BEYOND DELIBERATE INDIFFERENCE: IMPROVING JAIL HEALTH CARE WITH FALSE CLAIMS ACTS

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Over 11 million people are admitted into U.S. jails annually. Every year, countless men and women die in jail before they are convicted of any crime because health care providers neglect their medical needs. Jail health care is a frequent and worthy subjection of litigation. Section 1983 has traditionally served as the foothold for prison litigants to seek relief through the courts, but the Prison Litigation Reform Act has severely restricted its efficacy.

In 2016, the Office of the New York State Attorney General filed claims against a private jail health care provider under the New York State False Claims Act and other state statutes. The enforcement action resulted in some, albeit limited, relief for incarcerated people, and suggests that state false claims acts may prove to be a useful tool for correctional reform where Section 1983 has failed. This Note makes the case for legislating robust state false claims acts and litigating under them to improve jail health care. Although counties and municipalities are increasingly outsourcing jail medical services to private contractors, thereby driving down quality of care, privatization also creates new opportunities for reform.

INTRODUCTION

MEDICAL neglect and mismanagement of care persists in jails and prisons. In 1972, federal courts ordered some of the first remedial relief for inadequate correctional health care in *Newman v. Alabama*.[1] *Newman* chronicles egregious treatment of incarcerated people by medical staff in an Alabama prison. Chief Judge Frank Minis Johnson describes one geriatric and incontinent inmate who was forced to sit on a bench next to his bed for days so as not to soil it. He fell so frequently that his legs turned blue, and he died from a subsequent botched amputation.[2] The Fifth Circuit decision makes mention of a quadriplegic inmate who suffered bed sores infested with maggots because he was moved and bathed so infrequently. In the month before his death, he received wound care and a bath on one occasion.[3] Alabama facilities continued to administer drip ether to women prisoners during obstetric operations for twenty years after it had been discontinued in the public sphere.

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[1] Newman v. Alabama, 349 F. Supp. 278 (M.D. Ala. 1972), *aff'd in part*, 503 F.2d 1320 (5th Cir. 1974).

[2] *Id.*

[3] Newman v. Alabama, 503 F.2d 1320, 1324 (5th Cir. 1974).

Contemporary correctional health care bears resemblance in too many respects to the inadequate services in Alabama institutions more than fifty years ago.[4] In a recent settlement between inmates and the medical provider in a Virginia prison, court documents describe similarly chilling medical treatment. One woman suffered four amputations of the same leg because prison staff neglected her bloods clots and wound care: doctors amputated first her foot, then her lower leg, then an inch above her knee, and then another inch of her thigh.[5] Another woman died from rectal cancer that medical professionals failed to diagnose and treat. She died because her tumor, which had grown outside of her buttocks, caused a blood infection that spread throughout her body.[6]

Incarcerated people bear the brunt of inadequate care but taxpayers foot the bill. Cities, counties, states, and the federal government have historically provided care in correctional facilities but are increasingly outsourcing the job to private, sometimes for-profit companies. Correctional health care is now a sizeable industry worth more than $3 billion annually.[7] Private companies provide medical services in over half of all state prisons and local jails.[8] Approximately 11.4 million people are admitted to jail facilities every year. [9] This means private companies likely provide medical care to many millions of inmates in jails alone. Tax revenue is used not only to pay private companies to provide medical services, but also to pay settlements to injured inmates or families of the deceased. These settlements sometimes amount to millions of dollars in damages for just one instance of injury or death.[10]

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[4] *See, e.g.*, Plata v. Schwarzenegger, No. C01-1351 THE, 2005 WL 2932253 at *1 (N.D. Ca. Oct. 3, 2005) (finding the California prison system is "broken beyond repair. The harm already done in this case to California's prison inmate population could not be more grave, and the threat of future injury and death is virtually guaranteed in the absence of drastic action."; Complaint, Scott v. Clarke, 3:12-cv-00036-NKM (W.D. Va. July 24, 2012) (alleging systemic and repeated failure to provide medical care sufficient to meet minimum standards of Eighth Amendment, and describing instances of failure); Gary A. Harki, *At Fluvanna Correctional Center For Women, Horror Story After Horror Story in Medical Care*, VIRGINIA POLITICS (Dec. 10, 2016).

[5] Inmate Declarations at 104–08, Scott v. Clarke, 3:12-cv-00036-NKM (W.D. Va. Sept. 2, 2014).

[6] Harki, *supra* note 4.

[7] Rupert Neate, *Welcome to Jail Inc: How Private Companies Make Money off US Prisons*, GUARDIAN (June 16, 2016), https://www.theguardian.com/us-news/2016/jun/16/us-prisons-jail-private-healthcare-companies-profit.

[8] *Id.*

[9] TODD D. MINTON & ZHEN ZENG, BUREAU OF JUSTICE STATISTICS, JAIL INMATES AT MIDYEAR 2014 2 (2015), http://www.bjs.gov/content/pub/pdf/jim14.pdf.

[10] *See, e.g.*, Nina Agrawal, *County Approves $1.7-million Settlement Over Jail Suicide*, LOS ANGELES TIMES (Oct. 17, 2017), http://beta.latimes.com/local/lanow/la-me-ln-settlement-jail-suicide-20171017-

While the privatization of prison industry incentivizes inadequate provision of correctional care, new legal protections arise where corporations, not the government, are defendants in prison litigation cases. Historically, the Eighth Amendment has served as the foothold for litigation to improve correctional medical care. Prisoners and their attorneys have sought relief under 42 U.S.C. § 1983 ("Section 1983") since the early 1970s. Plaintiffs may seek damages as well as prospective relief to remedy their injuries under Section 1983, but the battle is hard-fought. Structural reform litigation has resulted in much court-ordered reform over the last half-century, yet the Prison Litigation Reform Act (PLRA) has severely limited prospects for remedying inadequate correctional medical care since its enactment in 1996.[11] In light of the challenges to winning an Eighth Amendment claim, alternate sources of protections must be legislated while mismanagement of correctional care persists.

State false claims acts (FCAs) provide a novel and viable protection against inadequate correctional medical care. State FCAs are generally modeled after the federal statute, which authorizes private citizens to sue parties who commit fraud in making payments to or receiving payments from the government.[12] Often, these contractors are corporations, like private correctional health care providers. Billing for services not rendered or submitting falsified records are examples of potentially actionable conduct under a false claims act. FCAs often contain special incentives and protections for whistleblowers and provide that local and state government may intervene to prosecute the alleged fraud themselves without the consent of the plaintiff. Twenty-two states have enacted legislation to incentivize private citizens to sue contractors for fraud against the government generally, and another eight states have enacted statutes that prohibit fraud in filing Medicaid claims only.[13]

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story.html ($1.7M to family of man with schizophrenia who jumped to his death in Los Angeles jail); Brendan J. Lyons, *$1 Million Settlement in Albany County Jail Death Case*, TIMES UNION (Nov. 1, 2017), http://www.timesunion.com/news/article/1-million-settlement-in-Albany-County-jail-death-12311965.php#photo-13276334 ($1.1M to family of man who died when nurses at Albany County jail in New York waited twelve hours after he suffered a stroke to call an ambulance); Jack Queen, *Summit County to Pay Out Nearly $4 Million in Settlements Over Jail Inmate Death, Assault,* DENVER POST (Nov. 17, 2017), http://www.denverpost.com/2017/11/17/james-durkee-summit-county-jail-death-settlement/ (preliminary $3.5M settlement to family of a man who died of alcohol withdrawal in a Breckenridge, Colorado jail).

[11] *See generally*, Margot Schlanger, *Trends in Prisoner Litigation, as the PLRA Enters Adulthood*, 5 U.C. IRVINE L. REV. 153, 169 (2015) [hereinafter Schlanger, *Trends in Prisoner Litigation*].

[12] 31 U.S.C. §§ 3729–33 (2016).

[13] See *State False Claims Acts*, TAXPAYERS AGAINST FRAUD EDUC. FUND, https://www.taf.org/Public/Resources_by_Topic/FAC__False_Claims_Act/State_FCA_s/Public/Resources_by_Topic/FCA__False_Claims_Act/State_FCA_s.as

Private correctional medical providers run the risk of violating FCAs where they provide sub-contractual care but request full payment under the terms of the contract. Indeed, governments who contract for correctional medical services are purchasing care that meets the Constitutional standard of care set out in the Eighth Amendment, and a violation of the Eighth Amendment may be evidence of a violation of an FCA. In 2016, the New York State Attorney General reached one of the first successful settlements against a correctional health care provider based in significant part on claims under a state FCA in *People ex rel. Schneiderman v. Armor Correctional Health and Medical Services of New York.*[14] *Armor* provides important insight as to how state FCAs protect against deficient correctional health care by private providers, and will be examined further in this paper.

This paper makes the case for using state false claims acts to improve correctional health care, and jail health care in particular. Part I broadly outlines the contours of contemporary jail health care and increasing trends towards privatization with some historical reference. Part II sets forth some of the challenges to obtaining relief under the current prison and jail litigation regime with particular focus on Section 1983

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px?hkey=a0879c08-1539-44f6-8b51-f8aed240c448. States with false claims acts that cover more than just Medicare are California (California False Claims Act, CAL. GOV'T CODE § 12650–56 (2013)), Delaware (Delaware False Claims and Reporting Act, DEL. CODE ANN. tit. 6 §§ 1201–11 (2016)), Florida (Florida False Claims Act, FLA. STAT. §§ 68.081–.083 (2016)), Georgia (Georgia Taxpayer Protection False Claims Act, GA. CODE ANN. §§ 23-3-120 to -127 (2016)), Hawaii (False Claims to the State, HAW. REV. STAT. § 661-21 to -31 (2016), False Claims to the Counties, HAW. REV. STAT. § 46-171 to -181 (2016)), Illinois (Illinois False Claims Act, 740 ILL. COMP. STAT. 175 (2016)), Indiana (Indiana False Claims and Whistleblower Protection Act, IND. CODE § 5-11-5.5 (2016)), Iowa (Iowa False Claims Act, IOWA CODE § 685 (2016)), Massachusetts (Massachusetts False Claims Act, MASS GEN. LAWS ch. 12 §§ 5A–O (2016)), Minnesota (Minnesota False Claims Act, MINN. STAT. § 15C (2016)), Montana (Montana False Claims Act, MONT. CODE ANN. §§ 17-8-401 to -416 (2015)), Nevada (Nevada – Submission of False Claims to State or Local Government, NEV. REV. STAT. § 357.010–.250 (2016)), New Hampshire (New Hampshire False Claims Act, N.H. REV. STAT. ANN. § 167:58–61e (2016)), New Jersey (New Jersey False Claims Act, N.J. STAT. ANN. § 2A:32C-1 to -17 (2016)), New York (New York False Claims Act, N.Y. STATE FIN. LAW § 187–194 (2016)), North Carolina (North Carolina False Claims Act, N.C. GEN. STAT. § 1-605 to -618 (2016)), Rhode Island (Rhode Island False Claims Act, R.I. GEN. LAWS § 9-1.1-1 to .9), Tennessee (Tennessee False Claims Act, TENN. CODE ANN. § 4-18-101 to -108 (2016), Vermont (Vermont False Claims Act, VT. STAT. ANN. tit. 32 § 630–42 (2016)) and Virginia (Virginia Fraud Against Taxpayers Act, VA. CODE ANN. § 8.01-216.1–.19 (2016)). Eight additional states have false claims acts that only cover Medicaid fraud.

[14] Stipulation of Settlement and Discontinuance, People ex rel. Schneiderman v. Armor Corr. Health Med. Services of N.Y., Inc., No. 450835 (N.Y. Sup. Ct. 2016) [hereinafter *Armor* settlement].

and the PLRA. Part III discusses elements of the New York State False Claims Act as they relate to jail health care litigation and the New York Attorney General's *Armor* settlement. Finally, Part IV anticipates challenges to enforcing state false claims acts against correctional health providers. State false claims acts are no perfect remedy for inadequate correctional care, but they may prove useful to state attorneys general, taxpayers, and incarcerated people as the privatization of correctional industry continues to grow.

While the hope is that concepts discussed in this paper will inform efforts to improve correctional health care generally, the analysis itself is limited to jail health care and the New York State False Claims Act. Jail health care and the New York State FCA are discussed specifically because they map on to *Armor*, one of the few successful actions to date where enforcement of a state false has improved correctional care. It bears mentioning that jail health care is distinct in important ways from medical care provided in prisons, and these distinctions will be discussed in brief. Perhaps the most important distinction is that many people held in jails have not been sentenced with any crime and are awaiting their court date or trial in jail simply because they could not afford bail.[15] Additionally, it is also important to bear in mind that FCAs are not uniform across jurisdictions, and unique provisions of other state FCAs may render conclusions in this paper inapplicable to other states. Nonetheless, analysis set forth here hopefully provides some starting point for practitioners concerned with quality of care in correctional facilities nationwide.

I. JAILS AND THE CORRECTIONAL HEALTH CARE LANDSCAPE

Nicole Carmen was admitted to Schenectady County Jail in upstate New York in April 2013 for a parole violation. Ms. Carmen was thirty-nine years old and the mother of three children. A Schenectady native, she was scheduled to graduate from the local community college that next month with a degree in social science.[16] Ms. Carmen was also addicted to heroin, and informed the nurse upon intake that she had recently been using up to six "bundles" of heroin daily.[17] Ms. Carmen went through violent withdrawal over the next several days with little to no medical treatment. She repeatedly vomited and defecated on herself, her bedding, and the floor. Inmates attempted to clean her cell and provide

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[15] *See* Nathan Tempey, *Half The People Awaiting Trial in NYC Jails Are There Because They Can't Afford Bail*, GOTHAMIST (May 18, 2017), http://gothamist.com/2017/05/18/bail_still_wrong.php.

[16] *Nicole Lynn Carmen Obituary*, DAILY GAZETTE (May 2, 2013), http://www.legacy.com/obituaries/dailygazette/obituary.aspx?pid=164573914.

[17] Complaint at 4, Chase v. Corr. Med. Care, Inc., 1:14-CV-0474 (N.D.N.Y. 2014). Six bundles of heroin weigh approximately three grams. *See* National Drug Intelligence Center, *New York Drug Threat Assessment* (Nov. 2002), https://www.justice.gov/archive/ndic/pubs2/2580/heroin.htm.

her with fresh bed sheets and clothing on multiple occasions, and complained to corrections officers of the foul smell and that she needed medical attention. On the third day, Ms. Carmen could no longer control her bowels and the walls and floors of her cell were covered with vomit, bile, and feces. She was incoherent and exhibited jerky motions on the left side of her body.

A nurse assessed Ms. Carmen in her cell that third day and stated, after a cursory observation, that there was nothing wrong with her and that she was "faking it."[18] Within twenty-four hours, Ms. Carmen was transported out of the facility in a coma on a stretcher, and she died five days later. After two and a half years, Schenectady County and the private health care provider, Correctional Medical Care, settled with Ms. Carmen's estate for $425,000.[19]

Nicole Carmen's experience of inadequate medical care is not an isolated incident in New York State or even in Schenectady County.[20] Reports of jail and prison fatalities and serious injury due to poor health care are plentiful, although public records are far from representative as many settlements between injured parties and health care providers remain confidential. The extent of the injury that poor jail health care causes every year is impossible to estimate given the data that is currently available. Some statistics, however, help describe the landscape.

Millions of people receive health care at jail facilities every year. While 739,000 people are incarcerated in jails on any given day, about 11.4 million jail admissions take place annually.[21] Jail populations are heterogeneous and might include pretrial detainees, locally or state sentenced inmates, apprehended probation or parole violators, apprehended pretrial or sentenced inmates from other jurisdictions, or ICE detainees.[22] At any given time, about sixty-three percent of jailed persons are held pre-conviction, awaiting trial.[23] Incarcerated populations range in age, and include children and young teenagers who are tried as adults.[24]

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[18] Complaint, *supra* note 17 at 7.

[19] Chase v. Corr. Med. Care, Inc., No. 1:14-CV-0474, 2015 U.S. Dist. LEXIS 170982, at *2 (N.D.N.Y. 2015).

[20] *See* N.Y. STATE COMM'N OF CORR., FINAL REPORT OF THE NEW YORK STATE COMMISSION OF CORRECTION: IN THE MATTER OF THE DEATH OF LATISHA MASON, AN INMATE OF THE SCHENECTADY COUNT JAIL 6 (2012), http://s3.documentcloud.org/documents/625023/latishamasoncmcinc.pdf (describing Latisha Mason's death at Schenectady County Jail in February 2011. The New York State Commission of Corrections determined that the jail health care provider at the time, Ellis Hospital, provided her with inadequate care.).

[21] TODD D. MINTON & ZHEN ZENG, *supra* note 9, at 1–2.

[22] *Id.* at 7.

[23] *Id.* at 3.

[24] *See* 28 C.F.R. §§ 31.303(d)(1)(v), (e)(2) (2016) (requiring states who receive federal funds under the Juvenile Justice and Delinquency Prevention Act to house youth separately from adults, but exempting youth charged with felonies).

Jailed people may be released almost immediately upon their admission or spend years in custody. The average length of stay at a jail facility is twenty-three days,[25] with an average weekly turnover rate of fifty-eight percent.[26] As of March 2015, fifteen percent of inmates spent more than one year in jail awaiting trial at New York City's Rikers Island,[27] the second largest jail jurisdiction in the country.[28] Some detainees have spent as many as seven years on Rikers Island awaiting adjudication.[29]

Jail populations are meaningfully distinct from prison populations. Indeed, the Chief Medical Officer at MHM/Centurion, a correctional health services corporation, commented that the two settings are as different as an emergency room and a nursing home.[30] Jail populations are highly transient whereas prison populations are not. Incarcerated people in prisons are serving sentences that exceed one year whereas jails confine people either sentenced to less than a year or people awaiting trial. Health services in a jail facility must be tailored to meet not only the needs of people detained for years on end,[31] but also the needs of people detained for hours or days. Almost twenty-five percent of inmates at Rikers Island are released within three days of their admission, while

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[25] RAM SUBRAMANIAN ET AL., VERA INST. OF JUST., INCARCERATION'S FRONT DOOR: THE MISUSE OF JAILS IN AMERICA 10 (Feb. 2015), http://www.safetyandjusticechallenge.org/wp-content/uploads/2015/01/incarcerations-front-door-report.pdf.

[26] TODD D. MINTON & ZHEN ZENG, *supra* note 9, at 8.

[27] Michael Schwirtz & Michael Winerip, *New Plan to Shrink Rikers Island Population: Tackle Court Delays*, N.Y. TIMES (Apr. 13, 2015), http://www.nytimes.com/2015/04/14/nyregion/mayor-de-blasios-plan-to-shrink-rikers-population-tackle-court-delays.html?_r=1.

[28] TODD D. MINTON, BUREAU OF JUSTICE STATISTICS, JAIL INMATES AT MIDYEAR 2010 – STATISTICAL TABLES 10 (2011), http://www.bjs.gov/content/pub/pdf/jim10st.pdf.

[29] Andrew Cohen, *Why Carlos Montero Has Been in Rikers Island for Seven Years Without Trial*, MARSHALL PROJECT (June 19, 2015), https://www.themarshallproject.org/2015/06/19/why-carlos-montero-has-been-in-rikers-for-seven-years-without-trial#.Oe799PYiC.

[30] Jeffrey E. Keller, *How Does Jail Medicine Differ From Prison Medicine?*, JAIL MEDICINE, http://www.jailmedicine.com/how-does-jail-medicine-differ-from-prison-medicine/.

[31] Jail detainees may await trial for years. Kalief Browder was incarcerated at sixteen and awaited trial for three years for stealing a backpack. He spent almost two years in solitary confinement, and was released without conviction. He committed suicide two years after his release. *See* Jennifer Gonnerman, *Before the Law*, NEW YORKER (Oct. 6, 2014), https://www.newyorker.com/magazine/2014/10/06/before-the-law; Michael Schwirtz & Michael Winerip, *Kalief Browder, Held at Rikers Island for 3 Years Without Trial, Commits Suicide,* N.Y. TIMES (June 8, 2015), https://www.nytimes.com/2015/06/09/nyregion/kalief-browder-held-at-rikers-island-for-3-years-without-trial-commits-suicide.html.

fifty percent are released within nine days.[32] Significant resources in jail health care are devoted to intake and obtaining medical records from detainees' community providers, which can take days or weeks.

Jail populations have unique medical needs. People detained in jails generally carry higher rates of disease than the general population.[33] Many inmates in jails do not receive quality health care on a regular basis in the community and may have received little more than emergency care during most of their lives. Nationwide, sixty-eight percent of jailed people have a history of substance abuse or dependence.[34] In its most recent report, the Bureau of Justice Statistics found that sixty percent of jail inmates exhibit symptoms of a mental health disorder, with fifty-four percent of all jail inmates reporting symptoms that meet criteria for mania, and twenty-four percent reporting symptoms that meet criteria for psychotic disorder.[35] The rate of disability among jail inmates is just under forty percent.[36] Nationwide studies of trends on income, education, and health histories have not been undertaken. However, a disproportionate rate of people in New York City jails come from the city's low-income neighborhoods.[37] Half of all people in New York City jails held pretrial are incarcerated because they cannot make bail of less than $5,000.[38]

Public health advocates laud jails as promising environments for remedying unequal access to health care. Jails present an opportunity to treat those who exhibit higher incidence of illness than the general population.[39] In 2012, 2.3 million health care visits took place in California

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[32] Rosa Goldensohn, *Average NYC Jail Stay is 3 Times Longer Than Reported, DOC Commish Says*, DNAINFO (July 22, 2015), https://www.dnainfo.com/new-york/20150722/east-elmhurst/average-stay-at-rikers-is-3-times-longer-than-reported-doc-commish-says.

[33] Dora M. Dumont et al., *Jail as Public Health Partners: Incarceration and Disparities Among Medically Underserved Men*, 12 INT'L J. MEN'S HEALTH 213, 215 (2013).

[34] JENNIFER C. KARBERG & DORIS J. JAMES, BUREAU OF JUSTICE STATISTICS, SUBSTANCE DEPENDENCE, ABUSE, AND TREATMENT OF JAIL INMATES, 2002 1 (2005), https://www.bjs.gov/content/pub/pdf/sdatji02.pdf.

[35] DORIS J. JAMES & LAUREN E. GLAZE, MENTAL HEALTH PROBLEMS OF PRISON AND JAIL INMATES 1–2 (2006), https://www.bjs.gov/content/pub/pdf/mhppji.pdf.

[36] JENNIFER BRONSON ET AL., BUREAU OF JUSTICE STATISTICS, DISABILITIES AMONG PRISON AND JAIL INMATES, 2011–2012 3 (2015), https://www.bjs.gov/content/pub/pdf/dpji1112.pdf.

[37] THE CITY OF N.Y. MAYOR BILL DE BLASIO, PRELIMINARY MAYOR'S MANAGEMENT REPORT 53 (2015), http://www.nyc.gov/html/ops/downloads/pdf/pmmr2015/2015_pmmr.pdf.

[38] Letter from Independent Budget Office Director Ronnie Lowenstein to New York City Council Member Rory Lancman (May 16, 2017), http://www.ibo.nyc.ny.us/iboreports/pretrial-detention-rates-may-2017.pdf.

[39] Dumont, *supra* note 33, at 215.

jails alone.[40] Public health scholars have conducted extensive research on the incidence and treatment methods for HIV, sexually transmitted diseases and infections, addiction, and mental illness in jail populations. Inmates with health needs that went unmet prior to incarceration can benefit from screening, care, and extended treatment via community-based partners upon release. Jail admission has even been used as an opportunity to enroll uninsured inmates in health insurance under the Affordable Care Act.[41]

However, jails also present significant challenges to providing adequate medical services to incarcerated people. Jail health care is limited in its scope by competing interests in jails and prisons alike, such as the safety of patients and staff, patient privacy and confidentiality, limited institutional resources, and misconduct by correctional staff. Overcrowding, unsanitary conditions, poor nutrition, lack of ventilation, forced idleness, violence, trauma, and solitary confinement can have a long-lasting negative impact on the health of incarcerated people.[42]

The transience of jail populations complicates the effective provision of care and requires extensive institutional infrastructure for patient evaluation and treatment. Jail health care staff need medical records immediately upon admission to best understand the needs of their patients. However, in reality, inmates are often released before jail health services receive medical records from community providers. High rates of mental illness and addiction present additional challenges to administering medical services in a jail setting. For instance, detainees may be unwilling or unable to accurately communicate their medical history during intake because they are intoxicated or subject to an episode of mental instability.[43]

Jail health care is costly for counties and cities because of the unique medical needs of the jail populations, exacerbated by conditions of incarceration, and the challenge of providing care in a correctional setting. Expenses include hospital visits, pharmaceuticals, mental health and substance abuse care, regular medical services, and transportation costs. Health care services can generally comprise seven to thirteen percent of

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[40] MIA BIRD & SHANNON MCCONVILLE, PUBLIC POLICY INSTITUTE OF CALIFORNIA, HEALTH CARE FOR CALIFORNIA'S JAIL POPULATION, PUB. POLICY INST. OF CAL. 1 (2014), http://www.ppic.org/main/publication_quick.asp?i=1105.

[41] *Id.*

[42] *See* DAVID CLOUD, VERA INST. OF JUSTICE, ON LIFE SUPPORT: PUBLIC HEALTH IN THE AGE OF MASS INCARCERATION 12–14 (2014), https://storage.googleapis.com/vera-web-assets/downloads/Publications/on-life-support-public-health-in-the-age-of-mass-incarceration/legacy_downloads/on-life-support-public-health-mass-incarceration-report.pdf (discussing how poor conditions in detention negatively impact inmate health).

[43] Dumont, *supra* note 33, at 215.

total jail expenses.[44] As much as twenty percent of costs associated with running jails may be devoted to health care. In King County, Washington, a jurisdiction where 2,000 people are detained in jails on any given day, that twenty percent amounts to $28 million per year.[45] The cost of providing medical in jails is on the rise as regulations become more stringent. Between 2001 and 2007, costs per detainee rose in thirty-five states at a twenty-eight percent median.[46] The National Commission on Correctional Health Care requires correctional facilities, jails included, to provide timely intake screening, comprehensive exams and periodic health maintenance and chronic-illness management consultations.[47]

States, counties, and cities are increasingly contracting with private companies to provide correctional health care.[48] There are no published statistics on the percentage of counties nationwide who contract with third parties for medical services, although estimates suggest about fifty percent.[49] In 2008, correctional medical corporations cared for more than twenty percent of all people incarcerated in New York State jails outside of New York City, and for ninety percent of those incarcerated in New York City jails.[50] Jail providers claim they cut costs through "bill scrubbing and discount negotiation for medical claims, bulk purchasing and sub-contracting, service reporting and on-site services."[51] Private providers may also promise to indemnify counties in litigation, purchase their own insurance coverage and provide industry-specific expertise.[52]

Local and state governments contract with private correctional health care providers through a bidding process where vendors are often chosen based on the cheapest offer.[53] Private providers expand their prof-

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[44] CHRISTIAN HENRICHSON ET AL., VERA INST. OF JUSTICE, THE PRICE OF JAILS: MEASURING THE TAXPAYER COST OF LOCAL INCARCERATION 32 n.13 (2015), http://www.safetyandjusticechallenge.org/wp-content/uploads/2015/05/The-Price-of-Jails-report.pdf.

[45] *Id.* at 14, 28.

[46] PEW CHARITABLE TRS., MANAGING PRISON HEALTH CARE SPENDING 5 (2013), http://www.pewtrusts.org/~/media/legacy/uploadedfiles/pcs_assets/2014/pctcorrectionshealthcarebrief050814pdf.pdf.

[47] *Id.* at 7.

[48] Neate, *supra* note 7.

[49] *Id.*

[50] Noga Shalev et al., *Characterizing Medical Providers for Jail Inmates in New York State*, 101 AM. J. PUB. HEALTH 693, 695 (2011). Only 8 of 57 counties contracted with correctional medical corporations. Other counties provided care through contracts with local providers and through the public health systems.

[51] S. HEALTH PARTNERS, http://www.southernhealthpartners.com/why-choose-us (last visited Dec. 11, 2016).

[52] *Id.*

[53] For example, Armor Correctional Health Services underbid competitor Corizon by $17 million to win the Virginia state prison health care contract in 2013 after Corizon's $76.5 million two-year contract with the Virginia Depart-

it margin by limiting the costs of their services. They cut costs by employing less staff, through telemedicine, by purchasing wholesale generic instead of brand-name pharmaceuticals, and other measures.[54]

Only a handful of jail health care providers win most contracts and those firms are largely financially successful. In 2016, the director of business development for Correctional Medical Group Companies, the largest correctional health care vendor in California, characterized the state of the business as "terrific."[55] Its 2015 revenues were between $120 and $150 million. Other industry giants include Corizon Health, Wexford Health Services, Inc., MHM Correctional Services, Inc., and Correct Care Solutions, LLC, who care for about forty-five percent of incarcerated people nationwide and total an estimated $782 million in revenue.[56] Industry leader Corizon Health's revenue increased by 15.6 percent between 2012 and 2015 to $1.5 billion, even though it was the subject of at least 1,300 lawsuits between 2011 and 2016.[57]

II. LIMITED RELIEF FOR SUBSTANDARD CORRECTIONAL HEALTH CARE UNDER THE EIGHTH AMENDMENT

The courts are one of the few avenues whereby incarcerated people, their families, and public interest attorneys may win relief and restitution for improper correctional medical care. Litigants fight an uphill battle to win constitutional claims both because of Eighth Amendment jurisprudence and because of the Prison Litigation Reform Act. In order to make out an Eighth Amendment claim, prisoners must show that a medical professional knew of and disregarded a substantial risk to her serious medical needs, a high bar for plaintiffs to meet. The Prison Litigation Reform Act contains exhaustion requirements, limitations on attorneys' fees, frequent flier provisions, and other elements that can be fatal even to meritorious claims. Further, trends suggest that judges are less likely to order injunctions requiring broad structural reforms, which decreases the impact of individual Eighth Amendment suits.

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ment of Corrections expired. *See* David Reutter, *Virginia Must Improve Prison Medical Care Under Proposed Class-action Settlement*, PRISON LEGAL NEWS 14 (Aug. 2015), https://www.prisonlegalnews.org/media/issues/08pln15.corrected.pdf.

[54] *See generally* CHAD KINSELLA, COUNCIL OF STATE GOV'TS, CORRECTIONS HEALTH CARE COSTS (2004), https://www.prisonpolicy.org/scans/csg/Corrections+Health+Care+Costs+1-21-04.pdf/ (discussing possible cost-cutting tactics for correctional medical care budgets).

[55] Neate, *supra* note 7.

[56] *A Look At The Players In Corrections Health Care*, OPEN MINDS (Mar. 18, 2015), https://www.openminds.com/market-intelligence/executive-briefings/look-players-corrections-health-care/.

[57] Neate, *supra* note 7.

A. Eighth Amendment jurisprudence: The deliberate indifference standard

In New York State jails, providers may not demonstrate deliberate indifference towards the serious medical needs of inmates. Technically, the standard is complicated by the fact that jails confine people held pre- and post-conviction. The Eighth Amendment prohibits cruel and unusual punishment and only convicted persons may be punished under the Due Process Clause of the Fourteenth Amendment. [58] However, in New York, courts apply the deliberate indifference standard to all people held in jails irrespective of conviction status.[59]

The Supreme Court articulated the deliberate indifference standard in *Estelle v. Gamble*.[60] *Estelle* established that convicted persons have a constitutional right to medical care and set out a two-pronged test for determining lawful provision of care. The '*Estelle* test' requires (1) that the inmate has a serious medical need and (2) that actions or omissions of the prison were sufficiently harmful to evidence deliberate indifference to that need.[61] Deliberate indifference may manifest in the response to a prisoner's needs, in denial or delay of access to medical care, or intentional interference with treatment once prescribed.[62]

In the Second Circuit, the first prong requires an objective determination that the deprivation was sufficiently serious. Sufficient seriousness requires two findings. First, the plaintiff must show deprivation of adequate care. Care is adequate where a provider has acted reasonably in response to a prisoner health risk.[63] Prison officials "who act reasonably [in response to an inmate health risk] cannot be found liable under the

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[58] *See* City of Revere v. Massachusetts General Hospital, 463 U.S. 239, 244 (1983) (finding the Eighth Amendment had no application to medical care received by plaintiff after he has shot by police because "there had been no formal adjudication of guilt…"); Ingraham v. Wright, 430 U.S. 651, 672 n.40 (1977) (finding that "Eighth Amendment scrutiny is appropriate only after the State has complied with the constitutional guarantees traditionally associated with criminal prosecutions…[T]he State does not acquire the power to punish with which the Eighth Amendment is concerned until after it has secured a formal adjudication of guilt in accordance with due process of law.").

[59] *See* Iacovangelo v. Corr. Med. Care, Inc., 624 Fed. Appx. 10, 12 (2d Cir. 2015) ("A claim for indifference to the medical needs of a pre-trial detainee in state custody is properly analyzed under the Due Process Clause of the Fourteenth Amendment, though such claims should be analyzed under the same standard irrespective of whether they are brought under the Eighth or Fourteenth Amendment.") (quoting Caiozzo v. Koreman, 581 F.3d 63, 72 (2d Cir. 2009)). Other jurisdictions may not apply identical standards for prisoners held pre- and post-conviction.

[60] Estelle v. Gamble, 429 U.S. 97 (1976).

[61] *Id.* at 106.

[62] *Id.* at 104–05.

[63] Salahuddin v. Goord, 467 F.3d 263, 279–80 (2d Cir. 2006) (quoting Farmer v. Brennan, 511 U.S. 836, 844–47 (1994).

Cruel and Unusual Punishments Clause," but failing to take reasonable measures may suggest liability.[64] Second, the plaintiff must show that the inadequate care was "sufficiently serious."[65] The plaintiff must show harm caused by the deprivation, or show what harm the deprivation will likely cause.[66] Serious medical need can be demonstrated by factors including but not limited to whether a reasonable doctor or patient would find the injury important and "worthy of comment or treatment," whether the medical need affects the plaintiff's daily activities, and whether the plaintiff suffers chronic and substantial pain.[67] Harm caused by a delay, interruption, or lack of treatment is another potential factor.[68]

The second prong in the *Estelle* test is a subjective inquiry. Under *Estelle*, prisoners do not have a Constitutional claim for mere negligence on the part of the provider or for inadvertent failure to provide adequate medical services.[69] Instead, the defendant "must know of and disregard" an excessive risk to inmate health or safety.[70] In other words, plaintiffs must prove not only that the defendant was aware of facts from which an inference could be drawn that substantial risk of serious harm existed, but also that the defendant actually drew the inference.[71] As long as a medical provider sincerely believed that her conduct posed no serious harm to the plaintiff, she is free of liability, even if her belief is objectively wrong.[72]

B. Remedies: Section 1983, monetary damages, and the decline in court-ordered injunctions

Courts compel correctional institutions to provide health care that meets the standards set out in *Estelle* with injunctions and other remedies. For the past two decades, however, courts have been increasingly reluctant to supervise compliance with court-ordered reform. This section will sketch out the bounds of Section 1983, the available remedies, and the declining success of correctional reform litigation.

Plaintiffs historically sought relief for Eighth Amendment violations in prisons and jails under Section 1983.[73] Section 1983 provides plain-

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[64] *Id.* at 279–80.

[65] *Id.* at 280.

[66] *See* Helling v. McKinney, 509 U.S. 32–33 (1993).

[67] Chance v. Armstrong, 143 F.3d 698, 702 (2d Cir. 1998).

[68] *Salahuddin*, 467 F.3d at 280.

[69] Estelle v. Gamble, 429 U.S. 105–06 (1976).

[70] Farmer v. Brennan, 511 U.S. 836, 837 (1994).

[71] *Id.* at 836–37; *see also Salahuddin*, 467 F.3d at 280.

[72] *Salahuddin*, 467 F.3d at 281.

[73] 42 U.S.C. § 1983 (2016). Section 1983 is not the only statutory provision whereby prisoners may obtain relief. Section 504 of the Rehabilitation Act of 1973, 29 U.S.C. § 794, also provides protections prohibits discrimination against persons with disabilities, including incarcerated people, and 42 U.S.C. § 1985 prohibits conspiracy related to deprivations of civil rights. *See* Alison

tiffs a cause of action against government officials who, under color of law, deprived them of "rights, privileges, or immunities secured by the Constitution and laws" of the United States.[74] Private plaintiffs take on the role of private attorney general when they enforce their constitutional rights against government employees.[75] Private correctional health care companies and individual medical practitioners act under color of law for the purposes of Section 1983 and are liable for unconstitutional conduct.[76]

The Department of Justice also has the authority to investigate and prosecute civil rights violations by departments of correction. The Civil Rights Division has initiated sixty-one investigations of prisons and jails, excluding juvenile correctional facilities.[77] Only about one-third of those matters have been formally closed and many resulted in settlement agreements.

While state attorneys general also have standing to prosecute civil rights violations by departments of correction, this author was unable to find any evidence of them doing so. Perhaps state attorneys general do not enforce constitutional protections for incarcerated people because their offices, which are relatively small compared to the Department of Justice, would be put in the position of prosecuting and defending those same actions. If this is the case, then constitutional rights of incarcerated people are systemically under-enforced.

Plaintiffs must satisfy several elements to succeed in a Section 1983 claim. They must allege both a deprivation of a constitutional right or right under federal law, as discussed *supra*, and that the deprivation took place under color of state law.[78] *West v. Atkins* clearly established that health care providers in correctional settings act under color of law.[79] How the medical provider is employed, whether by the state directly or through contract, does not alter the analysis. The relevant relationship is

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Brill, *Rights Without Remedy: The Myth of State Court Accessibility After the Prison Litigation Reform Act*, 30 CARDOZO L. REV. 645, 652 n.37 (2008).

[74] *Id.*

[75] Newman v. Piggie Park Enterprises, 390 U.S. 400, 402 (1968) (per curiam) (a private plaintiff obtains an injunction under Title II of the Civil Rights Act of 1964 "as a 'private attorney general,' vindicating a policy that Congress considered of the highest priority.").

[76] *See* West v. Atkins, 487 U.S. 42, 57 (1988) (holding that a physician who contracted with the state to provide part-time medical services at a state prison acted "under color of law" within in the meaning of Section 1983).

[77] *See Special Litigation Section Cases and Matters*, U.S. DEP'T JUST., https://www.justice.gov/crt/special-litigation-section-cases-and-matters0#corrections.

[78] McCloud v. Jackson, 4 Fed. App'x 7 at *9 (2d Cir. 2001) (quoting Rodriguez v. Weprin, 116 F.3d 62, 65 (2d Cir. 1997).

[79] *See West*, 487 U.S. at 55 (finding that correctional health care providers are only authorized to treat prisoners "clothed with the authority of state law.").

the physician's function within the state system, not the terms of her employment.[80]

In addition to these two elements, Section 1983 must overcome other significant hurdles. For instance, there is no respondeat superior liability under Section 1983.[81] Plaintiffs must show that the care provider's own individual action violated the patient's Eighth Amendment rights.[82] Liability is determined based on a range of factors, and an exhaustive list will not be set out here.[83] Suffice it to say that plaintiffs must show that the defendant proximately caused the unconstitutional health care alleged. Plaintiffs must also contend with procedural requirements that may limit their ability to bring claims, including statutes of limitation,[84] class certification, and attorneys' fees.

Prisoners may obtain monetary damages under Section 1983. Plaintiffs sporadically win sizeable settlements, and those settlements are generally paid for with tax dollars. Settlements can be significant. Confidentiality clauses make estimating average award size impossible, although media outlets occasionally report on large settlements. In 2015, Alameda County in California and Corizon Health Care settled with the family of a man who died in prison for $8.3 million.[85] Corizon paid 150 settlements from 2007 to 2016 for claims arising in New Mexico alone,

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[80] *Id.*

[81] Green v. Bauvi, 46 F.2d 189, 194 (2d. Cir. 1995).

[82] Ashcroft v. Iqbal, 556 U.S. 662, 676 (2009).

[83] The Second Circuit district courts historically applied the Colon factors but are split on which factors apply after *Ashcroft v. Iqbal*. See discussion in Rush v. Fischer, 923 F. Supp. 2d 545, 551–52 (S.D.N.Y. 2013). The *Colon* factors are (1) the defendant participated directly in the alleged constitutional violation; (2) the defendant, after being informed of the violation through a report or appeal, failed to remedy the wrong; (3) the defendant created a policy or custom under which unconstitutional practices occurred, or allowed the continuance of such a policy or custom; (4) the defendant was grossly negligent in supervising subordinates who committed the wrongful acts; or (5) the defendant exhibited deliberate indifference to others' rights by failing to act on information indicating that unconstitutional acts were occurring. Colon v. Coughlin, 58 F.3d 865, 873 (2d Cir. 1995).

[84] The statute of limitations in New York State is three years. Patterson v. Cty. of Oneida, N.Y., 375 F.3d 206, 225 (2d Cir. 2004).

[85] Police arrested decedent Martin Harrison for jay walking in Oakland, California and booked him at the county jail after a warrant check revealed he did not appear for a driving under the influence charge, and he died five days later. Plaintiff's counsel alleged that his intake screening was conducted by a nurse without requisite credentials and that he went through severe alcohol withdrawal after correctional staff failed to summon medical care. CALIFORNIA'S MILLION DOLLAR SETTLEMENTS 2015, THE RECORDER 9, 10 (2016), https://www.drivecms.com/uploads/ haddadandsherwin.com/TheRecorder_Top_Settlements_2016.pdf.

ranging from $7,000 to $192,400 each.[86] Cities, counties, and states routinely indemnify individuals and vendors who provide correctional services for violations of prisoners' constitutional rights for significant sums. In 2016, New York City agreed to settle with the family of a deceased inmate at Rikers Island for $5.75 million for unconstitutional care, the largest New York City settlement over an inmate death in custody.[87] Corizon provided the medical care in question, but New York City paid the bill. Private providers purchase professional liability insurance and civil rights endorsements to protect against Section 1983 settlements in the event that they are not indemnified.[88]

Courts may also award injunctive relief to successful Section 1983 plaintiffs. Civil rights attorneys obtained the first court orders related to prison and jail conditions in the early 1970s and correctional health care has been a reoccurring subject of structural reform litigation ever since.[89] Winning a claim for injunctive relief, however, is no simple task. An individual plaintiff must show with sufficient likelihood that she personally will be harmed again in a similar way (a nearly impossible task if demanding improved services for potentially isolated events like cancer screening, for example).[90] It is not enough to show that others will be similarly harmed unless the plaintiff is a member of a class.

Correctional consent decrees themselves are on the decline. The number of jail inmates housed in a facility under court order decreased by thirty percent between 1983 and 2006.[91] Margot Schlanger ascribes the decline primarily to the PLRA and to the increasing conservatism of the federal bench, doctrinal shifts in injunction jurisprudence, and a de-

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[86] Phaedra Haywood, *Corizon Paid $4.5M to Settle Inmate Lawsuits*, NEW MEXICAN (June 28, 2016), http://www.santafenewmexican.com/news/local_news/corizon-paid-m-to-settle-inmate-lawsuits/article_70013e63-6133-5468-b6e0-2bdb91ed5a3d.html.

[87] Benjamin Weiser, *City to Pay $5.75 Million Over Death of Mentally Ill Inmate at Rikers Island*, N.Y. TIMES (Sept. 27, 2016), http://www.nytimes.com/2016/09/28/nyregion/rikers-island-lawsuit-bradley-ballard.html?_r=0.

[88] *See, e.g.*, Advanced Correctional Healthcare's Risk Management Program, ADVANCED CORRECTIONAL HEALTH CARE, https://www.advancedch.com/services/legal/.

[89] Margot Schlanger, *Civil Rights Injunctions Over Time: A Case Study of Jail and Prison Court Orders*, 81 N.Y.U. L. REV. 550, 552 n.4 (2006) [hereinafter Schlanger, *Civil Rights Injunctions*].

[90] City of Los Angeles v. Lyons, 461 U.S. 95, 111 (1983) (finding federal courts had no jurisdiction over plaintiff's claim for injunctive relief barring chokeholds as a law enforcement practice where plaintiff alleged he was subjected to chokehold by police officer because plaintiff did not show "any real or immediate threat that [he] would be wronged again…").

[91] Margot Schlanger, *Trends in Prisoner Litigation, as the PLRA Enters Adulthood*, 5 U.C. IRVINE L. REV. 153, 169 (2015) [hereinafter Schlanger, *Trends in Prisoner Litigation*].

crease in funding for inmates' legal services, although others argue that structural reform litigation was on the decline before the PLRA was passed. [92] Injunctions have become less intrusive over time and link remedial measures such as auditing procedures directly to performance indicators.[93] Consent decrees are not the only remedy that require institutional reform. Plaintiffs and defendant departments of correction or correctional health care providers may arrive at settlement agreements that require increased staffing, additional training and court supervision in addition to money damages.[94]

Courts have had an undeniable impact on correctional practice since prison litigation took hold. *Brown v. Plata* is perhaps the most notorious judicial intervention in correctional health practices.[95] *Plata* consolidated two class actions by California prisoners against the state governor for violations of their Eighth Amendment rights.[96] At the time the cases were consolidated, California prisons were designed to hold 80,000 people but in fact held 156,000. California correctional facilities had been operating at almost 200 percent capacity for at least eleven years when litigation commenced.[97]

While health care violations were alleged, the courts identified overcrowding as the predominant problem. In the first action, prisoners with mental illness alleged inadequate mental health care.[98] The district court ordered remedial relief and appointed a monitor after finding overwhelming systemic failure to deliver necessary care to mentally ill inmates.[99] Prisoners with serious medical conditions filed the second case alleging inadequate care. The court found that the California prison medical system was "broken beyond repair," and ordered remedial relief.[100]

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[92] Schlanger, *Civil Rights Injunctions*, *supra* note 89, at 553 n.5, 589–601.

[93] *See generally* John J. Jeffries & George A. Rutherglen, *Structural Reform Revisited*, 95 CAL. L. REV. 1387, 1411 (2007).

[94] *See, e.g.*, Stipulation and Order of Settlement at 3, M.H. v. County of Alameda, C11-2868 JST (LB) (N.D. Cal. 2015) ($8.3 million correctional health care settlement between decedents family, private health care provider and county included prospective terms on staffing, training and four years of court-supervised monitoring).

[95] Brown v. Plata, 563 U.S. 493 (2011). For a detailed discussion on *Plata*, see Margot Schlanger, *Plata v. Brown and Realignment: Jails, Prisons, Courts and Politics*, 48 HARV. C.R.–C.L. L. REV. 165 (2013).

[96] *Brown*, 563 U.S. at 500 (2011).

[97] *Id.* at 502.

[98] Coleman v. Wilson, 912 F. Supp. 1282, 1316 (E.D. Cal. 1995).

[99] *Brown*, 563 U.S. at 505 (describing witness testimony that fifty sick inmates might be held together in a twelve-by-twenty foot cage for five hours awaiting treatment, and egregious cases of specific misconduct, including one young man who suffered seventeen months of testicular pain and died of testicular cancer after doctors failed to conduct cancer screening).

[100] Plata v. Schwarzenegger, No. C01-1351 THE, 2005 WL 2932253 at *1 (N.D. Ca. Oct. 3, 2005).

It appointed a receiver after the State failed to comply with the remediation plan.[101]

The special monitor and receiver reported significant noncompliance with remedial orders and, in 2010, twenty years after the first of the two cases was filed, a three-judge panel ordered California to reduce its prison population to 137.5 percent capacity, a reduction of some 46,000 people.[102] In an opinion by Justice Kennedy, the Supreme Court found that any remedy would not be "effective absent a reduction in the prison system population" and affirmed the three-judge order. Kennedy characterized the reduction as of "unprecedented sweep and extent."[103] Justice Scalia described the court order as "perhaps the most radical injunction issued by a court in our Nation's history."[104]

Although structural reform litigation has its critics, court orders remain one of the only means to create equal opportunity despite a resistant majority. Structural reform litigation was born out or *Brown v. Board* and subsequent desegregation decrees.[105] Thereafter, plaintiffs sued school, housing authorities, and mental hospitals for violations of their constitutional rights. Indeed, consent decree negotiations "reallocated power to different parties in a radically altered political context."[106] Critics argue that court orders are undemocratic judicial intervention into matters in which judges have little expertise, and that they violate the basic principles of federalism.[107] History instructs, however, that structural reform litigation is one of the few mechanisms that enforces constitutional rights where a majority targets a minority for systemic dehumanization. Indeed, American incarceration deprives incarcerated people of conventional mechanisms for advocacy such as voting, financial self-sufficiency, and by extent political donations, and community organizing.

Court-ordered reform is no panacea. The *Armor* litigation, discussed *supra*, reveals the shortcomings of court-monitored relief. In 2016, New York State Attorney General Eric Schneiderman sued the private health

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[101] *Id.* at *3 ("It is an uncontested fact that, on average, an inmate in one of California's prisons needlessly dies every six to seven days due to constitutional deficiencies in the medical delivery system.").

[102] Coleman v. Schwarzenegger, Nos. CIV S-90-0520 LKK JFM P, C01-1351 TEH, 2010 WL 99000 (E.D. Cal. and N.D. Ca. Jan 12, 2010).

[103] *Brown*, 563 U.S. at 500–01.

[104] *Id.* at 550 (Scalia, J. dissenting).

[105] *See* Jeffries & Rutherglen, *supra* note 93, at 1408.

[106] *See id.* at 1410.

[107] *See* 141 CONG. REC. S14408-01 (1995) (statement of Sen. Abraham) (statement on introducing the PLRA, "Judicial orders entered under Federal law have effectively turned control of the prison system away from elected officials accountable to the taxpayer, and over to the courts. In the process they also undermine the legitimacy and punitive and deterrent effect of prison sentences."); *see generally* Paul J. Mishkin, *Federal Courts as State Reformers*, 35 WASH. & LEE L. REV. 949 (1978).

provider in Nassau County jails after three decades of litigation and court supervision. Courts had ordered Nassau County to improve jail health care in the 1980s, the Department of Justice entered into a consent decree with the County for improved care from 2002 to 2008, and a court again ordered monitoring in 2013 as a result of legal advocacy by the New York Civil Liberties Union. Clearly, these individual instances of court-ordered reform did not solve the problem. Resolution is only possible where departments of correction have the resources to make improvements, which means either increased spending by taxpayers or decreases in prison or jail populations. Where counties and states have been unwilling to pay the price of adequate care for the people it incarcerates, jail administrators have used consent decrees to "strong-arm" money for their budgets out of local government.[108]

C. Decreased prospects for relief after the PLRA

The Prison Litigation Reform Act severely limits relief for inadequate correctional health care through the federal courts. Prison litigation comprised a significant part of the federal docket before Congress passed the PLRA in 1995. Inmates in jails and prisons filed about 2,300 civil rights claims in federal district court in 1970 when prisoner litigants first brought Section 1983 actions. Filings continued to increase dramatically until a peak of about 39,000 in 1995, when they made up twenty percent of the federal docket and fifteen percent of federal civil trials.[109] Congress enacted the PLRA in 1996 and prisoner civil rights cases declined. While the U.S. prison population increased more than forty percent between 1995 and 2014, prison litigation decreased by more than fifty percent.[110] Prisoners filed about 18,300 civil rights claims in 2014.[111] Twen-

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[108] Schlanger, *Civil Rights Injunctions*, *supra* note 89 at 632; *see also id.* at 563 (quoting jail administrator, "[t]o be sure, we used 'court orders' and 'consent decrees' for leverage. We ranted and raved for decades about getting federal judges 'out of our business'; but we secretly smiled as we requested greater and greater budges to build facilities, hire staff, and upgrade equipment. We 'cussed' the federal courts all the way to the bank.").

[109] Margot Schlanger, *Inmate Litigation*, 116 HARV. L. REV. 1555–58, 1583 (2003).

[110] JAN M. CHAIKEN, BUREAU OF JUSTICE STATISTICS, CORRECTIONAL POPULATIONS IN THE UNITED STATES, 1995 1 (1997), http://www.bjs.gov/content/pub/pdf/cpius951.pdf (reporting that at year-end 1995, only 1,577,000 people were incarcerated in jails and prisons); DANIELLE KAEBLE ET AL., BUREAU OF JUSTICE STATISTICS, CORRECTIONAL POPULATIONS IN THE UNITED STATES, 2014 2 (2016), http://www.bjs.gov/content/pub/pdf/cpus14.pdf (reporting that 2,224,400 people were incarcerated in jails or prisons at year end 2014).

[111] FEDERAL JUDICIAL CASELOAD STATISTICS, TABLE C-2. U.S. DISTRICT COURTS—CIVIL FEDERAL JUDICIAL CASELOAD STATISTICS 3 (2014), http://www.uscourts.gov/sites/default/files/statistics_import_dir/C02Mar14.pdf.

ty-nine states saw a decrease in prisoner litigation of more than seventy percent between 1995 and 2002.[112]

Congress passed the PLRA to decrease frivolous prisoner litigation, but the Act contained few, if any, means to distinguish frivolous from meritorious claims.[113] It imposes a variety of requirements on prison litigants, limits federal oversight of state facilities, and purports to encourage prison litigation in state venues.[114] There is little evidence, however, to suggest that prisoners have sought relief in state venues previously available to them in federal courts.[115]

The PLRA limits prisoner plaintiffs' ability to file actions in federal court. It prohibits waiver of filing fees for most indigent prisoner plaintiffs.[116] Prison litigants who have filed three or more actions in federal venues that were dismissed as frivolous or malicious or for failure to state a claim may not file actions or appeals unless the prisoner is under "imminent danger of serious physical injury."[117] Under the PLRA, incarcerated plaintiffs must exhaust administrative procedures, which often require error-free filing of multiple grievances and timely and complicated internal appeals processes within a hostile correctional bureaucracy.[118] The PLRA limits attorneys' fees to no more than twenty-five percent of a judgment, if monetary damages are awarded at all, and hourly fees may not constitute more than 150 percent of the federal statutory hourly rate for court-appointed counsel.[119] In 2012, ninety-five percent of prisoner plaintiffs represented themselves *pro se* in Section 1983 claims.[120]

The PLRA also limits the relief available to prisoner plaintiffs in federal fora. Data suggests that after the PLRA was enacted, prisoner plaintiffs lost more cases pretrial, arrived at fewer settlements, and went to trial less often.[121] Settlements are finalized later in the litigation process.[122] As a result, prisoner plaintiffs are far less successful than other kinds of federal litigants. Overall, the average plaintiff success rate for all district court cases in 2012 was fifty-four percent, with labor and employment plaintiffs the most successful at eighty percent.[123] In comparison, eleven percent of prisoner plaintiffs obtained judgments through

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[112] Schlanger, *Trends in Prisoner Litigation*, *supra* note 11, at 161.

[113] *See* 141 CONG. REC. S14408-01 (1995) (statement of Sen. Dole) ("[The PLRA] address[es] the alarming explosion in the number of frivolous lawsuits filed by State and Federal prisoners.")

[114] Alison Brill, *supra* note 73, at 649.

[115] *See generally id.*

[116] 28 U.S.C. § 1915(b) (2016).

[117] *Id.* § 1915(g).

[118] 42 U.S.C. § 1997e(a) (2013).

[119] *Id.* § 1997e(d).

[120] Schlanger, *Trends in Prisoner Litigation*, *supra* note 11, at 167.

[121] *Id.* at 163.

[122] *Id.*

[123] *Id.* at 165.

civil rights litigation. Only habeas plaintiffs were less successful, at seven percent.

Lastly, PLRA provisions limit court-ordered relief. The Act only permits consent decrees that are narrowly drawn, that extend no further than necessary to correct the violation of the federal right, and that are the least intrusive means necessary to correct violation of the federal right.[124] It also permits the termination of any court order upon the motion of any party one or two years after the prospective relief is granted.[125] From 1983 to 2006, the number of total jail facilities under court supervision nationwide dropped from eighteen percent to eleven percent.[126] While fifty-one percent of prisoners were incarcerated in jails with court orders in 1983, only twenty percent were housed in jails with court orders in 2006.[127]

III. THE NEW YORK FALSE CLAIMS ACT AND *ARMOR*

The New York False Claims Act (NYFCA) is one of many state false claims acts modeled after the federal statute. Congress first passed the federal False Claims Act in 1863 to prohibit false or fraudulent claims against the government in light of rampant fraud in Civil War era defense contracts.[128] Title XIX of the Social Security Act provides monetary incentives to states for passing their own FCAs that penalize false Medicaid claims.[129] States with their own Medicaid FCAs that meet statutory requirements receive an additional ten percent in the recoveries shared by federal and state governments in state Medicaid fraud actions. New York adopted its own False Claims Act in 2007 and has recovered hundreds of millions of dollars under NYFCA since.[130] Acting New York State attorney general and former state senator Eric Schneiderman has characterized the statute as "the most powerful tool to fight fraud against the government, especially fraud by corrupt contractors."[131]

State FCAs are heterogeneous with some common themes. While private citizens may bring claims against other private parties under FCAs, the statutes also authorize state attorneys general to prosecute under the act. FCA *qui tam* provisions incentivize whistleblowers to bring

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[124] 18 U.S.C § 3626(a)(1)(A) (1997).

[125] *Id.* § 3626(b)(1).

[126] Schlanger, *Trends in Prisoner Litigation*, *supra* note 11, at 169.

[127] *Id.*

[128] 31 U.S.C. §§ 3729–33 (2016)*; see Kane ex rel. United States v. Healthfirst, Inc.*, 120 F. Supp. 3d 370, 379 (S.D.N.Y. 2015) (quoting S. REP. NO. 99-345 (1863), *as reprinted in* 1986 U.S.C.C.A.N. 5266.

[129] 42 U.S.C § 1396h (2007).

[130] Press Release, *Senator Eric T. Schneiderman Shepherds Historic Anti-Fraud Taxpayer Prot. Measure Through Legislature*, N.Y. STATE SENATE (July 1, 2010), https://www.nysenate.gov/newsroom/press-releases/eric-t-schneiderman/senator-eric-t-schneiderman-shepherds-historic-anti.

[131] *Id.*

FCA actions, and often include protections against future retaliation. FCAs also set out civil damages provisions which may provide that plaintiffs can recover two or three times the amount of damages sustained as a result of the actionable conduct.

NYFCA likely prohibits private jail health care providers from submitting claims for payment where their services violate the terms of their contracts with local and state government. The Act creates liability for a person who "(a) knowingly presents, or causes to be presented a false or fraudulent claim for payment or approval; [and] (b) knowingly makes, uses, or causes to be made or used, a false record or statement material to a false or fraudulent claim."[132] Under NYFCA, plaintiffs may win six to twelve thousand dollars in civil penalties plus treble damages, or double damages for defendants' good behavior.[133]

The New York legislature passed NYFCA in 2007 and amended it substantially in 2010 after Congress changed the federal false claims statute. While some states have enacted FCAs that only apply to Medicare fraud, NYFCA extends liability to all fraudulent claims made against the government. NYFCA bears significant resemblance to other state FCAs except that it applies to claims submitted before the Act was established,[134] subject to a ten-year statute of limitations,[135] and the attorney general may adopt regulations to implement the statute.[136]

In 2016, the Office of the New York State Attorney General (NYAG) filed a successful action against Armor Correctional Health Medical Services ("Armor"), the health care provider for jails in Nassau County, based in part on NYFCA claims. *Armor* settled before a court could rule on whether the health care contractor violated the statute. However, the relative success of the *Armor* case suggests that NYFCA and FCAs present effective protections for incarcerated people who receive inadequate health care from private contractors.

A. Armor

Nassau County jails had already been the site of considerable scrutiny before Armor won its medical services contract. In 1981, the county entered into a consent judgment with prisoner plaintiffs who alleged constitutional violations. The judgment included provisions on medical services.[137] Prisoners brought and won claims against the county for fail-

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[132] N.Y. STATE FIN. LAW § 189(1)(a)–(b) (2016).

[133] *Id.* at § 189(1)(h)–(2).

[134] *See, e.g.*, United States ex rel. Bilotta v. Novartis Pharmaceuticals Corp., 50 F. Supp. 3d 497, 540 (S.D.N.Y. 2014) (quoting the New York State legislature in enacting the NYFCA, "section thirty-nine of the act [which amended the New York Finance Law to add the New York FCA] shall apply to claims filed or presented prior to, on or after April 1, 2007.").

[135] N.Y. STATE FIN. LAW § 192(1) (2016).

[136] *Id.* at § 194 (2016).

[137] *See* Badgley v. Varelas, 729 F.2d 894, 896 (2d Cir. 1984).

ure to comply with that consent judgment over the next decade.[138] The county entered into a settlement agreement in 2002 with the Department of Justice after it investigated Nassau County Correctional Center and the U.S. Attorney General filed a complaint alleging deliberate indifference to inmates' medical needs, among other claims.[139] Nassau University Medical Center provided health care at the facility during this period. The settlement included extensive provisions on medical and mental health care, as well as specific auditing requirements.[140] Department of Justice monitoring continued until 2008.[141]

In 2011, Nassau County awarded the jail health care contract to Armor.[142] The initial contract price was $10.5 million annually, which increased to $11.6 after twelve months.[143] Seven inmates died during the first year of the contract and the New York Civil Liberties Union reported that complaints related to quality of care increased dramatically.[144] The New York Civil Liberties Union filed an action in response to complaints of inadequate care and the court compelled the county to appoint a board of visitors in 2013.[145]

NYAG commenced its action in response to complaints and troublesome findings during the contract period. At the time NYAG filed the *Armor* complaint in 2016, the New York State Commission of Correction's Medical Review Board, who oversees jail and prison health care in the state, found egregious lapses of care in five deaths over that five-year

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[138] *See id.*; Badgley v. Santacroce, 853 F.2d 50 (2d Cir. 1988); Badgley v. Santacroce, 815 F.2d 888 (2d Cir. 1987); Badgley v. Santacroce, 800 F.2d 33 (2d Cir. 1986), *cert. denied*, 479 U.S. 1067 (1987).

[139] Settlement Agreement, United States v. Nassau Cty. Sherriff's Dep't (E.D.N.Y. 2002), https://www.clearinghouse.net/chDocs/public/JC-NY-0010-0002.pdf.

[140] *Id.* at 2–8.

[141] *See Special Litigation Section -- Archives*, U.S. DEP'T JUST. (Aug. 6, 2015), https://www.justice.gov/crt/special-litigation-section-archives-0.

[142] Complaint at 9, Marone v. Nassau Cty, No. 12-003630, slip. op. (N.Y. Sup. Ct. Aug. 31, 2012), 2012 WL 12885206.

[143] Complaint at 7, People ex rel. Schneiderman v. Armor Corr. Health Med. Services of N.Y., Inc., No. 450835 (N.Y. Sup. Ct. July 11, 2016), 159-201 http://www.nysba.org/Sections/Health/3_24_17_Panel_4.html [hereinafter *Armor* complaint]. Armor agreed to provide "medical, mental health, substance abuse treatment, dental, pharmacy, laboratory and diagnostic services, onsite specialty services (including orthopedic, physical therapy, obstetrics and gynecology, optometry, dialysis and infectious diseases); facilitate off-site specialty services and discharge planning; maintain an infirmary; establish a quality improvement program overseen by a utilization review committee and to adhere to the National Commission on Correctional Health Care standards regarding jail health."

[144] Marone v. Nassau Cty., 967 N.Y.S.2d 583, 586 (2013) (granting order of mandamus).

[145] *Id.* at 593.

period.[146] Four additional deaths were under investigation.[147] NYAG's alleged multiple violations of New York State Finance Law § 189, New York Executive Law § 63(12), and New York Executive Law § 63-c in its *Armor* complaint.[148]

The case settled just under three months after it was filed. The settlement reflected some of the relief sought in the complaint, with marked discrepancies. NYAG requested Armor never bid on another contract in New York State, and Armor agreed to suspend any New York State bidding for three years.[149] NYAG requested $3 million in damages for NYFCA violations (three times the amount of damages allegedly sustained as a result of the violations), and Armor agreed to pay NYAG $350,000, of which NYAG intended to pay Nassau County $250,000.[150] NYAG requested a monitor but was not awarded a monitor in the settlement, although the settlement provided that the court would retain jurisdiction for the purpose of enforcing the agreement and Armor would pay the cost of enforcing the agreement if a court determined breach.[151]

The following section will set out elements of NYFCA claims against jail health care providers and then discuss standing and recovery under the statute. There is limited state court case law on point.[152] Courts rely on federal FCA precedent in deciding NYFCA actions and so federal precedent will be discussed *infra*.[153] The *Armor* complaint will be used to describe elements of NYFCA claims, although its significance may only be judged against the success of the settlement.

Plaintiffs must properly allege four elements to make out a NYFCA claim against jail health providers. The elements of a NYFCA claim are (1) a demand for payment of government funds; (2) that is false; where

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[146] *Armor* complaint, *supra* note 143, at 3.

[147] *Id.* at 4.

[148] *Id.* at 5.

[149] *Armor* settlement, *supra* note 14, at 3; *Armor* complaint, *supra* note 143, at 40–42.

[150] *Armor* settlement, *supra* note 14, at 3; *Armor* complaint, *supra* note 143, at 39, 41.

[151] The Nassau County Legislature voted to appoint a monitor to oversee Armor in September 2016 before NYAG and Armor reached a settlement. *Nassau Lawmakers Vote to Hire Monitor for Jail Health Provider,* LONG ISLAND NEWS 12 (Sept. 13, 2016), http://longisland.news12.com/story/34745703/nassau-lawmakers-vote-to-hire-monitor-for-jail-health-provider.

[152] Westlaw cited thirty-three notes on NYFCA decisions as of December 17, 2016.

[153] *See* Kane ex rel. United States v. Healthfirst, Inc., 120 F. Supp. 3d 370, 381 (S.D.N.Y. 2015); United States ex rel. Bilotta v. Novartis Pharmaceuticals Corp., 50 F. Supp. 3d 497, 509 (S.D.N.Y. 2014); United States ex rel. Corp. Compliance Assocs. v. N.Y. Soc. for the Relief of the Ruptured and Crippled, Maintaining the Hosp. for Special Surgery, No. 07-CV-292 (PKC), 2014 WL 3905742, at *11 (S.D.N.Y. Aug 7, 2014).

(3) the falsity is material to payment and (4) the defendant had knowledge of the material falsity. All four elements and damages must be proved by a preponderance of the evidence.[154]

B. Elements

1. A Claim

Defendants must have submitted a claim for payment to state or local government. In the correctional health care context, providers' requests for payment to counties or state government likely fall squarely within the definition of "claim" under Section 188 of NYFCA. Requests or demands for money or property presented to officers, employees, or agents of the state or local government under contract or otherwise all fall under NYFCA.[155] NYFCA does not apply to requests or demands for payment that the government has already paid as compensation for government employment or as an income subsidy "with no restrictions on that individual's use of the money or property."[156] In *Armor*, the provider's submission of claim vouchers for payment constitutes a "claim" for the purposes of NYFCA.[157]

2. Falsity

Second, plaintiffs must show that claims were indeed false or fraudulent. FCA liability may attach to falsehood by act or omission. Under a theory of "implied false certification," a defendant may be liable under the FCA for specific representations about goods or services provided if the defendant also fails to disclose her noncompliance with a contractual requirement that renders the representation misleading.[158] Legally false certifications are of particular salience in the jail health care context. The falsity element may be satisfied when providers bill the government for inadequate health services, and certainly when providers bill for services not rendered at all.[159] Indeed, even half-truths may constitute actionable misrepresentations under NYFCA.[160]

In *Armor*, NYAG showed falsity by presenting evidence that Armor submitted requests for payment while failing to meet its contractual obli-

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[154] N.Y. STATE FIN. LAW § 192(2) (2016).

[155] *Id.* at § 188(1) (2016).

[156] *Id.*

[157] *Armor* complaint, *supra* note 143, at 8.

[158] Universal Health Servs. v. United States ex. rel. Escobar, 2016 U.S. LEXIS 3920, at ***3 (U.S. June 16, 2016).

[159] *See* Swanson v. Battery Park City Auth., No. 15-CV-6938 (JPO), 2016 WL 3198309, at *4 (S.D.N.Y. June 8, 2016) (explaining that legally false certifications are "predicated upon a false representation of compliance with a federal statute or regulation or a prescribed contractual term") (quoting Mikes v. Straus, 274 F. Supp. 3d 687, 698 (2d Cir. 2001)).

[160] *Universal Health Servs.*, 2016 U.S. LEXIS at ***20, n.3.

gations.[161] Nassau County agreed to pay Armor $11.6 million annually for a variety of health services.[162] In order to receive payment, the contract required that Armor submit vouchers which described the services provided and payment requested for those services. The contract explained that the vouchers served as certified that Armor rendered its services in accordance with the contract.[163] Further, Armor was to substantiate the vouchers with monthly self-audit reports which were to include twenty-four contractually required indicators. The contract required fee reductions for failure to meet those benchmarks.[164]

NYAG alleged that Armor's repeated requests for payment despite persistent failure to meet contractual obligations amounted to actionable falsity under NYFCA. Armor allegedly failed to describe the services it billed to the county and failed to provide documentation as required under contract.[165] Further, Armor failed to conduct adequate self-assessments, provide adequate sick-call procedures, administer medication, refer patients to specialists, and maintain equipment, medical records, and adequate staffing levels.[166]

3. Materiality

The alleged falsity must also be material to payment. [167] Materiality in the false claims context is defined as "having a natural tendency to influence, or be capable of influencing, the payment or receipt of money or property."[168] Government must not explicitly specify that a contractual provision, statute, or regulation is a condition of payment for materiality to attach. However, evidence that a violation is material might include that the government consistently refused to pay claims in other cases based on non-compliance with the same statutory, regulatory, or contractual requirement.

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[161] *Armor* complaint, *supra* note 143, at 7.

[162] *Id.* (Armor agreed to provide "medical, mental health, substance abuse treatment, dental, pharmacy, laboratory and diagnostic services, onsite specialty services (including orthopedic, physical therapy, obstetrics and gynecology, optometry, dialysis and infectious diseases); facilitate off-site specialty services and discharge planning; maintain an infirmary; establish a quality improvement program overseen by a utilization review committee and to adhere to the National Commission on Correctional Health Care standards regarding jail health.").

[163] *Id.* at 8.

[164] *Id.* at 9.

[165] *Id.* at 8.

[166] *Id.* at 3.

[167] N.Y. STATE FIN. LAW § 190(1) (2016).

[168] The definitions for materiality under the federal FCA and New York statute are identical. *See* 31 U.S.C. § 3729 (b)(4) and N.Y. STATE FIN. LAW § 188(5) (2016).

Materiality is a demanding standard that cannot be met where non-compliance is minor or insubstantial.[169] There is insufficient evidence of materiality even where the defendant *knows* that the government would be entitled to refuse payment if she disclosed a contractual violation.[170] A defendant's failure to disclose a violation of a contractual, statutory, or regulatory provision that the Government expressly designates as a condition of payment is only indicative, but not dispositive, of FCA liability.[171]

Materiality may be particularly difficult to establish in the correctional health care context because often, as in *Armor*, the government continues to pay claims despite contractual violations. Under *Universal Health v. Escobar*, there is strong evidence against materiality where the government pays a claim in full despite full knowledge that a certain requirement is violated.[172] In *Armor*, materiality was not explicitly discussed in the petitioner's complaint beyond reference to specific contractual language, which may not be sufficient evidence of materiality under *Escobar*. In fact, the Nassau County Comptroller continued to pay Armor although Armor submitted vouchers that did not include the documentation required by the contract, and the Nassau County Comptroller only suspended payment once NYAG litigation commenced.[173]

There is evidence in NYAG's complaint that Armor's violations were material to the contract. For instance, plaintiffs alleged that Armor failed to fill contractually required clinical mental health staff positions. The Clinical Coordinator position was vacant for nineteen months and the Psychiatric Advanced RNP/PA position was vacant for over a year. The State Medical Review Board determined in two inmate deaths that Armor provided substandard medical care. Specifically, Armor failed to appropriately refer inmates for mental health evaluations, conduct proper assessments, or plan adequately for care, and short-staffing might very well have been material to the quality of care provided, and by extension, to the falsity of the implied certification in subsequent requests for payment.[174]

4. Knowledge

Defendants must have knowledge of the material falsity for liability to attach. NYFCA defines knowledge as actual knowledge of the infor-

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[169] Universal Health Servs. v. United States ex. rel. Escobar, 136 S. Ct. 1989, 1995 (2016).

[170] *Id.*

[171] *Id.*

[172] *Id.*

[173] Bridget Murphy, *Nassau Sheriff Stands by Jail Health Care Provider Armor*, NEWSDAY (Sept. 10, 2016), https://www.newsday.com/long-island/nassau/nassau-sheriff-stands-by-jail-health-care-provider-armor-1.12296093.

[174] *Armor* complaint, *supra* note 143, at 28.

mation, acting with deliberate ignorance of the truth or falsity of the information, or acting with reckless disregard for the truth or falsity of information.[175] Defendants may have actual knowledge of the materiality of a condition for payment even where the government has not expressly described the condition as material for payment.[176] Knowledge may be found where a defendant knows her conduct was "aggressive and risky, and . . . motivated by a desire to gain competitive advantage."[177]

In *Armor*, NYAG did not explicitly plead knowledge of material falsity. Instead, NYAG alleged clear violations of contractual provisions. For example, NYAG alleged that the health care provider submitted vouchers for payment in violation of contractual provisions. Between 2011 and 2015 Armor only conducted 136 of the 240 to 300 self-audits required under contract, and it failed fifty-one percent of its self-assessments.[178] Under contract, Armor was required to create corrective action plans in response to failed audits, and to reduce fees at $100 per day for each plan not completed within forty-five days from the date of occurrence.[179] If this allegation were proved to be true, it might provide knowledge of the violation, as it would be reasonable to assume that Armor read the contract. Further, a daily fee for failing to enact a corrective action plan may actually suggest knowledge of materiality given that the contract included specific monetary penalties for the violation. However, these conclusions are speculative.

5. Standing and recovery

NYFCA is a wholly different species of statute than Section 1983 because of its standing, *qui tam*, and damage provisions. Attorneys general and private citizens may bring actions under the Act. Under Section 190 of the Act, the attorney general has the authority to investigate NYFCA violations and to bring civil actions against violating parties on behalf of New York State or the local government.[180] Section 190 also authorizes and incentivizes *qui tam* actions, whereby private persons litigate under the Act on their own behalf or on behalf of the local government or New York State. The attorney general may elect to supersede

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[175] N.Y. STATE FIN. LAW § 188(3)(a) (2016).

[176] *Universal Health Servs.*, 136 S. Ct. 1989 at 2001 (explaining that "[i]f the Government failed to specify that guns it orders must actually shoot, but the defendant knows that the Government routinely rescinds contracts if the guns do not shoot, the defendant has 'actual knowledge.' Likewise, because a reasonable person would realize the imperative of a functioning firearm, a defendant's failure to appreciate the materiality of that condition would amount to 'deliberate ignorance'…").

[177] People ex rel. Schneiderman v. Sprint Nextel Corp., 970 N.Y.S.2d 164, 173 (N.Y. Sup. Ct. 2013).

[178] *Armor* complaint, *supra* note 143, at 12–13.

[179] *Id.* at 14.

[180] N.Y. STATE FIN. LAW § 190(1) (2016).

or intervene in an action brought by a private individual or she may authorize a local government who has sustained damages to do so within sixty days of filing.[181] The attorney general may not intervene or supersede where the action is brought by a city with a population of one million or more.[182]

Qui tam plaintiffs stand to win sizeable monetary awards in New York if their actions succeed. If the attorney general or local government elects to intervene in a *qui tam* action and wins, the original plaintiff is entitled to between fifteen and twenty-five percent of the settlement.[183] If the attorney general or local government declines to convert the *qui tam* action, successful plaintiffs are entitled to twenty-five to thirty percent of settlement or proceeds.[184] While the incentives are substantial, *qui tam* plaintiffs are liable for the defendant's attorney's fees and other associated costs of litigation in the event the court finds for the defendant and determines that the claim was clearly "frivolous, clearly vexatious, or brought primarily for purposes of harassment."[185]

NYFCA also affords whistleblowers protection against retaliation. Any plaintiff is entitled to relief if they are harassed, threatened, demoted, suspended, or discharged for any lawful conduct associated with a *qui tam* NYFCA claim, or for efforts to stop violations of the Act.[186] The Act protects whistleblowers who violate duties owed to their employer when they submit evidence to the attorney general, local government, *qui tam* plaintiff, or the *qui tam* plaintiff's counsel for the "sole purpose of furthering efforts to stop one or more violations of [NYFCA]."[187] *Qui tam* plaintiffs may also be entitled to relief if a current or prospective employer penalizes her for bringing a claim.[188] Plaintiffs are not required to proceed in their underlying FCA claim to obtain remedial relief for retaliation.[189] They may be entitled to injunctions against discrimination, hiring or reinstatement, payment of two times back-pay, and compensation for special damages, including litigation costs.[190]

IV. IMPLICATIONS

NYFCA might very well provide increased protections against inadequate health care for incarcerated people and against exploitation of taxpayer money by correctional health corporations. For one, NYFCA

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[181] *Id.* § 190(2)(b) (2016).
[182] *Id.*
[183] *Id.* § 190(6)(a) (2016).
[184] *Id.* § 190(6)(b).
[185] *Id.* § 190(6)(d).
[186] New York ex rel. Kurana v. Spherion Corp., No. 15 Civ. 6605, at *17 (S.D.N.Y. Nov. 10, 2016).
[187] N.Y. STATE FIN. LAW § 191(2) (2016).
[188] *Id.* § 191(1) (2016).
[189] *New York ex rel. Kurana*, No. 15 Civ. 6605 at *17.
[190] *Id.* § 191(1).

claims do not carry the same stigma as prisoner litigation under Section 1983. Attorney general involvement gives claims under the Act an air of legitimacy. Indeed, the damage and remedy *qui tam* provisions in the Act suggest that the New York State legislature actually intended to encourage actions pursuant to NYFCA. Other elements of the Act also make it a more promising foothold for correctional health care litigation than Section 1983 and the Eighth Amendment. NYFCA has a longer statute of limitations and a more generous damage provision. Perhaps most importantly, the Prison Litigation Reform Act does not limit potential relief.

However, there are also significant disadvantages to using NYFCA against correctional health care providers to improve care. First, and most importantly, while NYFCA actions can result in extensive and important injunctive relief, they do not make whole the injured, incarcerated people who suffer inadequate medical services. In *Armor*, NYAG requested that the court permanently enjoin the health provider from continuing to violate the NYFCA, that a monitor oversee contract compliance and that the provider be prohibited from bidding in future New York State contracts.[191] While NYAG also sought monetary damages and obtained a monetary award, that money went to the Nassau County coffer, not to those who were permanently, physically injured by Armor, or to the families of the deceased. It could be argued that damages from NYFCA actions indirectly pay Section 1983 awards since counties are often on the hook for those awards, and damages counties receive from successful NYFCA action go directly to their coffers. However, payment in those instances depends on a successful Section 1983 action, which, as discussed *supra*, is an uphill battle.

Relatedly, NYFCA casts government (ultimately the taxpayers), not the injured patient, as the victim of correctional health care contractor fraud. There is some value to this shift in perspective. Successful plaintiffs in Section 1983 actions against health care contractors are rightly compensated for health care mismanagement so severe that it amounts to cruel and unusual punishment under the Eighth Amendment. Not only are these sometimes multi-million dollar settlements often kept secret, but even when they are publicized, taxpayers may not fully comprehend that they are oftentimes paradoxically footing the bill for the health care company *and* the errors in care it knowingly made. Under NYFCA, on the other hand, government is compensated instead of penalized for the mismanagement of private correctional care and whistleblowers may also receive large awards. Incarcerated people who may suffer life-long injuries, or the families of those who have died because of the contract violations, receive no compensation, even if NYFCA may provide evidence useful in a related Section 1983 suit.

Further, NYFCA seems more readily available for enforcement by NYAG, local government, and correctional health care employee whis-

[191] *Armor* complaint, *supra* note 143, at 41–42.

tleblowers than incarcerated people. The Act provides that the attorney general may supersede or intervene in any action under the statute.[192] NYAG is cloaked with all the authority of the state and has considerable expertise on NYFCA enforcement across industries. However, NYAG has limited staff, resources, and industry-specific experience. The discrepancy between the NYAG damages request in its *Armor* complaint and the damages provision in the *Armor* settlement might suggest that NYAG prioritizes enforcing compliance with the law over winning large settlements for itself, local government, and individual harmed parties. Incarcerated people who have already been injured or have died due to health care contractor mismanagement again stand to lose.

Correctional health care employees are also well-suited to enforce NYFCA. They have their own industry expertise, insider knowledge, and access to data which might prove crucial to bringing a successful NYFCA claim. NYFCA provides protections for whistleblowers as well as significant economic incentives.[193] However, employees may reasonably fear reprisal for initiating a *qui tam* action, even though they are theoretically protected against retaliation. Corrections unions have considerable power and may instill fear and loyalty in staff that reduces the chances they will bring an action at all.[194]A *qui tam* action may permanently reduce a whistleblowers job prospects.

Prisoners, on the other hand, may be best suited to appeal their own substandard medical treatment. Some have ample time and considerable legal expertise. They observe and experience inadequate care first hand. Accountability is likely best maintained where the directly harmed have meaningful opportunity to dispute misconduct they themselves experience. NYFCA, however, focuses on the contractual relationship between the county and the health care provider, not on the rights of the prisoner patient. NYFCA does not protect incarcerated plaintiffs from retaliation.[195] Perhaps incarcerated people may be able to bring successful *qui tam* actions, but those actions have yet to be publicized.

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[192] N.Y. STATE FIN. LAW § 190(2)(b) (2016).

[193] *Id.* § 190(6); *id.* § 191 (2016).

[194] Joseph Goldstein, *Suit Accuses Rikers Officers of Illegal Strike*, N.Y. TIMES (Nov., 25, 2013), http://www.nytimes.com/2013/11/26/nyregion/suit-accuses-rikers-officers-of-illegal-strike.html (reporting The New York City corrections officers union refused to transport inmates to court in order prevent inmates from testifying against officers who had assaulted an inmate)*; see generally* Jarrod Shanahan, *Solidarity Behind Bars: NYC's Correction Officers' Benevolent Association*, THE BROOKLYN RAIL (SEPT. 7, 2017), https://brooklynrail.org/2017/09/field-notes/Solidarity-Behind-Bars-NYCs-Correction-Officers-Benevolent-Association (discussing the New York City correction officers' union).

[195] Inmates bringing health care claims risk that correctional staff will retaliate in kind. *See* Kelly Weill, *Lawsuit: Prison Guards Retaliated Against Inmates Denied Health Care*, THE DAILY BEAST (Jul, 24, 2017), https://www.thedailybeast.com/lawsuit-prison-guards-retaliated-against-

Also, local government may under-enforce NYFCA against corrections venders. Sheriffs' departments in particular may actually prove an obstacle to penalizing corrections industry contractors who are accountable for false claims. During Armor's contract with Nassau County, Nassau County Sheriff Michael Sposato defended the company even after the Commission of Corrections investigated five fatalities and published reports that described Armor's medical services as "grossly incompetent."[196] The Nassau County Comptroller's audit found that the Sheriff's Department failed to adequately supervise Armor.[197] Despite deaths and complaints related to Armor's provision of care in Nassau County jails, the Sheriff's Department continued to praise the provider for enhanced inmate health services and renewed its contract in 2015 without presenting any alternative providers to the county legislature for approval.[198] In every state of the county speech since 2012, Sposato lauded the contract as a multi-million dollar savings for taxpayers. At the same time, the county and Armor were defending a Section 1983 action brought by family of one of the deceased, Bartholomew Ryan, which would result in a jury award to the family of $8 million.[199]

In Nassau County, the sheriff is the highest corrections official and provides for all staffing and "care, custody, and control" of detainees, and is appointed by an elected official.[200] Sheriffs may be reluctant to oust their own health care providers because it may reveal that they misjudged or mishandled the bidding process, and because any shortcomings might contribute to liability in a Section1983 litigation.

Local government can present further political conflicts. During the *Armor* litigation, the Nassau County Legislature questioned the County Executive's administration attorney to understand why violations by Armor were not uncovered sooner, only to discover that the administra-

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inmates-denied-health-care (describing how correctional staff retaliated against half of the incarcerated plaintiffs after they testified in an Arizona correctional health care action).

[196] Bridget Murphy, *Nassau Sheriff Didn't Properly Oversee Problem-Plagued Health Care Provider, Audit Says*, NEWSDAY (Oct. 17, 2016), http://www.newsday.com/long-island/nassau/nassau-comptroller-s-audit-says-sheriff-didn-t-provide-adequate-jail-oversight-1.12465579.

[197] *Id.*

[198] Ann Givens et al., *I-Team Exclusive: Nassau Jail Insiders Blame Deaths on Medical Neglect*, NBC (Sept. 8, 2015), http://www.nbcnewyork.com/news/local/Jail-Health-Care-Nassau-County-Rikers-Armor-Correctional-Health-Services-Inmate-Death-Medical-Neglect-325730591.html.

[199] Robert E. Kessler, *Jury Awards Nearly $8M, Finds Armor, Nassau Negligent in Vet's Death*, NEWSDAY (Apr. 12, 2017), http://www.newsday.com/long-island/nassau/federal-jury-finds-armor-nassau-county-negligent-in-death-of-veteran-1.13448250.

[200] *Sheriff's Department*, NASSAU COUNTY, LONG ISLAND, N.Y., https://www.nassaucountyny.gov/1891/Sheriffs-Department.

tion attorney was married to Sheriff Sposato. One legislator characterized the administration attorney's testimony as "incredibly defensive of the sheriff, who happens to be her husband."[201]

It is not yet clear whether NYFCA will develop into an effective tool for correctional health care reform. The elements of the statute itself, particularly the materiality and knowledge requirements, present significant challenges to successful enforcement. Similarly, hostility from law enforcement and local government may undercut the efficacy of the statute against correctional health care companies. Finally, NYFCA does not compensate incarcerated people for their injuries. However, in light of the barriers to reform under Section 1983, and the PLRA in particular, NYFCA may very well present a viable alternative.

CONCLUSION

This paper only discusses some of the many disadvantages and advantages to remedying improper correctional health care through state false claims actions as compared to Section 1983 litigation. Case law on state false claims acts, and the New York State False Claims Act in particular, is in its nascency. At the same time, incarcerated people in jails across the nation are suffering inadequate medical care with life-altering and lethal results. In the jail context, people who have not yet been convicted of any crime are routinely subjected to substandard and life-endangering care. Counties and states are sporadically paying sizeable settlements for unconstitutional medical treatment. All the while, vendors are not providing the services they promised under contract, but they are collecting profit just the same. Correctional health care vendor bidding is driving down the cost of care to artificial lows, even while the cost of care generally is increasing. Indeed, the bidding process itself may exacerbate, if not engender, the very problems this paper addresses.

States, counties, and cities who contract with jail health care providers must strengthen the vendor procurement process if state false claims acts are to provide the relief that state legislatures intended. Contracts should clearly set out expectations and penalties for violations. Local and state government should conduct regular oversight of contracts to determine compliance, with special attention to auditing requirements, staffing levels and credentialing, timely provision of care, and the like. Comptrollers must withhold payment when vendors violate their contracts.

This paper suggests that an alternative to Section 1983 litigation is needed to improve correctional health care, and that state false claims acts might provide a viable foothold for relief. Perhaps private citizens,

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[201] *Nassau Lawmakers Vote to Hire Monitor for Jail Health Provider,* LONG ISLAND NEWS 12 (Sept. 12, 2016), http://longisland.news12.com/story/34745703/nassau-lawmakers-vote-to-hire-monitor-for-jail-health-provider.

and correctional health care staff in particular, will serve as effective whistleblowers in the future. State attorneys general have the most authority under state FCAs to bring claims, and they are accountable to the people through the electoral process. Voters would do well to elect state legislators who will pass false claims acts that prohibit all fraud against state and local government, and to elect local government officials and attorneys general who will enforce those statutes to protect incarcerated people and taxpayers alike.