HEALTH CAPITAL Topics
Volume 19
Issue 10
October 2026
Jessica L. Bailey-Wheaton, Esq., Editor
Todd A. Zigrang, MBA, MHA, FACHE, CVA, ASA, ABV, Publisher

# DOJ Centralizes Healthcare Fraud Enforcement

On October 15, 2026, the U.S. Department of Justice (DOJ) National Fraud Enforcement Division (Fraud Division) and the U.S. Department of Health and Human Services (HHS) Office of Inspector General (OIG) issued a joint policy that makes the Fraud Division's Health Care Fraud Section the single point of entry for companies seeking to voluntarily self-disclose potentially criminal healthcare conduct.[1] The policy caps a year in which DOJ consolidated federal criminal fraud enforcement into a new division, expanded its use of data analytics to generate cases, and placed healthcare first among its corporate enforcement priorities. This Health Capital Topics article reviews these developments and the revised self-disclosure framework.

## The Fraud Division

DOJ created the Fraud Division on April 7, 2026,[2] and formally established it through a final rule that took effect August 24, 2026.[3] The rule assigns the Fraud Division criminal proceedings related to healthcare fraud, fraud involving health plans, and controlled substances distribution and diversion schemes, along with authority to seek injunctions against fraud under 18 U.S.C. § 1345 and to seize or forfeit property in related matters.[4] The Fraud Division may also prosecute any federal criminal offense it identifies while investigating a matter within those categories.[5]

In an August 13, 2026 memorandum, Assistant Attorney General (AAG) Colin M. McDonald stated that the Fraud Division would reach approximately 500 attorneys and staff by August 24, 2026, and would continue to grow rapidly over the following two years.[6] The memorandum identified healthcare as one of five enforcement priorities, singling out telemedicine programs, Medicare and Medicaid fraud, controlled substance diversion, and home health and hospice schemes as targets for data-driven enforcement.[7]

## Corporate Enforcement Directives

On October 1, 2026, AAG McDonald issued Directive 26-12, which lists fraud schemes involving the healthcare industry, including healthcare fraud, controlled substances distribution, and violations of the Federal Food, Drug, and Cosmetic Act, first among four corporate enforcement priorities.[8] The directive instructs prosecutors to place "great weight" on ten factors in charging and resolution decisions, including management knowledge of the scheme, efforts to conceal fraud from government agencies or auditors, conduct lasting three years or more, conduct affecting three or more federal districts, and conduct causing financial harm to 25 or more victims or $25 million or more in loss.[9] Prosecutors were required to report all ongoing corporate investigations to the Fraud Division's Corporate Enforcement Section within seven days, and that section now holds primary responsibility for evaluating companies' compliance with criminal resolutions.[10] At the same time, the directive pledges to guard against overbroad corporate enforcement that could interfere with legitimate business operations, and it directs Division leadership to design programs that incentivize whistleblowers, including those who participated in the misconduct.[11]

One week later, Directive 26-13 instructed Fraud Division prosecutors to assess potential tax violations in every case, to prioritize early, pre-indictment seizure of fraud proceeds, and to pursue civil restraining orders and injunctions against healthcare offenses.[12] It also requires prosecutors to address general deterrence in every sentencing presentation and to seek upward variances where the Sentencing Guidelines range does not adequately reflect the seriousness of the offense.[13]

## Data-Driven Case Generation

DOJ's 2026 National Health Care Fraud Takedown, announced June 23, 2026, resulted in charges against 455 defendants, including 90 physicians and other licensed medical professionals, in schemes involving over $6.5 billion in alleged false claims.[14] DOJ credited its Health Care Fraud Unit's Data Analytics Team with detecting a spike in Medicare payments for amniotic wound allografts that led to prosecutions, and announced an agreement under which the Fraud Division will deploy analytics algorithms and artificial intelligence (AI) tools within the Centers for Medicare & Medicaid Services (CMS) Integrated Data Repository.[15]

On August 24, 2026, DOJ launched the National Fraud Detection Center (NFDC), a prosecutor-led, multi-agency team intended to address the lack of cross-program visibility that has allowed some fraud schemes to operate across multiple federal programs undetected.[16] Its inaugural members include the Federal Bureau of Investigation (FBI), IRS Criminal Investigation, and the inspector general offices of HHS and several other federal agencies.[17] Directive 26-12 states that the Fraud Division is using the NFDC and partner analytics to

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proactively generate leads and open new individual and corporate investigations.[18]

Data analysis also increasingly drives civil enforcement under the False Claims Act (FCA). FCA settlements and judgments exceeded $6.8 billion in fiscal year (FY) 2025, the highest single-year total in the statute's history, of which over $5.7 billion involved the healthcare industry, and whistleblowers filed a record 1,297 qui tam suits.[19] In April 2026, DOJ's Civil Division launched the Fraud Oversight through Careful Use of Statistics (FOCUS) initiative to prioritize its work with "data miners," who analyze publicly available government data for potential signals of fraud.[20]

These capabilities may also reach beyond ongoing provider operations to discrete transactions.[21] For example, a change of ownership creates a natural "before and after" comparison, so a shift in an acquired physician group's coding or billing patterns after closing could become the basis for further scrutiny, even though legitimate post-acquisition changes, such as improved documentation, can generate the same data signals as fraud.[22]

**A Single Front Door for Self-Disclosure**

The October 15th joint policy addresses a long-standing complication: a single course of conduct, such as an illegal remuneration arrangement or billing for medically unnecessary services, frequently gives rise to overlapping criminal, civil, and administrative exposure, leaving companies to decide not only whether to disclose but where.[23] Under the policy, a company that makes a qualifying voluntary self-disclosure to the Health Care Fraud Section regarding conduct involving a federal healthcare program receives the benefits of both DOJ's Corporate Enforcement and Voluntary Self-Disclosure Policy (CEP) and OIG's Health Care Fraud Self-Disclosure Protocol (SDP), with no separate submission through the OIG portal; the Health Care Fraud Section forwards a copy of the disclosure to OIG.[24] Those SDP benefits do not extend to resolution of mandatory exclusion.[25] Conversely, a disclosure made only to OIG generally will not qualify as a voluntary self-disclosure under the CEP or satisfy the criteria for a declination, although it may be considered as part of a company's cooperation and remediation.[26]

The CEP, released in March 2026 as DOJ's first Department-wide corporate enforcement policy, provides that DOJ will decline to prosecute a company that voluntarily self-discloses misconduct, fully cooperates, and timely remediates, absent aggravating circumstances, although the company must still pay disgorgement, forfeiture, and restitution.[27] Companies that cooperate and remediate but fall short of a qualifying disclosure, or that present aggravating factors, are eligible for a non-prosecution agreement with a term of under three years, no independent compliance monitor, and a reduction of 50% to 75% off the low end of the Sentencing Guidelines fine range.[28]

OIG simultaneously updated the SDP to state that it is not available for disclosure of federal crimes, which should instead be disclosed to DOJ.[29] The update also moves the deadline for submitting completed internal investigation findings and damages calculations to 90 days from the date of initial submission, rather than 90 days from acceptance into the SDP.[30] The updated protocol retains OIG's general practice of requiring a minimum multiplier of 1.5 times single damages, as well as minimum settlement amounts of $100,000 for kickback-related matters and $20,000 for other matters.[31]

Practitioners have noted limits on the policy's practical reach. As one former DOJ fraud prosecutor observed, the government's data capabilities may make it difficult for companies to disclose conduct that DOJ does not already know about, which is a threshold element of a voluntary self-disclosure under the CEP.[32] Another former federal prosecutor characterized the announcement as more "evolution than revolution."[33]

**Conclusion**

Over the course of 2026, criminal healthcare fraud enforcement has been consolidated within a single DOJ division with expanding staff, cross-agency data access, and written directives that rank healthcare first among its corporate priorities. The October 15th joint policy clarifies where potentially criminal healthcare conduct should be disclosed, aligning DOJ and OIG procedures around a single submission. The value of that pathway depends on disclosure occurring before the government learns of the conduct, while the Fraud Division's investments in analytics and interagency data sharing are designed to shorten that window.


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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); V*aluing 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.

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