Justice Department Unveils $6.5 Billion Healthcare Fraud Crackdown

Prosecutors charged around 450 defendants in alleged fraud spanning Medicaid and hospice care

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WASHINGTON—The Justice Department on Tuesday unveiled charges against around 450 defendants for alleged healthcare fraud totaling over $6.5 billion as part of the Trump administration's stepped-up antifraud efforts.

The announcement includes charges against 90 medical professionals and targets a range of alleged healthcare fraud schemes, such as wound care and opioid distribution. It also includes what officials said is a record number of Medicaid fraud defendants, with nearly 300 people accused of submitting over $500 million in false Medicaid claims.

Federal officials said the operation spanned 57 federal court districts and 41 states and territories, involving 46 state Medicaid Fraud Control Units in what they described as the department's largest coordinated antifraud effort to date. They added that authorities seized more than $127 million in cash, luxury vehicles, jewelry and other assets.

"This announcement marks the greatest combined federal and state effort in combating healthcare fraud in history," Acting Attorney General Todd Blanche told reporters Tuesday. "These alleged fraudsters will face justice."

In one of the cases, prosecutors charged the owner of several healthcare businesses in the Los Angeles area, including at least four hospices, with a scheme that they say involved paying kickbacks and bribes to enroll people who weren't actually terminally ill in hospice care. Prosecutors allege the scheme resulted in nearly $27.7 million in fraudulent Medicare claims for medically unnecessary hospice services, with Medicare paying about $26.9 million.

According to the indictment, prosecutors allege the scheme involved enrolling deceased Medicare beneficiaries in hospice after their deaths using stolen personal information obtained through a funeral home employee, and creating backdated medical records to make it appear the patients had qualified for hospice before they died.

The owner of the hospices, Oren David Shachar, also personally approached Medicare beneficiaries, according to the indictment, misrepresented hospice as a program focused on improving quality of life rather than end-of-life care, and concealed that enrolling in hospice would limit their access to other Medicare-covered treatments. The indictment further alleges that the owner paid beneficiaries up to $400 a month in cash and provided groceries, alcohol, televisions, furniture and other gifts to keep them enrolled, while also offering referral payments to beneficiaries who recruited others into the program.

A lawyer for Shachar, who pleaded not guilty in the case, didn't return a request for comment.

Officials said the Los Angeles case illustrates the types of complex fraud schemes the department is seeking to identify earlier through new investigative tools and expanded coordination across agencies.

"This was a concerted effort to stay under the radar, and it indicates the cat-and-mouse game that we're involved in," said Jacob Foster, acting chief of the Justice Department's Health Care Fraud Unit.

The Trump administration has intensified its focus on what it describes as government waste while launching a so-called "war on fraud." Democratic critics have argued some of the administration's efforts are politically motivated attempts to target blue states and programs that conservatives have sought to cut, such as Medicaid, a federal and state program that provides health coverage to millions of low-income people.

As part of Tuesday's announcement, the Justice Department also unveiled a series of new data-sharing agreements across the federal government that officials said will significantly expand their access to fraud-related data.

Among them are memorandums of understanding with the Federal Trade Commission, giving prosecutors access to consumer-complaint data relevant to telemarketing and telemedicine scams. Officials announced an agreement with the Department of Homeland Security, providing travel information that can help identify providers billing for services while they are physically outside their clinics.

The Justice Department also announced an agreement with the Centers for Medicare and Medicaid Services that gives prosecutors access to CMS's fraud-detection system, which uses machine learning to identify suspicious billing by healthcare providers. Officials said the tool is already helping investigators spot potential fraud faster and send cases to specialized teams that analyze emerging fraud trends.

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