PRESS RELEASE

National Health Care Fraud Takedown Results in 324 Defendants Charged in Connection with Over $14.6 Billion in Alleged Fraud

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Largest Justice Department Health Care Fraud Takedown in History

More than Doubles Prior Record of $6 Billion

The Justice Department today announced the results of its 2025 National Health Care Fraud Takedown, which resulted in criminal charges against 324 defendants, including 96 doctors, nurse practitioners, pharmacists, and other licensed medical professionals, in 50 federal districts and 12 State Attorneys General's Offices across the United States, for their alleged participation in various health care fraud schemes involving over $14.6 billion in intended loss. The Takedown involved federal and state law enforcement agencies across the country and represents an unprecedented effort to combat health care fraud schemes that exploit patients and taxpayers.

Demonstrating the significant return on investment that results from health care fraud enforcement efforts, the government seized over $245 million in cash, luxury vehicles,

cryptocurrency, and other assets as part of the coordinated enforcement efforts. As part of the whole-of-government approach to combating health care fraud announced today, the Centers for Medicare and Medicaid Services (CMS) also announced that it successfully prevented over $4 billion from being paid in response to false and fraudulent claims and that it suspended or revoked the billing privileges of 205 providers in the months leading up to the Takedown. Civil charges against 20 defendants for $14.2 million in alleged fraud, as well as civil settlements with 106 defendants totaling $34.3 million, were also announced as part of the Takedown.

Today's Takedown was led and coordinated by the Health Care Fraud Unit of the Department of Justice Criminal Division's Fraud Section and its core partners from U.S. Attorneys' Offices, the Department of Health and Human Services Office of Inspector General (HHS-OIG), the Federal Bureau of Investigation (FBI), and the Drug Enforcement Administration (DEA). The cases were investigated by agents from HHS-OIG, FBI, DEA, and other federal and state law enforcement agencies. The cases are being prosecuted by Health Care Fraud Strike Force teams from the Criminal Division's Fraud Section, 50 U.S. Attorneys' Offices nationwide, and 12 State Attorneys General Offices.

"This record-setting Health Care Fraud Takedown delivers justice to criminal actors who prey upon our most vulnerable citizens and steal from hardworking American taxpayers," said Attorney General Pamela Bondi. "Make no mistake – this administration will not tolerate criminals who line their pockets with taxpayer dollars while endangering the health and safety of our communities."

"As part of making healthcare accessible and affordable to all Americans, HHS will aggressively work with our law enforcement partners to eliminate the pervasive health care fraud that bedeviled this agency under the former administration and drove up costs," said Secretary Robert F. Kennedy Jr. of the Department of Health and Human Services.

"The Criminal Division is intensely committed to rooting out health care fraud schemes and prosecuting the criminals who perpetrate them because these schemes: (1) often result in physical patient harm through medically unnecessary treatments or failure to provide the correct treatments; (2) contribute to our nationwide opioid epidemic and exacerbate controlled substance addiction; and (3) do all of that while stealing money hardworking Americans contribute to pay for the care of their elders and other vulnerable citizens," said Matthew R. Galeotti, Head of the Justice Department's Criminal Division. "The Division's Health Care Fraud Unit and U.S. Attorneys' Offices stand united with our law enforcement partners in this fight, and we will continue to use every tool at our disposal to protect the integrity of our health care programs for the American people."

"The scale of today's Takedown is unprecedented, and so is the harm we're confronting. Individuals who attempt to steal from the federal health care system and put vulnerable patients at risk will be held accountable," said Acting Inspector General Juliet T. Hodgkins of

HHS-OIG. "Our agents at HHS-OIG work relentlessly to detect, investigate, and dismantle these fraud schemes. We are proud to stand with our law enforcement partners in protecting taxpayer dollars and safeguarding patient care."

"Health care fraud drains critical resources from programs intended to help people who truly need medical care," said FBI Director Kash Patel. "Today's announcement demonstrates our commitment to pursuing those who exploit the system for personal gain. With more than $13 billion in fraud uncovered, this is the largest takedown for this initiative to date. Together, the FBI and our law enforcement partners will continue to hold those accountable who steal from the American people and undermine our health care systems."

Transnational Criminal Organizations

29 defendants were charged for their roles in transnational criminal organizations alleged to have submitted over $12 billion in fraudulent claims to America's health insurance programs.

For instance, a nationwide investigation known as Operation Gold Rush resulted in the largest loss amount ever charged in a health care fraud case brought by the Department. These charges were announced in the Eastern District of New York, the Northern District of Illinois, the Central District of California, the Middle District of Florida, and the District of New Jersey against 19 defendants. Twelve of these defendants have been arrested, including four defendants who were apprehended in Estonia as a result of international cooperation with Estonian law enforcement and seven defendants who were arrested at U.S. airports and the U.S. border with Mexico, cutting off their intended escape routes as they attempted to avoid capture.

The organization allegedly used a network of foreign straw owners, including individuals sent into the United States from abroad, who, acting at the direction of others using encrypted messaging and assumed identities from overseas, strategically bought dozens of medical supply companies located across the United States. They then rapidly submitted $10.6 billion in fraudulent health care claims to Medicare for urinary catheters and other durable medical equipment by exploiting the stolen identities of over one million Americans spanning all 50 states and using their confidential medical information to submit the fraudulent claims. As alleged, the organization exploited the U.S. financial system by laundering the fraudulent proceeds and deploying a range of tactics to circumvent anti-money laundering controls to transfer funds into cryptocurrency and shell companies located abroad. The arrests announced today also include a banker who facilitated the money laundering of fraud proceeds on behalf of the organization through a U.S.-based bank.

The Health Care Fraud Unit's Data Analytics Team and its partners detected the anomalous billing through proactive data analytics, and HHS-OIG and CMS successfully prevented the organization from receiving all but approximately $41 million of the approximately $4.45 billion that was scheduled to be paid by Medicare. HHS and CMS intend to seek to return the $4.41

billion in escrow to the Medicare trust fund for needed medical care. The scheme nonetheless resulted in payments of approximately $900 million from Medicare supplemental insurers. To date, law enforcement has seized approximately $27.7 million in fraud proceeds as part of Operation Gold Rush.

In another action involving foreign influence, charges were filed in the Northern District of Illinois against five defendants, including two owners and executives of Pakistani marketing organizations, in connection with a $703 million scheme in which Medicare beneficiaries' identification numbers and other confidential health information were allegedly obtained through theft and deceptive marketing. The defendants allegedly used artificial intelligence to create fake recordings of Medicare beneficiaries purportedly consenting to receive certain products. According to court documents, the beneficiaries' confidential information was then illegally sold to laboratories and durable medical equipment companies, which used this unlawfully obtained and fraudulently generated data to submit false claims to Medicare. Certain defendants controlled dozens of nominee-owned durable medical equipment companies and laboratories that allegedly submitted fraudulent claims for products and services the beneficiaries did not request, need, or receive. Certain defendants also allegedly conspired to conceal and launder the fraud proceeds from bank accounts they controlled in the United States to bank accounts overseas. In total, the defendants caused approximately $703 million in alleged fraudulent claims to Medicare and Medicare Advantage plans, which paid approximately $418 million on those claims. The government seized approximately $44.7 million from various bank accounts related to this case.

Finally, a defendant based in Pakistan and the United Arab Emirates who owned a billing company allegedly orchestrated a scheme to prey upon vulnerable individuals in need of addiction treatment by conspiring with treatment center owners to fraudulently bill Arizona Medicaid approximately $650 million for substance abuse treatment services. According to court documents, some of the services billed were never provided, while other services were provided at a level that was so substandard that it failed to serve any treatment purpose. As part of the conspiracy, treatment center owners allegedly paid illegal kickbacks in exchange for the referral of patients recruited from the homeless population and Native American reservations. The defendant received at least $25 million of ill-gotten Arizona Medicaid funds as a result of the conspiracy and is charged with a money laundering offense for his alleged use of those funds to purchase a $2.9 million home located on a golf estate in Dubai.

Fraudulent Wound Care

Charges were filed in the District of Arizona and the District of Nevada against seven defendants, including five medical professionals, in connection with approximately $1.1 billion in fraudulent claims to Medicare and other health care benefit programs for amniotic wound allografts. As alleged, certain defendants targeted vulnerable elderly patients, many of whom were receiving hospice care, and applied medically unnecessary amniotic allografts to these

patients' wounds. Many of the allografts allegedly were applied 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. Certain defendants allegedly received millions in illegal kickbacks from the fraudulent billing scheme.

"Today's unprecedented enforcement action demonstrates that CMS and our federal partners are united in our mission to protect the integrity of Medicare and Medicaid by crushing waste, fraud, and abuse," said CMS Administrator Dr. Mehmet Oz. "Every dollar we prevent from going to fraudsters is a dollar that stays in the system to serve legitimate beneficiaries. Through advanced data analytics, real-time monitoring, and swift administrative action, CMS is leading the fight to protect Medicare, Medicaid, and the trust Americans place in these vital programs. We're not waiting for fraud to happen — we're stopping it before it starts."

Prescription Opioid Trafficking

74 defendants, including 44 licensed medical professionals, were charged across 58 cases in connection with the alleged illegal diversion of over 15 million pills of prescription opioids and other controlled substances. For example, five defendants associated with one Texas pharmacy were charged with the unlawful distribution of over 3 million opioid pills. As alleged, the defendants conspired to distribute massive quantities of oxycodone, hydrocodone, and carisoprodol, which were subsequently trafficked by street-level drug dealers, generating large profits for the defendants. This coordinated action is a continuation of the Health Care Fraud Unit's systematic approach to stopping drug trafficking organizations and their pharmaceutical wholesale suppliers, which together have fueled an epidemic of prescription opioid abuse for nearly a decade.

DEA also announced today that in the last six months, DEA charged 93 administrative cases seeking the revocation of pharmacies, medical practitioners, and companies authority to handle and/or prescribe controlled substances.

"Health care fraud isn't just theft — it's trafficking in trust. Today's announcement shows that when doctors become drug dealers and treatment centers become profit-driven fraud rings, DEA will act," said Acting Administrator Robert Murphy of the DEA. "We're targeting the entire ecosystem of fraud — from pill mills in Texas to kickback clinics exploiting Native communities. If you abuse your medical license to push poison or pad your pockets, we will hold you accountable."

Telemedicine and Genetic Testing Fraud

In today's Takedown, 49 defendants were charged in connection with the submission of over $1.17 billion in allegedly fraudulent claims to Medicare resulting from telemedicine and genetic testing fraud schemes. For example, in the Southern District of Florida, prosecutors charged an owner of telemedicine and durable medical equipment companies with a $46 million scheme in

which Medicare beneficiaries were allegedly targeted through deceptive telemarketing campaigns and then fraudulent claims were submitted to Medicare for durable medical equipment and genetic tests for these beneficiaries. The Department continues to focus on eliminating health care fraud schemes that depend on telemedicine, including schemes involving fraudulent claims for genetic testing, durable medical equipment, and COVID-19 tests.

Other Health Care Fraud Schemes

The other cases announced today charge an additional 170 defendants with various other health care fraud schemes involving over $1.84 billion in allegedly false and fraudulent claims to Medicare, Medicaid, and private insurance companies for diagnostic testing, medical visits, and treatments that were medically unnecessary, provided in connection with kickbacks and bribes, or never provided at all. For example, in the Western District of Tennessee, prosecutors charged three defendants, including business owners and a pharmacist, with a $28.7 million scheme to defraud the Federal Employees' Compensation Fund by allegedly billing for medications for injured United States Postal Service employees that were never prescribed by a licensed practitioner and largely were not dispensed as claimed. And in the Western District of Washington and the Northern District of California, prosecutors charged medical providers with allegedly stealing fentanyl and hydrocodone, respectively, that was meant for the providers' patients, including child patients in need of anesthesia.

"VA's Integrated Veteran Care Programs provide critical community-based health care to our nation's disabled veterans and their dependents," said Acting Inspector General David Case of the Department of Veterans Affairs Office of Inspector General (VA-OIG). "Robust oversight of VA's health care system is one of VA-OIG's highest priorities. VA-OIG is committed to holding accountable those who defraud government benefits programs intended to care for our nation's heroes."

Breaking Down Silos in the Fight Against Health Care Fraud

In connection with the coordinated nationwide law enforcement operation, the Department is announcing that it is working closely with HHS-OIG, FBI, and other agencies to create a Health Care Fraud Data Fusion Center to bring together experts from the Department's Criminal Division, Fraud Section, Health Care Fraud Unit Data Analytics Team; HHS-OIG; FBI; and other agencies to leverage cloud computing, artificial intelligence, and advanced analytics to identify emerging health care fraud schemes. The Health Care Fraud Unit's Data Analytics Team was established in 2018 to enhance the Unit's ability to detect, investigate, and prosecute complex health care fraud schemes. Joining forces with data analysts from HHS-OIG, FBI, and other partners will increase efficiency, detection, and rapid prosecution of emerging health care fraud schemes. It will also implement the President's Executive Order Stopping Waste, Fraud, and Abuse by Eliminating Information Silos (Exec. Order No. 14243, 3 C.F.R. 294 (2025)) by reducing

duplicative data teams, increasing operational efficiency through a whole-of-government approach, and leveraging cloud computing, artificial intelligence, and other agency resources.

Principal Assistant Deputy Chief Jacob Foster, Assistant Deputy Chief Rebecca Yuan, Trial Attorney Miriam L. Glaser Dauermann, and Data Analyst Elizabeth Nolte, all of the Health Care Fraud Unit of the Criminal Division's Fraud Section, led and coordinated this year's Takedown. The cases are being prosecuted by the Health Care Fraud Unit's National Rapid Response, Florida, Gulf Coast, Los Angeles, Midwest, New England, Northeast, and Texas Strike Forces; U.S. Attorneys' Offices for the District of Arizona, Central District of California, Northern District of California, Southern District of California, District of Columbia, District of Connecticut, District of Delaware, Middle District of Florida, Northern District of Florida, Southern District of Florida, Middle District of Georgia, District of Idaho, Northern District of Illinois, Eastern District of Kentucky, Western District of Kentucky, Eastern District of Louisiana, Middle District of Louisiana, District of Maine, District of Massachusetts, Eastern District of Michigan, Western District of Michigan, Northern District of Mississippi, Southern District of Mississippi, District of Montana, District of Nevada, District of New Hampshire, District of New Jersey, Eastern District of New York, Northern District of New York, Southern District of New York, Western District of New York, Eastern District of North Carolina, Western District of North Carolina, District of North Dakota, Northern District of Ohio, Southern District of Ohio, Northern District of Oklahoma, Western District of Oklahoma, District of Oregon, Eastern District of Pennsylvania, District of South Carolina, 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 Washington, and Northern District of West Virginia; and State Attorneys General's Offices for California, Illinois, Indiana, Louisiana, Massachusetts, Michigan, Missouri, New York, Ohio, Pennsylvania, South Carolina, and Wisconsin. The Health Care Fraud Unit's Data Analytics Team used cutting-edge data analytics to identify and support the investigations that led to these charges.

In addition to FBI, HHS-OIG, DEA, and CMS, HSI, VA-OIG, 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. The Medicaid Fraud Control Units of California, the District of Columbia, Florida, Georgia, Illinois, Indiana, Louisiana, Massachusetts, Michigan, Missouri, New York, North Carolina, North Dakota, Ohio, Pennsylvania, South Carolina, Texas, Virginia, and Wisconsin also participated in the investigation of many of the federal and state cases announced today.

The Fraud Section leads the Criminal Division's efforts to combat health care fraud through the Health Care Fraud Strike Forces. Prior to the charges announced as part of today's nationwide Takedown and since its inception in March 2007, the Health Care Fraud Strike Force, which

operates in 27 districts, charged more than 5,400 defendants who collectively billed Medicare, Medicaid, and private health insurers more than $27 billion.

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

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.

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Topic

HEALTH CARE FRAUD

Components

Criminal Division | Criminal - Criminal Fraud Section | Drug Enforcement Administration (DEA) | Federal Bureau of Investigation (FBI)

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