish procedures to withhold certain figures when the population of prisoners in a given data category is small enough to potentially reveal the prisoner's identity (similar to how the state handles vital records). When it is important to look at information about the evolution of a prisoner's health over time, presenting the data by prisoner cohort would be especially useful. For example, the department could identify the health characteristics of incoming prisoners by year (or multi-year period) and then report on the health characteristics of that group over time.

Health Characteristics of Prisoners Nationwide

While the available data on the health of incoming and existing prisoners in Michigan is sparse, data from around the country can be used to develop a better understanding of prisoner health generally. The broader national trends may not all map perfectly onto the situation in Michigan, but absent better data from the department, it is useful context.

The U.S. Department of Justice's Bureau of Justice Statistics (BJS) periodically surveys federal and state prisoners on a variety of topics, including numerous health-related issues. The most recent survey took place in 2016, with BJS reporting findings in 2021.[70]

Chronic Health Conditions. Among the state prisoners surveyed nationwide, 51 percent reported ever having a chronic health condition, with 40 percent experiencing a chronic health condition at the time.[D] The most common chronic health condition was high blood pressure (29 percent), followed by arthritis (18 percent), asthma (17 percent), diabetes (8 percent), and heart-related problems (seven percent). Ten percent of state prisoners surveyed reported that they had Hepatitis C at some time, four percent had experienced a sexually transmitted infection in their lifetimes, and one percent had HIV/AIDS. The survey also found that 46 percent of state prisoners were overweight (Body Mass Index of 25 to 30) and 28 percent were obese (Body Mass Index over 30).[71]

Disability. Forty percent of state prisoners reported having a disability. The most common disability types were cognitive disability (24 percent), ambulatory disabilities (12 percent), vision disabilities (12 percent), and hearing disabilities (10 percent). Additionally, 26 percent of state prisoners reported being told at some point in their lives that they had attention deficit disorder, 25 percent reported ever having attended special education classes, and 15 percent had been told they had a learning disability.[72]

Substance Use. Among state prisoners who were not incarcerated for the entire year prior to their offense, 49 percent met the criteria for having a substance use disorder during that period. Ninety percent of state prisoners reported ever using drugs and 65 percent reported using drugs in the 30 days prior to their arrest. Additionally, 31 percent of state prisoners reported drinking alcohol and 39 percent of state prisoners reported using drugs at the time of their offense.[73]

Mental Health. An estimated 43 percent of state prisoners surveyed had a history of mental health problems, including 27 percent being told at some point in their lives that they had a major depressive disorder. About 23 percent of state prisoners reported bipolar disorder and 22 percent reported an anxiety disorder. Post-traumatic stress disorder was reported by 14 percent of state prisoners. Fourteen percent of state prisoners surveyed had experienced serious psychological distress in the 30 days prior to their interview and 39 percent of those prisoners had previously stayed in a hospital overnight for a mental health issue.[74]

It is difficult to draw a direct one-to-one comparison between this data and broader health data about the general public because the methodologies vary, but the data is quite clear that prisoners have higher rates of disability,[75] substance use disorder,[76] and mental health issues[77] than the population at large. The data is mixed on chronic health conditions, as the prison population is much younger than the adult population as a whole and the BJS data is not granular enough to perfectly compare rates. For instance, state prisoners have similar rates of high blood pressure as the population at large, but the rates are higher for prisoners when compared to similarly aged people in the general population.[78] A similar phenomenon exists with diabetes, as the rate in the general population is higher overall but appears to be lower when comparing age groups.[79] For asthma, state prisoners have nearly double the rate of the general population.[80] The prison population and the general population have similar shares of people considered above normal weight by body mass, but the prisoner population has a higher overweight share (BMI 25 to 29.9) compared to the general population and a lower obese share (30.0 and higher).[81]

[D] Defined as "cancer, high blood pressure, stroke, diabetes, arthritis, asthma, cirrhosis of the liver, and heart- or kidney-related problems."

Overall, the general statements from MDOC and the broader national survey data (see box) paint a consistent picture that the prison population is less healthy than the general population, particularly when it comes to mental health and substance abuse issues.[82] It is difficult to draw conclusions about the efficacy of the health care and treatment prisoners receive while in custody, as the health data upon intake is not available to compare with health data at later stages of incarceration. While the data available certainly substantiates the idea that prisoners need more care than the average citizen, the baseline health data needed to know what that would entail and the associated costs and if the dollars being spent on prisoner health care are being allocated properly is lacking. As noted earlier (see box on page 5), the FY2023 appropriations act required the MDOC to provide a "status report on efforts to develop measurable data and outcomes for physical and mental health care within the prisoner population," but as of August 2023, the report had not been published. A similar provision was included in the FY2024 appropriations act.

Without better data, policymakers do not have a way to forecast whether a particular proposed policy change will move the needle on these expenditures or whether any changes would help prisoners avoid recidivating.

Understanding Prison Health Care Cost-Drivers

While MDOC reports high-level data on health care spending in prisons, evaluating the adequacy of its health care delivery and the efficiency of its health care spending requires significantly more granular data. More detailed spending data, as well as the health outcome metrics discussed earlier, are necessary for evaluating why prison health care costs are growing and what the state can do, if anything, to combat these cost increases.

The delivery of health care is a complex and expensive undertaking, particularly in a secure setting like a state prison. Numerous variables shape the cost of providing health care services within the MDOC, all of which are connected to the broader health care industry.

Federal and state stakeholders – including MDOC – have theorized about increasing prison health care costs,[83] but there remains a limited understanding of exactly which factors actually drive the cost increases. Without a handle on the reasons for the increases, policymakers and the public cannot evaluate whether the state is spending its resources as efficiently as possible, nor can they properly design policies and allocate resources in a manner that might allow the state to rein in the growing expenditures. Similarly, without better data, policymakers do not have a way to forecast whether a particular proposed policy change will move the needle on these expenditures or whether any changes would help prisoners avoid recidivating.

Federal Prisons Also Lack Quality Health Care Data

It should be noted that MDOC is not the only entity that has failed to produce this kind of information. In 2017, the U.S. Government Accountability Office (GAO) came to a very similar conclusion about the federal Bureau of Prisons (BOP).[84] GAO found that the cost of health care in the BOP increased 36 percent between FY2009 and FY2016, even after adjusting for inflation. Like MDOC, BOP cited "an aging inmate population, rising pharmaceutical prices, and increasing costs of outside medical services as factors that accounted for its overall costs," but GAO reported that "BOP lacks or does not analyze certain health care data necessary to understand and control its costs."

General Increases in Health Care Sector Costs

Prison health care exists within a broader health care ecosystem and certain costs are driven by ordinary market factors that are mostly unrelated to the correctional system setting. For instance, some proportion of MDOC's health care budget goes toward medical supplies that are not specific to the needs of prisoners (e.g., gloves, band-aids, syringes, over-the-counter medications). While MDOC can (and likely does) leverage its size when purchasing these kinds of items, the department and its vendor are at the mercy of the overall market.

It is very likely that costs of this nature account for some increase in the per prisoner spending as has been seen over the last two decades, but data is not available to isolate the magnitude of this issue. While there is no perfect way to account for the impact of broader trends in health care costs, MDOC could identify total expenditures related to medical supplies over time, as well as per unit costs for these items (or sets of items). There are also likely a set of services (e.g., laboratory work) which are similarly impacted by the broader health care industry. Metrics of this nature would allow the public to understand how much the department is spending on goods and services that essentially cannot be utilized much differently. If syringes cost 75 percent more than they did in 2010, MDOC cannot do much beyond paying for them. The state's options at that point would be to further decrease the prison population or tackle broader health care supply costs, but in either case, the policy approach would extend well beyond prisoner health care and MDOC.

Mental Health

Mental health services are a major component of prison health care spending in Michigan, accounting for roughly 13 percent of per prisoner health care spending, according to MDOC.[85] The department reports that 33 percent of prisoners are on its mental health caseload,[86] up from 24 percent in 2019.[87] However, as noted above, per prisoner spending on mental health has declined over the last two decades.

While the department reports on these top-level metrics regularly, the data leaves many questions unanswered. It is certainly clear that incoming prisoners are in greater need of mental health treatment than the population at large, but the public lacks any real insight into how well the department is handling that treatment.

The public would benefit from MDOC reporting more granular data about what the mental health budget is being spent on and how that has changed over time. Not only would it be beneficial to understand the breakdown in terms of how the money is allocated, but it is also important to demonstrate the cost variation across prisoners on the caseload. The department has noted that there is a split between prisoners with more and less serious mental health issues, but there is no available data that speaks to the costliness of any given slice of the mental health caseload. One could imagine the department spends much more per prisoner for the highest acuity prisoners, but there is no data on this subject. Alternatively, the costs could be relatively equivalent irrespective of an individual's particular mental health issue. More broadly, a better handle is needed on what is driving the change in cost. There is a significant difference between prisoners receiving more care and that care being more expensive on a per unit basis. Policy solutions will vary depending on the nature of the expenses and where the money is going.

The department does not report any data on the outcome of mental health treatment in prison. There is not good data on how MDOC is measuring the success of its treatment programs and whether they are appropriately designed and implemented. Mental health problems cascade into all sorts of other issues, including physical health, professional success, and personal conduct. The department should report on how it is evaluating whether its overall mental health regime is improving the well-being of prisoners. Proactive and preventative treatment is typically more cost-effective than responsive treatment. There may be opportunities for the department to spend more money on additional early interventions and screenings that ultimately saves money in the long run, but without data on how prisoner mental health changes over the course of their time in custody, policymakers do not know if there are opportunities there or not.

In addition to the high-level caseload statistics and the cost of mental health services overall, the de-

partment should report more detailed data on the breakdown of mental health issues among prisoners, the type and quantity of treatment they receive, and how those prisoners are progressing during treatment. The public needs more information on how this money is being utilized and whether prisoners are better off. This is not to say that there is anything fundamentally misguided about the department's mental health approach, but the absence of data leaves policymakers in the dark.

Substance Abuse

Many of the questions and conclusions regarding mental health data also apply to substance abuse. Unfortunately, MDOC currently provides even less data on its substance abuse caseload and expenditures. The public and policymakers need a much better grasp of the size of the substance abuse problem among incoming prisoners, how those issues progress while in prison, and what the department spends on this aspect of health care.

At a basic level, more information is needed on the prevalence of substance abuse issues over time and the severity of the issues upon arrival. It is then important to understand the cost of substance abuse treatment in total, per prisoner, and per unit of treatment. Understanding these factors and how they have changed over time will allow policymakers to get a handle on how much substance abuse issues are driving costs in prison health care settings and available options to address the issue. As noted earlier, policy solutions will vary depending on the cause of the problem – an increase in need, an increase in cost, or both. Currently, the public has almost no insight into the costs associated with substance abuse treatment, limiting policymakers' ability to find solutions.

Infectious Disease

The department provides limited information on the cost of responding to infectious diseases. While there is some data on Hepatitis C prevalence in Michigan prisoners, there is limited data on the cost of Hepatitis C treatment. Beyond Hepatitis C, there is essentially no data on how much of the department's health care expenditures go toward combatting infectious diseases and what that money is spent on. Understanding the prevalence of other diseases over time and what the department has done to stop the spread and treat these diseases is critical for policymakers interested in managing costs.

There may be particular diseases that are especially prevalent and costly for the department or there could be places where greater spending on prevention could decrease the cost of treatment down the line. There is an additional wrinkle with infectious disease in that disease can easily spread from prisoners to staff, which can impact other operational functions within the department.

Preventative Care/Wellness

Regular medical checkups and maintenance are important for everyone, even those prisoners who do not enter MDOC custody with existing health issues. Understanding what the department spends on ordinary preventative care and wellness is a critical piece of the health care expenditure puzzle. Again, the MDOC does not break down its spending into enough detail to develop an understanding of how much money is directed at preventive care in prison or what that money is being spent on. In addition, MDOC does not provide yearly data on the number of annual wellness exams and primary care visits utilized by prisoners each year, which could elucidate how these costs have evolved over time.

Preventative care is particularly interesting because spending more on proactive health care could lead to overall cost reductions in the long run,[88] so it is possible that preventative care spending might not be increasing fast enough. As is the case with the other cost-drivers, the lack of data limits the specificity of recommendations that can be made to policymakers.

General Demand for Health Care

A broader demand for health care services generally could explain the cost increase. In other words, it could be that prisoners are simply seeking more care than they used to even after adjusting for other cost drivers such as substance abuse rates. MDOC does not currently provide any data that would confirm or rebuke this theory, but it should be relatively easy to track visits, procedures, etc. on a per prisoner basis. Policymakers would benefit from understanding whether this theory is true and how much it adds to the balance sheet.

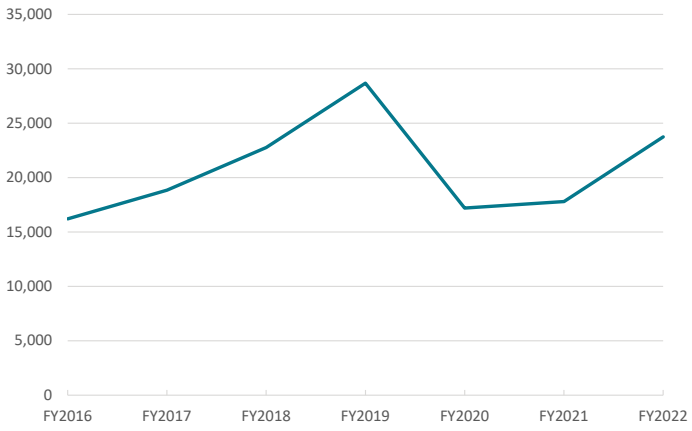
Specialty Care/In-Patient Care

The rise in specialty and in-patient care for prisoners over time appears to be relatively clear, but there is limited data on the exact nature of the issue. As noted above, per prisoner hospital/specialty care spending is a key component of the per prisoner health care spending increase. In this case, MDOC provides some quarterly data on the utilization of these services that sheds light on whether the cost increase is coming from more utilization or higher per unit costs.

Outpatient visits increased 77 percent between FY2016 and FY2019. The COVID-19 Pandemic appears to have impacted that trend in FY2020 and FY2021 with visits dropping by around 60 percent before a resurgence in FY2022 (see **Chart 6**).

Chart 6

Outpatient Visits by Michigan Prisoners, FY2016 to FY2022

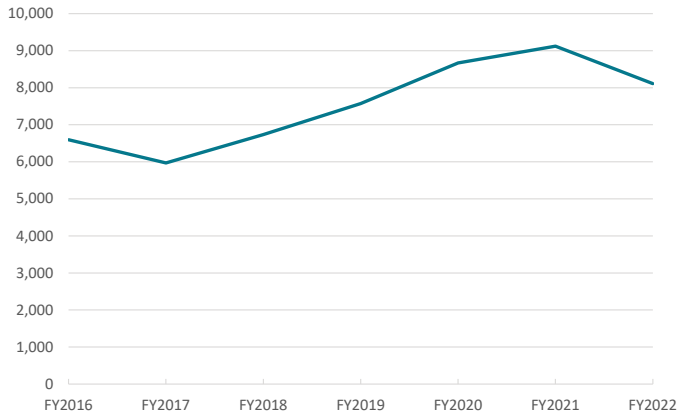


Source: Data compiled from MDOC Prisoner Health Care Utilization Quarterly Reports to the Legislature.

Inpatient hospitalization days rose more consistently, up 53 percent from FY2017 to FY2021, before an 11 percent decline in FY2022 (see **Chart 7**).

Chart 7

Inpatient Hospital Days by Michigan Prisoners, FY2016 to FY2022

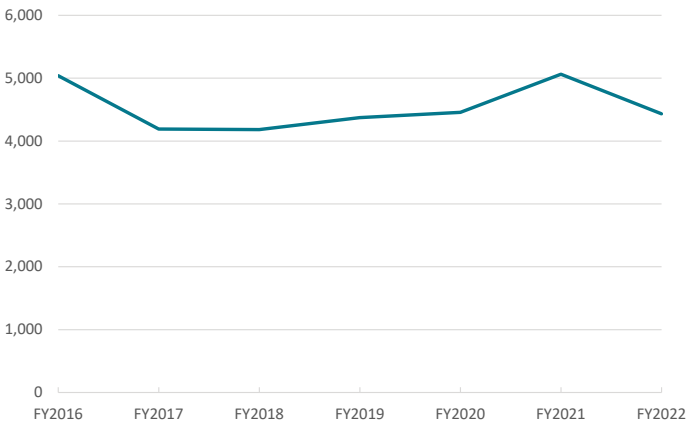


Source: Data compiled from MDOC Prisoner Health Care Utilization Quarterly Reports to the Legislature.

The trend is less consistent with respect to ER visits, which have hovered between 4,100 and 5,100 since FY2016, with more visits in FY2016 and FY2021 (see **Chart 8**).

Chart 8

Emergency Room Visits by Michigan Prisoners, FY2016 to FY2022



Source: Data compiled from MDOC Prisoner Health Care Utilization Quarterly Reports to the Legislature.

While this data is helpful and more robust than some other areas, additional information is needed. The department could provide data on the types of specialty care/reasons for visits, the total and per-visit costs of different types of care, the percentage of prisoners that utilize these services, and how all of this has changed over time. In particular, policy solutions could certainly vary depending on whether hospitalization costs are driven largely by older prisoners requiring longer-term care versus emergency visits for younger prisoners who return to prison quickly after receiving treatment.

Prescription Drugs

The cost of prescription drugs is another cost-driver that impacts the broader health care sector, but MDOC provides limited data on prescription drug utilization. The department does not report data on the number of prisoners who are prescribed one or more medications or how much those medications cost per unit and in total. Understanding how these figures have changed over time would shed light on how much of the growing expenditures are attributable to prescription drug costs. As is the case with other cost-drivers, whether the costs are related to a growing number of prescriptions or an increase in the per unit cost would lead policymakers to different possible solutions.

Aging Prisoners

One of the most consistent assertions from MDOC is that the aging prisoner population is responsible for increasing health care expenditures. And while the prisoner population is certainly aging and older people typically require more health care than younger people, the department has presented very little data demonstrating the role aging plays in increased health care spending.

The department should report health care costs associated with aging prisoners, or by age group generally, to demonstrate what costs are associated with older prisoners. Further, the department should provide information as to what services older prisoners utilize more often than younger prisoners, and how both of these variables have changed over time. In other words, data is needed to assess: 1) whether aging prisoners are more expensive relative to younger prisoners, and 2) has the spending difference between older and younger prisoners changed significantly over time.

It would be similarly useful to understand whether there are particular sets of older prisoners with specific health conditions that are costing the department a disproportionate share of money. Several years ago, the department identified a set of medically frail prisoners who were particularly expensive to treat in a prison setting and advocated for a statutory change to allow them to be paroled early so that they could receive care through Medicare.[89] While the medically frail definition was relatively narrow, there may be prisoners who do not meet that definition who are similarly expensive even if their medical condition is not quite as dire.

It certainly stands to reason that an aging prisoner population would lead to higher health care costs, but policymakers need actual data on the subject to develop policy solutions.

Staff Shortages

Data demonstrates staffing shortages at MDOC, but it is not clear if these shortages have broader consequences for the cost of health care in prison. It seems plausible that an understaffed health care system could lead to delayed care and other complications that drive up total system costs, but the impact of these shortages on the provisioning of care itself is not clear. If possible, it would be helpful for MDOC to demonstrate how the delivery of health care is complicated by vacancies (system wide or at individual facilities) and whether it can attribute any additional costs to this problem.

Certainly, understaffing is a problem, but the important question for this analysis is whether solving MDOC's chronic health care vacancy problem would make a significant impact on the efficiency of the system and overall prisoner health. If the department could provide data that would show that, it would make a strong case for decisive legislative action aimed at this problem.

Conclusion and Proposed Policies

The prison population is one of the more understudied societal groups, yet the state and the public maintain a substantial and often unrecognized stake in the well-being of prisoners. The health of prisoners has both economic and broader societal ramifications related to crime, recidivism, and public safety. Crafting policies that aim to improve the health of prisoners while reducing the financial burden on taxpayers could take on many different forms. These proposed policy solutions have been largely based on theoretical causes of poor quality of care and higher costs. Researchers who seek to develop policies for Michigan's prison population need the appropriate data to help tailor their recommendations for improved quality of care and cost-reduction.

Presently, policymakers and the public do not have the information necessary to evaluate whether the existing prisoner health care system is fulfilling its responsibility to those both in and out of prison to be good stewards of public money and create high-functioning institutions that serve society. The state invests a very significant amount in health care in prisons and there is a limited ability for anyone outside of the Department of Corrections to measure the return on that investment, both in human and financial terms.

The publication of the data and metrics discussed in this paper on a fixed schedule would allow policymakers and the public to study the information directly and provide the most robust oversight possible. However, collecting and releasing this data would certainly be a labor-intensive process – at least at first – that comes with additional costs for the department. An intermediate step could be for the legislature to mandate MDOC conduct or contract for a detailed analysis of the questions presented in the paper and report to the legislature on its findings. This approach reduces transparency and relies on MDOC to evaluate its own performance, but it could provide the legislature with much of the necessary information without waiting for the department to implement a public facing reporting infrastructure.

The state invests a very significant amount in health care in prisons and there is a limited ability for anyone outside of the Department of Corrections to measure the return on that investment, both in human and financial terms.

Considering the importance of tracking this data consistently over time, any legislative mandate should be done through permanent statute so that the legislature and department have a clear set of expectations about what data is needed and when it will be produced. While the legislature has established a number of reporting requirements through the annual appropriations process, these efforts are clearly insufficient given the limited data available in these reports. Putting reporting requirements in appropriations acts makes sense when the report is related to one-time funding or asks the department to conduct a one-time study, but authorizing an ongoing set of reporting requirements through boilerplate is inefficient. Leaving reporting requirements to the appropriations process creates uncertainly and fluidity because key legislators often move on to other committees or are termed out of office, leaving no one to ensure boilerplate provisions carry over to the next year.

Analyzing how well the state is providing for its prisoners and how efficiently it is doing so will open the door for policy improvements. But that analysis is an essential first step. Without the necessary data to evaluate health outcomes and spending practices, policymakers will not know which levers to push. They need to understand precisely why health care spending per prisoner has gone up so dramatically over the last two decades in order to design a policy response that will actually address the problem. Policy solutions need to be well-targeted, especially given the vulnerability of the prison population and the amount of money that is at stake.

There are a wide variety of options available to the department and the legislature when considering reform. If the data shows that the costs are coming from the health issues of the incoming prison population, policies should focus on social determinants of health to improve economically disadvantaged communities. These types of public health efforts may consequently reduce the number of people who enter prison in the first place. If the data shows the

health of prisoners deteriorates faster than those outside of prison, policies may need to focus on better preventative care. If the data shows that costs are being driven by the aging population, policymakers should look at shortening sentences or promoting early release for those deemed no longer a danger to society. If the problems seem to be associated with poor service delivery, the policy discussion may turn to system reform.

At this point, it is not possible to say that any of these solutions will address the problem. Each solution has its own internal logic, but pushing on every available lever is rarely an option. The state has a finite set of resources and there is intense competition over those resources, even among stakeholders that agree ideologically.

The state needs to undertake a serious effort to study prison health care so that it can take targeted steps toward reining in growing costs. That effort starts with gathering, synthesizing, and releasing much more data than the department currently does. MDOC should welcome this effort, but if it does not, the legislature should mandate it.

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