

National Health Care Fraud Takedown Results in 455 Defendants Charged in Connection with Over \$6.5 Billion in Alleged Fraud

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Record Medicaid Fraud Charges Largest Number of States Participating in Health Care Fraud Takedown History

The Justice Department today announced the 2026 National Health Care Fraud Takedown, which resulted in charges against 455 defendants, including 90 doctors and other licensed medical professionals, for their alleged participation in health care fraud and opioid abuse schemes involving over \$6.5 billion in false claims and significant patient harm, including death. Today's Takedown represents a new era in federal, state, and international cooperation to combat health care fraud: cases in 56 federal districts and 45 U.S. states and territories, with 50 state Medicaid Fraud Control Units participating, the most in Department history. In addition, unprecedented international cooperation over the two-week Takedown resulted in the apprehension and return to the United States of the following health care fraudsters: one defendant in Kyrenia in connection with an over \$3.7 billion scheme; two defendants in Estonia in connection with a previously charged \$10.6 billion scheme; and, in the Philippines, one of FBI's Most Wanted Fraudsters in connection with a previously-charged \$1.2 billion telemedicine fraud scheme. The Takedown involves the cutting-edge use of data analytics to target the worst actors; the seizure of over \$182 million in cash, luxury vehicles, jewelry, and other assets; and full-spectrum accountability for all criminal actors from doctor's offices to corporate boardrooms.

Today's coordinated enforcement action involves a whole-of-government approach, including:

- Actions by the Centers for Medicare and Medicaid Services (CMS) to suspend 1,079 providers and revoke billing privileges for 1,403 providers.

- 48 Civil Monetary Payment settlements amounting to over \$73 million, over 1,400 provider exclusions, and 25 actions by the U.S. Department of Health and Human Services, Office of Inspector General (“HHS-OIG”) under the Civil Monetary Penalties Law seeking more than \$10 billion in payments to the Medicare Trust Fund from payments that CMS caught and suspended before the funds were paid to the fraudulent providers.
- Civil charges against 13 defendants for \$14.8 million in health care fraud schemes, as well as civil settlements with 31 defendants totaling \$23 million.
- 928 administrative cases by the Drug Enforcement Administration (DEA) seeking the revocation of authority to handle and/or prescribe controlled substances since October 1, 2025.

“This year’s National Health Care Fraud Takedown represents the greatest whole-of-government effort to combat health care fraud in our Nation’s history,” said Acting Attorney General Todd Blanche. “Under the decisive leadership of President Donald Trump, Vice President JD Vance, the White House Task Force to Eliminate Fraud, and our law enforcement partners, this administration has ushered in a new era of enforcement that will safeguard taxpayer dollars.”

“We are aggressively scaling our offensive against anyone using health care as a front to steal from the American people,” said Assistant Attorney General Colin M. McDonald of the Justice Department’s National Fraud Enforcement Division. “As today’s cases and arrests show, there is no case too big, no scheme too complex, and no hiding place too remote for our relentless fraud-fighting team. Our message is simple: if you put profit over patients, you should expect to be put in prison.”

“Health care fraud steals from taxpayers, exploits vulnerable patients, and puts lives at risk,” said U.S. Department of Health and Human Services (HHS) Secretary Robert F. Kennedy, Jr. “Today’s historic enforcement action sends a clear message: if you use our health care system to enrich yourself at the expense of patients or the American people, we will find you, we will prosecute you, and we will hold you accountable. HHS will continue working with our law enforcement partners to protect patients, safeguard taxpayer dollars, and restore integrity to our health care system.”

“The coordination in the Health Care Fraud Takedown reinforces the Trump Administration’s efforts to end the crimes of bad actors who have ripped off U.S. taxpayers,” said Department of Homeland Security Secretary Markwayne Mullin. “This is a whole of government effort, to hold those who defraud our nation accountable. Our message is clear: if you steal from American taxpayers, you will face the consequences.”

"This results of this nationwide healthcare takedown are historic," said FBI Director Kash Patel. "Under the leadership of President Trump, Vice President Vance, and the White House Task Force to Eliminate Fraud, this FBI worked alongside our DOJ partners to arrest and charge over 450 people, including almost 100 medical professionals, for over \$6 billion in alleged healthcare fraud schemes - showing the enormous amount of work done by our interagency law enforcement team over the last month and beyond. While today's announcement is one of the largest on record—every arrest is a continued message to criminal actors who rob American taxpayers that you will not get away with your crimes."

Fraudulent Wound Care Schemes

Charges were filed against 11 defendants, including a company executive and eight medical professionals, across six districts in connection with billions of dollars in fraudulent claims for amniotic wound allografts. In the District of Arizona, the Vice President of Sales for a company that sold allografts was charged in a nationwide illegal kickback and health care fraud scheme. From approximately December 2021 through June 2024, providers billed Medicare over \$4 billion for this company's allografts, resulting in over \$2 billion in payments. This significant spike in allograft billings was alleged to have been driven not by medical necessity, but by a kickback scheme that generated substantial profit margins and lavish lifestyles for marketers and providers who participated. The company did not manufacture allografts and instead acquired allografts from tissue banks and relabeled them for sale at a 2,000% mark-up, charging up to \$1,450 per square centimeter. The defendant is alleged to have paid illegal kickbacks of approximately 40% of that amount, allowing marketers and medical providers to pocket approximately \$500-600 per square centimeter. These lucrative kickbacks allegedly caused the defendant and others to target hospice patients and apply the allografts without coordination with the patients' treating physicians, without proper treatment for infection, to superficial wounds that did not need this treatment, and to areas that far exceeded the size of the wound. The defendant received over \$24 million from the company, which he used to purchase multi-million-dollar houses, million-dollar life insurance policies, luxury vehicles, including a \$135,000 Maserati, and luxury watches. This follows 15.5- and 14-year sentences [obtained last year in connection with the scheme](#).

Today's charges reflect the Department's intention to prosecute both the architects of fraud and those who betray their oath to carry out the scheme. In the Southern District of Texas, a nurse practitioner was charged for a \$906 million scheme in which she applied medically unnecessary allografts and billed Medicare more than \$1 million per patient on average. As alleged, the defendant used the fraud proceeds to purchase

high-end vehicles, real estate, and luxury jewelry, and to fund the construction of a \$4.6 million of a beach resort in the Philippines. The government seized over \$30 million in bank accounts, a \$594,000 Ferrari 296 GTS, seven other high-end vehicles, an \$865,000 custom Bulgari necklace, and \$1 million worth of other luxury jewelry.

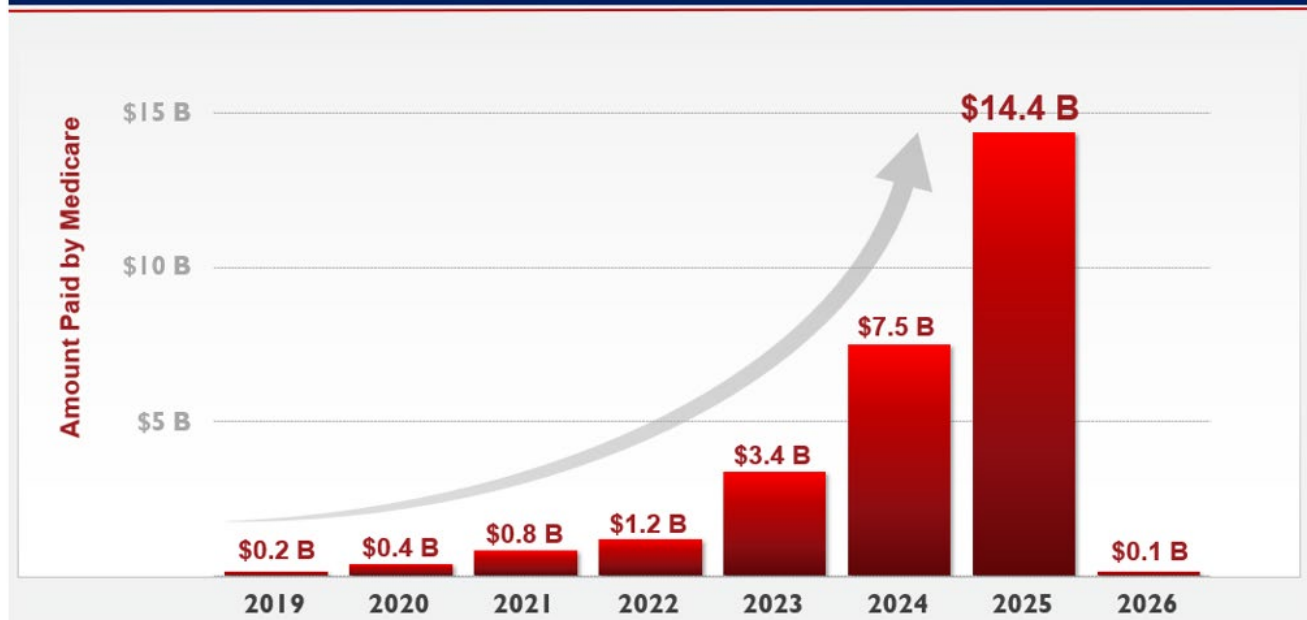


\$865,000 Bulgari necklace seized as proceeds of alleged Medicare fraud scheme involving wound allografts; rendering of beach resort in the Philippines constructed with \$4.6 million allegedly stolen from Medicare in wound allograft fraud scheme

Similarly, in the Middle District of Florida, three defendants were charged for their roles in an \$118 million allograft fraud scheme where a nurse practitioner allegedly used the proceeds to fund her lavish lifestyle, including a luxury box at an NFL stadium and over \$400,000 in fine art.

The Health Care Fraud Unit's Data Analytics Team detected a spike in payment for allografts, leading to prosecutions. CMS separately realigned payment, reducing Medicare's payment to \$127 per square centimeter starting on January 1, 2026. If CMS had not taken action to address unprecedented spending on allografts, the Part B premium increase caused by allograft payments alone would have cost every Medicare beneficiary in the country an extra \$11 a month.

Medicare Claims for Allografts 2019 – 2026



“Prosecuting criminals who steal from American patients is necessary—but stopping them before a single dollar leaves the building is smarter,” said CMS Administrator Dr. Mehmet Oz. “CMS is done playing catch-up. We’re deploying advanced data analytics to expose fraud networks, freeze suspicious payments, and shut down bad actors before they can do damage to the programs that millions of Americans depend on.”

Data Fusion Center, Financial Intelligence Review Team, and Data Analytics Enhancements

The Health Care Fraud Unit is a leader in employing advanced data analytics. Its Data Fusion Center —announced as part of last year’s Takedown and comprised of experts from the Unit’s Data Analytics Team, HHS-OIG, FBI, and other agencies—used advanced analytics in many of the cases charged today. The Department is announcing the first prosecution arising from the Fusion Center’s Financial Intelligence Review Team, which was formed last year to combine traditional data analytics with financial analysis, in connection with a \$67 million scheme to bill Illinois Medicaid for behavioral health services that were not provided. The defendant allegedly submitted claims to Medicaid for 500 or more hours of counseling and therapy services per day, well in excess of what the providers on staff could render even if all providers were working 24 hours per day, and diverted over \$27 million to brokerage accounts, \$10 million to a luxury car dealership he set up, \$4 million for real estate purchases and home improvements, one million for jewelry, watches, purchases, and other luxury items, and over \$616,022 for

vehicles. Data analysis established that patients were hospitalized at other institutions on days that the defendant billed for behavioral health services, and the Health Care Fraud Unit's specialized prosecutors opened the investigation within five days of the financial intelligence review. The defendant was arrested less than seven months later at the airport Sunday night attempting to leave the country.



Yacht and Bentley Continental GT purchased with proceeds of alleged fraud

In the Central District of California, charges were brought against a hospice owner and two marketers for a \$27.7 million Medicare fraud scheme in which the hospice owner allegedly tried to avoid detection through a scheme to purchase information of the recently deceased from a funeral home employee. The defendant was allegedly carrying out a hospice fraud scheme in which he fraudulently enrolled patients who were not terminally ill. Concerned that Medicare and law enforcement used data analytics to monitor the percentage of patients discharged from hospice alive (an indicator of fraud), the hospice owner allegedly paid illegal kickbacks of \$1,000 to \$3,000 per person to a funeral home employee in exchange for deceased Medicare beneficiaries' information. The defendant then allegedly billed Medicare for a few days of hospice services for these recently-deceased individuals who hadn't received hospice care and created fake, back-dated medical records claiming that the beneficiaries had been seen by a physician, thereby allegedly seeking to deceive Medicare by reducing his outlier data metrics.

In today's Takedown, the Department announced the seizure of over \$27 million in fraudulent Medicare payments in the Southern District of Florida as part of a data-driven effort to target "bust-out schemes" involving 12 clinics that billed Medicare millions of dollars for allografts that were never provided to patients. This novel and proactive "follow and seize the money" approach maximized recovery of stolen taxpayer dollars.

To enhance the deployment of advanced analytics to target health care fraud, the Fraud Division and CMS announced today that they have entered an agreement whereby the Fraud Division will be provided cloud computing space in the CMS Integrated Data Repository environment in which to deploy advanced data analytics algorithms and artificial intelligence tools. In addition, the Fraud Division entered into agreements with the Department of Homeland Security and the Federal Trade Commission aimed at breaking down data silos and improving access to information critical to identifying and combatting health care fraud. CMS also is announcing today that it is developing a Claims Core processing with electronic attestation, identify verification, and IP address log-in, and working to get pledges that all Medicaid, Managed Care, and other plans report the same standardized data fields used for Medicare Part B claims data.

Patient Harm

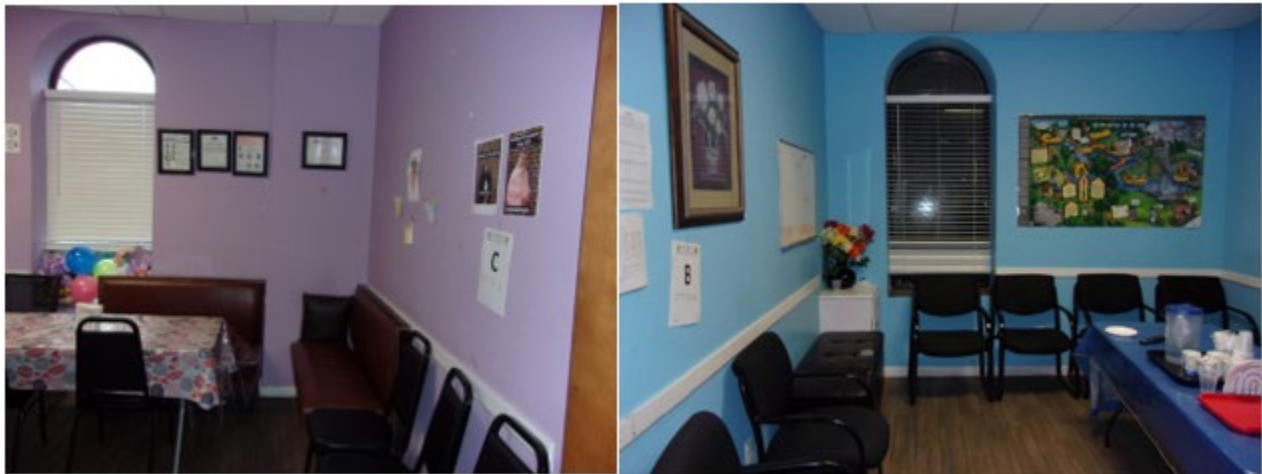
“Safeguarding the integrity of federal health care programs is central to our mission, and the results of this year’s National Health Care Fraud Takedown reflect the strength of our collective commitment. The cases announced today demonstrate not only the scale, but the seriousness of the misconduct uncovered, ranging from patient harming schemes to multibillion dollar fraud operations,” said HHS Inspector General T. March Bell. “HHS-OIG will continue to pursue those who engage in such conduct and hold them accountable. I am grateful for the tireless work of our special agents and for the partnership we share with our federal, state, and local law enforcement colleagues as we work together to protect patients and preserve public funds.”

In Alaska, state prosecutors charged a defendant for medical assistance fraud based on allegations that, while working as a personal care attendant for a Medicaid recipient, the defendant submitted false claims for regularly attending to the recipient’s health and hygiene, at the same time that she was admitted to the hospital for suffering from severe neglect, including being soiled in urine.

Medicaid Fraud

Data shows that Medicaid is a vital government benefit program increasingly targeted by criminals. Building upon the success of the recent [Minnesota Health Care Fraud Takedown](#) and the Acting Attorney General’s authorization of an enhancement for the Health Care Fraud Unit to investigate Medicaid fraud nationwide, today’s Takedown includes the largest number of Medicaid fraud defendants and Medicaid fraud loss charged in Department history: 295 defendants and over \$518 million in false claims submitted to Medicaid.

In the Eastern District of New York, charges were brought against eight defendants for their role in a \$38 million fraud on New York Medicaid for social adult day care services that were medically unnecessary, procured by kickbacks to marketers and beneficiaries, and never provided. Although the permitted occupancy of the social adult day cares (shown below) was only 30 people, the defendants fraudulently submitted claims for services provided to hundreds of beneficiaries per day.



Interior of Brooklyn social adult day care centers where allegedly fraudulent bills to New York Medicaid claimed hundreds of beneficiaries received services per day

In the Eastern District of Virginia, the co-owner of a mental health company was charged with a \$49 million Virginia Medicaid fraud scheme that targeted the homeless by offering them illegal bribes in the form of hotel stays in exchange for using their Medicaid numbers to bill for crisis stabilization services that they did not need or receive. In the District of Arizona, a defendant was charged for submitting \$44 million in fraudulent claims for behavioral services, primarily targeting Native Americans struggling with substance abuse. As alleged, the defendant billed for services that were never provided and falsified therapy notes to reflect that patients had attended therapy sessions.

Transnational Organizations, International Cooperation, and the Most Wanted Fraudsters List

Today's Takedown demonstrates that no fraudster can hide from the law, whether in the United States or abroad, and involved unprecedented international cooperation. In the [2025 National Health Care Fraud Takedown](#), 29 defendants were charged for their roles in a transnational criminal organization alleged to have submitted over \$10 billion in fraudulent claims. Since then, the organization continued the scheme, and, in the Southern District of Florida, Ibrahim Hilmi was charged in connection with an additional

\$3.7 billion in false claims for urinary catheters and other durable medical equipment that was never provided. Though the defendant fled, he was apprehended in Kyrenia and made his initial appearance yesterday in the Southern District of Florida. In addition, two other members of the organization who were charged in last year's Takedown were apprehended in Estonia, extradited to the United States, and made their initial appearance in the Eastern District of New York on June 12. Five additional defendants were charged in connection with the scheme.



Ibrahim Hilmi landing in the United States after being apprehended in a \$3.7 billion fraud

On June 4, the FBI announced the creation of the [Most Wanted Fraudsters List](#). The list included Herb Kimble, a fugitive in a \$1.2 billion telemedicine and durable medical equipment scheme, who, on June 8—just four days later—was apprehended in the Philippines. On June 16, Kimble was indicted in the District of South Carolina with three counts of failure to appear at court hearings. In connection with the Takedown, as a result of the apprehension of Kimble and one other recently-apprehended fraudster on the list, today the FBI announced two new additions to the Most Wanted Fraudsters List: Khalid Satary, wanted in a \$547 million genetic testing Medicare fraud scheme, who, after being released on bond over the government's objection, fled the country and is believed to be in the United Arab Emirates; and Emylee Thai, wanted in a \$90 million genetic testing Medicare fraud scheme, who was released on bond, cut-off her ankle monitor, and fled to Vietnam via private charter using a fake passport.

The Department thanks the governments of Estonia, the Philippines, and Turkey for their cooperation in the apprehension of these health care fraud fugitives and defendants.

Illegal Opioid Distribution

36 defendants, including 28 licensed medical professionals, were charged in connection with the alleged illegal diversion of prescription opioids and other controlled substances that resulted in patient harm. In the Eastern District of Pennsylvania, three defendants were charged with conspiracy to unlawfully distribute controlled substances. The defendants allegedly operated a voicemail refill line that allowed patients to request and receive refills of Schedule II controlled substance prescriptions—though some patients who used the refill line to obtain Schedule II controlled substances from the defendants suffered drug overdoses and died, the defendants continued to operate the refill line to prescribe Schedule II controlled substances without interacting with patients. In the Southern District of Texas, a pharmacist and two clinic managers were charged by indictment with drug conspiracy in connection with the distribution of more than 3.4 million pills of opioids and other controlled substances, many of which were prescribed to patients brought to the clinics and pharmacy by street-level drug traffickers for further distribution.

“DEA occupies a unique place in this fight—we sit at the intersection of healthcare, regulation, and law enforcement. Our job is to protect the controlled substance supply chain and ensure medications reach patients who legitimately need them,” said DEA Administrator Terrance Cole. “Those who exploit that system for personal profit threaten both public safety, public health, and the integrity of our healthcare system. We will continue to identify these criminals, stop them, and hold them accountable.”

“Health care fraud is not a victimless crime — it robs American workers of their earned benefits, steals from taxpayers, and undermines the very programs meant to protect them. The Department of Labor, Office of Inspector General is committed to rooting out these despicable schemes with unrelenting determination,” said Anthony P. D’Esposito, Inspector General, U.S. Department of Labor. “Together, with our agency and law enforcement partners, we are dismantling fraudulent operations and holding perpetrators accountable for their crimes against the American people. Real care doesn’t come with kickbacks and fake claims. To every fraudster exploiting the system: your time is up. We will find you; we will investigate you, and we will bring you to justice.”

Today’s Takedown was led and coordinated by the Department’s Health Care Fraud Unit and its core partners from U.S. Attorneys’ Offices, HHS-OIG, FBI, DEA, and Medicaid Fraud Control Units (MFCUs) across the country. The cases are being prosecuted by

Health Care Fraud Strike Force teams, 56 U.S. Attorneys' Offices, and 45 State Attorneys General's Offices nationwide.

Acting Health Care Fraud Chief Jacob Foster, Acting Principal Assistant Chief Rebecca Yuan, Assistant Chief Justin Woodard, and Data Analyst Elizabeth Nolte, all of the Health Care Fraud Unit, led and coordinated this year's Takedown. Assistant Chief Emily Gurskis and Acting Assistant Chiefs Miriam Glaser Dauermann and Jil Simon provided valuable coordination assistance.

The cases are being prosecuted by the Health Care Fraud Unit's National Rapid Response, Florida, Gulf Coast, Los Angeles, Midwest, New England, Northeast, Texas, and West Coast Strike Forces; U.S. Attorneys' Offices for the Middle District of Alabama, District of Arizona, Central District of California, Southern District of California, District of Colorado, District of Connecticut, District of Delaware, Middle District of Florida, Northern District of Florida, Southern District of Florida, Northern District of Georgia, District of Hawaii, District of Idaho, Northern District of Illinois, Northern District of Iowa, Southern District of Iowa, Western District of Kentucky, Eastern District of Louisiana, Middle District of Louisiana, District of Massachusetts, Eastern District of Michigan, Southern District of Mississippi, District of Montana, District of Nebraska, District of New Hampshire, District of New Jersey, District of New Mexico, Eastern District of New York, Northern District of New York, Southern District of New York, Eastern District of North Carolina, Middle District of North Carolina, Western District of North Carolina, Northern District of Ohio, Northern District of Oklahoma, Western District of Oklahoma, District of Oregon, Eastern District of Pennsylvania, Middle District of Pennsylvania, Western District of Pennsylvania, District of Puerto Rico, District of Rhode Island, District of South Carolina, District of South Dakota, Middle District of Tennessee, Western District of Tennessee, Northern District of Texas, Southern District of Texas, Western District of Texas, District of Vermont, Eastern District of Virginia, Western District of Virginia, Northern District of West Virginia, Southern District of West Virginia, Eastern District of Wisconsin, and Western District of Wisconsin; and State Attorneys General's Offices, through their MFCUs, in Alaska, Arizona, Arkansas, California, Colorado, Connecticut, Delaware, Florida, Georgia, Hawaii, Idaho, Illinois, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Montana, Nebraska, Nevada, New Hampshire, New Jersey, New Mexico, New York, Ohio, Oklahoma, Oregon, Pennsylvania, Puerto Rico, Rhode Island, South Carolina, Tennessee, Utah, Vermont, Virgin Islands, Washington, Wisconsin, and West Virginia. In addition, the MFCUs for Alabama, North Carolina, South Dakota, Texas, and Virginia participated in the investigation of federal cases announced today.

In addition to FBI, HHS-OIG, DEA, and MFCUs, CMS, Homeland Security Investigations, the Department of Veterans Affairs, Office of Inspector General, IRS Criminal Investigation, Defense Criminal Investigative Service, Department of Labor, United States Postal Service Office of Inspector General, Office of Personnel Management Office of Inspector General, and other federal, state, and local law enforcement agencies participated in the operation.

"Healthcare fraud schemes deprive veterans of needed services and rob taxpayers," said Inspector General of the Department of Veterans Affairs Cheryl Mason. "As VA Inspector General, I made it a priority for all VA OIG components to actively pursue those who attempt to defraud VA healthcare programs."

"Today's coordinated takedown reflects the Department of War Office of Inspector General's unwavering commitment to protecting Service members, retirees, and their families from those who exploit federal health care programs," said Inspector General Platte B. Moring III. "Working alongside our law enforcement partners, the Defense Criminal Investigative Service continues to pursue schemes that endanger patients, erode trust in the medical system, and divert resources critical to military readiness."

On April 7, the Department of Justice announced the creation of the National Fraud Enforcement Division. The Fraud Division is laser-focused on investigating and prosecuting those who commit fraud against the American people. The Department's work to combat fraud supports President Trump's Task Force to Eliminate Fraud, a whole-of-government effort chaired by Vice President J.D. Vance to eliminate fraud, waste, and abuse within Federal benefit programs.

Prior to the charges announced as part of today's nationwide Takedown and since its inception in March 2007, the National Fraud Division's Health Care Strike Force program, currently comprised of nine strike forces operating in federal districts across the country, has charged more than 6,200 defendants who collectively billed federal health care programs and private insurers more than \$45 billion. In addition, CMS, working in conjunction with HHS-OIG, are taking steps to hold providers accountable for their involvement in health care fraud schemes. More information can be found at www.justice.gov/criminal-fraud/health-care-fraud-unit.

An indictment, information, or complaint is merely an allegation. All defendants are presumed innocent until proven guilty beyond a reasonable doubt in a court of law.

The following materials related to today's announcement are available on the Health Care Fraud Unit's website through these links:

- [Graphics and Resources](#)
- [Case Descriptions](#)
- [Court Documents](#)

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