

Publications

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What Health Care Organizations Should Know About the DOJ's 2026 Fraud Takedown

Key Takeaways

- The DOJ's 2026 National Health Care Fraud Takedown resulted in criminal charges against 455 defendants, including 90 doctors and other licensed medical professionals, in alleged schemes involving over \$6.5 billion in false claims.
- The operation reflected expanded federal, state and international coordination, with cases brought in 56 federal districts and 45 U.S. states and territories, and with 50 state Medicaid Fraud Control Units participating — the most in DOJ history.
- The DOJ emphasized continued use of data analytics, enhanced interagency coordination and parallel administrative remedies, including CMS provider suspensions and revocations, HHS-OIG exclusions and civil monetary penalty actions, and DEA administrative actions involving controlled substances.

On June 23, the Department of Justice (DOJ) announced the results of its 2026 National Health Care Fraud Takedown.¹ This nationwide enforcement action led to criminal charges against 455 defendants for their alleged participation in health care fraud and opioid abuse schemes involving over \$6.5 billion in false claims. The Takedown included cases in 56 federal districts and 45 U.S. states and territories, with participation from 50 state Medicaid Fraud Control Units. The DOJ also announced the seizure of over \$182 million in cash, luxury vehicles, jewelry and other assets.

In addition to the criminal charges, the DOJ highlighted a broad set of civil and administrative actions. The Centers for Medicare and Medicaid Services (CMS) suspended 1,079 providers and revoked billing privileges for 1,403 providers. The U.S. Department of Health and Human Services Office of Inspector General (HHS-OIG) announced 48 civil monetary penalty (CMP) settlements exceeding \$73 million, more than 1,400 provider exclusions and 25 actions under the CMP law seeking more than \$10 billion in payments to the Medicare Trust Fund from payments CMS identified and suspended before disbursement. The DOJ also reported civil claims against 13 defendants involving \$14.8 million in alleged fraud schemes and civil settlements with 31 defendants totaling \$23 million.

Notably, the DOJ framed the Takedown as part of the administration's broader anti-fraud

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- Adrienne E. Frazier
- Ellen H. Persons
- Gulnara Anzarova
- Alexandra A. Beato

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initiative led by the White House Task Force to Eliminate Fraud. Statements from the DOJ and FBI leadership emphasized a whole-of-government approach involving federal, state and international enforcement partners, as well as the increasing use of data analytics and financial intelligence to identify and pursue alleged fraud schemes affecting federal health care programs. The cases highlighted in this year's Takedown provide insight into the administration's enforcement priorities, particularly its heightened focus on Medicaid fraud, behavioral health services, wound care products and other areas perceived to present significant program integrity risks.

Reflecting that focus, the 2026 Takedown included the largest Medicaid fraud enforcement action in DOJ history, with 295 defendants charged in connection with more than \$518 million in alleged false claims. Cases involved behavioral health services, crisis stabilization programs, adult day care services and other Medicaid-funded programs. Several schemes allegedly targeted vulnerable populations, including homeless individuals and individuals struggling with substance use disorders.

The Takedown also targeted several other areas of health care fraud:

- **Fraudulent Wound Care Schemes:** The DOJ placed particular emphasis on alleged fraud involving amniotic wound allografts, charging 11 defendants, including a company executive and eight medical professionals, across six federal districts. The DOJ alleged that, from December 2021 through June 2024, providers billed Medicare more than \$4 billion for one company's allografts, resulting in over \$2 billion in payments. In one instance, the DOJ alleged that a company acquired allografts from tissue banks, relabeled them for sale at a 2,000% markup, charged up to \$1,450 per square centimeter and paid illegal kickbacks of approximately 40% of that amount. In another instance, the DOJ alleged a \$906 million scheme in which a nurse practitioner applied medically unnecessary allografts and billed Medicare more than \$1 million per patient on average.
- **Data Analytics and Program Integrity Enhancements:** The DOJ continued to stress its reliance on data analytics to detect outlier billing and identify high-risk schemes. The DOJ announced the first prosecution arising from the Data Fusion Center's Financial Intelligence Review Team, involving an alleged \$67 million Illinois Medicaid behavioral health scheme. The DOJ also announced new data-sharing and analytics-related efforts involving CMS, the Department of Homeland Security (DHS) and the Federal Trade Commission (FTC), including access to cloud computing space in CMS's Integrated Data Repository environment to deploy advanced analytics algorithms and artificial intelligence tools.
- **Transnational Organizations and International Cooperation:** The DOJ emphasized international coordination in the apprehension and return of defendants connected to large-scale health care fraud schemes. The Takedown included one defendant apprehended in Cyprus in connection with an alleged \$3.7 billion scheme, two defendants apprehended in Estonia in connection with a previously charged \$10.6 billion scheme, and one FBI Most Wanted Fraudsters List defendant apprehended in the Philippines in connection with a previously charged \$1.2 billion telemedicine fraud scheme.
- **Illegal Opioid Distribution:** The DOJ charged 36 defendants, including 28 licensed medical professionals, in connection with the alleged illegal diversion of prescription opioids and other controlled substances. The charged conduct included allegations involving a voicemail refill line for Schedule II controlled substances and a separate alleged drug conspiracy involving more than 3.4 million pills of opioids and other controlled substances.

This year's Takedown underscores the DOJ's continued focus on health care fraud enforcement, particularly in areas involving wound care products, Medicaid, behavioral

health, hospice, controlled substances, telemedicine, durable medical equipment and schemes identified through claims-data analytics. The announcement also reflects the DOJ's increasing use of coordinated criminal, civil and administrative tools to address alleged misconduct by providers, suppliers, marketers and executives.

Health care providers, suppliers and executives should consider reassessing compliance programs, reviewing referral and compensation arrangements, auditing medical necessity documentation, monitoring outlier billing trends and preparing for increased scrutiny where billing practices may create program-integrity risk. Organizations should also consider whether existing controls are sufficient to detect kickback risk, patient-harm concerns, aberrant utilization patterns and vulnerabilities in high-reimbursement service lines.

Polsinelli's Government Investigations and Health Care attorneys have extensive experience with health care fraud investigations and are prepared to assist with compliance reviews, internal investigations and responses to potential enforcement actions.

[1] <https://www.justice.gov/opa/pr/national-health-care-fraud-takedown-results-455-defendants-charged-connection-over-65>