PRIORITIZING PATIENT PROTECTION: PROSECUTORIAL DISCRETION IN HEALTHCARE FRAUD INVESTIGATIONS

*RYAN P. KNOX**

INTRODUCTION

Healthcare fraud poses a major threat to patients and the United States healthcare system. Estimates place the cost of fraud and abuse at between 10 and 25 percent of total healthcare spending.[1] Given the massive scale of the problem, prosecutors' offices across the country consider healthcare fraud enforcement a top priority.[2]

* J.D., New York University School of Law, 2019; B.S., Health Science, Boston University, 2016. I would like to thank Mary Ann Chirba, Jim Brennan, Victoria Hamscho, Kathryn Morris, Chase Weidner, and the staff editors of the *Annual Survey of American Law* for their thoughtful comments. A version of this Essay was originally prepared for Professor Ellen Biben and Professor Linda Lacewell for the Fall 2018 course Ethics in Government: Investigation and Enforcement at New York University School of Law.

1. David A. Hyman, *Health Care Fraud and Abuse: Market Change, Social Norms, and the Trust "Reposed in the Workmen,"* 30 J. LEGAL STUD. 531, 532 (2001) (10 percent); Jane Kim, *Staying Responsible Within the Healthcare Industry in the Era of the Responsible Corporate Officer Doctrine*, 14 IND. HEALTH L. REV. 129, 130 (2017) ("Fraud and other misconduct across the entire health system accounts for up to $272 billion or more than 25% of overall healthcare budget."). Healthcare fraud is sometimes discussed as healthcare fraud, abuse, and waste. *See, e.g.*, Isaac D. Buck, *Enforcement Overdose: Health Care Fraud Regulation In An Era Of Overcriminalization and Overtreatment*, 74 MARYLAND L. REV. 259, 303 (2015) ("fraud, waste, and abuse"). Another study focusing on waste and overtreatment in the United States healthcare system estimated that one in three dollars is due to waste and concluded that $530 billion in waste, 69 percent of all waste, resulted from unnecessary services, excessive administrative costs, and inefficient delivery of care. *See id*. at 275 (citing Debra Sherman, *Stemming the Tide of Overtreatment in U.S. Healthcare*, REUTERS (Feb. 16, 2012), https://www.reuters.com/article/us-overtreatment-idUSTRE81F0UF20120216 [https://perma.cc/5H3K-5ZPW]; *The Cost of Health Care: How Much is Waste?*, NAT'L ACAD. PRESS, http://resources.nationalacademies.org/widgets/vsrt/healthcare-waste.html (last visited Mar. 10, 2019)).

2. *See* Anthony Kyriakakis, *The Missing Victims of Health Care Fraud*, 3 UTAH L. REV. 605, 607-08 (2015) ("Top law enforcement officials repeatedly describe health care fraud as one of the nation's highest law enforcement priorities, a fact borne out by the most recent FBI Financial Crimes Report, which revealed the number of pending cases for health care fraud in fiscal year 2011 outnumbered those for securities and commodities fraud, financial institution fraud, corporate fraud, money laundering, insurance fraud, and mass marketing fraud.") (citations omitted); Dayna Bowen Matthew, *An Economic Model to Analyze the Impact of False Claims Act Cases on*

Put simply, healthcare fraud is fraud conducted in relation to the provision of or billing for medical services.[3] Offenses include fraudulent billing by healthcare providers, providing unnecessary and potentially dangerous services for financial gain, kickback payments, and false advertising.[4] Prominent cases have ranged from massive schemes of improper billing[5] to doctors purposely misdiagnosing patients with cancer and administering (and billing them for) unnecessary chemotherapy treatments.[6]

Prosecutors have great discretion in their work. They can choose which cases to pursue, which cases to settle, which cases to enter into plea bargains, which statutes to enforce, and how to enforce them.[7] This

Access to Healthcare for the Elderly, Disabled, Rural and Inner-City Poor, 27 AM. J.L. & MED. 439, 440 (2001) ("As early as 1978 the Department of Justice (DOJ) announced that the prosecution of Medicare and Medicaid fraud was one of its top priorities.").

3. *See* Kyriakakis, *supra* note 2, at 612-13 (defining healthcare fraud).

4. Kyriakakis, *supra* note 2, at 616-17; *Off-Label Pharmaceutical Marketing: How to Recognize and Report It*, CTRS. FOR MEDICARE & MEDICAID SERVS. (Oct. 2015), https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/Medicaid-Integrity-Education/Downloads/off-label-marketing-factsheet.pdf [https://perma.cc/3J9Y-M93Z]. A recent review of prosecutions and law enforcement reports identified seven types of healthcare fraud conduct that are commonly prosecuted: (1) No services or items provided; (2) Medically unnecessary services or items provided; (3) Excessive services or items provided; (4) Upcoding (billing for a more expensive service than the one provided); (5) Duplicate claims; (6) Unbundling; and (7) Kickbacks. Kyriakakis, *supra* note 2, at 616-17.

5. *See, e.g.*, Press Release, Dep't of Justice, U.S. Attorney's Office, D. Mass., Mylan Agrees to Pay $465 Million to Resolve False Claims Act Liability Mylan Underpaid Medicaid Rebates on EpiPen (Aug. 17, 2017), https://www.justice.gov/usao-ma/pr/mylan-agrees-pay-465-million-resolve-false-claims-act-liability [https://perma.cc/Q85R-3X93].

6. *See* Kyriakakis, *supra* note 2,at 606 (citing Zlati Meyer, *Oakland County Cancer Doctor Accused of Unnecessary Treatments, Defrauding Medicare of Millions*, DETROIT FREE PRESS (Aug. 7, 2013), http://www.freep.com/article/20130806/NEWS05/308060139/Oakland-Countyoncologist-charged-with-Medicare-fraud, [http://perma.cc/FTM8-FZZY]; Complaint at 2, United States v. Fata, No. 2:13-mj-30484 (E.D. Mich. *filed* Aug. 6, 2013)).

7. *See* Stephanos Bibas, *The Need For Prosecutorial Discretion*, 19 TEMP. POL. & C. R. L. REV. 369, 369 (2010) (discussing the choices and considerations of prosecutors exercising discretion); *see also* Sharon Finegan, *The False Claims Act and Corporate Criminal Liability: Qui Tam Actions, Corporate Integrity Agreements and the Overlap of Criminal and Civil Law*, 111 PENN ST. L. REV. 625, 672 (2007) ("The enforcement of criminal and civil statutes prosecuted by the government necessarily involves prosecutorial discretion in determining what crimes and offenders to prosecute. Government officials seek to enforce statutes in ways which serve the public good. In deciding whether to bring an action, prosecutors consider much more than merely whether a violation of the law has occurred. Prosecutorial discretion involves

discretion is readily apparent when looking at the types of healthcare fraud cases brought by prosecutors across the country. Many, if not most, healthcare fraud cases focus on harm done to federal government health insurance programs (through improper reimbursement) as opposed to harm done to individual patients (through physical harm, improper treatment, or overpayment).[8] Both the cases brought against and the penalties imposed upon entities that commit healthcare fraud support the notion that prosecutors prioritize—and the healthcare fraud enforcement scheme is geared towards—protecting the public fisc over individual public health and welfare.

Attorneys represent the interests and legal positions of their clients.[9] In the case of federal prosecutors, their clients are less clear; they could be representing the United States, the government, the people, an individual victim, or the intangible goal of justice.[10] Federal prosecutors pursuing healthcare fraud investigations could be viewed as attorneys protecting the public—the individual victims of healthcare fraud and those put in danger by the fraudulent actors—or as government attorneys defending the fiscal integrity of the federal government health insurance programs, in particular Medicare and Medicaid.[11] The interests of patients and the federal health programs may not align in all cases or all

incorporating decisions about public benefit and private harm into a calculus regarding whether to pursue an apparent violation of the law.") (citations omitted).

8. Kyriakakis, *supra* note 2, at 625 ("Despite the diversity of harms caused by health care fraud, including the significant physical harms experienced by patients, criminal cases of health care fraud are widely viewed and treated as white-collar crimes that cause only economic harms. The prevailing enforcement paradigm involves treating health care fraud like a traditional fraud offense. Federal agents 'follow the money.' Federal prosecutors charge offenders with seeking to enrich themselves by deceiving and defrauding victims—generally, private insurers and government benefit programs, such as Medicare. And federal judges fashion sentences using sentencing guidelines driven primarily by the amount of economic loss. Under this model, the government recovers billions of dollars annually.").

9. Scott Ingram, *Representing the United States Government: Reconceiving The Federal Prosecutor's Role Through A Historical Lens*, 31 NOTE DAME J.L. ETHICS & PUBLIC POL'Y 293, 293 (2017) ("Attorneys represent clients and advocate their clients' legal positions.").

10. *See id.* at 298 ("There are many possible answers to whom the prosecutor represents. These include the public, victims, law enforcement agencies, United States Attorneys, the Attorney General, the President, and the United States government.").

11. *See* Kyriakakis, *supra* note 2, at 613; *see also* Irene Oritseweyinmi Joe, *The Prosecutor's Client Problem*, 98 BOSTON UNIV. L. REV. 885, 984-904 (considering prosecutor's clients being the victim, the police, the community, the defendant, and the law). Prosecutors are generally viewed as government attorneys and enforcers of the rule of law. *See* Ingram, *supra* note 9, at 303 ("Within these oft-quoted sentences the Court identifies not only the United States government as the prosecutor's client, but also the law").

areas of healthcare fraud, resulting in an ethical dilemma for prosecutors. As prosecutors are viewed primarily as attorneys for the government,[12] this dilemma does not rise to the level of a violation of professional ethics or legal ethics.[13] However, as attorneys acting in the public interest, prosecutors have a duty to the people, but recent decisions prioritize harm to government programs over harm to individual patients, largely removing the patient element that should be central to healthcare fraud enforcement.[14]

This article examines the ethical issues of prosecutorial discretion attendant to healthcare fraud investigations and cases. In particular, it focuses on a tension that arises out of a healthcare prosecutor's role as attorney for the government and for the people. Part I discusses the types of healthcare fraud offenses, the victims of each offense, and the remedies for each offense. Part II considers how prosecutorial discretion impacts which offenses, victims, and remedies are emphasized and the ethical challenges arising from these decisions. Part III explains the options in- and outside of the healthcare enforcement scheme for individual patient-victims to redress their harm and highlights the barriers that patients face to bringing lawsuits. Part IV recommends a reprioritization of healthcare fraud enforcement in order to ensure prosecutors protect not only the government purse but also the people.

12. *See id*. ("The federal prosecutor's origins demonstrate that they represent the United States government.").

13. For a discussion of the scope of prosecutorial discretion in relation to executive priorities and the rules of professional responsibility specific to prosecutors, *see* Amie N. Ely, Note, *Prosecutorial Discretion as an Ethical Necessity: The Ashcroft Memorandum's Curtailment of the Prosecutor's Duty to Seek Justice*, 90 CORNELL L. REV. 237 (2004). Scott Ingram generally concludes that the goal of federal prosecutors is seeking justice and their client is the United States government. *See* Ingram, *supra* note 9, at 338. Throughout the article, Ingram emphasizes the nuance in the prosecutor's role as representative of the United States and the people and the importance of identifying a client in making decisions involving prosecutorial discretion. This article builds upon this nuance to argue that the current prosecutorial decision-making disregards the prosecutor's duty to the people, and while not a violation of professional rules or legal ethics in the sense that they are punishable, it is an ethical dilemma for prosecutors and a policy failure in the healthcare fraud system leading to unethical decisions as a matter of health policy. While I argue that the prosecutorial discretion in healthcare fraud cases raises ethical issues for prosecutors as representatives of the people, it can equally be argued, and is intimated in this paper, that the results of prosecutorial discretion in healthcare fraud cases demonstrate a greater ethical failure on the part of government officials as representatives of the people, *id*. at 303 (discussing representation in the United States government), as their legislative decisions provided greater protection to the public fisc as opposed to individual victims of healthcare fraud.

14. For a discussion of the constitutional basis of prosecutors and government attorneys acting in the public trust as public fiduciaries, *see generally* Robert G. Natelson, *The Constitution and the Public Trust*, 52 BUFF. L. REV. 1077 (2004).

Additionally, Part IV recommends ways for prosecutors to address financial healthcare fraud and noncompliance issues while still prioritizing cases of individual patient harm and patient access to healthcare.

In sum, this article argues that prosecutors' first duty is to the public. Prosecutors should investigate and pursue healthcare fraud cases that have most harmed individual victims and use enforcement mechanisms that enforce healthcare fraud violations without unnecessary harm to access to healthcare. As a result, prosecutors will be able to maximize resources in order to best protect the public health and welfare.

I. HEALTHCARE FRAUD OFFENSES AND ENFORCEMENT

Healthcare fraud encompasses a broad range of conduct and can be prosecuted using several federal as well as comparable state statutes.[15] Healthcare fraud can be treated as general financial corporate fraud and prosecuted under more general statutes. For example, prosecutors can charge mail fraud, wire fraud, conspiracy, and violations of the Racketeer Influenced and Corrupt Organizations (RICO) Act.[16] There is also a specific Healthcare Fraud Statute which prohibits defrauding "any health care benefit program."[17] Some of the other common statutes used in prosecuting healthcare fraud offenses include the federal False Claims Act, the Anti-Kickback Statute, the Stark Law, and their respective state law equivalents.[18] The False Claims Act generally prohibits individuals or companies from submitting a fraudulent reimbursement to the government.[19] The Anti-Kickback Statute "broadly criminalizes the

15. *See* Joan H. Krause, *Teaching Fraud and Abuse Law*, 61 ST. LOUIS L. J. 457, 458-59 (2017); Joan H. Krause, *A Patient-Centered Approach To Health Care Fraud Recovery*, 96 J. CRIM. L. & CRIMINOLOGY 579, 584 (2006) ("Health care fraud is actionable under a wide range of federal criminal, civil, and administrative statutes."); Kyriakakis, *supra* note 2, at 613 ("In a review of all reported prosecutions of health care providers between 1908 and 1988, one scholar found thirty different statutes were used to prosecute health care providers in federal courts and twenty statutes were employed in state courts.").

16. Krause, *Patient-Centered*, *supra* note 15, at 585.

17. 18 U.S.C. § 1347 (2012).

18. Joan H. Krause, Skilling *And The Pursuit Of Healthcare Fraud*, 66 U. MIAMI L. REV. 363, 367 (2012) [hereinafter Krause, *Pursuit*]; Krause, *Patient-Centered*, *supra* note 15, at 584 ("Some of these [healthcare fraud] laws, such as the Medicare and Medicaid Anti-Kickback Statute, the 'Stark Law' prohibition on physician self-referral, and the provisions governing exclusion from the federal health care programs, specifically target improper health care activities.").

19. 31 U.S.C. §§ 3729–3733 (2012); *see also* Hyman, *supra* note 1, at 535.

solicitation or receipt of remuneration in connection with items or services for which payment could be made under Medicare or Medicaid."[20] The Ethics in Patient Referrals Act of 1989, commonly called the Stark Law, "prohibits physicians from referring Medicare and Medicaid patients to ancillary providers in which they or their family members hold a financial interest and prohibit service providers from billing for services performed as a result of [these prohibited] referrals."[21]

Each statute prohibits some type of conduct that financially harms a federal government program. For instance, the Anti-Kickback Statute prohibits kickback payments related to Medicare and Medicaid services.[22] While in some ways the Anti-Kickback statute "seeks to limit the influence of financial incentives over health care referral decisions,"[23] its enforcement focuses on the financial impact on the federal government, not on the harm to the patient. Similarly, the Stark Law applies only to "designated health services," which, by definition, are "payable, in whole or in part, by Medicare,"[24] and the False Claims Act penalizes fraud to federal health programs, independent of harm to any individual patient.[25]

In addition to covering different activities, these statutes also give rise to a variety of penalties and remedies. False Claims Act violations leave defendants liable for civil penalties between $5,500 and $11,000 per violation and treble damages (three times the government's loss due to the fraudulent claims).[26] Anti-Kickback Statute violations can result in five years imprisonment, a $25,000 fine per violation, and exclusion from federal healthcare programs.[27] Stark Law violations can lead to penalties of up to $15,000 per service, treble damages (three times the monetary penalty), and exclusion from federal health programs.[28] Generally, felonies lead to mandatory exclusion from federal health programs while misdemeanors lead to permissive exclusion, giving prosecutors and the Secretary of Health and Human Services discretion to enforce exclusion.[29] With such a range of potential penalties,

20. Hyman, *supra* note 1, at 534-35; *see* 42 U.S.C. § 1320a-7b(c) (2012).
21. Hyman, *supra* note 1, at 535*; see* 42 U.S.C. § 1395nn (2012).
22. *See* 42 U.S.C. § 1320a-7b (2012).
23. Krause, *Pursuit*, *supra* note 18, at 370.
24. 42 U.S.C. § 1395nn (2012).
25. Kyriakakis, *supra* note 2, at 615; *see* 31 U.S.C. §§ 3729–3733 (2012).
26. 31 U.S.C. §3729(a)(1) (2012).
27. 42 U.S.C. §1320a-7b(c) (2012).
28. 42 U.S.C. §1395nn(g) (2012); 42 U.S.C. § 1320a-7 (2012).
29. *See* DAVID W. OGDEN & ELISABETH COLLINS COOK, U.S. CHAMBER INSTITUTE FOR LEGAL REFORM, THE EXCLUSION ILLUSION: FIXING A FLAWED HEALTH CARE

prosecutors must balance the benefits and challenges of each option when making charging decisions.

II. DISCRETION AND ETHICAL TENSIONS IN HEALTHCARE FRAUD ENFORCEMENT

Given the array of potential charges and remedies available to them, prosecutors have a great deal of discretion in whether to prosecute a healthcare actor, which charges to bring, and which remedies to seek.[30] Especially in complex cases, prosecutors have discretion in enforcement over "which harms and which victims to focus on."[31] Some factors taken into consideration with enforcement priorities include agency and government priorities, criminal justice system incentives, and prosecutors' and investigators' interest in improving arrest and indictment statistics.[32] In practice, however, that discretion tends to result in prosecutors prioritizing one type of healthcare fraud offense: economic harms to federal government health programs. In emphasizing cases with great financial harm over individual patient harm, prosecutors have demonstrated a value judgement. Effectively, by prioritizing and putting more resources towards healthcare fraud offenses that harm the government, prosecutors have prioritized their duty to represent the federal health programs over their duty to represent and protect the people.

The problems associated with this prioritization become clear when they are considered alongside a salient feature of the healthcare fraud prosecution scheme. Namely, given the variety of potentially suitable charges and penalties, prosecutors have tremendous negotiating power.[33] Admittedly, jail time is rare and exclusion from federal programs even rarer.[34] However, even the risk of imprisonment, exclusion from federal healthcare programs, and/or mounting fines and penalties can effectively end or suspend the career or institutional existence of the healthcare actor.[35] Facing these potentially disastrous consequences, many

ENFORCEMENT SYSTEM 9-10 (2012); Tim Drake et al., *Health Care Fraud*, 50 AM. CRIM. L. REV. 1131, 1176-1177 (2013).

30. Krause, *Pursuit*, *supra* note 18, at 367-68.

31. Kyriakakis, *supra* note 2, at 630.

32. *Id*.

33. Joseph W. Golinkin II, Note, *Fishing With Landmines: Healthcare Fraud And The Civil False Claims Act – Where We Are, How We Got Here, And The Case For More Trials*, 40 AM. J. CRIM. L. 301, 302 (2013).

34. OGDEN & COOK, *supra* note 29, at 8-18 (reviewing potential and common remedies in healthcare fraud cases).

35. *See id*. at 10; Golinkin, *supra* note 33, at 302 (referring to exclusion from federal health programs as a death sentence).

healthcare actors have few meaningful choices and seek plea or settlement agreements.[36] As a result, fewer and fewer healthcare fraud cases are going to trial, and prosecutors are reaching settlements for increasingly large amounts.[37] In 2018, the federal government collected $2.5 billion in healthcare fraud judgments and settlements.[38]

These settlements raise several ethical considerations for healthcare fraud prosecutors. First, prosecutors have personal and financial incentives to pursue these federal government-focused cases that often result in large settlements. Healthcare fraud enforcement programs are in large part funded by awards and settlements from these investigations.[39] This incentivizes prosecutors to investigate and charge companies with significant financial means (who will be able to pay penalties) and to reach large settlements.[40] In practice, this could incentivize prosecutors to charge companies on less than adequate evidence who may in fact be

36. OGDEN & COOK, *supra* note 29, at 4-5.

37. Golinkin, *supra* note 33, at 302 ("When dealing with healthcare companies, the government possesses unique powers that they can deploy to coerce opposing parties to waive their right to a trial. Specifically, federal prosecutors can threaten defendants with exclusion from Medicare and Medicaid. For a healthcare company, exclusion amounts to a death sentence—'large organizations have such a large stake in avoiding exclusion from Medicare that they readily settle pending charges, making much of fraud control resemble a rebate program more than a law enforcement exercise.'").

38. *See* Press Release, U.S. Dep't of Justice, Office of Pub. Affairs, Justice Department Recovers Over $2.8 Billion from False Claims Act Cases in Fiscal Year 2018 (Dec. 21, 2018), https://www.justice.gov/opa/pr/justice-department-recovers-over-28-billion-false-claims-act-cases-fiscal-year-2018 [https://perma.cc/G8V2-AMZ5].

39. Kyriakakis, *supra* note 2, at 643-44. Specifically, the FBI, HHS, and the United States Attorney's Offices "have a significant interest in maximizing the health care fraud recoveries that fund" directly or indirectly their future budgets. *Id*. at 644; *see also* Joan H. Krause, *A Conceptual Model of Health Care Fraud Enforcement*, 12 J. L. & POL'Y 55, 60-61 (2003) (explaining that "The DOJ and OIG benefit in both direct and indirect ways from these appropriations [the Health Care Fraud and Abuse Account which is funded by Congress and healthcare fraud cases]. Directly, this guaranteed source of funding has permitted the hiring of additional FBI and OIG agents assigned specifically to health care fraud. Indirectly, a form of an attenuated 'bounty' system exists, whereby some of the money collected from health care fraud recoveries is available for appropriation back to the enforcement agencies. HIPAA directed the bulk of these recoveries to be deposited into the perennially near-insolvent Medicare Part A Trust Fund. A significant portion of this money, however, can be appropriated back to the Health Care Fraud and Abuse Control Account to fund future law enforcement activities. As one commentator has noted, 'although this is not a pure bounty system, it is much closer than had previously been the case.'").

40. Kyriakakis, *supra* note 2, at 643-44.

innocent,[41] and to reach large and potentially unfair settlements with these companies using the threat of destructive remedies (both financial penalties and exclusion). Further, the benefit to the prosecutors' office incentivize them to focus specifically on these cases that cause large financial harm to the government—and will in turn likely result in funding of their future investigations—as opposed to harms to individual patients. There are benefits from these settlements in deterring future healthcare fraud and maintaining the liquidity and integrity of federal health programs. While this may not in itself violate a prosecutors' ethical duties, as the financial benefit to the prosecutor's office is indirect and indefinite, the personal financial incentive for prosecutors' offices may give rise to questions about the integrity of healthcare fraud enforcement actions.[42]

Second, the large settlements may also "create a substantial disincentive to contract with the government, and at a time when there are difficulties keeping providers in the Medicare and Medicaid markets."[43] The magnitude of this deterrence should not be such that

41. *But see id*. at 631 ("[P]ressures to hasten the completion of investigations do not seem to have led to an epidemic of half-baked criminal charges unsupported by sufficient evidence.").

42. *See* Finegan, *supra* note 7, at 673 ("Further, public prosecutors are forbidden from having a pecuniary interest in the outcome of litigation that they pursue on behalf of the government. This ensures that prosecutorial discretion is exercised solely for the benefit of the public and not for the personal gain of the prosecutor. Thus, prosecutorial discretion is an essential tool in ensuring that actions pursued by the government serve the public and do not impinge unnecessarily on liberty interests."); Krause, *Model*, *supra* note 39, at 60-61 (discussing the indirect bounty system where prosecutors offices can be funded in part by healthcare fraud recoveries). Even so, the existence alone of this financial interest, though attenuated, has raised concern. Many in the healthcare provider community view the funding system as a "a self-perpetuating enforcement machine" and argue that "[r]ewarding those who enforce Medicare fraud and abuse regulations with more program funds creates strong institutional incentives for those enforcers to pursue as many investigations and fraud and abuse prosecutions as possible, thus increasing the risk that the innocent as well as the guilty will suffer punishment." *See* Krause, *Patient-Centered*, *supra* note 15, at 597-98 (quoting Jonathan Emord, *Murder by Medicare: The Demise of Solo and Small Group Medical Proactices*, 21-3 REGULATION 31, 32 (1998)); *see also* Joan H. Krause, *Regulating, Guiding, and Enforcing Health Care Fraud*, 60 N.Y.U. ANN. SURVEY AM. L. 241, 247 (2004) [hereinafter Krause, *Regulating*] ("What is clear is that the federal government now characterizes health care fraud enforcement as protecting both *patients* and the *federal Treasury*.") (emphasis in original). This personal benefit might even be viewed as particularly unseemly in the healthcare fraud context, as prosecutors are often going after healthcare providers who receive some personal benefit (though potentially indirect or tangential) in violation of the Anti-Kickback Statute or the Stark Law, when they themselves receive some indirect benefit to their office through that very prosecution.

43. Hyman, *supra* note 1, at 540.

healthcare providers who could be helping patients are disincentivized from working with the federal government. Healthcare fraud enforcement should protect patients, not put their access to healthcare at risk.

The remedy of exclusion from federal government healthcare programs also raises significant ethical and public health concerns. The threat of exclusion from federal health programs can be coercive. While government health insurance programs can survive excluding a single company, virtually no company or healthcare provider can survive being excluded from all federal health programs.[44] These potential consequences are too severe and cause many healthcare companies and individual healthcare actors to accept plea agreements and settlements that may not be necessary or desirable because of the threat of a worse outcome.[45] This ethical challenge goes beyond whether seeking exclusion in cases harming the government is ethical considering the desire for a settlement, also calling into question whether this type of remedy benefits and protects the public. Removing a healthcare company from the market for non-compliance without active harm to the public does not protect public health and welfare. Quite the opposite: it can threaten patient access to necessary healthcare services, especially in communities where there are fewer healthcare providers and in healthcare markets where there are few alternative treatment options. Prosecutors seeking this remedy prioritize the public fisc, punishing and making an example of companies who have not properly billed the federal government. In cases where the healthcare entity poses a risk to patients, federal exclusion is justified. However, its coercive nature and potential for decreased patient access to healthcare must be considered by prosecutors in healthcare fraud cases.

Prosecutorial discretion allows prosecutors to choose cases and seek remedies, but as government attorneys acting in the public trust, these choices should be scrutinized. Current healthcare fraud cases prioritize harm to the government, and prosecutors disregard their duty to individual patients and do nothing to provide remedies to patient victims, whether their harm be physical or economic. Healthcare fraud enforcement priorities should be reformed so that prosecutorial discretion is used to protect patients, not just the federal government.

44. OGDEN & COOK, *supra* note 29, at 5.

45. *Id.* at 4-5.

III. LACK OF PATIENT REMEDIES

In addition to the remedies sought by the government, the remedies and recourse available to individual patient victims must be considered in addressing the healthcare fraud enforcement scheme and prosecutorial choices. Healthcare fraud settlements almost never benefit individual patients; there is no system to distribute settlement funds to patients, often leaving individual victims without remedies.[46] There is limited ability for patients to pursue redress on their own. Of the three major healthcare fraud statutes discussed in this Article, only the False Claims Act has a private right of action.[47] The False Claims Act allows individuals to bring cases on behalf of the government: these are called *qui tam* actions.[48] Individuals bringing *qui tam* cases are entitled to a share of the settlement, in the range of 15 to 30 percent.[49] While the individual can bring the action and benefit financially from it, they are redressing an individual harm: they are benefitting from notifying the government of the conduct and assisting the government in the case.[50]

There are other legal means for patients to remedy their individual harms from harmful healthcare fraud actions by providers. Patients could bring medical malpractice claims if the doctor acted negligently by providing unnecessary treatments during the fraudulent scheme.[51] However, very few patients actually file claims for medical negligence.[52]

46. *See* Krause, *Patient-Centered*, *supra* note 15, at 596 ("Despite the influx of dollars from successful fraud enforcement, the current law provides few avenues for these funds to be allocated directly to injured beneficiaries. . . In a civil false claims act, for example, a portion of the proceeds (usually 15-30%) will be awarded to any *qui tam* relator(s) who initiated the suit. Most of the remaining funds – as well as those recovered from civil monetary penalties, other civil assessments, and criminal fines or forfeitures – are deposited into the perennially near-insolvent Medicare Part A Trust Fund.") (footnotes omitted).

47. *See* 31 U.S.C. § 3730(b) (2012) (*qui tam* provisions).

48. *See id*.; Finegan, *supra* note 7, at 627-28.

49. *See* 31 U.S.C. § 3730(b) (2012).

50. Krause, *Model*, *supra* note 39, at 137-38 (citations omitted) ("Although the drafters of the 1986 FCA amendments envisioned qui tam relators as helpful sources of information that otherwise would not have been available to the government, the reality has been quite different. The Supreme Court has acknowledged this, cynically concluding that "qui tam relators are . . . motivated primarily by prospects of monetary reward rather than the public good." Critics have argued that the FCA qui tam provisions undermine prosecutorial discretion by permitting relators to maintain suits that the government has declined to join, and by requiring the government to expend significant resources to review voluminous qui tam filings.").

51. *See* Kyriakakis, *supra* note 2, at 644.

52. *See generally* David A. Hyman & Charles Silver, *Medical Malpractice Litigation and Tort Reform: It's the Incentives, Stupid*, 69 VAND. L. REV. 1085, 1089

This could be related to lack of awareness that they have a claim, inability to find an attorney who will take the claim, or inability to afford an attorney.[53] Within this context, the importance of prosecutors' emphasizing patient harm in their healthcare fraud enforcement actions is clear. Healthcare fraud actions protecting individual patients, regardless of the remedy, protect the public health and represent the interests of individual victims who may not be able to represent themselves.

IV. PROSECUTORIAL DISCRETION AND REPRIORITIZING HEALTHCARE FRAUD ENFORCEMENT

The current healthcare fraud enforcement system is unethical and could lead to counterproductive results. Enormous settlements place huge risk and burden on healthcare companies at the expense of patient safety.[54] Exclusion from federal health programs is a catastrophic threat to healthcare companies, incentivizing companies to accept unfair plea agreements and settlements. Where exclusion is enforced for financial frauds and regulatory noncompliance, prosecutors may put patients access to healthcare at risk even where healthcare providers have not put patients at risk.

Overall, the healthcare fraud enforcement system must become more patient-centered.[55] Cases should focus more on harms to individual patients—cases where individual victims have been harmed by unnecessary or improper treatment knowingly administered for financial gain—and on remedies that do not put patient access to healthcare at risk. In prioritizing these cases, prosecutors better fulfill their role as lawyers protecting public health and welfare and not corporate compliance monitors.

Prosecutorial discretion has been identified before as a means to protect the legitimacy of the healthcare fraud enforcement scheme,[56] and

(2006) ("At the highest level, one can compare the estimated number of medical injuries—more than one million per year—to the number of malpractice lawsuits filed nationwide— approximately 85,000 annually. With about ten times as many injuries as malpractice claims, the only conclusion possible is that injured patients rarely file lawsuits.") (footnotes omitted); Joanna Shepherd, *Uncovering the Silent Victims of the American Medical Liability System*, 67 VAND. L. REV. 151 (2014). *See also* Kyriakakis, *supra* note 2, at 648-50 (discussing the potential for medical malpractice claims and the findings of Joanna Shepherd's article).

53. *See generally* Hyman & Silver, *supra* note 52; Shepherd, *supra* note 52.

54. OGDEN & COOK, *supra* note 29, at 2.

55. *See generally* Krause, *Patient-Centered*, *supra* note 15.

56. Joan H. Krause, *Health Care Providers and the Public Fisc: Paradigms of Government Harm Under the Civil False Claims Act*, 36 GA. L. REV. 121, 214 (2001)

it can and should be used to adjust the current healthcare fraud enforcement priorities. Prosecutors working on healthcare fraud investigations and cases going forward should prioritize cases where the harm was directed at individual patients over government programs. This model has several benefits. In terms of public health and safety, emphasizing individual patient victims better protects the public from dangerous healthcare companies and doctors. While focusing prosecutorial resources on economic harms to the public fisc is important to maintain the integrity and liquidity of the system, it does little to protect patients from bad healthcare actors. Cases where companies fraudulently advertised or distributed a dangerous or potentially ineffective product and cases where a doctor administered unnecessary and potentially dangerous medical treatments pose a significantly greater risk to society. Prosecutors could use healthcare fraud enforcement to punish bad actors for their economic harm to the system while redressing the harm to the individual patient victims. This model of healthcare fraud enforcement would be truer to the prosecutor's duty as lawyer for the people. By focusing on individual patient harm and healthcare entities that are a threat to public health, prosecutors prioritize the public welfare and safety. In doing so, prosecutors would better fulfill their role as lawyers for the people, not enforcers of healthcare compliance.

This is not to say that prosecutors should completely disregard financial fraud to federal health programs; prosecutors should continue to investigate and try these cases but should emphasize alternative remedies to exclusion and massive settlements. For example, increasing the use of deferred prosecution agreements, corporate integrity agreements, and internal and external corporate compliance and oversight programs would better accomplish many of the goals of healthcare fraud enforcement without raising the ethical questions of the current potentially coercive settlement regime.[57]

Deferred prosecution agreements (DPAs) allow prosecutors to bring charges, defer prosecution of those charges, and eventually drop

("[P]rosecutorial discretion should be exercised so as to minimize unfairness resulting from fraud investigations concerning good faith interpretations of ambiguous provisions.").

57. OGDEN & COOK, *supra* note 29, at 6; *see also id*. at 7 ("Indeed, the proposed approach would give companies powerful incentives to adopt and maintain state-of-the-art corporate integrity programs. But this new approach would also mitigate the extremely counterproductive aspects of the current regime—the unfairness and enormous inefficiencies produced by the outsized leverage it places in the hands of government lawyers and agents and the way it functionally ousts the courts from their role of applying and articulating the law and protecting the rights of the accused.").

the charges altogether, if the terms of the agreement are followed.[58] DPAs generally involve implementation of corporate governance and compliance programs that are stricter than general corporate integrity agreements.[59] For prosecutors, DPAs result in essentially an admittance of guilt and a program to improve compliance; both prosecutors and the company benefit by avoiding the company's exclusion from federal health programs.[60] Prosecutors have recognized the effectiveness of DPAs in the healthcare fraud context, explaining that DPAs "can achieve substantial corrective actions while preserving prosecutorial resources and protecting providers such as hospitals and the patients who rely on them."[61] This is not to say DPAs are without their own challenges and limitations. For one, DPAs have "little or no judicial oversight" and the agreement and its enforcement are left exclusively to the prosecutor.[62] Some DPAs have been criticized and accused of prosecutorial overreaching.[63] As current prosecutorial discretion in healthcare fraud enforcement is prioritizing financial harms and seeking

58. *See* Paul W. Shaw & Benjamin M. Welch, *The Use of Deferred Prosecution Agreements in Healthcare Fraud Cases, in* AHLA-PAPERS P09230735, 602 (2007) ("A DPA results in the health care entity avoiding the potential adverse consequences of a criminal conviction, such as exclusion from continued participation in the Medicare and Medicaid programs. At the same time, the requirements of a DPA can be much more onerous than a traditional corporate integrity agreement entered into following a criminal investigation."); Brittney Nagle, Note, *Dead on Deferral?: Whether to Prosecute Companies That Fail to Comply with DPAs*, 3 N.Y.U. PROCEEDINGS 41, 42 (2018) https://proceedings.nyumootcourt.org/2018/02/dead-on-deferral-whether-to-prosecute-companies-that-fail-to-comply-with-dpas/ [https://perma.cc/6DEJ-FABP] ("Under a DPA, a defendant, in this context usually the corporation itself, agrees to waive indictment and be charged criminally, and in exchange the prosecutor agrees to defer criminal charges under the condition that the defendant fulfills certain conditions within a specified time.") (citing Steven R. Peikin, *Deferred Prosecution Agreements: Standard for Corporate Probes*, N.Y. L.J. (Jan. 31, 2005), http://www.newyorklawjournal.com/id=900005422568/Deferred-Prosecution-Agreements:-Standard-for-Corporate-Probes?slreturn=20140117032629). Another possible and related type of agreement that could be used in healthcare fraud enforcement would be non-prosecution agreements (NPAs). NPAs involve the government agreeing to drop the charges in exchange for the healthcare fraud offender, usually a corporation, reforming its corporate practices. *See* John T. Boese et al., *Healthcare Behind Bars: The Use of Criminal Prosecutions in Forcing Corporate Compliance*, 3 J. HEALTH & LIFE SCI. L. 91, 116-17 (2009).

59. *See* Shaw & Welch, *supra* note 58.

60. *See id*.

61. *See id*. (citing Peyton M. Sturges, *Increase in Quality of Care Data Spur Actions Targeting Failure of Care*, 16 Health L. Rep. (BNA) No. 6 at 167 (Feb. 8, 2007)).

62. *See id*.

63. *See id*.

large financial settlements, DPAs as a solution may exacerbate some existing problems. Still, DPAs may be a good tool to redirect resources from cases focusing on financial harms to patient harms and allow prosecutors to place greater focus on the impact of the agreement on public health and access to healthcare. These long-term approaches are better and more sustainable systems, to prevent economic-focused healthcare fraud in large organizations and to improve compliance with healthcare regulations.

While the conflict in the prosecutors' role in these actions would not be removed—as the prosecutor inevitably is still a government lawyer, representing the government interest, and a lawyer for the public—this prioritization would mitigate the ethical dilemma when a prosecutor enters a larger healthcare settlement or excludes a healthcare actor from federal health programs. Going forward, prosecutors should work to better fulfill their role as an attorney protecting the public health by investigating and pursing healthcare fraud cases that have most harmed individual victims and by working to remedy individual victim harms.

CONCLUSION

Healthcare fraud is and will continue to be a major concern. Prosecutors' offices across the country should continue to prioritize healthcare fraud enforcement but should place greater emphasis on healthcare fraud offenses that harm individual patients as opposed to only those that cause economic harms to federal government health insurance programs. As government attorneys, prosecutors represent both the public and the government, and thus face an inherent conflict when exercising prosecutorial discretion in healthcare fraud cases. Reprioritizing healthcare fraud offenses harming individual patients over economic harms to federal government healthcare programs will result in prosecutors better fulfilling their role as attorneys protecting the public, not personal attorneys of government agencies.