Health Care Advocacy

How Elder Law Attorneys Can Combat Health Care Fraud Through the False Claims Act

By Ken Levine, Esq.

The False Claims Act rewards those who help expose misconduct that harms both vulnerable individuals and the public fisc.

Elder law attorneys routinely come across systemic failures in the health care system for their clients — such as chronic understaffing, neglect, abuse, phantom billing, and medically unnecessary procedures. These issues often surface during routine client representations, and fixing the larger problem is usually beyond the attorney's immediate mandate. Yet many cases provoke the same thought: *Someone should really do something about this*.

The False Claims Act offers a powerful way to act — by bringing systemic abuse to the government's attention. A not-insignificant side benefit is that successful cases can be very lucrative for those who bring them.

Rewarding Whistleblowers for Identifying Government Fraud

The False Claims Act (31 U.S.C. §§ 3729–3733) is the federal government's primary anti-fraud statute.1 It allows private citizens to bring whistleblower actions on the government's behalf against entities that knowingly submit false claims for payment. Defendants face treble damages plus per-claim civil penalties of about $14,000 to $28,000 per false claim as of July 3, 2025.2

Today, these *qui tam* cases play a central role in fighting health care fraud. The federal government spends roughly $2 trillion annually on Medicare and Medicaid combined,3 and fraud is pervasive in the system. These programs are consistently the largest source of False Claims Act recoveries. In fiscal year 2025, for example, the government collected more than $6.8 billion in False Claims Act settlements and judgments, of which $5.7 billion involved health care.4

Under the statute, whistleblowers (known as "relators") receive 15% to 30% of any government recovery.5 Because judgments and settlements regularly reach into the tens or hundreds of millions of dollars, even a modest percentage yields substantial awards. Since 1986, total False Claims Act recoveries have exceeded $85 billion.6

These financial incentives exist for a good reason: fraud involving federal health care dollars is often hidden, normalized within institutions, or unlikely to be exposed without

insider or advocate intervention. The False Claims Act rewards those who help expose misconduct that harms both vulnerable individuals and the public fisc. The incentives are plainly working: in fiscal year 2025, whistleblowers filed a record 1,297 qui tam suits, the highest number in a single year.

Elder Law Attorneys Are Well Positioned to Identify Health Care Fraud

The classic False Claims Act whistleblower is a company insider with access to internal records. But insiders are not the only effective whistleblowers. Elder law attorneys, through their client work, have unique access to information that can reveal large-scale fraudulent practices, including billing and medical records; admission agreements and care plans; Explanation of Benefits (EOB) statements; and firsthand witness accounts about improper medical practices or substandard care.

On their own, these observations may appear anecdotal. But a few specific, well-documented examples can serve as the cornerstone for uncovering sweeping fraud — particularly when matched with publicly available data that corroborates the account.

Consider a client residing in a nursing home providing grossly substandard care. Other residents at the same facility — and possibly throughout the nursing home chain — are likely experiencing the same substandard conditions. Publicly available staffing data, financial disclosures, and state inspection reports can corroborate the specific resident observations and experience of the deficient care. Because the federal and state governments pay for a substantial portion of care at these facilities, and resident health and safety is at stake, the government has strong motivation to investigate. The U.S. Department of Justice[7] and state attorneys general[8] have brought numerous such cases in recent years.

Common Cases Elder Law Attorneys May Encounter

Grossly Substandard Care ("Worthless Services")

Facilities funded by Medicare or Medicaid must meet minimum standards of care. Chronic understaffing, untreated wounds, medication errors, malnutrition, recurring injuries, or persistent neglect may render the services legally "worthless," creating False Claims Act liability.[9] In September 2025, for example, the U.S. Department of Justice sued ProMedica Health System and its affiliates under the False Claims Act, alleging that four nursing homes they operated provided "grossly substandard" care, including inadequate wound care, failures to maintain resident hygiene, and failure to provide feeding assistance — and that staff falsified medical records to cover it up. That lawsuit grew out of two whistleblower complaints filed years earlier.[10] In July 2025, a group of Ohio nursing homes agreed to pay $3.61 million to resolve similar allegations.[11] These types of "worthless services" cases could be launched by a client's account of neglect, combined with medical records, family observations, and publicly available staffing and financial data.

Fraudulent or Inflated Billing

Billing schemes are among the most common forms of health care fraud. Red flags include billing for services never provided, upcoding to higher-paying service levels, billing for medically unnecessary procedures, charging for therapy when a resident was unable to participate, and physician "ghost visits." Recent cases illustrate the range of billing fraud the government is pursuing. In 2025, Vohra Wound Physicians faced claims of $45 million from the U.S. Department of Justice based on allegations that it overbilled Medicare for unnecessary wound care procedures and upcoded services, driven by corporate quotas pressuring physicians to maximize revenue.12 A chain of skilled nursing facilities paid $21.3 million after admitting to imposing quotas for Medicare therapy services and billing for unnecessary treatment.13 In another case, a Texas nursing home and hospital paid more than $6.5 million for billing services that were not medically necessary or were not part of a documented care plan.14 A single patient's medical billing records or EOBs can provide the initial evidence of a facility-wide fraudulent practice.

Kickbacks and Improper Financial Arrangements

Kickbacks that influence medical decisions can also violate the False Claims Act. Examples include payments or incentives tied to referrals between hospitals and nursing homes, home health agencies rewarding volume-based referrals, and pharmacies or durable medical equipment suppliers offering remuneration in exchange for utilization.15 In 2025, a health system paid $31.5 million to settle allegations that it induced physician referrals through expensive meals, alcohol, cigars, and technology subsidies.16 In another case, a hospice company paid $9.2 million to resolve allegations that it paid kickbacks to medical directors in the form of stipends and sign-on bonuses tied to referral volume.17 Because elder law attorneys navigate these networks on behalf of clients, they may be the first to spot improper financial relationships like these.

Hospice and Home Health Fraud

These sectors have generated significant False Claims Act activity in recent years. Common schemes involve enrolling patients who are not terminal, falsely certifying "homebound" status, billing for nonexistent visits, and pressuring families into accepting unnecessary services.18 In 2025, Saad Healthcare agreed to pay $3 million to resolve allegations that it knowingly submitted false claims for patients in Alabama who were not terminally ill — a case initiated by two former employees who filed a whistleblower complaint.19 In 2024, a hospice provider paid $19.4 million to settle allegations that it billed for patients who were ineligible for the Medicare hospice benefit.20 Families may raise these types of concerns with elder law counsel long before regulators become aware of any fraud.

What Elder Law Attorneys Can Do

Elder law attorneys who see potential fraud should gather and preserve documents and witness accounts, and consult with counsel experienced in False Claims Act litigation to assess whether the facts support a case. Key steps include documenting specific

instances of health care fraud while the evidence is fresh, collecting billing statements and medical records, and noting patterns that may extend beyond a single client. Successful False Claims Act actions serve three goals at once: they expose systemic health care failures, leading to heightened oversight and improved resident care; recover misused government funds; and reward those who bring fraud to light.

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1 U.S. Dept. of Just., Civ. Div., *The False Claims Act* (updated Jan. 15, 2025), https://www.justice.gov/civil/false-claims-act (accessed Apr. 5, 2026).

2 31 U.S.C. § 3729(a)(1). As of July 3, 2025, the False Claims Act (FCA) penalty range is $14,308 to $28,619 per violation. Civil Monetary Penalty Adjustments for Inflation, 89 Fed. Reg. 106308 (Dec. 30, 2024), https://www.federalregister.gov/documents/2024/12/30/2024-31310/civil-monetary-penalty-adjustments-for-inflation (accessed Apr. 5, 2026).

3 Ctrs. for Medicare & Medicaid Servs., *NHE Fact Sheet* (last modified Jan. 14, 2026), https://www.cms.gov/data-research/statistics-trends-and-reports/national-health-expenditure-data/nhe-fact-sheet (accessed Apr. 5, 2026) (reporting Medicare spending of $1.1 trillion and Medicaid spending of $932 billion in 2024).

4 U.S. Dept. of Just., *False Claims Act Settlements and Judgments Exceed $6.8B in Fiscal Year 2025* (Jan. 16, 2026), https://www.justice.gov/opa/pr/false-claims-act-settlements-and-judgments-exceed-68b-fiscal-year-2025 (accessed Apr. 5, 2026).

5 31 U.S.C. § 3730(d)(1)–(2). When the government intervenes, the relator receives 15–25%; when the government declines, 25–30%.

6 U.S. Dept. of Just., *supra* n. 4 (noting total FCA recoveries now exceed $85 billion since 1986, with whistleblowers filing a record 1,297 qui tam suits in FY 2025).

7 *See e.g. United States v. Am. Health Found. Inc.,* No. 22-02344, 2023 U.S. Dist. LEXIS 56071, at *1 (E.D. Pa. Mar. 31, 2023) (denying motion to dismiss in a FCA worthless services case, where the complaint alleged that residents of the nursing homes frequently did not receive adequate medical, dental, or psychiatric treatment, and were not properly cared for, and two federal health beneficiaries died as a result of inadequate supervision); Audrey Davis & Clay T. Lee, *Whether Worth Less or Worthless, Quality of Care Issues Under the FCA Are Worth Noting,* Natl. L. Rev. (June 6, 2019), https://natlawreview.com/article/whether-worth-less-or-worthless-quality-care-issues-under-fca-are-worth-noting (accessed Apr. 5, 2026).

8 *See e.g.* N.Y. Atty. Gen., *Attorney General James Sues Owners and Operators of Four Nursing Homes for Financial Fraud and Resident Neglect* (June 28, 2023), https://ag.ny.gov/press-release/2023/attorney-general-james-sues-owners-and-operators-four-nursing-homes-financial (accessed Apr. 5, 2026); Cal. Atty. Gen., *Attorney General Bonta Holds Skilled Nursing Facility Chain Accountable for*

Misrepresenting its Quality of Care and Putting Patients at Risk (June 24, 2025), https://oag.ca.gov/news/press-releases/attorney-general-bonta-holds-skilled-nursing-facility-chain-accountable (accessed Apr. 5, 2026).

9 *See Universal Health Servs., Inc. v. United States ex rel. Escobar,* 579 U.S. 176 (2016) (addressing implied false certification theory under the FCA); U.S. Dept. of Just., *Department of Justice Launches a National Nursing Home Initiative* (Mar. 3, 2020), https://www.justice.gov/archives/opa/pr/department-justice-launches-national-nursing-home-initiative (accessed Apr. 5, 2026).

10 U.S. Dept. of Just., *United States Intervenes and Sues ProMedica Health System, Inc. and Its Affiliates for Providing Grossly Substandard Nursing Home Services* (Sep. 2, 2025), https://www.justice.gov/opa/pr/united-states-intervenes-and-sues-promedica-health-system-inc-and-its-affiliates-providing (accessed Apr. 5, 2026).

11 U.S. Dept. of Just., *Ohio Based Nonprofit and Affiliated Nursing Homes Agree to Pay $3.61M to Resolve False Claims Act Liability* (June 3, 2025), https://www.justice.gov/opa/pr/ohio-based-nonprofit-and-affiliated-nursing-homes-agree-pay-361m-resolve-false-claims-act (accessed Apr. 5, 2026).

12 U.S. Dept. of Just., *United States Files False Claims Act Complaint Against Vohra Wound Physicians Management and Its Owner Alleging False Claims for Wound Care Services* (Apr. 4, 2025), https://www.justice.gov/opa/pr/united-states-files-false-claims-act-complaint-against-vohra-wound-physicians-management-and (accessed Apr. 5, 2026).

13 U.S. Dept. of Just., *The Grand Health Care System and Twelve Affiliated Skilled Nursing Facilities to Pay $21.3 Million for Allegedly Providing and Billing for Fraudulent Rehabilitation Therapy Services* (July 10, 2024), https://www.justice.gov/usao-ndny/pr/grand-health-care-system-and-twelve-affiliated-skilled-nursing-facilities-pay-213 (accessed Apr. 5, 2026).

14 U.S. Dept. of Just., *Skilled Nursing Facility and Acute Care Hospital to Pay $6.5 Million to Settle Civil False Claims Act Allegations* (Feb. 28, 2025), https://www.justice.gov/usao-wdtx/pr/skilled-nursing-facility-and-acute-care-hospital-pay-65-million-settle-civil-false (accessed Apr. 5, 2026).

15 42 U.S.C. § 1320a-7b(b) (Anti-Kickback Statute). Kickback violations can serve as predicates for FCA liability. *See* 42 U.S.C. § 1320a-7b(g).

16 U.S. Dept. of Just., *Fresno-Based Community Health System Agree to Pay $31.5 Million to Resolve Allegations of False Claims Act Violations* (May 14, 2025), https://www.justice.gov/usao-edca/pr/fresno-based-community-health-system-agree-pay-315-million-resolve-allegations-false (accessed Apr. 5, 2026).

17 U.S. Dept. of Just., *Mahlega Abdsharafat and Creative Hospice Settle Health Care Kickback Claims for $9.2 Million* (June 11, 2025), https://www.justice.gov/usao-

ndga/pr/mahlega-abdsharafat-and-creative-hospice-settle-health-care-kickback-claims-92-million (accessed Apr. 5, 2026).

18 *See e.g.* Taylor McKeel Sample, *Healthcare Fraud Enforcement Trends from 2024 and Issues to Watch in 2025,* ABA (June 4, 2025), https://www.americanbar.org/groups/health_law/resources/esource/2025/healthcare-fraud-enforcement-trends-2024-issues-watch-2025/ (accessed Apr. 5, 2026).

19 U.S. Dept. of Just., *Saad Healthcare Agrees to Pay $3M to Settle False Claims Act Allegations That It Billed Medicare for Ineligible Hospice Patients* (Feb. 21, 2025), https://www.justice.gov/opa/pr/saad-healthcare-agrees-pay-3m-settle-false-claims-act-allegations-it-billed-medicare (accessed Apr. 5, 2026).

20 U.S. Dept. of Just., *Kindred and Related Entities Agree to Pay $19.428M to Settle Federal and State False Claims Act Lawsuits Alleging Ineligible Claims for Hospice Patients* (July 17, 2024), https://www.justice.gov/archives/opa/pr/kindred-and-related-entities-agree-pay-19428m-settle-federal-and-state-false-claims-act (accessed Apr. 5, 2026).

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