



The 2026 National Health Care Fraud Takedown

On June 23, 2026, the U.S. Department of Justice (DOJ) announced the 2026 National Health Care Fraud Takedown, charging 455 defendants, including 90 physicians and other licensed medical professionals, in schemes involving over \$6.5 billion in false claims and, in several instances, patient harm that included death.¹ The coordinated action reached 56 federal districts and 45 states and territories, with 50 state Medicaid Fraud Control Units (MFCUs) participating, the most in DOJ history.² This Health Capital Topics article reviews the scope of the 2026 Takedown and the expanding role of data analytics in moving federal healthcare fraud enforcement toward prevention before payment.

The 2026 Takedown set records for Medicaid enforcement. DOJ charged 295 defendants in connection with over \$518 million in false claims submitted to Medicaid, the largest number of Medicaid fraud defendants and the largest Medicaid fraud loss charged in its history.³ The expanded focus followed an enforcement enhancement authorizing the Department's Health Care Fraud Unit to investigate Medicaid fraud nationwide.⁴

The action drew on a whole-of-government approach. The Centers for Medicare & Medicaid Services (CMS) suspended 1,079 providers and revoked the billing privileges of 1,403 providers.⁵ The HHS Office of Inspector General (HHS-OIG) brought 25 actions under the Civil Monetary Penalties Law seeking over \$10 billion for the Medicare Trust Fund, along with 48 civil settlements totaling over \$73 million and over 1,400 provider exclusions.⁶ The Drug Enforcement Administration (DEA) pursued 928 administrative cases seeking to revoke controlled-substance authority since October 1, 2025.⁷ Authorities reported seizures of over \$182 million in cash, vehicles, jewelry, and other assets.⁸

International cooperation produced several high-profile apprehensions, including a defendant tied to an over \$3.7 billion durable medical equipment scheme who had fled to, and was returned from, Cyprus, two members of a transnational organization extradited from Estonia, and a fugitive in a \$1.2 billion telemedicine scheme apprehended in the Philippines.⁹ The Federal Bureau of Investigation (FBI) added two defendants charged in genetic-testing schemes who fled the country to a Most Wanted Fraudsters List it created earlier in June.¹⁰

A defining feature of the 2026 Takedown was the central role of data analytics. DOJ credited its Health Care Fraud Unit Data Fusion Center, which combines analysts from DOJ, HHS-OIG, and the FBI, with supporting many of the charged cases, and announced the first prosecution arising from the Center's Financial Intelligence Review Team.¹¹ In that matter, prosecutors opened an investigation within five days of a financial-intelligence review into a \$67 million scheme that billed Illinois Medicaid for behavioral health services, including claims for 500 or more counseling hours in a single day.¹²

The amniotic wound graft, or allograft, cases highlight how analytics shaped both enforcement and payment policy. After the Health Care Fraud Unit's Data Analytics Team detected a spike in allograft billings, charges followed against 11 defendants across six districts.¹³ In one matter, providers billed Medicare over \$4 billion for a single company's allografts between December 2021 and June 2024, with the products relabeled and sold at a markup of roughly 2,000%, reaching up to \$1,450 per square centimeter.¹⁴ Separately, CMS realigned payment for these products, reducing Medicare's rate to \$127 per square centimeter effective January 1, 2026.¹⁵ CMS estimated that, absent the adjustment, allograft spending alone would have raised each Medicare beneficiary's monthly Part B premium by \$11.¹⁶

The agencies framed the action as a move away from paying claims first and pursuing recovery later. As CMS Administrator Mehmet Oz put it, the agency is working to "expose fraud networks, freeze suspicious payments, and shut down bad actors" before they reach federal programs.¹⁷ Consistent with that posture, CMS and DOJ's National Fraud Enforcement Division announced an agreement giving the Division cloud-computing space within the CMS Integrated Data Repository to deploy analytic and artificial intelligence tools, together with new data-sharing agreements with the Department of Homeland Security and the Federal Trade Commission.¹⁸

DOJ underscored the patient-safety stakes that keep healthcare fraud a top white-collar enforcement priority.¹⁹ In the Southern District of Florida, the medical director of a cardiovascular testing practice was charged in an \$89 million scheme involving unnecessary tests marketed to student athletes; according to the charges, he approved one student's abnormal results in roughly 11 seconds, and the student later died of complications from

an enlarged heart.²⁰ In the Central District of California, a hospice owner was charged in a \$27.7 million scheme that allegedly enrolled patients who were not terminally ill and billed for recently deceased individuals whose information was purchased from a funeral home employee, masking the share of hospice patients discharged alive.²¹

The 2026 Takedown continues an annual enforcement tradition, but its emphasis on real-time analytics, prepayment suspensions, and integrated federal and state data sharing marks a structural change in how the government identifies and disrupts healthcare fraud. For providers, billing and utilization patterns that diverge from clinical norms may now invite scrutiny before claims are paid rather than years afterward. As enforcement moves upstream, time will tell whether the analytics now driving charging decisions also reshape how the industry monitors its own coding, utilization, and documentation.

1 “National Health Care Fraud Takedown Results in 455 Defendants Charged in Connection with Over \$6.5 Billion in Alleged Fraud” U.S. Department of Justice, Office of Public Affairs, Press Release, June 23, 2026, <https://www.justice.gov/opa/pr/national-health-care-fraud-takedown-results-455-defendants-charged-connection-over-65> (Accessed 6/24/26).
2 *Ibid.*
3 *Ibid.*
4 *Ibid.*
5 *Ibid.*
6 *Ibid.*
7 *Ibid.*
8 *Ibid.*
9 *Ibid.*
10 *Ibid.*
11 *Ibid.*

12 *Ibid.*
13 *Ibid.*
14 *Ibid.*
15 “Calendar Year (CY) 2026 Medicare Physician Fee Schedule Final Rule (CMS-1832-F)” Centers for Medicare & Medicaid Services, Fact Sheet, October 31, 2025, <https://www.cms.gov/newsroom/fact-sheets/calendar-year-cy-2026-medicare-physician-fee-schedule-final-rule-cms-1832-f> (Accessed 6/24/26).
16 U.S. Department of Justice, Office of Public Affairs, Press Release, June 23, 2026.
17 *Ibid.*
18 *Ibid.*
19 *Ibid.*
20 *Ibid.*
21 *Ibid.*

FREE eBook DOWNLOAD

HEALTH CAPITAL
Topics
2025

DOWNLOAD HERE



LEADERSHIP

(800) FYI -VALU

Providing Solutions in an Era of Healthcare Reform

- Firm Profile
- HCC Services
- HCC Leadership
- Clients & Projects
- HCC News
- Health Capital Topics
- Contact Us
- Email Us

- Valuation Consulting
- Commercial Reasonableness Opinions
- Fairness Opinions
- Litigation Support & Expert Witness
- Financial Feasibility Analysis & Modeling
- Intermediary Services
- Certificate of Need
- ACO Value Metrics & Capital Formation
- Strategic Planning
- Industry Research Services



Todd A. Zigrang, MBA, MHA, FACHE, CVA, ASA, ABV, is the President of **HEALTH CAPITAL CONSULTANTS (HCC)**, where he focuses on the areas of valuation and financial analysis for hospitals, physician practices, and other healthcare enterprises. Mr. Zigrang has over 30 years of experience providing valuation, financial, transaction and strategic advisory services nationwide in over 2,500 transactions and joint ventures. Mr. Zigrang is also considered an expert in the field of healthcare compensation for physicians, executives and other professionals.

Mr. Zigrang is the co-author of *“The Adviser’s Guide to Healthcare - 2nd Edition”* [AICPA - 2015], numerous chapters in legal treatises and anthologies, and peer-reviewed and industry articles such as: *The Guide to Valuing Physician Compensation and Healthcare Service Arrangements (BVR/AHLA)*; *The Accountant’s Business Manual (AICPA)*; *Valuing Professional Practices and Licenses (Aspen Publishers)*; *Valuation Strategies*; *Business Appraisal Practice*; and, *NACVA QuickRead*. Additionally, Mr. Zigrang has served as faculty before professional and trade associations such as the American Society of Appraisers (ASA); the National Association of Certified Valuators



and Analysts (NACVA); the American Health Lawyers Association (AHLA); the American Bar Association (ABA); the Association of International Certified Professional Accountants (AICPA); the Physician Hospitals of America (PHA); the Institute of Business Appraisers (IBA); the Healthcare Financial Management Association (HFMA); and, the CPA Leadership Institute. He also serves on the Editorial Board of *The Value Examiner* and *QuickRead*, both of which are published by NACVA.

Mr. Zigrang holds a Master of Science in Health Administration (MHA) and a Master of Business Administration (MBA) from the University of Missouri at Columbia. He is a Fellow of the American College of Healthcare Executives (FACHE) and holds the Certified Valuation Analyst (CVA) designation from NACVA. Mr. Zigrang also holds the Accredited in Business Valuation (ABV) designation from AICPA, and the Accredited Senior Appraiser (ASA) designation from the American Society of Appraisers, where he has served as President of the St. Louis Chapter. He is also a member of the America Association of Provider Compensation Professionals (AAPCP), AHLA, AICPA, NACVA, NSCHBC, and, the Society of OMS Administrators (SOMSA).



Jessica L. Bailey-Wheaton, Esq., is Senior Vice President and General Counsel of HCC. Her work focuses on the areas of Certificate of Need (CON) preparation and consulting, as well as project management and consulting services related to the impact of both federal and state regulations on healthcare transactions. In that role, Ms. Bailey-Wheaton provides research services necessary to support certified opinions of value related to the Fair Market Value and Commercial Reasonableness of transactions related to healthcare enterprises, assets, and services.

Additionally, Ms. Bailey-Wheaton heads HCC’s CON and regulatory consulting service line. In this role, she prepares CON applications, including providing services such as: health planning; researching, developing, documenting, and reporting the market utilization demand and “need” for the proposed services in the subject market service area(s); researching and assisting legal counsel in meeting regulatory requirements relating to licensing and CON application development; and, providing any requested support services required in litigation challenging rules or decisions promulgated by a state agency. Ms. Bailey-Wheaton has also been engaged by both state government



agencies and CON applicants to conduct an independent review of one or more CON applications and provide opinions on a variety of areas related to healthcare planning. She has been certified as an expert in healthcare planning in the State of Alabama.

Ms. Bailey-Wheaton is the co-author of numerous peer-reviewed and industry articles in publications such as: *The Health Lawyer (American Bar Association)*; *Physician Leadership Journal (American Association for Physician Leadership)*; *The Journal of Vascular Surgery*; *St. Louis Metropolitan Medicine*; *Chicago Medicine*; *The Value Examiner (NACVA)*; and *QuickRead (NACVA)*. She has previously presented before the American Bar Association (ABA), the American Health Law Association (AHLA), the National Association of Certified Valuators & Analysts (NACVA), the National Society of Certified Healthcare Business Consultants (NSCHBC), and the American College of Surgeons (ACS).



Janvi R. Shah, MBA, MSF, CVA, serves as Senior Financial Analyst of HCC. Mrs. Shah holds a M.S. in Finance from Washington University Saint Louis and the Certified Valuation Analyst (CVA) designation from NACVA. She develops fair market value and commercial reasonableness opinions related to healthcare enterprises, assets, and services. In addition she prepares, reviews and analyzes forecasted and pro forma financial statements to determine the most probable future net economic benefit related to healthcare enterprises, assets, and services and applies utilization demand and reimbursement trends to project professional medical revenue streams and ancillary services and technical component (ASTC) revenue streams.



For more information please visit:
www.healthcapital.com