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A Human Rights Framework for Advancing the Standard of Medical Care for Incarcerated People in the United States in the Time of COVID-19

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Abstract

The COVID-19 pandemic has underscored the lack of resources and oversight that hinders medical care for incarcerated people in the United States. The US Supreme Court has held that "deliberate indifference" to "serious medical needs" violates the Constitution. But this legal standard does not assure the consistent provision of health care services. This leads the United States to fall behind European nations that define universal standards of care grounded in principles of human rights and the ideal of equivalence that incarcerated and non-incarcerated people are entitled to the same health care. In this paper, we review a diverse legal and policy literature and undertake a conceptual analysis of policy issues related to the standard of care in correctional health; we then describe a framework for moving incrementally closer toward a universal standard. The expansion of Medicaid funding and benefits to corrections facilities, alongside a system of comprehensive and enforceable external oversight, would meaningfully raise the standard of care. Although these changes on their own will not resolve all of the thorny health problems posed by mass incarceration, they present a tangible opportunity to move closer to the human rights ideal.

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Introduction

The COVID-19 pandemic has brought into sharp relief the health risks of incarceration. As the virus first swept across the United States in the spring of 2020, the disease ravaged people in places of detention.[1] By the summer of 2020, there were more than fivefold higher COVID-19 cases in prisons than in the general population and threefold higher mortality when accounting for differences in age.[2] Two years into the pandemic, the cumulative incidence of COVID-19 remained more than threefold higher in prisons.[3]

While some carceral facilities undertook remarkable efforts to protect residents and staff, these efforts have frequently been hampered by a lack of resources, diversion of care away from routine chronic disease care, disjointed implementation of public health preventive measures, and fragmented planning. In other facilities, there was a marked pattern that led to avoidable suffering. In one Texas facility that housed primarily elderly and medically vulnerable residents, an astonishing 6% of the population died of COVID-19. A federal district court found a marked pattern of neglect and a lack of precautions.[4] In the egregious example of Cummins Correctional Facility in Arkansas—a prison where virtually all residents were eventually infected with COVID-19—the custodial and medical staff reportedly ignored all requests for care from the residents and required all but the sickest residents to report to work shifts. As one resident recalled, "I watched nurses put the paper sick calls [written requests for health care] in the shredder and never blink an eye."[5]

The COVID-19 crisis has no contemporary precedent in modern carceral health in the United States, yet many of the harms were predictable and avoidable. Conditions of close confinement due to overcrowding in often poorly ventilated, antiquated facilities provided a ready environment for the virus to spread.[6] The daily movement of staff between their communities and carceral places of work, along with the arrival of newly incarcerated individuals, enabled the virus to travel between carceral facilities and surrounding communities.[7] Conditions that allowed COVID-19 to proliferate inside were exacerbated by the understaffing of medical providers in many facilities, inconsistent testing, and a lack of access by staff and residents to basic prevention measures early in the pandemic, including face masks and hygiene supplies.[8] Fully confronting these structural problems will require addressing mass incarceration and the attendant overcrowding present in many facilities. This overcrowding is the result of decades of growth in a punitive system that disproportionately affects poor people of color.[9]

In this paper, we argue that the COVID-19 pandemic has presented an opportunity to systematize standards and oversight of health care for incarcerated people in the United States, not only in the context of disease outbreaks but also more generally. By standard of care, we refer to the covered services, guidelines, and practices and procedures that govern the delivery of care in carceral settings. We argue that standards of care must carry flexibility in their implementation, while also helping define a transparent and measurable benchmark for quality of care and ultimately helping clinicians deliver care consistent with the best medical interests of patients.

We urge two reforms that would raise the standard of care. First, we advocate for expanding Medicaid financing and required benefits to correctional facilities, while tailoring this coverage to the context of jails and prisons. Second, we argue for federal and state oversight modeled on the oversight required in long-term care and other congregate settings to ensure compliance with standards. We argue that these standards must be enforceable, something that has been a major challenge under the status quo. These steps, taken together, would move carceral health care closer to equity between incarcerated and non-incarcerated people, an ideal grounded in the principle of fairness and expressed in human rights frameworks for carceral facilities. We acknowledge that this approach would still leave much work to improve the health of incarcerated people, most fundamentally by still needing to shift US society's overreliance on incarceration in the first place, but it is nevertheless an essential step

forward for people confined in these facilities. We close by describing some of the tasks that lie ahead.

COVID-19 and the long-standing failures of US carceral health care

COVID-19 put on full display the harms of mass incarceration in the United States. As Benjamin Barsky and colleagues argue in relation to the pandemic, "perhaps no collective preexisting condition has been more acute and preventable than that associated with the U.S. system of mass incarceration."[10] As of May 2022, there were almost 810,000 confirmed cases and 3,412 deaths in US prisons and jails.[11] These cases are almost surely an undercount of the true burden, due to inconsistent testing and reporting from carceral authorities.[12] Nor do these numbers fully convey the morbidity of trauma and isolation, combined with fear of infection, that has afflicted incarcerated people.[13] To quote a resident of a Michigan prison, "It's inevitable. So we're basically just sitting back and biding our time until we get sick."[14]

Most carceral health care systems were not equipped to deal with a public health emergency such as the COVID-19 pandemic. Facilities that were already underperforming in their delivery of care for acute and chronic health conditions and which often lacked adequate dental, mental health, and other components of health care, were called on to address a monumental, resource-intensive challenge. In many facilities, resource constraints intersected with inconsistent infection control practices, including measures to implement testing and contact tracing and to reduce vectors of community spread, which were not effectively implemented in most facilities. Outbreaks among staff frequently have preceded outbreaks among residents, suggesting that staff were a common vector for COVID-19.[15] However, few steps were taken to reduce transmission from staff to people in custody. For example, while some facilities have had strong compliance with face-mask wearing among staff, others had (and continue to have) widespread flouting of these requirements.[16]

During the height of the pandemic, supplies were sometimes slow to flow from state agencies to prisons. In some of the most egregious documented cases, carceral authorities flagrantly ignored the severe and worsening conditions of patients with COVID-19, leading to likely avoidable deaths of patients in custody.[17] This lack of urgency also plagued vaccination efforts in some facilities. Most state vaccination allocation policies enabled prison guards and other frontline staff to access vaccines well before incarcerated people, ignoring recommendations from expert groups that incarcerated people be given vaccine access at the same time as carceral staff.[18] Vaccination rates in prisons have varied widely.[19] Moreover, there have been continual challenges addressing vaccine hesitancy among incarcerated people, which itself can indicate low trust in carceral health providers and inadequate outreach and education.[20]

In short, the COVID-19 experience crystallizes three critical points that we expand on in this paper. First, in carceral facilities, health care providers should be empowered to implement strong public health prevention measures, including better sanitary conditions and de-crowding efforts. These elements are among the "structural determinants of health."[21] Second, financing must be allocated to enable facilities to provide access to health care services at least equivalent to the quality afforded to the community. This goal can be achieved by building capacity within facilities, though in smaller facilities or for more specialized treatments, care for incarcerated people must be rendered in the community. Third, there must be a robust system for monitoring and enforcement. Such a system would encompass clear metrics for oversight, transparency to the public, and plans for remediation of shortcomings.

The Mandela Rules and equivalence

The "North Star" in defining a standard of care should be international rules on the rights of the incarcerated, particularly the United Nations (UN) Standard Minimum Rules for the Treatment of Prisoners, the most recent version of which is referred to as the Mandela Rules, in honor of Nelson

Mandela.[22] Although not a comprehensive set of standards or guidelines, they set forth that "prisoners should enjoy the same standards of health care that are available in the community, and should have access to necessary health-care services free of charge without discrimination on the grounds of their legal status." The Mandela Rules are an outgrowth of long-standing principles for the treatment of prisoners that date back to the 1955 UN Congress on Crime Prevention and Criminal Justice.[23] The 2015 update includes 122 rules covering all aspects of prisoners' rights. Among these, 23 deal explicitly with medical and health services (rules 24–46). The Mandela Rules provide a strong basis for defining a carceral standard of care, including these elements:

- A set of required medical services and conditions that warrant evaluation and treatment
- Standards for adequate staffing
- Standards for medical records
- Provisions that cover prevention, hygiene, and public health preparedness
- Due process and coverage appeals
- Adequate care during reentry
- Medical ethics.[24]

A commitment to the principle of equivalence reflects the ideal that a person's incarcerated status does not diminish their basic entitlement to the same care that similarly situated people in the outside would receive. In the European Union, the principles of equivalence are foundational to carceral health care and were written into law even before the adoption of the Mandela Rules.[25] In 2006, the Council of Europe amended its European Rules on Prisons to require health services under the conditions and with a frequency consistent with health care standards in the community. The European Court of Human Rights has cited the equivalence standard in its decisions.[26]

Although many jurisdictions strive to provide care equivalent to that provided in the community, US courts will not uniformly enforce equivalence. Some courts have held to the effect that the Constitution "does not require medical care that comports with the community standard of care."[27] Within the European Union there exists a European network of national preventive mechanisms that monitors the health care and sanitary conditions for incarcerated people and measures compliance with the specific rules that have been adopted in each country (for example, countries have rules that encompass staffing and timely assessment in custody).[28] Similarly, in the United Kingdom, the standard is "to give prisoners access to the same quality and range of health care services as the general public receive from the National Health Service."[29]

The precise translation of these rules into practice is challenging and varies across the European Union, and even within that bloc there is some heterogeneity in the scope and delivery of carceral health care.[30] As Gérard Niveau argues, translating equivalence into carceral settings is challenging for at least two reasons. First, incarcerated people often have greater health needs than non-incarcerated people and require relatively more health interventions than the community.[31] To make valid comparisons, it is therefore important to adequately account for the underlying differences in health needs between incarcerated and non-incarcerated people, meaning that measures that compare spending and other health care parameters must adjust for the greater burden of illness among incarcerated people. The goal of equivalence is to ensure that comparable needs receive comparable care in both quality and scope. We return to this issue in the context of oversight later in this paper.

A second challenge with an equivalence standard is that the elements of choice and autonomy are intentionally limited for incarcerated people. Even if health care practitioners have the same qualifications and training in carceral settings as in the community, incarcerated people rarely can select from a list of practitioners, for example, to find someone who matches their cultural background or care preferences. Furthermore, even if the practitioners and range of services are of comparable

quality, it has been argued that the special vulnerability of incarcerated people to adverse health outcomes requires going beyond equivalence and giving priorities to incarcerated people that do not typically exist in the community.[32] For example, certain medical treatments may need to be "fast tracked" for incarcerated people in ways that are not normally required for non-incarcerated people to ensure that the special health risks of incarceration and the precarious period after release are addressed.[33]

A third challenge is that the purview of correctional health extends beyond conventional health care services to encompass aspects of daily life that are medicalized in secure facilities. Access to resources such as bottom bunks, dietary accommodations, and even mundane items such as ice chips based on health needs often require medical approval. The peculiarity of medicalization of everyday life in correctional facilities has no parallel in community settings and is therefore beyond the reach of a uniform equivalence standard.

Whatever the limitations of an equivalence standard, however, it captures a fundamental ideal of justice that health needs in society should be met in relation to the urgency and health vulnerability of the people who have those needs. At its core, equivalence is rooted in a commitment to the moral equality of people, expressing the same rights to have health needs met between incarcerated and non-incarcerated people. Additionally, health care in carceral institutions must be decoupled from punishment since people do not forfeit all human rights (including the right to health care) when they become incarcerated. It is illegitimate to effectively add to the sentences of detained individuals by withholding resources or treatments that should otherwise be available to them outside of carceral settings.[34]

In the next section, we describe how a US framework for equivalence has gone largely unbuilt and neglected. With an eye toward the goal of equivalence, we then show how to build on this structure to begin to improve the standard of carceral health care.

The US (non) approach to the standard of care

The United States does not come close to the Mandela Rules requirement of equivalence. Indeed, several political and legal realities in the United States explicitly rule out the direct application of the Mandela Rules. Foremost, the United States does not consider UN interpretations of treaties binding. However, there may be scope for indirect influences. For example, the State Department often cites these interpretations—especially those of the UN Convention against Torture, which the United States has ratified, albeit with reservations—in its annual human rights reports. The Mandela Rules have also achieved widespread legitimacy, and like other international human rights standards can be employed to press states and the federal government to move toward adherence with them. Because there are so many detention and imprisonment systems in the United States, it is likely that some systems will be more open to adhering to these rules than others. It is therefore reasonable to anticipate incremental, system-by-system moves toward following the Mandela Rules as administrators, the carceral health community, and reformers recognize their value.

Implementing the Mandela Rules would be a vast improvement over current law. Most prominently, constitutional standards under the Eighth Amendment require only that carceral staff not be "deliberate[ly] indifferen[t] to serious medical needs of prisoners," or, as more recently refined, that prison staff who essentially know of a "substantial risk of serious harm" take reasonable steps to abate that risk.[35] These judicial standards leave much room for discretion from carceral administrators as they determine what health care services their facility will provide. These standards are also interpreted diversely between courts.[36] Certainly, there have been instances in which the courts have taken stronger measures to affirm access to health and health care resources for incarcerated people. For example, the Supreme Court has allowed lower courts to uphold the regulation of environmental tobacco smoke and other risks, even if the adverse outcome has not yet come to fruition.[37] In 2011, the

Supreme Court upheld a massive prisoner release order in California upon proof that overcrowding was leading to seriously adverse health conditions and that years of efforts had failed to provide relief.[38]

However, due process as conceived under the Mandela Rules is continually thwarted in correctional health care. A key hindrance is the Prison Litigation Reform Act, enacted by Congress in 1996 and signed into law by President Bill Clinton.[39] The act, among other measures designed to deter and nullify legal actions brought by incarcerated persons, requires that incarcerated persons "exhaust" their facilities' grievance processes before seeking relief in court, meaning that several weeks or months must pass between the injury or risk and when they can file a lawsuit.[40] There is generally no exception for emergencies, and it was this provision that prevented residents from obtaining COVID-19 protective measures in the judicial system.[41] Even when a person is successful and, for example, convinces a court to require a facility to make changes to prevent the spread of COVID-19, these changes expire after a period of 90 days to two years, depending on the nature of the judicial order issued and actions of the defendant, after which the plaintiff must essentially prove his or her case again to continue the relief won.[42]

The absence of a standard with clearly defined covered services sheds light on stymied or delayed work to improve health care in carceral settings, such as initial resistance to antiretroviral treatments for HIV/AIDS and antiviral medications for hepatitis C.[43] Similar struggles have played out in efforts to address needs in sexual and reproductive health, including hormone and surgical therapy for gender-affirming care for transgender patients and access to abortion and contraception.[44] Moreover, medications for opioid use disorder such as buprenorphine and methadone are not in many correctional facilities despite clear evidence that they would be lifesaving in the midst of a national opioid overdose crisis.[45]

These examples typify some of the wide-ranging variation in correctional health care services, but existing data on carceral health care are scarce as there is no national database on health status, per capita health spending for incarcerated people, or service utilization. The national incidence of medical and psychiatric conditions among incarcerated people is uncertain. A now-dated survey of prison administrators reveals widespread differences in types of services offered onsite (and no comparable data exist for jails or other places of detention).[46] Spending on correctional health care is likewise known to vary widely. Annual per capita health care spending in a 2015 survey of state departments of correction ranged from almost US$20,000 in California to about US$2,000 in Louisiana, with a median of US$5,720.[47]

In the absence of national standards, several disparate sources have influenced the prevailing norms of care in correctional health care. We review three sources of health care norms: contracted health care services, guidelines from expert bodies, and voluntary accreditation standards. These influences are not nearly strong enough to achieve a comprehensive standard but are worth considering because of their reach, power, and authority in correctional health care.

Many correctional facilities contract their services to private for-profit health care companies and, to a lesser extent, local government or academic medical centers.[48] According to a 2018 survey by Reuters, 62% of US jails contract with a private company to deliver some or all of their health services.[49] Currently, the correctional health care landscape is dominated by a few large and many smaller firms, and their business is valued at US$9.3 billion.[50] In state prisons in 2015, 17 systems used a direct provision model, 20 contracted with vendors, 8 used a hybrid (direct and contracted) model, and 4 had a state university partnership.[51] The practice of contracting health care to private vendors could push toward some uniform standards through requirements for services, cost, and quality. In particular, health care vendors have the ability to negotiate contracts that cover a consistent set of services and can impose organization-wide quality-control measures enforced and made transparent through various auditing and quality-control techniques.

However, uniformity is by no means guaranteed. The specific manner that medical services are provided depends on the terms of the contract for health services in each facility. Thus, each company can offer widely varying experiences for patients depending on what the jurisdictions are willing to cover.

While there have been successful examples of private firms providing contracted services, helping lower costs without compromising quality of care, many firms have escaped accountability for lapses.[52] However, the Supreme Court has held that health providers acting under contract with public correctional authorities cannot escape liability by virtue of their privatized relationship.[53] News reports highlight some egregious cases where privatized health care vendors engaged in deliberate understaffing, widespread denials of care, and unnecessarily burdensome utilization management to deter access to health care.[54] While, in theory, state correctional agencies have leverage through the request for proposal (RFP) process and may even fine companies for failure to maintain quality, many RFPs result in few bids, often in a market of just a few large companies. A 2017 review of 81 jail health care RFPs by the Pew Charitable Trusts concluded that "few RFPs laid out performance requirements and financial penalties or incentives that would hold contractors accountable for meeting service requirements."[55]

A different type of norm comes from the guidelines and advocacy positions of expert bodies. Various medical specialties provide specific guidelines for the care of incarcerated people. For example, the American College of Obstetrics and Gynecology has advocacy positions and standards for caring for pregnant people during incarceration.[56] Similarly, major international health organizations such as the World Health Organization define guidelines for the care of people with HIV who are incarcerated.[57] In the United States, the Centers for Disease Control and Prevention has put forward specific standards for incarcerated people and, most recently, guidelines for infection control during the COVID-19 pandemic.[58] However, in all cases, these guidelines are voluntary and do not generally constrain the decisions made by individual correctional authorities or medical care providers, or courts adjudicating prison health care cases.

A third, and sometimes overlapping, factor shaping the norms of care is third-party accreditation. The two most prominent accrediting bodies are the National Commission on Correctional Health Care (NCCHC) and the American Correctional Association. NCCHC is the most prominent health accrediting body and publishes manuals of standards related to jails, prisons, and juvenile detention facilities that are revised every five years.[59] To become accredited, facilities must meet these standards and undergo periodic reaccreditation review by NCCHC. Accreditation has the potential to establish minimum benchmarks for the standard of care by enumerating different functions and indicators for compliance that would need to be fulfilled by inspectors. For example, NCCHC manuals define the essential and important elements that must be met for functions such as governance, medical records, delivery of care, and staffing.[60] These standards are sometimes incorporated into the RFP process, requiring vendors to either obtain (or maintain) accreditation.

However, accreditation has severe limitations regarding standards of care. Because accreditation is fee based, the entire accreditation process can be costly and difficult to navigate. It is also voluntary. Further, with one or two limited exceptions related to triage, NCCHC focuses on the existence of policies and procedures rather than the attainment of specific quality metrics. Also, while surveyors may examine some aspects of quality of care, providing quality care is not a general requirement for accreditation, and facilities with poor access or poor quality of care as judged by either the experience of patients (including the often degrading treatment that patients endure from staff) or outcomes for patients may still qualify for accreditation. Indeed, facilities accredited by both organizations have been found unconstitutional by courts nonetheless.[61] Furthermore, most facilities, particularly jails, are not accredited. Accreditation is notoriously expensive, raising conflicts of interest, since the accreditor depends on the goodwill and continued

business of the correctional health industry. As a result, accreditors may need to accommodate the industry's priorities and to moderate the content of standards and the scope of auditing.[62] Finally, accreditation standards require that facilities implement policies and practices but do not require that a specific level of quality of care be provided. It is possible to satisfy accreditation standards and provide substandard clinical care to patients.

In sum, the United States overlays a vague constitutional standard on a patchwork system that has no central standards, metrics, or authority. Accountability for care is often further circumscribed by vague contracts that are difficult to enforce. While third-party accreditation is perceived to set national standards, the reach and scope of accreditation remains limited.

Moving closer to equivalence: Medicaid

To improve medical care, a more stable source of funding is needed alongside clear standards. Medicaid funding could create needed resources and a transparent, comprehensive, and consistent set of covered services grounded in an achievable community standard, but adapted to the complexities of the carceral environment. As in Europe, the equivalence standard would benchmark care to the national health care system.[63] In a recent article, Marin Olson and colleagues argue that "the services that Medicaid covers could serve as a model for a reasonable set of mandated health services within correctional facilities to ensure care in these institutions is commensurate with care available in the community."[64]

Because of its program rules, Medicaid has been hemmed in from playing a wider role in correctional health care, at least until now. In 1965, when the program was first established, it was limited to covering the health care needs of specific groups of non-institutionalized people living in poverty—people with severe disabilities and women and children on welfare.[65] Congress did not want to assume costs that states were paying for people in institutions other than residents of long-term care facilities and explicitly excluded incarcerated individuals through the "Inmate Exclusion" clause.[66]

Since 1965, however, Medicaid has grown in scope considerably. In half a century, it has grown from a relatively niche program to a program that now covers 56 million people living in the United States, including most people below the poverty level.[67] Most significantly, the 2010 Affordable Care Act provided a Medicaid expansion intended to cover virtually all non-institutionalized people below 138% of the federal poverty level and provided expansive subsidies to states.[68] The US Supreme Court ruled in 2012 that states could not be forced to expand Medicaid, which triggered a fiercely partisan fight over the law.[69] By 2022, 38 states and the District of Columbia had a Medicaid expansion.[70] There is ample evidence showing that Medicaid expansion improves access to care, reduces chronic disease, and saves lives among new enrollees.[71]

The growth of Medicaid has created more opportunities to coordinate care for people leaving correctional facilities. Under current statute, this takes the form of ensuring that incarcerated people have prompt access to a Medicaid card as soon as they are released.[72] Indeed, 43 states have opted to suspend Medicaid benefits during incarceration, rather than terminating coverage and requiring individuals to re-enroll in the program.[73] In many states, caseworkers from Medicaid will help individuals complete the necessary paperwork to regain their benefits prior to reentry to ensure that individuals have a working Medicaid card on their day of release. These efforts have been shown to have substantial benefits to post-release coverage and access to care.[74]

Further opportunities to use Medicaid during reentry could be on the horizon. The Medicaid Reentry Act was included as part of the Build Back Better legislation being considered in 2022.[75] If passed, the act would allow Medicaid funds to cover services for individuals in the 30 days prior to release from a prison or jail. This would be a major change, the first significant step toward paring back the Medicaid Inmate Exclusion. Indeed, in many jails where many people serve sentences of less than a month, the act would effectively cover the full duration of stays. As of this writing (May 2022),

the Build Back Better legislation appears unlikely to advance as proposed, but it is possible that a compromise bill may move forward. The Medicaid Reentry Act is believed to enjoy some bipartisan support and could potentially pass as a stand-alone piece of legislation in a future Congress.

Even if the Medicaid Reentry Act does not pass, there may be some promising advances made through the Medicaid waiver process. The idea of partially repealing the Inmate Exclusion has a history; states such as New York have previously applied for Section 1115 waivers that allow Medicaid to cover some health care costs, including COVID-19-related costs, for people in jails and prisons.[76] Provisions of the SUPPORT Act also created a pathway for states to obtain waivers from the federal government to use Medicaid to cover services for individuals with substance disorders in the 30 days prior to release, but guidance on how states could implement these provisions did not initially get provided.[77] Six states (Arizona, California, Kentucky, Montana, Utah, and Vermont) have waivers that were under consideration as of this writing to seek greater flexibility around the Medicaid Inmate Exclusion in the period prior to release.[78]

The extension of Medicaid coverage requirements to jails and prisons as envisioned in the Medicaid Reentry Act has several benefits and provides a foundation for a longer-term expansion of Medicaid into correctional health. First, it would allow for consistent funding for carceral health and continuity of coverage for people who were already eligible for the program on the day before entering the facility. Ideally, this would mean that during a period of incarceration people would have assurance that their ongoing treatments and health needs would be met in a manner consistent with the services they received prior to incarceration. Second, for many incarcerated people, it would also raise the average standard of care, offering broader choice and more benefits than exist now. The 10 essential health benefits that are standard in Medicaid coverage and protected under statute would reach beyond the kinds of services typically offered to incarcerated people.[79] This would include coverage of contraceptive services, substance use treatment, and the full array of prescription medications provided under Medicaid. Third, it would create more timely and seamless transitions around ongoing health needs, allow for more portability of health records, and provide assurance that medications and other services would be covered during the period of reentry.

For these reasons, Medicaid coverage would be a major step toward the Mandela Rules equivalence standard and even beyond it. As the program grows to cover most poor Americans, and particularly people leaving correctional facilities, it defines a viable community standard—no small feat for a country that has long abjured universal coverage. For people covered by Medicaid, the program has moved closer to a consistent set of benefits. Medicaid benefits are typically covered at no cost for enrollees, although those closer to the poverty line may be asked to provide nominal co-payments for services such as visits to the emergency department or prescription drugs. Beyond the required benefits, many states opt to cover additional services in Medicaid. For example, 47 states and the District of Columbia provide at least emergency dental coverage in Medicaid, and 35 cover some diagnostic, preventive, and restorative treatments.[80] Similarly, most states opt to include services such as optometry and podiatry, though the scope of these benefits varies.[81]

It must be acknowledged that the full expansion of Medicaid into correctional health requires grappling with substantial implementation considerations. The first issue is that not all Medicaid benefits can be easily grafted onto correctional health. Correctional care encompasses services that make it qualitatively different in many respects. While some benefits—such as coverage of the prescription drug formulary or requirements to offer vaccinations and preventive health exams—would be relatively straightforward to implement, other benefits would be much more complicated to implement given the unique staffing and clinical environment of jails and prisons. For example, there is no translatable Medicaid benefit for intake screening. Another critical issue relates to staffing and access to specialists. Medicaid programs

typically create network adequacy standards that must be met by managed care plans. These standards would need to be wholly reconceptualized in correctional settings and would likely need to be adapted to myriad factors, including the size of the facility and whether there is an outside specialist who can be readily brought on site (or to whom patients can be transported) to provide care. This issue is critical, since poor specialist availability is often a major bottleneck in correctional health care. Access may also be practically overcome with greater use of telehealth, a service modality that already exists in many facilities and is reimbursed to some extent by all Medicaid programs.[82]

While we believe that correctional facilities would generally be motivated to meet Medicaid standards to take advantage of federal funding (which typically covers more than two-thirds of the total cost of care), working through the specification of a correctional Medicaid benefit will be a complex and necessary undertaking. It requires a wider process of federal and state regulation and stakeholder engagement. A full process of inclusive rule-making and a phase-in period for full compliance can help surface specific issues and develop workable approaches. Broadly, the critical task will be to develop regulations that encompass a certain amount of generality and uniformity (that any correctional entity would need to meet), while still creating adequate flexibility to allow services and coverage to adapt to the unique constraints and resources of each facility. This concern goes in two directions—it is important that a Medicaid standard does not create an unattainable target for facilities that have very low capacity, and equally important (for the small number of facilities that go beyond what state Medicaid programs offer) that the introduction of Medicaid does not "level down" the quality of services. For high-performing facilities, it may be beneficial to create aspirational standards that are markers of excellence or high quality and which could be linked to special incentives.

It can be useful to consider other prior areas where Medicaid has been expanded, particularly into institutional settings. For example, Medicaid created a single national standard for long-term care facilities under the Nursing Home Reform Act. It states that nursing homes "must provide services and activities to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident in accordance with a written plan of care."[83] A similar standard, along with detailed requirements for services and access, could be established for carceral facilities. Doing so could dramatically reduce inequalities that currently exist for people incarcerated within the same state—for example, by reducing the perpetuation of unequal care that exists between neighboring jails or between jails and prisons. A critical element of any national standard will be consistent oversight and quality assurance.

Oversight and quality assurance

Coverage and standards require oversight to ensure that benefits are consistently and equitably provided. Unlike the constitutional deliberate indifference standard, the focus should be not just on egregious violations of the limited rights recognized as constitutionally based but on quality of care.[84] Currently, there is no national oversight system, and even the term "oversight" has broad, inconsistent uses in corrections. We think that the core concern is to ensure that there is transparency and impartial documentation of how health care is actually being provided through on-the-ground fact-finding. Michele Deitch recently defined correctional oversight as

> *an independent, external mechanism designed, at a minimum, to ensure the collection, dissemination, and use of unbiased, accurate, and first-hand information about correctional conditions of confinement or the treatment of incarcerated individuals, primarily through on-site access to the facilities.*[85]

As Deitch and her team document, oversight practices vary widely across different authorities and have different levels of independence, authority, resources to conduct their investigations, and ability to make their findings public. Furthermore, some oversight bodies have the ability to set stan-

dards (i.e., to enact regulations) while others are tasked with monitoring compliance with existing guidelines but do not define standards to be met. In general, oversight bodies in the United States are weak where they exist and nonexistent in many jurisdictions. Nevertheless, Deitch's team found that from 2010 to 2020, there was a substantial growth in the number of jail and prison systems that came under external oversight in the United States. There are many forms of such external oversight, such as the New York City Board of Corrections, an independent body that inspects and reports on conditions in the city's jails in conjunction with the city's minimum standards set by its Jail Regulations, and ombuds models for state prisons in New Jersey and Washington State.[86] External oversight is also sometimes provided through monitors appointed through court-ordered consent decrees, though their work arises only after considerable harms have been endured.[87] Although far from perfect, they have had some successes in identifying and forcing remediation of conditions of confinement.[88]

In most US cases, oversight is more limited in scope and access than the more robust and wide-ranging oversight models that exist, for example, in the United Kingdom (through Her Majesty's Inspectorate of Prisons, which publishes comprehensive facility-based reports) and in the Committee for the Prevention of Torture in Europe, whose inspectors regularly make unannounced inspections of prisons and write comprehensive fact-finding reports.[89] These reports, moreover, have been relied on by the European Court of Human Rights to make binding decisions on the health rights of incarcerated people.[90] The United States could adopt a similar approach and could advance oversight by agreeing to a protocol of the Convention against Torture that establishes the framework for this kind of mechanism.

Outside of a human rights framework, the US Congress could take steps to create an oversight body that ensures that facilities are meeting minimal standards. The presence of Medicaid funding for health care programs increases the leverage of federal authorities to regulate conditions in facilities. The comparison with long-term care facilities is instructive, where standards are enforced through state inspections. As Nina Kohn explains, historically, long-term care regulations have had mixed effects, particularly as the thoroughness and quality of inspections delegated to state agencies are often weak or inadequate, and accountability has been all too often absent even when penalties are available.[91] Even violations of easily measurable metrics such as staff ratios have been overlooked. Thus, a federal framework for independent inspection by teams of inspectors as free of dual loyalty conflicts as possible would need to have clear guidelines for the training of the inspectors and rigor of the inspections. Inspectors should be authorized to have access to speak confidentially with health care staff, incarcerated persons, correctional personnel, and administrators, as well as given unfettered access to health care records and other documents.[92] They should also have "golden key" access, allowing inspectors to enter a facility without prior notice and to go anywhere in the facility. Findings should be made public, and compliance with resulting recommendations should be assessed with binding remediation plans implemented if necessary. These recommendations are consistent with the guidelines offered by the American Bar Association.

To the greatest extent possible, it is important to insulate oversight efforts from "capture" in the political process. This is best accomplished by establishing independence of the regulators—that is, situating oversight bodies outside of the control and influence of correctional agencies, private vendors, and other such stakeholders. This reduces the potential conflict of interest that currently exists in voluntary accreditation, whereby the accreditor is dependent on the agencies and therefore may be reluctant to find faults or to impose strong conditions for remediation. In general, it is better to take the regulator outside of the normal political chain of command. Even placing the oversight body under the control of governors can raise potential challenges, since regulators may be reluctant to challenge elected officials or their appointees. However, we also recognize that there is a tension between making the regulator entirely arms-length from government authorities and giving it the

power to engage political authorities where needed. Oversight should also encompass a direct role for advocacy and inclusion from people who are currently or formerly incarcerated. The input of incarcerated people is infrequently solicited and often selectively ignored. We therefore recommend the creation of residents' councils that are consulted as part of the oversight process.

Finally, it is important that a system of oversight be oriented toward enforceable corrective actions and systemic remedial plans, when called for. The two elements of the system can work together: a quality-improvement paradigm can spur cultural changes that encourage learning across correctional health systems, disclosures of errors, and creativity in developing better solutions. The ultimate goal would be to break down the secretive culture that has pervaded correctional health care and to encourage friendly competition toward better care. Indeed, one of the tragedies of the COVID-19 pandemic in correctional health care is that learning across facilities was piecemeal and often emphasized failures of care rather than problem-solving that could be shared widely. However, corrective action also must be possible through the regulatory process. This may include developing new avenues for the legal enforcement of care standards through the courts, including allowing for private enforcement of the regulatory standards and repeal or relaxation of the Prison Litigation Reform Act. Ultimately, the test of the oversight system must be the progressive achievement of better, more reliable, and safe health care for incarcerated people.

Conclusion

Access to comprehensive health care for incarcerated people is a requirement of international human rights doctrines. The standard of equivalence, which is core to correctional health care in Europe, has long proven elusive in the United States despite the legal basis to have some health needs met under the Eighth Amendment. We have argued in this paper, however, that moving toward equivalence is now a more realistic goal and could concretely be achieved by expanding the benefits and financing of Medicaid to correctional facilities, while ensuring that correctional health care is subject to external oversight to ensure that care is provided equitably and with transparency. We conclude with some practical observations about the challenges and opportunities that lie ahead.

Perhaps the clearest challenge is finally repealing the Medicaid exclusion for incarcerated people. The bipartisan principles of the Medicaid Reentry Act provide the most significant momentum toward repeal by allowing for Medicaid funding to cover incarcerated people 30 days prior to their release. While this still keeps most funding responsibility for prisons at the state level, it is a potentially transformative change. Even if the Medicaid Reentry Act is not immediately passed, we believe that proposed 1115 waivers could meaningfully advance the goals of broadening Medicaid funding in jails and prisons. Beyond the immediate potential to shift more financing to Medicaid, the introduction of Medicaid funding creates pressure for correctional facilities to begin aligning services with existing Medicaid benefits while adapting to the unique circumstances of correctional facilities and to introduce external oversight from Medicaid as a payer that is necessarily invested in ensuring that correctional facilities meet the program's standards.

More generally, we foresee challenges to creating broader national oversight of correctional health care. We believe that an incremental campaign focused first on transparency is important. As noted, there is a glaring gap in data on the health needs of incarcerated people and their access to care. Federal laws could increase data collection and introduce health care measures into facilities. For example, the federal government could lay the groundwork for expanding data collection of health surveys into correctional facilities. Currently, other data collection efforts such as the American Community Survey Group Quarters component are already successfully being implemented in correctional facilities.[93] There are also opportunities to create better models of oversight. For example, the federal Bureau of Prisons could commit to new

standards of transparency, such as reporting on health care quality metrics such as those found in the Healthcare Effectiveness Data and Information Set core measures promulgated by the National Center for Quality Assurance. These measures span six domains that reach beyond the current criteria used by correctional health care accreditation.[94]

A third challenge that must be acknowledged is that efforts to reform correctional health care must coexist alongside a campaign to reform correctional institutions as a whole, as well as the wider campaign to end mass incarceration. It might be argued that bolstering correctional health care and spending more federal dollars in this arena reduces pressure to slow the growth of incarceration. According to this theory, the greater availability of Medicaid funding could reduce budgetary pressure that typically leads jurisdictions to seek ways to reduce correctional budgets, including efforts to decarcerate more rapidly. However, we do not see the two goals in tension. For example, it is possible to create decarceral goals as a condition for federal grants (e.g., providing grants for reducing population size), an idea that was seriously considered by the Biden administration.[95]

Fourth, and related, correctional health care cannot be narrowly construed to draw limits at the boundaries of medical care; it should also encompass the public health metrics that reflect overcrowding and environmental exposures. This includes violence, sanitation, corrections, and custody, each of which has an important interaction with health in places of detention. That is, creating comprehensive health care standards are necessary but not sufficient to boost the health of incarcerated people. As noted earlier, correctional health already has a toehold in the oversight of living conditions, but mainly in the context of requests for accommodations such as bunking. However, we believe that greater external monitoring and measurement of changes in health status can draw attention to environmental conditions that affect health and health care. For example, public health prevention goals could be incorporated into the standard Medicaid plan, similar to patient safety standards that currently govern long-term care facilities.

Despite their high walls and steel doors, prisons and jails remain part of the community and are fully integrated with a community's epidemiological environment. A move toward equivalence acknowledges this reality on two levels—first by upholding that incarceration does not nullify human rights claims to have basic health needs met by the state and second by clarifying that what happens in prisons matters to everyone in society. COVID-19 has proven that there is no magic barrier that prevents correctional facilities from diseases circulating rapidly in the population and, in turn, from becoming a source of transmission back into the community. The point has a more general significance as people who leave correctional facilities contribute to the collective health and well-being of society. In the final calculation, greater attention to the health of incarcerated people underscores the fundamental reality that we are all in this together.

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