UIC Law Review

Volume 29 | Issue 4 Article 6

Summer 1996

Third Party Liability or the False Claims Act: It Is Time for Consultants to Pay the Price for Their Bad Advice, 29 J. Marshall L. Rev. 923 (1996)

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NOTES

THIRD PARTY LIABILITY OR THE FALSE CLAIMS ACT: IT IS TIME FOR CONSULTANTS TO PAY THE PRICE FOR THEIR BAD ADVICE

UNITED STATES V. DOLE[1]

Hillary Dole is an experienced registered nurse, most recently employed as the head nurse at County Memorial Hospital's adult and pediatric wing. Her husband, Newt, has held a string of jobs that generally included accounting, bookkeeping and office management responsibilities in small enterprises. Although they were financially comfortable, the Doles were interested in a retirement investment. After looking into a number of investment possibilities, they decided to invest their life savings in a home health agency. They hoped that such an investment would provide a stable income and, ultimately, a financial gain on the sale of the business when they eventually decided to retire.

To this end, the Doles purchased a small existing facility with the intention of expanding the business. Shortly after the sale, several consultants approached the Doles offering their expertise in the area of Medicare and Medicaid reimbursement. Many of the consultants pointed out that the client list the Doles acquired included a very high proportion of Medicare patients and that, as a result, the business was greatly dependent upon Medicare revenues for its operating capital. Since the Doles had no

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1. This hypothetical case illustrates the danger to operators of Medicare-certified agencies who rely on unscrupulous third party consultants. The nature of Medicare cost reporting often requires the service of consultants because individuals who are unfamiliar with Medicare cost reporting will find difficulty in acquiring even a working knowledge of the process. See *infra* notes 29-32 and accompanying text for a discussion of the economic necessity of Medicare cost reporting consultants. Federal law requires that the Health Care Finance Administration must certify health care providers before they may provide services to Medicare patients. 42 C.F.R. §§ 489.1-489.18 (1995).

Consultants provide individuals with the opportunity to participate in Medicare without first obtaining the necessary cost reporting expertise. See *infra* notes 29-32 and accompanying text for a discussion of the economic necessity of Medicare cost reporting consultants. There are, unfortunately, many consultants who prey on unsuspecting providers, promising their clients additional cash flow. This Note seeks to hold such consultants liable for the fraud contained in the cost reports of their unwitting clients.

previous direct experience with Medicare cost reporting, they decided to hire Dewey Cheatham, a consultant, to assist them.

The Doles agreed to pay the consultant a flat fee for the basic filing of the annual Medicare cost report. Additionally, the consultant agreed to suggest certain strategic cost reporting procedures. The contract provided that if the Doles included Cheatham's modifications in the annual cost report, the Doles would pay Cheatham a percentage of any additional Medicare revenues resulting from such suggestions. Cheatham identified several potential enhancements to the Doles' cost report, each of which would increase Medicare reimbursement. Impressed with Cheatham's recommendations, the Doles implemented all of the suggestions in their annual cost reports for their first three fiscal years.

After the Doles filed their third annual Medicare cost report, the Department of Justice seized the records of the Doles' home health agency. Agents from the Department informed the Doles that the seizure resulted after an eighteen-month investigation for Medicare fraud. The government terminated all Medicare payments and indicted the Doles for filing numerous false claims with the federal government. The false claims were directly related to cost report modifications recommended by the consultant. Although the Doles claim to have had no knowledge of any fraudulent cost reporting activities, they are now facing civil and criminal fines, penalties and forfeitures of nearly $500,000, as well as the possibility of several years of imprisonment.[2] While the Doles now face severe legal penalties for their naivete, the unscrupulous Cheatham walked away from the incident, leaving the Doles to suffer the consequences alone.

INTRODUCTION

The number of cases against people like the Doles is growing at an astonishing rate.[3] In light of the recent focus on Medicare fraud prevention, this Note analyzes the ability of the federal government to hold Medicare and Medicaid cost reporting consultants liable for the fraud and abuse typically ascribed solely to their clients.[4] The purpose of this Note is to establish that the federal

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2. See *infra* notes 12-13, 21-23, 50 and accompanying text for a description of the magnitude of liabilities for Medicare fraud.

3. See as recent examples of Mediare Fraud litigation, United States v. Erickson, 75 F.3d 470 (9th Cir. 1996); United States v. Henry, [1994-1 Transfer Binder] Medicare & Medicaid Guide (CCH) ¶ 41,995 (6th Cir. Nov. 29, 1993); United States v. Calhoon, 859 F. Supp. 1496 (M.D. Ga. 1994); United States v. Mickman, No. CIV.A.89-7826, 1993 WL 541683 (E.D. Pa. Dec. 22, 1993), *aff'd*, 52 F.3d 318 (3d Cir. 1995).

4. New government initiatives, as well as this Note, will focus on fraud and abuse problems in the health care industry. See *infra* notes 10-11 and accompa-

government can, and should, charge the responsible third parties for the fraud attributable to their clients under at least three theories: 1) Third Party Theory, or Reliance Theory; 2) Criminal Conspiracy Theory; and 3) Causation Theory.

Part I of this Note discusses the increasing grasp of Medicare fraud and the government's response to this serious problem. Part II outlines the purpose of the Medicare cost report, as well as the responsibilities associated with cost report submission. Part III examines state law doctrine and the federal courts' treatment regarding third party liability. Part III also discusses the applicability of the Reliance Theory to Medicare fraud. Part IV examines the Federal False Claims Act and its applicability to third party consultants in Medicare cost reporting. The Criminal Conspiracy and the Causation Theories are actions under the penumbra of the False Claims Act. Thus, Part IV discusses these theories as well. Finally, Part V advocates the federal prosecution of Medicare consultants individually or jointly with their clients to recover some portion of the billions of tax dollars lost annually to Medicare fraud.

I. BACKGROUND

In 1994, the federal government spent roughly $162 billion on the Medicare and Medicaid programs.[5] Various sources estimate that as much as ten percent, or $16.2 billion, of the 1994 Medicare budget now lines the pockets of criminals.[6] Due to the ever-growing losses to fraud,[7] fraud loss prevention is currently a

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nying text for a discussion of "Operation Restore Trust."

5. *See Medicare Hearings on Controlling Costs and Improving Care: Hearings Before the Subcomm. on Health of the House Comm. on Ways and Means*, 104th Cong., 1st Sess. 76 (1995) (statement of William J. Scanlon, Associate Director, U.S. General Accounting Office).

6. *See Waste, Fraud and Abuse in the Medicare Program: Joint Hearing Before the Subcomm. on Health and Environment and Subcomm. on Oversight and Investigations of the House Comm. on Commerce*, 104th Cong., 1st Sess. 65, 67 (1995) [hereinafter *Waste, Fraud and Abuse*] (statement of Michael F. Mangano, Principal Deputy Inspector General, Department of Health and Human Services); *Gaming the Health Care System: Trends in Health Care Fraud: Hearing Before Senate Special Comm. on Aging*, 104th Cong., 1st Sess. 66 (1995) [hereinafter *Gaming the System*] (statement of June Gibbs Brown, Inspector General, Department of Health and Human Services).

7. 141 CONG. REC. S1116 (statement of Sen. Hatch). Experts estimate that fraud bleeds the Medicare and Medicaid programs of five to ten percent of their total annual outlay. *Id.* In the 1980 federal fiscal year, the Medicare program cost American taxpayers $34 billion. *Waste, Fraud and Abuse*, *supra* note 6, at 67. Of that, fraud claimed an estimated five to ten percent, or $1.7 to $3.4 billion. 141 CONG. REC. S1116 (statement of Sen. Hatch). Ten years later, in federal fiscal year 1990, the Medicare program cost $107 billion. *Waste, Fraud and Abuse*, *supra* note 6, at 67. Again applying the historical five to ten percent annual fraud loss esti-

prominent item on the agendas of various federal agencies, especially those which interact with and administer the Medicare and Medicaid programs.[8] U.S. Attorney General Janet Reno recently stated that she wants to "[l]et the message be very, very clear. We have made health care fraud a priority and we will pursue it as vigorously as we can."[9]

Demonstrating the Clinton Administration's commitment to eradicating Medicare and Medicaid fraud, the Department of Health and Human Services ("HHS") introduced a comprehensive effort to combat the problem. In May, 1995, a joint effort known as Operation Restore Trust became the latest and perhaps the broadest-reaching weapon in the war against fraud.[10] Operation Restore Trust involves the coordinated efforts of the Federal Bureau of Investigation, the HHS and state law enforcement officials, and focuses on problems in the skilled nursing facility (SNF), home health agency (HHA) and durable medical equipment

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mate, the 1990 Medicare budget contributed $5.35 to $10.7 billion to illicit coffers. 141 CONG. REC. S1116 (daily ed. May 22, 1995) (statement of Sen. Hatch). Budgeted expenditures for the Medicare program alone, together with estimates for fraud loss based on historical experience, for the last five years of the 20th century are as follows (dollars in billions):

Yearly Estimates	1995	1996	1997	1998	1999
Medicare Expenditures	$157.1	$178.3	$194.2	$210.8	$228.6
Fraud Loss:					
Low Estimate	$7.9	$8.9	$9.7	$10.5	$11.4
High Estimate	$15.7	$17.8	$19.4	$21.1	$22.9

Id.; *Analytical Perspectives: Proposed 1996 Budget of the United States Government, available in* 1995 WL 110790 (O.M.B.) (West Feb. 1995) (disclosing estimated Medicare expenditures, federal fiscal years 1995-99).

8. Several congressional committees heard from representatives of a variety of federal departments that health care fraud is a very real and present problem requiring swift and stringent measures. *See, e.g.*, *Gaming the System*, *supra* note 6, at 66 (statements of June Gibbs Brown, Inspector General, Office of Inspector General, Department of Health and Human Services, and Hon. Louis J. Freeh, Director, Federal Bureau of Investigation); *Health Care Fraud: Hearing Before a Subcomm. of the Senate Comm. on Appropriations*, 103rd Cong., 2d Sess. 60 (1994) (statement of Bruce C. Vladeck, Administrator, Department of Health and Human Services); *Waste, Fraud and Abuse*, *supra* note 6, at 67 (statement of Michael F. Mangano, Principal Deputy Inspector General, Department of Health and Human Services); HHS Fact Sheet, May 3, 1995, *reprinted in* Medicare & Medicaid Guide, (CCH) ¶ 43,213 (May 18, 1995); 141 CONG. REC. H3373-74 (daily ed. Mar. 21, 1995) (statement of Rep. Barrett).

9. *Enforcement: NME to Pay $379 million in Penalties Under Settlement with Federal Agencies*, 3 HEALTH L. REP. (BNA) No. 27, at D-11 (July 7, 1994) [hereinafter *NME*].

10. See *Gaming the System*, *supra* note 6, at 66 for statements and testimony regarding Operation Restore Trust. Operation Restore Trust also will attack fraud in the durable medical equipment (DME) supply industry. *Id.* However, this Note deals with cost reporting consultants. Since DME suppliers do not file a Medicare cost report, this Note will not address DME fraud.

(DME) industries.[11]

Taxpayers can take solace in the fact that fraud loss does not occur because federal contributions to the Medicare trust fund are being thrown to packs of thieving providers, but primarily because a few bad, albeit large, apples are at work.[12] Most Medicare and Medicaid fraud may be ascribed to large schemes perpetrated by closely held businesses.[13] However, that fact should work no

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11. See *Gaming the System*, *supra* note 6, at 66 for a discussion of the coordinated efforts of numerous federal agencies to combat medicare fraud.

12. Cost report fraud tends to manifest itself in large scale operations. *See, e.g.*, United States v. Henry, [1994-1 Transfer Binder] Medicare & Medicaid Guide (CCH) ¶ 41,995 (6th Cir. Nov. 29, 1993). In *Henry*, the federal government charged the defendants with multiple instances of Medicare cost report fraud. *Id.* The court entered a large judgment against three employees at a facility that served as a home office for several home health agencies. *Id.* The judgment consisted of terms of imprisonment totaling 10 years and more than $7.16 million in fines, forfeitures, and restitutions. *Id.* The litany of alleged cost report fraud included concealing transactions with related organizations and charging the profit earned by the related organizations, a non-allowable cost, as an expense to the Medicare program. *Id.*; *see* 18 U.S.C. §§ 1001-1002 (1988). Also, the defendant paid physicians to refer patients to the defendant's agency and concealed these paybacks within employees' compensation. *Henry*, [1994-1 Transfer Binder] Medicare & Medicaid Guide (CCH) at ¶ 41,995. Referral payments are not only improper for Medicare purposes, but also may be a violation of the Medicare anti-kickback statute. 18 U.S.C. §§ 1001-1002 (1988); 42 U.S.C. § 1320a-7(b)(7) (1988). Additionally, the defendant in *Henry* falsified accounting records to make it appear that the agency paid bonuses to employees, although the payments were never made. *Henry*, [1994-1 Transfer Binder] Medicare & Medicaid Guide (CCH) at ¶ 41,995. The scheme included the creation of false payroll checks and illicit accounting entries as means to cover the fraud. *Id.* Finally, the provider booked improbable amounts for business trip mileage (e.g., 2,000 miles driven by a single individual in a single day) and included personal travel cost to Cancun, Mexico, as Medicare reimbursable expenses. *Id.*

The largest court award to date was a $21 million consent judgment against an operator of DME companies. *Consent Decree Orders $21 Million Judgment, Lifetime Ban from Medicare*, 5 MEDICARE REP. (BNA) No. 21, at D-19 (May 27, 1994); *and see* United States v. Mickman, No. CIV.A.89-7826, 1993 WL 541683 (E.D. Pa. Dec. 22, 1993), *aff'd*, 52 F.3d 318 (3d Cir. 1995). The court found that Mickman participated in a "scheme to defraud [Medicare], including filing of false Certificates of Medical Necessity, falsification of authorization for payment forms, billing for items never shipped, and the submission by the corporate defendants of fraudulent claims." *Mickman*, No. CIV.A.89-7826, 1993 WL 541683, at *1.

13. Many of the largest recoveries related to Medicare fraud prosecution involve enterprises, each of which only a handful of investors runs, but which operate like much larger syndicates due to the volume of business they conduct with the Medicare program. *See, e.g.*, *False Claims: National Lab to Pay $100 million to Settle False Claims Allegations*, 1 HEALTH L. REP. (BNA) No. 14, at D-16 (Dec. 31, 1992) [hereinafter *National Lab*]; *NME*, *supra* note 9, at D-11.

In December 1992, the Department of Justice announced a $111.4 million settlement for false claims allegations, at that time the government's single largest victory in the war against fraud. *National Lab*, *supra*, at D-16. The California-based National Health Laboratories, Inc., performs blood tests nationwide. *Id.* The settlement included three payees: the federal government, $100 million; state Medicaid programs, $10.4 million; and the Civilian Health and Medical Program of the

mercy upon smaller scale schemes effected by less obvious criminals.[14] Clever operators, understanding the loss tolerances of the Medicare and Medicaid program administration and the Office of the Inspector General and Department of Justice, know just how far to push their schemes.[15]

Uniformed Services (CHAMPUS), $1 Million. *Id.* The allegations involved submission of false claims for unnecessary and unperformed services, for which the three government programs paid a flat fee intended to approximate cost. *Id.*

A $379 million settlement against National Medical Enterprises, Inc., announced in June of 1994, dwarfed the 1992 *National Lab* settlement. *NME*, *supra* note 9, at D-11. More than $324 million of the settlement related to losses bilked from federal programs (Medicare, Medicaid, the Federal Employee Health Benefit Program, and CHAMPUS), and $16.3 million related to state Medicaid program losses. *Id.* The justice department charged National Medical Enterprises with "unnecessary patient admission and treatment, extending patients' hospital stays to maximize insurance coverage, billing insurance programs multiple times for the same service or billing where no service was provided, and billing Medicare for payments to doctors to induce referrals of patients to its [psychiatric and substance abuse] facilities." *Id.*

Most recently, on August 24, 1995, a federal grand jury indicted American Health Care, Inc. (formerly ABC Home Health Services Inc.), as well as executives of the corporation, on 82 counts relating to an alleged conspiracy. *False Claims: Federal Officials Announce Indictment of ABC Home Health for Medicare Fraud*, 4 HEALTH L. REP. (BNA) No. 35, at D-16 (Aug. 31, 1995). The government charged American Health Care with abuses including, but not limited to, the following:

> The indictment alleges ABC fraudulently obtained reimbursement from the Medicare program for personal airplane trips by [Jack and Margie] Mills[, the president and chief executive officer, and the chief operating officer, respectively,] and their friends and family members to Cozumel, Mexico, college football games, and other personal excursions; rebates or kickbacks from the vendor of aircraft fuel; and wages and salaries of ghost employees of ABC who did not work full-time for ABC performing patient care-related duties.

Id.

14. Many cases involving Medicare fraud do not relate to elaborate and sophisticated stratagem, but still may result in large amounts of fraud loss. Frequently providers merely suppress the related nature of business transactions. *See, e.g.*, United States v. Calhoon, 859 F. Supp. 1496 (M.D. Ga. 1994); United States v. Kensington Hospital, [1993-1 Transfer Binder] Medicare and Medicaid Guide (CCH) ¶ 41,053 (E.D. Pa. Jan. 21, 1993); United States v. Oakwood Downriver Medical Ctr., 687 F. Supp. 302 (E.D. Mich. 1988). In *Calhoon*, the government indicted the defendant on fourteen counts, three counts of mail fraud and eleven counts of Medicare fraud, for failure to disclose the related parties with which it did business. 859 F. Supp. at 1497. In *Kensington*, the government convicted the defendant on six counts of fraud and fraud-related crimes stemming from the manipulation of the Medicare cost report. [1993-1 Transfer Binder] Medicare and Medicaid Guide (CCH) at ¶ 41,053. The provider manipulated the cost report to channel Medicare funds to organizations related to the provider. *Id.* The defendant in *Oakwood Downriver* was related to a clinic through interlocking boards of directors, but did not disclose the relationship in the Medicare cost report. 687 F. Supp. at 303-04.

15. See *Waste, Fraud and Abuse*, *supra* note 6, at 67 (statement of Michael F. Mangano, Principal Deputy Inspector General, Department of Health and Human

This class includes the minority of health care consultants who would subject their unwitting clients to the potential criminal and civil sanctions for commission of a fraud upon the government.[16] Such consultants are motivated by the higher commissions they will earn as a result of their clients' increased reimbursement.[17] Moreover, the subset of the consulting industry that induces clients to misrepresent reimbursable Medicare or Medicaid expenses does so without threat of repercussion. To date, the consulting industry appears entirely untouched by fraud litigation.[18]

The amount of fraud loss directly attributable to improper recommendations by consultants is presently indeterminable. Many cases brought under the federal False Claims Act (FCA), however, result in very large liabilities against providers.[19] Quite probably, some of these cases resulted from consultant-driven fraud with the unwitting providers bearing the burden of a judgment or settlement while the consultant walked away untouched.[20] Moreover, when the provider understands that the consultant's suggested scheme is fraudulent, a criminal conspiracy is present.[21] Although no case establishes the existence of

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Services) and at 73-80 (statement of Sarah F. Jaggar, Director, Health Financing and Policy Issues, Health, Education, and Human Services Division, United States General Accounting Office) for a discussion of governmental fraud loss exposure thresholds.

16. See False Claims Act (FCA), 31 U.S.C. § 3729(a) (1994) for the penalties available under the FCA.

17. See *supra* notes 1-2 and accompanying text for a discussion of the hypothetical case United States v. Dole.

18. See *supra* notes 11-14 for a discussion of Medicare fraud cases in which the government named only the provider in its suits for fraud.

19. See *supra* note 13 for a description of judgments against providers under FCA.

20. See *infra* notes 47-50 and accompanying text for a discussion of cost reporting certification and liability under the FCA. *Cf. Florida Nursing Home Agrees to Repay more than $400,000*, HEALTH CARE DAILY (BNA) at D-9.1 (June 15, 1995) [hereinafter *Florida Nursing Home*] (discussing billing fraud liability attributable to consultant). No U.S. court has yet adjudicated the liability of Medicare consultants for the fraudulent acts of their clients. However, the *Florida Nursing Home* settlement and surrounding facts suggest that the provider accepted liability for the fraud of their consultants. *Id.*

21. *See* United States v. Murphy, 937 F.2d 1032, 1038-39 (6th Cir. 1991) (holding that rigging of bids submitted to the federal government may be actionable under the conspiracy theory of the False Claims Act); Kelsoe v. Federal Crop Ins. Corp., 724 F. Supp. 448, 452-53 (E.D. Tex. 1988) (holding that individuals who conspire to submit fraudulent crop insurance claims are liable under the False Claims Act); United States v. Hill, 676 F. Supp. 1158, 1182 (N.D. Fla. 1987) (holding that conspiring to get false claims paid from Farm Home Administration and Small Business Administration may be actionable under the False Claims Act). See also *infra* notes 49-50, 127-52 and accompanying text for a general discussion of the False Claims Act and conspiracy theories.

consultant's liability in such a situation, the law recognizes instances in which causation is attributable to a third party.[22]

Typically, Medicare and Medicaid fraud fits into two general categories: billing fraud and cost report fraud.[23] Billing fraud occurs when an individual submits a Medicare or Medicaid claim to the insurance carrier for payment, notwithstanding the fact that the services for which the provider seeks payment were never rendered or were unnecessary.[24] Cost report fraud occurs when a party files a Medicare cost report knowing that the program does not cover certain costs for which the party seeks reimbursement.[25]

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22. Recently, the federal government reached a $414,000 settlement with a Florida nursing home, CHR Associates, Inc., d/b/a Claridge House, for improper Medicare claims. *Florida Nursing Home*, *supra* note 20, at D-9.1. A third party billing company, Handled With Care, submitted the claims on behalf of the nursing home. *Id.* The government has not announced that it will prosecute the billing agent. *Id.* Instead, the Justice Department elected to pursue the provider directly. *Id.* The third party submitted claims that supposedly corrected the provider's omissions, but these so-called corrections actually were the third party's fraudulent inventions. *Id.* Like the Doles in the introductory hypothetical, the provider denied any wrongdoing and claimed that it justifiably relied on the assurances of Handled With Care because the firm was expert at recovering lost claims. *Id.* See *infra* notes 29-32 and accompanying text for a discussion of the reliance that small agencies reasonably place on the work of consultants. CHR Associates, Inc., the provider in *Florida Nursing Home*, certainly reaped the benefits of any fraudulent claims submitted by the billing agent since the claims were paid to them directly, but the billing consultant also received payment based on a percentage of the allegedly "lost claims" recovered. *Florida Nursing Home*, *supra* note 20, at D-9.1.

23. *NME*, *supra* note 9, at D-11. NME is a durable medical equipment (DME) supplier. *Id.* DME suppliers do not file cost reports for reimbursement. See *infra* notes 38-39 and accompanying text for a discussion of Medicare cost reporting forms. Instead, DME suppliers bill the various Medicare contractors directly for payment, knowing that only a small percentage of all claims processed are actually reviewed. *Waste, Fraud and Abuse*, *supra* note 6, at 67. This arrangement makes DME and other directly billed services particularly attractive to parties who would defraud the government by billing for excessive or undelivered services. *Id.*

Cost report fraud differs from billing fraud in that billing fraud is usually committed by filing a series of false bills, while cost report fraud manifests itself in a single document. *See, e.g.*, *Henry*, [1994-1 Transfer Binder] Medicare & Medicaid Guide (CCH) at ¶ 41,995 (holding that cost report fraud includes the following activities: concealing transactions with related organizations and charging profit of same as expense to Medicare program, concealing kickbacks to physicians for patient referrals, falsifying accounting records to inflate expense and including personal travel cost as Medicare reimbursable expense); United States v. Alemany Rivera, 781 F.2d 229, 232 (1st Cir. 1985) (holding that concealing transactions with related organizations constitutes cost report fraud); United States v. Smith, 523 F.2d 771, 776-78 (5th Cir. 1975) (detailing how concealing personal home remodeling expenses and concealing transactions between hospital and nepotistic joint venture, including personal home diaper delivery service costs with hospital laundry account, are examples of cost report fraud); United States v. Calhoon, 859 F. Supp. 1496, 1499 (M.D. Ga. 1994) (holding that a defendant who sought reimbursement for non-allowable advertising expenses had committed cost report fraud).

24. *See, e.g.*, *National Lab*, *supra* note 13, at D-11.

25. *See, e.g.*, *Henry*, [1994-1 Transfer Binder] Medicare & Medicaid Guide

Most providers in the three targeted industries — HHAs, SNFs and DME supply — are well informed regarding claims billing procedures.[26] Therefore, providers typically perform this task without the assistance of a contractor.[27] Given the limited involvement of consultants with claims billing practices, third party liability issues rarely arise in conjunction with billing fraud.[28]

On the other hand, the cost reporting function requires a great deal of knowledge of federal and state regulations regarding cost reimbursement.[29] Providers of health care services are, therefore, more likely to require a specialist, consultant or management company to assist them where cost report reimbursement issues are involved.[30] Consultants frequently prepare the cost reports for their clients and, although the client ultimately signs the certification page,[31] the consultants typically exercise a large

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(CCH) at ¶ 41,995 (describing one of the more common forms of cost report fraud: concealment of the related nature of parties with whom the provider transacts business); United States v. Corcoran, 872 F. Supp. 175 (M.D. Pa. 1993) (holding that willfully failing to disclose related party transactions and including physician kickbacks as employee expense constitutes cost report fraud).

The government tailored Medicare regulations to prevent reimbursement to a party for an amount in excess of cost, (i.e., a government-funded profit). 42 C.F.R. § 413.17 (1995). These regulations thus require providers to record expenses attributable to transactions with related parties at cost to the related party. *Id.* The manipulation of statistical data to improperly inflate the government's liability or improperly understate the amount due to the government also constitutes cost report fraud. *See* 42 C.F.R. § 413.9 (1995).

26. *See* 60 Fed. Reg. 45,487 (1995). Providers file insurance claims on the Universal Billing Form 92 (UB-92). *Id.* This form requires no special knowledge for filing Medicare claims beyond that which any health care provider would already possess for making a claim against any insurer. *Id.*

27. *Id.*

28. *But cf. Florida Nursing Home*, *supra* note 20, at D-9.1 (discussing a large settlement of a case in which a provider engaged a consultant to recover lost billings).

29. *See generally* 42 C.F.R. §§ 2.1-1007 (1995) (setting forth the core of Medicare regulations). Literally thousands of pages comprise the PROVIDER REIMBURSEMENT MANUALS, PRM-I and PRM-II, which explain the differences between those costs that are allowable under Medicare and those that are not, as well as the procedures to follow in filing a Medicare cost report. *See* HEALTH CARE FINANCING ADMIN., U.S. DEP'T. OF HEALTH & HUM. SERV., PUB. NOS. 15-I, 15-II, 15-27, PROVIDER REIMBURSEMENT MANUALS, PARTS I & II (1995).

30. See *infra* notes 35-36 and accompanying text for a discussion of the provider's burden of Medicare cost reporting. The sheer volume of Medicare regulations, promulgated almost daily, represents a daunting body of administrative law. *Id.* Most Medicare providers, especially smaller entities, would generally find it difficult to keep up to date with all the regulatory changes, as well as with the rulings from the Provider Reimbursement Review Board and from the federal courts. See *infra* note 36 and accompanying text for a discussion of the quantity of Medicare regulations.

31. See *infra* note 36 for a sample of the text of a cost report certification and

amount of professional discretion regarding the presentation of expenses and revenues in the cost report.[32]

Even though third parties exercise a great deal of control and discretion over cost reporting, all of the major litigation regarding Medicare fraud has thus far focused directly on the providers themselves.[33] While third party consultants are inexorably linked with the filed cost report, the government universally ignores consultants when it names parties in health care fraud cases.[34]

II. THE MEDICARE COST REPORT

This Part explains the official government uses of the vehicle

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for a discussion of the implications of signing a certification.

32. *See* 42 C.F.R. § 413.9 (1995). The Medicare program should only reimburse providers for reasonable and necessary costs related to the provision of covered services to Medicare eligible patients:

> (a) Principle. All payments to providers of services must be based on the reasonable cost of services covered under Medicare and related to the care of beneficiaries. Reasonable cost includes all necessary and proper costs incurred in furnishing the services, subject to principles relating to specific items of revenue and cost. . . .
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> (1) Reasonable Cost. . . . The regulations in this part take into account both direct and indirect costs of providers of services. The objective is that under the methods of determining costs, the costs with respect to individuals covered by the [Medicare] program will not be borne by individuals not so covered, and the costs with respect to individuals not so covered will not be borne by the program. . . .
>
> (2) Necessary and proper costs. Necessary and proper costs are costs that are *appropriate and helpful in developing and maintaining the operation of patient care facilities and activities*. They are usually costs that are *common and accepted occurrences in the field of the provider's activity*.
>
> (c). . . .
>
> (3) The determination of reasonable cost of services must be based on cost related to the care of Medicare beneficiaries. . . . *However, if the provider's operating costs include amounts not related to patient care, specifically not reimbursable under the program, or flowing from the provision of luxury items or services* (that is, those items or services substantially in excess of or more expensive than those generally considered necessary for the provision of needed health services), *such amounts will not be allowable*. . . .

42 C.F.R. §§ 413.9(a)-(c) (1995) (emphasis added).

Intentional or even reckless inclusion of non-allowable costs, including non-allowable direct costs as well as overhead costs, in a Medicare cost report would constitute a false claim against the federal government within the meaning of the False Claims Act. See *infra* notes 49-50 and accompanying text for a general discussion of the False Claims Act, and *supra* notes 12-14 and accompanying text regarding the intentional inclusion of non-allowable personal or non-patient care related expenses in the Medicare cost report.

33. See *supra* notes 12-14 and accompanying text for a discussion of various cases involving Medicare fraud. In all of those cases, the federal government pursued only the providers.

34. See *supra* notes 12-14 and accompanying text.

of cost report fraud: the Medicare cost report. This Part also describes what types of health care facilities must file Medicare cost reports. Finally, this section discusses the requirements that the government imposes upon providers seeking Medicare cost reimbursement.

The Health Care Finance Administration (HCFA), publishes Medicare regulations in an imposing series of manuals.[35] Though larger entities can afford to pay an employee trained in Medicare reimbursement to stay abreast of the regulatory developments and to file the Medicare cost report, smaller providers such as HHAs and SNFs frequently contract with a third party consultant for these services.[36] Consultants thus perform a service that is essential to the ability of many providers to participate in the Medicare program and to render health care services to Medicare patients.[37]

Most providers certified to participate in the Medicare program must submit a Medicare cost report.[38] This annual cost re-

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35. HCFA publishes numerous manuals that deal specifically with cost reporting and reimbursement issues. *See generally,* HEALTH CARE FINANCING ADMIN., U.S. DEP'T OF HEALTH & HUM. SERV., PUB. NO. 9, OUTPATIENT PHYSICAL THERAPY AND CORF MANUAL (1996); HEALTH CARE FINANCING ADMIN., U.S. DEP'T OF HEALTH & HUM. SERV., PUB. NO. 10, HOSPITAL MANUAL (1996); HEALTH CARE FINANCING ADMIN., U.S. DEP'T OF HEALTH & HUM. SERV., PUB. NO. 11, HOME HEALTH AGENCY MANUAL (1996); HEALTH CARE FINANCING ADMIN., U.S. DEP'T OF HEALTH & HUM. SERV., PUB. NO. 12, SKILLED NURSING FACILITY MANUAL (1996); HEALTH CARE FINANCING ADMIN., U.S. DEP'T OF HEALTH & HUM. SERV., PUB. NOS. 15-I, 15-II, 15-27, PROVIDER REIMBURSEMENT MANUALS, PARTS I, II, and ESRD respectively; HEALTH CARE FINANCING ADMIN., U.S. DEP'T OF HEALTH & HUM. SERV., PUB. NO. 21, HOSPICE MANUAL (1996); and HEALTH CARE FINANCING ADMIN., U.S. DEP'T OF HEALTH & HUM. SERV., PUB. NO. 29, RENAL DIALYSIS FACILITY MANUAL (1996).

36. The PROVIDER REIMBURSEMENT MANUAL PART I, HCFA PUB. NO. 15-I, a manual of general applicability to all types of providers, is itself more than 1,700 pages in length. HEALTH CARE FINANCING ADMIN., U.S. DEP'T OF HEALTH & HUM. SERV., PUB. NO. 15-I, PROVIDER REIMBURSEMENT MANUAL PART I § 100-3140 (1996). The immense volume of all Medicare manuals, compounded by periodic updates and elaborate instructions, makes the maintenance of these manuals difficult for individuals with responsibilities other than Medicare cost reporting. Administrative personnel at health care providers generally have little time to attend to the maintenance and study of Provider Reimbursement Manuals.

37. See *supra* notes 29-32 and accompanying text for a discussion of the economic necessity of having Medicare cost reporting consultants to facilitate smaller health care entities in Medicare operations.

38. 42 C.F.R. § 413.24(f) (1995). The government requires various entities to file their cost reports on different forms, depending on the type of facility. *See generally* HEALTH CARE FINANCING ADMIN., U.S. DEPT. OF HEALTH & HUM. SERV., PUB. NO. 15-II, PROVIDER REIMBURSEMENT MANUAL PART II § 100-3140 (1996) (containing the cost reporting instructions for all forms of Medicare cost reports). Most hospitals file HCFA Form 2552; skilled nursing facilities file either HCFA Form 2540, or HCFA Form 2540s; and home health agencies file HCFA form 1728. *Id.* Each of these cost reporting forms utilizes a unique method for cost allocation and calcula-

port is a standard form the government uses to determine the portion of a provider's total cost attributable to Medicare patient care.[39] Medicare pays each provider a series of estimated payments intended to approximate actual reasonable cost.[40] Medicare makes these payments on an interim basis and calculates the amount based upon claims submitted at the time care is given.[41] A fiscal intermediary[42] then audits the cost report and makes a final determination regarding the apportionment of cost between

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tion of Medicare allocable cost, and each type of facility is limited by various capitations. *Id.* HCFA does not require certain types of providers of patient care services, such as hospices, to file cost reports. 42 C.F.R. § 413.20 (1995).

39. 42 C.F.R. §§ 413.24(a)-(d), 413.60-74 (1995). The various cost reports compute "actual cost" differently for each provider type. *See generally* HCFA PUB. NO. 15-II (1995). Medicare pays skilled nursing facilities and most hospitals on the basis of the facility's average cost per dollar of revenue for ancillary services. HCFA Pub. 15-II, §§ 2813-14, 2817.2-2817.5 (1993). Medicare pays hospitals for routine services (i.e., those requiring admission as an inpatient) on the basis of diagnostic related groups, or DRGs. HCFA Pub. 15-II, §§ 2815, 2817-2817.1 (1993). HCFA statistically generates DRGs to represent a form of fee for service based upon the type of procedure. *See, e.g.*, Provider Agreements and Supplier Approval, 60 Fed. Reg. 45,893-908 (1995).

In addition to the DRG payment, hospitals may receive exceptional "outlier" payments for patients whose severity of illness exceeds the threshold for the specific DRG. *Id.* at 45,931-32. Furthermore, Medicare pays some hospitals additional amounts for capital costs, organ acquisition programs, graduate medical education teaching programs, paramedical teaching programs, Medicare bad debts and disproportionately high percentages of patients receiving public aid. HCFA PUB. NO. 15-II, § 2817.1 (1993).

Medicare pays skilled nursing facilities for routine services on the basis of the facility's average cost per Medicare patient day. HCFA PUB. NO. 15-II, § 1618 (1993). Finally, Medicare pays home health agencies for skilled care on the basis of the average cost per visit. HCFA PUB. NO. 15-II, § 3215 (1995). HHAs also receive payment for medical supplies and certain drugs on the basis of the facility's average cost per dollar of revenue for such items provided to Medicare patients. *Id.*

Reimbursable cost for each facility is subject to certain limitations. Medicare regulations limit SNFs, HHAs, and hospitals to the lesser of cost apportioned to the Medicare program or the revenue attributable to Medicare patients. HCFA PUB. NO. 15-I, §§ 2600-2616 (1985). Furthermore, Medicare regulations limit SNFs and HHAs to HCFA published cost capitations. HCFA PUB. NO. 15-II, §§ 1618, 3215.1 (1995). In any event, the cost attributed to the Medicare program must be necessary and proper according to Medicare regulations and statutes. See *supra* note 32 and accompanying text for a discussion of the requirement that costs be reasonable and necessary.

40. 42 C.F.R. § 413.9(a)(1) (1995). See *supra* note 32 for a discussion of the Medicare regulations regarding reasonable cost.

41. 42 C.F.R. § 413.9(a)(1).

42. Current U.S. law authorizes the Secretary of the Department of Health and Human Services to contract with public and private entities that serve as intermediaries. 42 U.S.C. § 1395h (1988). Medicare regulations define an intermediary as "an entity that has a contract with HCFA to determine and make Medicare payments for Part A or Part B benefits payable on a cost basis . . . and to perform other related functions." 42 C.F.R. § 421.3 (1995).

Medicare and non Medicare functions.[43] Upon completion of the audit, the fiscal intermediary computes a final settlement by comparing the audited cost apportioned to the Medicare program with the total interim payments.[44] The difference between amounts paid to the provider and the costs attributable to services rendered to Medicare patients is the final settlement.[45]

The cover sheet of every Medicare cost report contains a certification statement that the provider's administrator must sign before the intermediary accepts the cost report as valid.[46] The certification includes a statement that all information contained within the cost report is factually accurate.[47] By signing this certification, the administrator acknowledges an understanding that false statements are punishable by fine, imprisonment or both.[48]

When proof exists that a provider intentionally misrepresented information in the Medicare cost report, the government may use the certification, pursuant to the False Claims Act,[49] to prosecute the administrator or the provider for fraud.[50] Since Medi-

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43. 42 U.S.C. § 1395h.

44. *Id.*

45. 42 C.F.R. § 413.64(f) (1995). "Interim payments are made on the basis of estimated costs. Actual costs reimbursable to a provider cannot be determined until the cost reports are filed and costs are verified. Therefore, a retroactive adjustment will be made at the end of the reporting period. . . ." *Id.*

46. *See* 42 C.F.R. § 413.24(f)(4)(iii) (1995).

47. 42 C.F.R. § 413.24. The cost report certification, which follows a statement regarding penalties for fraud, is typified by the hospital certification:

> The following statement must immediately precede the dated signature of the [entity's] administrator or chief financial officer: I hereby certify that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet Statement of Revenue and Expenses prepared by ____ (Provider Name(s) and Number(s)) for the cost reporting period beginning ____ and ending ____ and that to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

42 C.F.R §413.24(f)(4)(iii). *See* PROVIDER REIMBURSEMENT MANUAL PART II, HCFA PUB. NO. 15-II, §§ 1606.1, 2890, 3203.1 (1995) (setting forth instructions for filing Office of Management and Budget ("OMB") forms 00938-0022, HHA certification, and 00938-0050, Hospital certification).

48. *Id.*

49. False Claims Act, 31 U.S.C. §§ 3729-30 (1988).

50. *Id.* at § 3729(a). The False Claims Act provides for "a civil penalty of not less than $5000 and not more than $10,000, plus three times the amount of damages which the Government sustains. . . ." *Id.* The Act imposes liability for conduct of individuals with "actual knowledge of the information, . . . deliberate ignorance of the truth or falsity of the information; or . . . reckless disregard of the truth or falsity of the information, and no proof of specific intent to defraud is required." *Id.*

care regulations do not require third party consultants to sign the certification, the liability of consultants for their fraudulent conduct in preparing the cost report remains untested.

III. PRESENT STATUS OF THIRD PARTY LIABILITY LAW

This Part explores state tort law as it relates to third party liability. The first Section sets forth a brief history of the law in this area. Section B discusses the majority and minority views of the state courts with regard to third party liability. Finally, Section C explains the applicability of existing tort law to third party preparers of Medicare and Medicaid cost reports.

A. The History of Third Party Liability

Early New York cases introduced the concept of third party liability into American jurisprudence.[51] These cases established that a party is liable to another, even absent privity of contract, where that party: 1) communicates, 2) information, spoken or in writing; 3) to another party; 4) with the expectation that the other party will provide the information to a third party.[52] Today, under the doctrine of third party liability, many professionals who render information services may be liable for negligence or fraud to third parties acting in reliance on those services.[53] Since Medicare consultants are professionals who render information services, which they expect their clients to rely upon, they too should be subject to third party liability.[54]

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at § 3729(b).

51. *See, e.g.*, Ultramares Corp. v. Touche, 174 N.E. 441 (N.Y. 1931) (examining auditor's liability to lenders relying on financial statements); Glanzer v. Shepard, 135 N.E. 275 (N.Y. 1922) (holding public weigher liable to buyer); Milliken v. Western Union Tel. Co., 18 N.E. 251 (N.Y. 1888). In *Milliken*, the court held that the defendant telegraph company owed a duty to the intended recipient of a message, though the sender of the message sought the telegraph company's service. *Id.* at 252. In *Glanzer*, a seller of beans engaged a weigher to issue a certificate of the weight of his product. 135 N.E. at 275. Thus, between the weigher and seller there was privity of contract. *Id.* However, the court held that the buyer, who was in privity of contract with only the seller, could assert a duty against the weigher for negligent performance of its duty because the weigher knew the buyer was to be "end and aim of the transaction." *Id.*

52. *See Ultramares*, 174 N.E. at 441; *Glanzer*, 135 N.E. at 275; *Milliken*, 18 N.E. at 251 (each discussing the evolution of third party liability to parties in privity). See *infra* note 66 and accompanying text for a discussion of the modern view of the privity doctrine.

53. *See* Denise M. Orlinski, *An Accountant's Liability to Third Parties:* Bily v. Arthur Young & Co., 43 DEPAUL L. REV. 859, 860 (1994) (presenting a history of the evolution of third party liability for accountants); Anna S. Rominger, *Accountants' Common Law Liability to Third Parties*, 37 RES GESTAE 508, 511 n.18 (1994) (discussing third party liability evolution and its application to accountants).

54. See *infra* notes 60-62 and accompanying text for a discussion of third party

Justice Cardozo, in his landmark 1931 majority opinion in *Ultramares Corp. v. Touche*, first applied third party liability to the accounting industry.[55] Under this general theory, an accountant is liable to third parties acting in reliance upon the accountant's work, even absent privity of contract between the accountant and the third party.[56]

In *Ultramares*, the defendant accountants performed an audit of their client's accounting records, and then prepared financial statements based upon the audit.[57] However, the accountants performed the audit negligently and, as a result, the financial statements contained material errors.[58] Although a third party acted in reliance upon the misrepresented information and thereby suffered an injury, Justice Cardozo held that the third party plaintiffs were not entitled to maintain a cause of action for negligence absent contractual privity, or its equivalent, with the accountants.[59] Today, most American jurisdictions have embraced the concept of third party liability, although the states apply three different tests.[60]

B. Majority and Minority State Views

Over the sixty-five years since *Ultramares*, state courts developed three well-defined categories of plaintiffs that may assert

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liability of professionals that render information services. *See also Ultramares*, 174 N.E. at 448. Justice Cardozo espoused, in dicta, that "[l]iability for negligence if adjudged in [*Ultramares*] will extend to many callings other than an auditor's. Lawyers [and] . . . [t]itle companies," under the proper circumstances, would also yield to this authority. *Id.*

55. *Ultramares*, 174 N.E. at 444.

56. *Id.*

57. *Id.* at 442.

58. *Id.* at 442-43. The modern approach to auditing performed by public accountants involves the use of generally accepted auditing standards to assure that those who perform audits exercise the skill and care required of the industry. CODIFICATION OF ACCOUNTING STANDARDS AND PROCEDURES, Statement on Auditing Standards No. 1, § 150 (Am. Inst. of Certified Pub. Accountants 1972).

59. *Ultramares*, 174 N.E. at 443. In *Ultramares*, the accountants were sheltered from liability for negligent misrepresentation to the creditors of the firm's client. *Id.* at 448. Justice Cardozo, distinguishing third party liability for negligence from third party liability for fraud or misrepresentation, stated that "if there has been neither reckless misstatement nor insincere profession of an opinion, but only honest blunder, the ensuing *liability for negligence . . . is to be enforced between the parties by whom the contract has been made.*" *Id.* (emphasis added). Cardozo contrasted these causes of action founded in negligence with intentional fraud or misrepresentation. *Id.* The professional cannot insulate himself from these causes of action, Cardozo held, by claiming a lack of privity. *Id.* This Section of the Note focuses on the negligence facet of third party liability claims. Where a consultant's acts rise to actual fraud, the FCA provides a more useful tool.

60. See Orlinski, *supra* note 53, at 860 nn.5-7 for a discussion of jurisdictions that have decided cases involving third party liability of accountants.

third party actions against accountants: 1) parties in privity, or near privity, of contract with the accountant; 2) members of an identifiable group whose reliance on the accountant's representations is actually foreseeable from the bargain between the parties; and 3) parties whose reliance on the accountant's representations is merely reasonably foreseeable.[61] Many courts have also held that third party liability should be imposed not only on accountants, but also on various other professionals who render information services to the public.[62]

1. Privity-Near Privity Rule

The privity and near privity rule, which developed out of the *Ultramares* case, is the most conservative application of third party liability.[63] Under this rule, only those plaintiffs whose relationship approximates privity to the contract between the accountant and the client may assert liability against the accountant.[64] This approach is a minority rule among the states that have embraced the notion of third party liability.[65] Proponents of this approach advance the fairness to the accountant and foreseeability of plaintiffs as major benefits of this approach.[66] Detractors

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61. See Rominger, *supra* note 53, 512 nn.20-35 for a discussion of the three third party liability categories; *see also* Orlinski, *supra* note 53, at 861 nn.5-7 (discussing rulings by state courts in each of these three general categories).

62. *See, e.g.*, Thomas v. Chase Manhattan Bank, 1 F.3d 320, 327 (5th Cir. 1993) (holding bank liable to trustee and investors for bank's withholding of superior knowledge resulting in loss to plaintiffs); Lincoln Alameda Creek v. Cooper Indus., 829 F. Supp. 325, 328-29 (N.D. Cal. 1992). Applying California law, the court in *Lincoln Alameda* stated, in dicta, that "for all groups of information-supplying professionals, liability is limited to those persons the information is intended to benefit." *Id.* (citing Bily v. Arthur Young & Co., 834 P.2d 745, 767 (Cal. 1992)). The *Bily* court recognized that, besides accountants, "other groups of professionals, such as engineers, supply information and evaluations for others to use." *Id.* at 328.

63. *See Ultramares*, 174 N.E. at 441. See *infra* note 66 for a discussion of the privity rule.

64. *See* Orlinski, *supra* note 53, at 872 nn.101-03 (discussing the *Ultramares* decision and the privity doctrines); *supra* note 54 for an explanation of the *Ultramares* holding; *infra* note 66 for a discussion of the limited application of the privity doctrine.

65. See Rominger, *supra* note 53, at 515 n.24 for a listing of the states that embrace this approach. Seven state courts and two federal district courts interpreting the laws of two additional states have adopted the privity rule. *Id.*; see also Orlinski, *supra* note 53, at 875 n.137 and accompanying text for a discussion of the states in favor of this approach.

66. The privity doctrine, as applied to negligence, appeared under a flag of caution waved by Justice Cardozo: "If liability for negligence exists, a thoughtless slip or blunder, the failure to detect a theft or forgery beneath the cover of deceptive entries, may expose accountants to a liability in an indeterminate amount for an indeterminate time to an indeterminate class." *Ultramares*, 174 N.E. at 444. Many courts embraced this oft-quoted passage with circumspection until the actual foreseeability approach was introduced in 1968, over 36 years later. *See* Rusch Factors,

contend that a negligent accountant should bear a greater burden for the misstatements because the accountant is in a better position to detect the problem and to prevent the loss.[67] Instead, those who oppose the privity approach argue for a broader protected class, such as that afforded by the actual foreseeability test.[68]

2. *Actual Foreseeability Rule*

The actual foreseeability test presumes that a class of potential plaintiffs is readily identifiable from the nature of the contract between the accountant and the client.[69] A special purpose audit typifies such a situation.[70] In this type of engagement the accountant may render an opinion on a client's financial statements so that the client can distribute the statements to an identifiable group of potential investors.[71] One or more of these investors may then choose to lend money to the client based upon the representations in the financial statements.[72] Both the accountant and the client expect that these potential creditors will act in reliance on the financial statements. Thus, the lenders'

Inc., v. Levin, 284 F. Supp. 85, 90-91 (D.R.I. 1968) (summarizing cases comprising the evolution of the actual foreseeability approach). In 1985, the Court of Appeals of New York reinterpreted the *Ultramares* rule and established the following three part test:

> (1) the accountants must have been aware that the financial reports were to be used for a particular purpose or purposes; (2) in the furtherance of which a known party or parties was intended to rely; and (3) there must have been some conduct on the part of the accountants linking them to that party or parties, which evinces the accountants' understanding of that party or parties' reliance.

Credit Alliance Corp. v. Arthur Andersen & Co., 483 N.E.2d 110, 118 (N.Y. 1985). This case has become the leading example of the privity doctrine, and manifests the most limited discretion in holding third parties liable. *See* Orlinski, *supra* note 53, at 874.

67. *See Rusch Factors*, 284 F. Supp. at 90-91 (discussing the burdens and benefits of protecting a broader class of potential plaintiffs).

68. *Id.*

69. *Id.* at 91. The *Glanzer* opinion, written by Justice Cardozo prior to the *Ultramares* decision, was the first case to extend liability for negligent misrepresentation to parties not in privity. *See Glanzer*, 135 N.E. at 275.

70. *See Rusch Factors*, 284 F. Supp. at 86; RESTATEMENT (SECOND) OF TORTS § 552, illus. 5-7 (1976 Main Vol.) (illustrating a situation analogous to a special purpose audit).

71. *See Rusch Factors*, 284 F. Supp. at 86; RESTATEMENT (SECOND) OF TORTS § 552 *supra* note 70. In *Rusch* the injured party required that the accountant's client obtain audited financial statements for the purposes of a loan. 284 F. Supp. at 86. The accountant prepared the financial statements negligently. *Id.* at 86-87. As a result, the lender was injured. *Id.*

72. *Rusch Factors*, 284 F. Supp. at 86-87; see also RESTATEMENT (SECOND) OF TORTS § 552, *supra* note 70, illus. 7 for a discussion of auditor's liability to a client's creditors.

the representations in the financial statements.[72] Both the accountant and the client expect that these potential creditors will act in reliance on the financial statements. Thus, the lenders' reliance on the financial statements is actually foreseeable as the result of the audit contract, even though the lenders are not in privity with the accountant.[73]

The majority of those states that have ruled on the subject apply the actual foreseeability test.[74] The advocates of this test believe that the more narrowly tailored privity test unfairly insulates the accountant from the actually foreseeable plaintiff.[75] Moreover, the proponents stress that the actual foreseeability test would not extend the liability of the accountant to an infinite number of plaintiffs, but only to those which the accountant would actually foresee.[76]

3. *Reasonable Foreseeability Rule*

Of all three approaches, the reasonable foreseeability test extends the accountants' liability to the greatest number of potential plaintiffs.[77] This approach does not require that the plaintiff be a party in privity, or near privity, with the accountant.[78] Neither must the plaintiff charge the accountant with knowledge of any specific use that the client will make of the accountant's work as required under the actually foreseeable approach.[79] This most inclusive of the three tests requires only that the accountant would reasonably foresee the plaintiff's use of, or reliance upon, the accountant's work.[80] The subjective reasonable foreseeability test is the rule in only a minority of states.[81]

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72. *Rusch Factors*, 284 F. Supp. at 86-87; see also RESTATEMENT (SECOND) OF TORTS § 552, *supra* note 70, illus. 7 for a discussion of auditor's liability to a client's creditors.

73. *See Rusch Factors*, 284 F. Supp. at 92-93.

74. *See* Orlinski, *supra* note 53, at 880 nn.162-64 (discussing states that have accepted actual foreseeability test).

75. *Id.* at 881 nn.165-67 and accompanying text (discussing arguments supporting actual foreseeability approach).

76. *Id.*

77. *See, e.g.*, Shapiro v. UJB Fin. Corp., 964 F.2d 272, 289-90 (3d Cir. 1992) (applying New Jersey law); Impex Agric. Commodities Div. Impex Overseas Corp. v. Parness Trucking Corp., 576 F. Supp. 587, 591 (D.N.J. 1983) (hereinafter *Impex Agric. Commodities*) (discussing the merits of the broad "reasonably foreseeable" test).

78. *See* H. Rosenblum, Inc. v. Adler, 461 A.2d 138, 153 (N.J. 1983); Citizens State Bank v. Timm, Schmidt & Co., 335 N.W.2d 361, 365 (Wis. 1983).

79. *See Rosenblum*, 461 A.2d at 153; *Timm, Schmidt & Co.*, 335 N.W.2d at 366.

80. *See Rosenblum*, 461 A.2d at 153; *Timm, Schmidt & Co.*, 335 N.W.2d at 365.

81. See Orlinski, *supra* note 53, at 863 nn.30-35 for a discussion of subjective reasonableness; *see also Impex Agric. Commodities*, 576 F. Supp. at 591 (discussing "reasonably foreseeable" test).

4. *Sixty-Five Years of* Ultramares

Today, the elements essential to assert third party liability are the same under the three general tests.[82] The distinction between those tests is the degree of notice that a third party will rely on the work of the professional.[83] States occasionally shift among the three rules,[84] so the challenge is to fit the work of a particular professional, such as the reimbursement consultant, into all three tests.

C. *Third Party Negligence Law Applied to Cost Reporting Consultants*

For the application of any of the three third party liability rules discussed above, the federal government becomes a third party acting in reliance upon the work of the consultant.[85] Thus, where the government suffers an injury as the result of negligent or wrongful acts of a provider's consultant, a third party liability issue arises.[86] Medicare consultants could, under the proper circumstances, be subjected to liability under each of the three methodologies.[87]

1. *Reimbursement Consultants and the Three Tests*

Starting with the broadest test, the reasonable foreseeability rule, a consultant is liable to the government as a reasonably foreseeable party.[88] The federal government, through its contractor, the fiscal intermediary, is often in a position of placing substantial reliance on the filed data, as well as on the representations of the consultant.[89] The cost report has one intended use — the

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82. Rominger, *supra* note 53, at 512 nn.20-35; see also Orlinski, *supra* note 53, at 861 nn.5-7 for a discussion of the three third party liability categories.

83. See Orlinski *supra* note 53, at 872 nn.101-03, 880 nn.162-65 for a discussion of the *Utramares* doctrine and the notice requirements under the actual foreseeability test; *see also Rosenblum*, 461 A.2d at 153 (discussing the reasonable foreseeability theory).

84. *See, e.g.*, Bily v. Arthur Young and Co., 834 P.2d 745 (Cal. 1992).

85. See *supra* notes 42-45 and accompanying text for a description of the reliance the government places on the work of consultants.

86. See *supra* notes 42-45 and accompanying text for a discussion of the responsibilities of the fiscal intermediary. *See also* 42 C.F.R. § 413.64(f)(2)(1995) (enumerating rate setting duties of the fiscal intermediary).

87. Rominger, *supra* note 53, at 512 nn.20-35; see also Orlinski, *supra* note 53, at 861 nn.5-7 for a discussion of the three third party liability categories.

88. See *supra* notes 77-80 and accompanying text outlining the "reasonable foreseeability" test; *see also Impex Agric. Commodities*, 576 F. Supp. at 591 (applying the reasonable foreseeability test).

89. See *supra* notes 42-45 and accompanying text for a discussion of how the government relies on data in filed cost reports.

generation of an annual final settlement for Medicare reimbursement.[90] That is, when a provider submits a Medicare cost report to the federal government, the provider necessarily understands that the government will rely on the data contained in the cost report. Likewise, Medicare consultants necessarily know that the government will rely on any of their contributions to the cost report. Therefore, the government is a reasonably foreseeable party that will act in reliance on the consultant's work.[91]

Moreover, the federal government is not simply *one* intended user of the cost report, and thus a party whose reliance on the consultant's work is merely reasonably foreseeable.[92] The government is virtually *the only* intended user of the cost report, and therefore an *actually* foreseeable party.[93] Accordingly, this also satisfies the classification scheme of the actual foreseeability rule for establishing third party liability.[94] The actual foreseeability test, while narrower in defining the appropriate class of potential plaintiffs, remains substantially the same as the reasonable foreseeability test in its determination of reliance.[95]

The privity or near privity test, however, provides the narrowest of the three potential plaintiff classifications.[96] Yet, even under this test, the federal government may sometimes assert third party liability claims against Medicare consultants who participate in filing fraudulent cost reports.[97] In many cases, the

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90. See *supra* notes 38-40 and accompanying text for a description of Medicare cost reporting functions.

91. See *supra* notes 32, 38-40 and accompanying text for a discussion of Medicare cost reporting forms, allowable costs, and the use of cost reports.

92. See *supra* notes 32, 38-40 and accompanying text for a discussion of Medicare cost reporting forms, allowable costs, and use of cost reports.

93. Though providers may use the cost report for non-official purposes, the cost report is intended for official use only. See *supra* notes 32, 38-40 and accompanying text for a discussion of Medicare cost reporting forms, allowable costs, and use of cost reports.

94. *See* RESTATEMENT (SECOND) OF TORTS, *supra* note 69, § 552 (describing the appropriate class of parties protected under the "actual foreseeability" test).

95. *See* Rusch Factors, Inc. v. Levin, 284 F. Supp. 85, 93 (D. R.I. 1968); H. Rosenblum, Inc. v. Adler, 461 A.2d 138, 153 (N.J. 1983). Jurisdictions following the actual foreseeability approach will find the reliance element satisfied where an injured party relied on information, for example financial statements supplied by defendant accountants, for a known use of that information. *Rusch Factors*, 284 F. Supp. at 93. The reasonably foreseeable approach similarly requires that the injured party must have relied upon information in the context of "a proper business purpose." *Rosenblum*, 461 A.2d at 153. Both tests have their roots in the traditional negligence formula: 1) duty; 2) breach of that duty; 3) causation, both legal and proximate; and 4) damages. W. PAGE KEETON ET AL., PROSSER AND KEETON ON THE LAW OF TORTS § 30, at 164-65 (5th ed. 1984).

96. *See Ultramares*, 174 N.E. at 441. *See also* Orlinski, *supra* note 53, at 872 nn.101-03 (discussing the *Ultramares* decision and the class of parties protected under the "privity or near privity" test).

97. *See, e.g.*, Credit Alliance Corp. v. Arthur Andersen & Co., 483 N.E.2d 110,

consultant confers directly with the government representative on behalf of the client, not only during the preparation stage of the engagement, but also during the intermediary's audit of the cost report.[98]

Where the consultant interacts with the government regarding the cost report, case law supports the contention that the relationship approaches or equals privity.[99] At least in cases where a Medicare consultant interacts with governmental representatives regarding a client's cost report, the government should satisfy the near-privity requirement of the more stringent test under *Ultramares*.[100] At issue under all three tests is the degree to which the government may reasonably be expected to rely on the work of the third party consultant.[101]

2. *The Issue of Reliance*

The extent to which the government relies upon the representations of the consultant is arguably minimal.[102] That is, the

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118 (N.Y. 1985). The test, as refined in *Credit Alliance*, and accepted as the governing rule in those jurisdictions which require privity or near privity, refers to the negligent party's conduct and linkage of that party to the injured plaintiff or plaintiffs. See *supra* note 66 and accompanying text for a discussion of the linkage of parties under the privity or near privity approach. Cases involving the negligent or willful conduct of Medicare consultants contain the necessary linkage between such consultants and the federal government.

98. See *supra* notes 38-45 and accompanying text for a description the Medicare cost report and the cost reporting process.

99. See Orlinski, *supra* note 53, at 872 nn.101-03 (discussing the *Ultramares* decision and the privity doctrines); see *supra* note 54 for an explanation of the *Ultramares* holding; see *supra* note 66 for a discussion of the limited application of the privity doctrine. The conduct of consultants, in their interactions with the government, provides the necessary linkage to find a relationship approaching privity. *Id.* In *European American Bank and Trust Co.*, decided with *Credit Alliance v. Arthur Andersen & Co.*, the court held that the defendant accountants bridged the nexus necessary for the formation of a relationship approaching privity. *Credit Alliance*, 483 N.E.2d at 120. The accountants knew of the identity of the third party plaintiffs, of their intent to rely upon defendants' audit work, and of the "particular purpose" for such reliance. *Id.* Moreover, the accountants and the third party plaintiff communicated, in writing and otherwise, and went so far as to meet together to discuss the issues relating to the accountants' client, Majestic Electro. *Id.*

100. See *supra* notes 55-59 and accompanying text for a discussion of the *Ultramares* rule.

101. *See Orlinski*, *supra* note 53, at 872 nn.101-03, 880 nn. 162-65 for a discussion of the *Utramares* doctrine and the notice requirements under the actual foreseeability test; *see also* H. Rosenblum, Inc. v. Adler, 461 A.2d 138, 153 (N.J. 1983) (discussing the reasonable foreseeability theory).

102. *See, e.g.*, Lampert v. Mahoney, Cohen & Co., 630 N.Y.S.2d 733, 735 (N.Y. App. Div. 1995) (holding that plaintiff may assume the risk where plaintiff's own examination would have identified misrepresentation resulting in loss). The Medicare fiscal intermediary could prevent some instances of fraud loss by performing

government has an administrative duty to assure that the cost reports are accurate and reasonably free from material misstatement.[103] However, that duty only arises at the time that the government completes its audit and review procedures and issues a final settlement of the cost report.[104]

In the time between the date the provider files the cost report and the date the government issues a final settlement, the government relies upon the filed data for a variety of uses, such as the setting of reimbursement rates.[105] If a cost report contains material misstatements that inflate the cost attributed to the Medicare program, the government is exposed to losses that may not become evident for a period of years.[106] Take the situation of the Doles, for example, from the hypothetical case introducing this Note.

The Doles filed their cost report for the fiscal year ending December 31, 1993, in the first six months of 1994.[107] Within sixty days of acceptance, the fiscal intermediary issued an initial settlement and perhaps used the filed data to recalibrate the provider's reimbursement rate.[108] After that essentially cursory

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the analysis necessary to assure that data submitted by the provider is accurate. *Id.* However, where the inaccuracies are latent and the misrepresentations carefully cloaked within layers of legitimate data, the means necessary to assure that the data is free from material error become unreasonable under the circumstances. See *infra* note 105 and accompanying text for a discussion of prompt payment mandated by federal regulations. See *supra* notes 42-45 and accompanying text for a discussion of fiscal intermediaries; *see also* 42 C.F.R. § 413.64(f)(2) (1995) (describing the timing requirements for cost report final settlement).

103. 42 C.F.R. §§ 413.20, 421.100(c) (1995); INTERMEDIARY MANUAL 13-4, § 4100.1 (1989).

104. *See* 42 U.S.C. § 1395h (1988); 42 C.F.R. § 413.64(f) (1995).

105. *See* 42 C.F.R. §§ 413.60, 413.64(c) (1995) (discussing Medicare reimbursement rate setting). Other uses of the filed cost report include the mandatory determination of an initial settlement due to the provider within ninety days of receipt of the cost report by the intermediary. 42 C.F.R. § 413.64(f)(2) (1995). "In order to reimburse the provider as quickly as possible, an initial retroactive adjustment will be made as soon as the cost report is received. For this purpose, the costs will be accepted as reported, unless there are obvious errors or inconsistencies, subject to a later audit." *Id.* The regulations calling for an initial retroactive settlement require only minimal scrutiny by the government until the final settlement is made. *Id.* "When an audit is made and the final liability of the program is determined, a final adjustment will be made." *Id.* Thus, the government necessarily places reliance in the filed data absent "obvious errors or inconsistencies." *Id.*

106. See *supra* notes 42-45 and accompanying text for a discussion of fiscal intermediaries; *see also* 42 C.F.R. § 413.64(f)(2) (describing the timing requirements for cost report final settlement).

107. *See* 60 Fed. Reg. 33,137 (1995).

108. See *supra* note 105 and accompanying text for a discussion of the use of filed cost reports. Note that the fiscal intermediary may place substantial reliance on filed cost reports for setting payment rates. 42 C.F.R. § 413.64(f)(2). Where a filed cost report reflects overstated Medicare cost, the payment rate may be inflat-

review for initial settlement,[109] the fiscal intermediary did nothing with the cost report until the fiscal intermediary issued a final settlement, months or even years later.[110] Because of the limited scope of the review of cost reports at the time of initial settlement, the government's intermediary necessarily places substantial reliance on the work of the cost report preparer.[111] In addition to the nature of this reliance, the nature of the consultants' work brings third party reimbursement specialists within the ambit of common law third party liability rules.

3. Third Party Reimbursement Consultants as Information Service Professionals

Courts have established third party liability against a broadening class of professionals rendering information services to the public.[112] Because many consultants are certified public accountants (CPAs) or are associated with divisions or departments of public accounting firms, the liability typically attached to accountants should apply to consultants as well.[113] In addition, attorneys, whose traditional duties have given rise to third party liability in theory as well as in case law, frequently act as cost reporting consultants.[114] Even though consultants are not typically engaged to certify the accuracy of the financial statements from which the cost report is prepared, their clients engage them to prepare cost reports in accordance with Medicare regulations and federal statutory law.[115]

It is unreasonable to assume that consultants would inform clients of the fraudulent nature of certain cost report modifications that would expose the client unknowingly to civil and criminal penalties.[116] Clients engage their professional consultants to present cost reports accurately so that the client may submit the

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ed as a result of the fiscal intermediary's reliance on the filed cost report. *Id.*

109. *Id.*

110. 42 C.F.R. § 413.64(f)(2) (1995).

111. See *supra* note 105 for a discussion of the initial settlement regulations.

112. See *supra* note 62 for a discussion of the growing category of potential defendants under third party liability theory.

113. *See* Orlinski, *supra* note 53, at 861 n.18, (discussing the reach of third party liability and the breadth of affected parties).

114. *See, e.g., Ultramares*, 174 N.E. at 448 (discussing the scope of the privity rule); *see also* Orlinksi, *supra* note 53 (discussing the application of third party liability to a variety of information service professionals).

115. See *supra* notes 46-47 and accompanying text for a discussion of the medicare cost report certification. Also, see *supra* notes 1-2 and accompanying text regarding the hypothetical case United States v. Dole for an illustration of those expectations.

116. See *supra* note 47 and accompanying text for a discussion of the cost report certification page.

cost report to the government.[117] Where negligent or fraudulent representations incriminate a provider, potentially an innocent party, the government, as a third party plaintiff, should pursue the consultant, an information service professional, jointly or severally with the client.[118]

The consultant's function, after all, is to prepare the cost report as accurately as possible.[119] There are those consultants who seek to hide as many creative elements of reimbursement maximization fakery as possible, assuming that the government surely cannot catch them all.[120]

Consultants fulfill a necessary and often essential role. They provide the technical knowledge required for Medicare provider participation to smaller players who cannot afford to educate themselves in a technical, dynamic and complex body of details.[121] The Doles, for example, in the hypothetical case introducing this Note, had no previous experience with Medicare reimbursement.[122] If the Doles were required to file the Medicare cost report without any technical assistance, they may have recon-

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117. See *supra* notes 47, 50 for a discussion of the penalties available under the FCA and Medicare regulations. The certifying client only intends to purchase the accurate preparation of the cost report. If the client has any other intentions, then by signing the certification page of the cost report the client exposes herself to the penalties available under the False Claims Act. See *supra* notes 49-50 for a discussion of FCA penalties. In such a case, a government action asserting a negligence theory against a provider is thus unnecessary as a criminal basis exists.

118. See *infra* Part V for a discussion of the proposal to encourage federal authorities to clamp down on Medicare consultants, and *see also* Temple v. Synthes Corp., Ltd., 498 U.S. 5, 7 (1990) (holding that joint tortfeasors need not be joined under FED. R. CIV. P. 19(a)).

119. See *supra* notes 25-32 for a discussion of the client's expectations of the cost reporting consultant.

120. *See Florida Nursing Home*, *supra* note 20, at D-9.1 (discussing consultant fraud); see *supra* notes 21-23 and accompanying text for a discussion of cost reporting machinations. In many cases, it is conceivable that consultants drove these schemes by recommending cost report modifications to their clients to give the appearance of reimbursement maximization. See *Florida Nursing Home*, *supra* note 20, at D-9.1. While the government has never launched litigation against a Medicare consultant as a third party defendant, the various theories of third party liability appear to open the doors to the government to take this type of action. *Id.*; see *supra* notes 112-26 and accompanying text for a suggestion of the possible application of third party liability to health care consultants.

121. See *supra* notes 1-2 and accompanying text regarding the hypothetical case United States v. Dole. The economic practicality of the health care industry requires that smaller players seek out qualified cost reporting professionals. See *supra* notes 29-32 and accompanying text for an explanation of why smaller entities may require the services of medicare consultants. Providers need consultants to assist with the reimbursement issues associated with health care businesses that deal with Medicare. *Id.* Simply put, without the assistance of consultants, many health care providers could not service the population of Medicare beneficiaries due to the complexity and dynamics of the industry. *Id.*

122. See *supra* notes 1-2 for a discussion of the introductory hypothetical.

sidered their decision to purchase the home health agency. Thousands of providers, such as the Doles, rely on consultants to apply the regulations and statutes legitimately in a manner that will not place the providers in legal jeopardy.[123]

Similarly, the government expects consultants to exercise professional judgment and conform to the applicable laws, relying perhaps more on the consultant than on an independent provider lacking the assistance of outside contractors.[124] Thus, when a consultant represents that she is serving as the client's paid cost report preparer, the consultant implicitly certifies that she has presented the cost report in accordance with the applicable regulations and statutes.[125] If, however, these consultants are held blameless, then the incentive to adhere to the Medicare regulations and statutes may be destroyed by the competing need to impress the client with additional revenue.[126] Therefore, negligence actions in tort may prove a great deterrent to consultant-induced fraud. However, federal statutes would provide an even greater anti-fraud tool.

IV. THE FEDERAL FALSE CLAIMS ACT

Congress originally enacted the Federal False Claims Act (FCA)[127] in 1863 to provide for civil penalties against parties who commit fraud against the government.[128] In its original form, the FCA provided for penalties of double damages and permitted the claim to be asserted by a private *qui tam* representa-

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123. See *supra* notes 29-32 and accompanying text for a discussion of clients' expectations of their cost reporting consultants.

124. See *supra* note 105 and accompanying text for a brief discussion of the federal regulations mandating prompt payment to providers. The health care industry expects a large degree of professionalism from consultants in the field of Medicare reimbursement since consultants typically hold themselves out publicly as "competent member[s] of the profession in obtaining and communicating information." Orlinski, *supra* note 53, at 868. *See* RESTATEMENT (SECOND) OF TORTS, *supra* note 70, § 552(1) (discussing suppliers of information).

125. *See* RESTATEMENT (SECOND) OF TORTS, *supra* note 70, § 552(1). No client expects his consultant simply to take a "here, sign this" approach with the cost report, as the certification page and its enumerated penalties makes clear the ramifications of falsities knowingly included in the cost report. See *supra* note 47. A client who clearly relies upon the consultant to assure the propriety of the data submitted to the government, and who then certifies to such accuracy in reasonable reliance upon the consultants' work, is entitled to the accountability associated with other professions. *See* Orlinski, *supra* note 53, at 868 (discussing client expectations of consultants); *see also* RESTATEMENT (SECOND) OF TORTS, *supra* note 70, § 552(1).

126. See, *e.g.*, *Florida Nursing Home*, *supra* note 20, at D-9.1 for an illustration of consultants' pecuniary motivation to misstate their clients' cost report data.

127. False Claims Act, 31 U.S.C. §§ 3729-30 (1988).

128. Act of Mar. 2, 1863, ch. 67, 12 Stat. 696 (1863) (codified as amended at 31 U.S.C. §§ 3729-30 (1988)).

tive, or "relator," who would receive one half of the penalties recovered.[129] Over time, the FCA became a tool to enlist the assistance of private individuals in policing adherence to certain statutes.[130]

Today's FCA provides for more stringent penalties than did its forerunner.[131] Also, the formal *qui tam* provisions allow specific awards to relators who bring actions on behalf of the government.[132] For these reasons, *qui tam* actions under the FCA are a major source of litigation in the field of health care fraud.[133]

The FCA applies to health care fraud in the same manner as to any fraudulent claim against the government.[134] There are many examples demonstrating the effectiveness of FCA actions, via both *qui tam* and independent government suits, against those who commit Medicare fraud.[135] Both forms of Medicare fraud — cost report and billing fraud — are actionable under the FCA.[136]

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129. Francis J. Serbaroli, *Provider Liabilities Under the False Claims Act*, 212 N.Y.L.J. 63 (1994). For a critical analysis of the application of the False Claims Act to health care fraud, see generally David J. Ryan, *The False Claims Act: An Old Weapon with New Firepower is Aimed at Health Care Fraud*, 4 ANNALS HEALTH L. 127 (1995). *But see* Clinton A. Krislov, *Scrutiny of the Bounty: Incentive Awards for Plaintiffs in Class Litigation*, 78 ILL. B.J. 286 (1990) (discussing the merits of *qui tam* actions). The *qui tam* doctrine is an English invention that permitted a private individual to bring charges against those who committed a fraud on the Crown. See Ryan *supra*, at 127.

130. See Ryan, *supra* note 129, at 128 for a brief discussion of the history of the FCA.

131. See Ryan, *supra* note 129, at 128; *see also* False Claims Act, 31 U.S.C. §§ 3729-30 (1988) (setting forth the penalties available under the FCA).

132. 31 U.S.C. §§ 3730(b)-(f).

133. *Qui tam* relators initiated the following cases against Medicare participants: United States *ex rel.* Wagner v. Allied Clinical Labs., Medicare & Medicaid Guide (CCH) ¶ 43,142 (S.D. Ohio 1995); United States *ex rel.* Public Integrity v. Therapeutic Technology Inc., 895 F. Supp. 294 (S.D. Ala. 1995); United States *ex rel.* Burns v. Family Practice Assoc., 162 F.R.D. 624 (S.D. Cal. 1995); Mikes v. Strauss, 889 F. Supp. 746 (S.D. N.Y. 1995); United States *ex rel.* Roy v. Anthony, [1994-2 Transfer Binder] Medicare & Medicaid Guide (CCH) ¶ 42,625 (S.D. Ohio 1994). *But see* United States *ex rel.* State of Wis. v. Dean, 729 F.2d 1100 (7th Cir. 1984) (discussing the limitations over parties eligible to maintain *qui tam* actions).

134. *See* False Claims Act, 31 U.S.C. § 3729(c). A claim against the government "includes any request or demand . . . for money or property which is made to a contractor, grantee, or other recipient if the United States Government provides . . . or . . . will reimburse . . . any portion of [that] money or property." *Id.*

135. *See, e.g.*, *Wagner*, Medicare & Medicaid Guide (CCH) ¶ 43,142; *Therapeutic Technology*, 895 F. Supp. at 294; *Family Practice Assoc.*, 162 F.R.D. at 624; *Mikes*, 889 F. Supp. at 746; *Anthony*, [1994-2 Transfer Binder] Medicare & Medicaid Guide (CCH) ¶ 42,625.

136. See *supra* notes 23-25 and accompanying text for cases dealing with both types of fraud. The categories of billings and cost reports each fit within the definition of a claim against the federal government. *See also* Federal Claims Act, 31 U.S.C. § 3729 (defining conduct actionable under the FCA). Thus, a false statement within either type of claim would trigger a legitimate cause of action under the

Several classifications of conduct are actionable under the FCA, any number of which have potential applicability to health care fraud.[137] These classes of conduct are further stratified into two categories of false claimants. The first category ("conspiracy theory" parties) consists of those who "knowingly" commit the act of making a false claim against the federal government.[138] The second category ("causation theory" parties) includes those who "knowingly" cause another party to commit the act of making a false claim against the federal government.[139]

The conspiracy theory requires an agreement between two or more parties to obtain payment from the government on a fraudulent or false claim, coupled with an overt act made in furtherance of that agreement.[140] The success of these claims varies since

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FCA. *Id.* §§ 3729-30.

137. *See* False Claims Act, 31 U.S.C. § 3729(a). Specifically, the FCA provides the following:

> [a]ny person who—
> (1) knowingly presents, or causes to be presented, to an officer or employee of the United States Government . . . a false or fraudulent claim for payment or approval;
> (2) knowingly makes, uses, or causes to be make or used, a false record or statement to get a false or fraudulent claim paid or approved by the Government;
> (3) conspires to defraud the Government by getting a false or fraudulent claim allowed or paid;
> . . . .
> (7) knowingly makes, uses, or causes to be made or used, a false record or statement to conceal, avoid, or decrease an obligation to pay or transmit money or property to the Government, is liable to the United States Government. . . .

Id.

138. *See id.* The Act does not explicitly use the terms "conspiracy theory" and "causation theory" party. Instead, the FCA enumerates conspiracies and causation among several types of conduct that constitute violations. *Id.*

139. See *supra* notes 34-35 and accompanying text for a discussion of classes of conduct actionable under FCA.

140. False Claims Act, 31 U.S.C. § 3729(a)(3). Although the FCA does not itself define conspiracy, the American Law Institute's MODEL PENAL CODE is instructive:

> (1) Definition of Conspiracy. A person is guilty of conspiracy with another person or persons to commit a crime if with the purpose of promoting or facilitating its commission he:
> (a) agrees with such other person or persons that they or one or more of them will engage in conduct which constitutes such crime or an attempt or solicitation to commit such crime; or
> (b) agrees to aid such other person or persons in the planning or commission of such crime or of an attempt or solicitation to commit such crime.
> . . .
> (5) Overt Act. No person may be convicted of conspiracy to commit a crime, other than felony of the first or second degree, unless an overt act in pursuance of such conspiracy is alleged and proved to have been done by him or by a person with whom he conspired.

MODEL PENAL CODE § 5.03 (1995). Mens rea, frequently the element that makes an

conspiracies are difficult to prove.[141] Moreover, the conspiracy theory under the FCA does not benefit from the liberal definitions given to "knowing" and "knowingly" as applicable to the causation manifestations of FCA violations.[142] While the conspiracy theory may be a difficult avenue to pursue fraud, the FCA provides an easier course via the causation theory.[143]

The causation theory under the FCA has two branches: direct and indirect causation.[144] Direct causation of a violation of the FCA is exemplified by a single actor who knowingly and personally makes a false claim against the government.[145] Indirect causation involves a party knowingly causing an instrumentality to make a false claim, even where the instrumentality is not aware of the fraud.[146]

The government may pursue Medicare fraud under the FCA using either the conspiracy or the causation theories.[147] The conspiracy theory, while not as widely successful as the causation theory, has resulted in many prosecutions.[148] In a conspiracy action involving a consultant and a fraudulent Medicare cost report, both the consultant and another party, presumably the Medicare

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otherwise legal activity criminal, often must be proved from circumstantial evidence alone. Sandstrom v. Montana, 442 U.S. 510, 525-27 (1979).

141. *See* MODEL PENAL CODE § 2.02 (1995); *see also Sandstrom*, 442 U.S. at 525-27.

142. *See* False Claims Act, § 3729(b). The FCA defines these terms as follows:

> (b) Knowing and knowingly defined.—For purposes of this section, the terms 'knowing' and 'knowingly' mean that a person, with respect to information—
> (1) has actual knowledge of the information;
> (2) acts in deliberate ignorance of the truth or falsity of the information; or
> (3) acts in reckless disregard of the truth or falsity of the information,
> and no proof of specific intent to defraud in required.

Id. Note that the conspiracy theory language of the FCA does not include the words "knowing" or "knowingly." False Claims Act, § 3729(a)(3).

143. *See* False Claims Act, 31 U.S.C. § 3730(b).

144. *See id.* at § 3729(a).

145. *See id.*

146. *See id.* For example, *A*, an employer, instructs *B*, a billing clerk and employee of *A*, to submit a claim to Medicare for payment. *A*, knowing the claim to be false, is liable under the FCA for indirectly causing *B* to submit the false or fraudulent claim. Presuming that *B* had neither knowledge of the falsity of the claim nor reason to doubt its validity, *B* is an innocent instrumentality of *A*, shielded from liability under the Act. *See id.* at § 3729(a)(1).

147. See *supra* notes 34-35 and accompanying text for a discussion of classes of conduct actionable under the FCA.

148. *See, e.g.*, United States v. Alemany Rivera, 781 F.2d 229 (1st Cir. 1985) (conspiring with related organizations); Klein v. Heckler, 761 F.2d 1304 (9th Cir. 1985) (conspiring among members of physicians' group); Mikes v. Strauss, 889 F. Supp. 746 (S.D.N.Y. 1995) (conspiring with related organizations); United States *ex rel.* McCoy v. California Medical Review, Inc., 723 F. Supp. 1363 (N.D. Cal. 1989) (conspiring with peer review organization); Peterson, D.O. v. Richardson, 370 F. Supp. 1259 (N.D. Tex. 1973) (conspiring with related organizations).

provider, must agree to submit a false claim for payment by filing a cost report.[149]

If a consultant signs the certification page of the cost report on behalf of the client and submits the cost report to the government knowing the cost report to contain false statements within the meaning of the FCA, the government could prosecute the consultant under the direct causation theory.[150] By contrast, where a consultant prepares the Medicare cost report knowing it to contain false statements within the meaning of the FCA, and then merely hands it over for the unwitting client to sign, the government could prosecute the consultant under the indirect causation theory.[151] Either theory presents an opportunity for the federal government to hold consultants accountable for consultant-induced fraud.[152]

V. THE FEDERAL GOVERNMENT SHOULD PURSUE CONSULTANTS DIRECTLY FOR THE FRAUD OF THEIR CLIENTS

This Note proposes that the federal government must adopt the means necessary to pursue third party consultants to reduce Medicare fraud.[153] This proposal deals with the fair application of existing law, not with the creation and retroactive application of new law, and thus, the proposal does not violate consultants' due process rights.[154] Adding burdens to the consultants' function, however, may perturb providers that require professional assistance to participate in the Medicare program.[155] This Section will discuss the benefits of holding third party consultants liable, especially in consideration of these concerns, under the various theories described above.

This Note has explored three general theories of culpability applicable to consultants who operate in the Medicare cost reporting arena: 1) the Reliance Theory,[156] a third party negligence ac-

149. See *supra* notes 140-42 and accompanying text for a discussion of the definition of conspiracy under the Model Penal Code.

150. See *supra* note 47 and accompanying text for a discussion of the certification page of the Medicare cost report.

151. See *supra* note 146 for an example of the instrumentality concept. In the hypothetical example, replace A with the consultant, and B with the client. The instrumentality concept remains valid under either construction.

152. See *supra* notes 144-46 and accompanying text for a discussion of the two branches of the causation theory.

153. See *supra* note 29-32 and accompanying text for a discussion of the essential nature of Medicare cost reporting experts in the health care industry.

154. See *supra* notes 63-81 and accompanying text for a discussion of various theories of third party liability and the FCA.

155. See *infra* notes 164-75 for a discussion of the burden created by the recognition of reimbursement consultants' liability.

156. See *supra* notes 51-60 and accompanying text for a discussion of third party

tion; 2) the Criminal Conspiracy Theory,[157] actionable under the FCA; and 3) the Causation Theories, also founded on the FCA.[158] To date, the government has had its share of victories against parties who defraud the Medicare and Medicaid systems, but the government triumphs most often by employing the potent False Claims Act as a weapon.[159] So far, the federal government has not directly confronted consultants that provide the methods to commit, or otherwise cause, an unknown quantity of health care fraud.[160] It is time the government takes action against medicare consultants for their negligent or criminal acts.

The government cannot pursue consultants liable for the fraud of their clients until such consultants are known. Therefore, the first step is to require the mandatory disclosure of the identity of paid preparers of Medicare cost reports. When their names are attached to the cost report, perhaps some of the deceitful consultants will be less eager to manipulate information that would land their clients, if not themselves, in jail.

Where consultants cause their uninformed clients to incur losses due to the negligent or fraudulent performance of the consultants' duties, then the government should pursue the consultants under one of the three third party negligence theories.[161] Justice Cardozo could have imagined this class of litigation fitting into his near privity test.[162] Either of the other two more expansive tests likewise would apply to hold the consultants accountable for their own negligence or intentional fraud.[163]

Additionally, the federal government should use the False

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reliance theory.

157. See *supra* notes 140-43 and accompanying text for a discussion of the criminal conspiracy theory under the FCA.

158. See *supra* notes 144-46 and accompanying text for a discussion of the causation theory under the FCA.

159. See *supra* notes 12-13 and accompanying text for a discussion of several FCA victories for the federal government). In addition to the FCA, other federal statutes have proven useful against health care fraud. *See, e.g.*, United States v. Khan, 53 F.3d 507 (2d Cir. 1995); United States v. Neufeld, D.O., 908 F. Supp. 491 (S.D. Ohio 1995); United States v. El-Difrawi, 898 F. Supp. 3 (D.D.C. 1995). However, such actions are usually premised on a FCA claim. *See, e.g.*, United States v. Shah, 44 F.3d 285 (5th Cir. 1995); *but see* United States v. Halper, 490 U.S. 435, 452 (1989) (holding that FCA treble damages constitute double jeopardy where such damages produce a punitive result).

160. See *supra* notes 12-13 and accompanying text for a discussion of cases involving Medicare fraud.

161. See *supra* notes 51-84 and accompanying text for a discussion of the negligence theories in tort law.

162. See *supra* notes 55-59 and accompanying text for a discussion of the *Ultramares* doctrine requiring privity and near privity for third party negligence cases.

163. See *supra* notes 69-81 and accompanying text discussing the foreseeability tests for third party liability.

Claims Act to prosecute consultants under the causation and conspiracy theories of criminal liability.[164] Such criminal theories apply where the consultants' acts exceed mere negligence, rising to the level of criminal conspiracies or falling under the FCA's umbrella of reckless or knowing acts.[165] The federal government has already applied these criminal theories to the prosecution of providers themselves.[166] The next logical step is to hold accountable the party responsible for the fraudulent representations. In cases such as the introductory hypothetical, this is the consultant.

While it is true that the government already has a party that it may hold liable for losses in such cases, namely the provider, taking the easy route will only treat a symptom, not the cause, of this class of fraud loss.[167] Where the provider does not have the means to pay the penalties and forfeitures or has declared bankruptcy, the government may win the fight but lose the battle: a six- or seven-figure settlement becomes much less valuable when written off as an uncollectible judgment from a financially devastated provider.[168]

The services rendered by the provider are essential to the community. Thus, another provider will almost certainly come along to care for the patients of a provider driven out of business due to bankruptcy or to losing a fraud case to the government. The new providers may just as easily contract with the previous consultant, oblivious to the fact that the consultant was the root of the problem. Thus, a symptom has been treated, but the parasite continues to destroy its host.

Applying third party liability and FCA concepts to Medicare consultants is arguably problematic because of the potential burden added to Medicare participation by small health care providers.[169] Additional exposure to liability for Medicare consultants

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164. See *supra* notes 137-40 and accompanying text for a discussion of the available FCA actions.

165. See *supra* notes 137-39 and accompanying text for a discussion of the conduct that violates the FCA.

166. See *supra* note 12-13 and accompanying text for a discussion of FCA cases against providers.

167. *See* 42 C.F.R. § 413.24(f)(4)(iii). A party who signs the certification page of the Medicare cost report becomes responsible for any fraud within the document. *Id.*

168. *See* Ryan, *supra* note 129, at 141 (discussing the Draconian nature of fines under the FCA); *see also* United States v. Halper, 490 U.S. 435, 452 (1989) (holding that FCA damages amounted to double jeopardy). An argument may be made that the FCA's fines and penalties may have a coercive effect upon a party charged with false claims violations. Ryan, *supra* note 129, at 127. For example, in theory a party might prefer to settle a FCA lawsuit, rather than fight it, because their Medicare revenues can be suspended during the litigation. *Id.* However, where the cost reporting consultant is involved, no such duress may be exerted because no transactions occur between intermediaries and consultants.

169. See *supra* notes 35-37 and accompanying text for a brief discussion of cost

may theoretically translate into additional costs for services because Medicare consultants may choose to purchase additional malpractice insurance to protect themselves.[170] However, of the three general categories of culpability for Medicare consultants,[171] two are criminal in nature.[172] Thus, malpractice liability insurance affords no protection to defendants in such cases.[173] Furthermore, Medicare consultants are already exposed to liability to their clients, so the costs of services should already reflect the malpractice insurance cost.[174] Finally, the massive economic impact due to Medicare fraud far outweighs the minor cost increases to individual providers for additional malpractice insurance.[175]

Heightening consultants' exposure to lawsuits will neither excessively inflate the cost of Medicare consultants' services nor economically impinge on small providers' ability to participate in Medicare.[176] One must wonder, then, why the federal government does not choose to pursue the Medicare consultants for the fraud of their clients. No federal policy supplies an acceptable rationale.[177] Whatever the reason, if the federal government is indeed serious about preventing Medicare fraud, it must reevalu-

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reporting burdens and special problems of small providers.

170. *See* Julie Faussie, *Limiting Liability in Public Accounting Suits: A Desperate Appeal from a Beleaguered Profession*, 28 VAL. U. L. REV. 1041, 1051 (1994) (discussing how professionals pass malpractice insurance cost along to ultimate consumers of the professionals' services).

171. See *supra* notes 61-62 and accompanying text for a discussion of the three categories of culpability.

172. See *supra* notes 127-52 for a discussion of the FCA actions.

173. Faussie, *supra* note 170, at 1052.

174. *Id.*

175. See *supra* notes 5-7 and accompanying text for a discussion of estimated Medicare losses due to fraud.

176. See *supra* notes 169-74 and accompanying text for an examination of the economic impact of consultants' liability.

177. Perhaps the government does not hold Medicare consultants accountable as a matter of litigation strategy: the government has a known party who signed their name to the cost report. 42 C.F.R. § 413.24(f)(4)(iii). Small providers are also less likely to have a legal defense fund due to their small size. See *supra* notes 29-32 and accompanying text for a discussion of the economic necessity of Medicare cost reporting consultants for smaller providers. The owner or operator of a small provider arguably presents a less-threatening opponent in a court of law than does a more cash-ready consulting firm. However, while pursuing a Medicare provider may result in an easier victory to the federal government, the victory rings hollow when a bankrupt provider cannot pay the judgment. See *supra* notes 167-68 and accompanying text for a discussion of liquidity concerns for judgments against small providers. It is true that consultants typically have larger war chests than providers to defend against these types of suits, but they also have deeper pockets to pay the judgments against them. *Id.* In short, a defendant that is actually able to pay the judgment against it is a more efficient party to pursue than a defendant that cannot.

ate its approach to Medicare fraud where consultants are involved, and should force these individuals to pay for their misdeeds.

CONCLUSION

Medicare consultants are the suppliers of information to providers, and ultimately to the federal government. Many times, their services are indispensable to smaller organizations. If that information is tainted, providers themselves are not solely responsible for the repercussions. Consultants are viewed by many providers as their only source of Medicare reporting information. Consultants who prey on the unsophisticated with promises of riches spread this taint without remorse. The government must use all the tools in its power to curb the spread of fraud loss in the health care industry. The federal government has not yet chosen to attack reimbursement consultants with the resources available in tort law and the federal statutes as it should.[178] Until the government brings all of its devices to bear upon all parties who perpetrate the huge levels of fraud in the Medicare system, the Hillary and Newt Doles of this country will continue to carry the full burden on behalf of all of the culprits.[179]

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178. See *supra* notes 112-26 for a discussion of the applicability of tort law to Medicare cost report consultants; see also *supra* note 131 for a description of the remedies available under the FCA.

179. See *supra* notes 1-2 describing the hypothetical case of United States v. Dole.