

# Healthcare Fraud: The Last Bastion of Federal and State White-Collar Enforcement

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## Key Takeaways

- Healthcare fraud remains the top enforcement priority for federal and state authorities, with increased investigations, penalties and coordinated actions-despite expectations that focus would shift to other white-collar areas after 2024.
- The risk of parallel civil, criminal and administrative liability is higher than ever for healthcare providers, as even minor compliance lapses can trigger multiple costly proceedings and significant financial exposure.
- Healthcare organizations should implement robust, proactive compliance programs that emphasize early issue detection, prompt evaluation and repayment of overpayments, and strategic self-disclosure to regulators in order to manage and mitigate enforcement risks.

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If, like many commentators, you expected a post-2024 shift away from traditional financial-crimes enforcement and toward emerging areas such as cybercrime, antitrust or consumer protection, that expectation has not materialized. Instead, the post-2024 enforcement landscape reflects a very different reality: healthcare fraud remains the steady center of gravity for federal prosecutors, state attorneys general (“AG”), and joint federal/AG teams. Far from tapering off, these authorities have doubled down on healthcare-related investigations, adopting an expansive view of the regulatory environment to drive recoveries, impose penalties and shape compliance expectations across the industry.

Although no official policy frames this focus, the structure of healthcare enforcement naturally creates opportunities for prosecutors to bring a large volume of investigations and high-value cases. Healthcare fraud sits at the intersection of federal and state funding, administrative oversight, and statutory authority—a rare convergence that allows government actors to pursue overlapping civil, criminal, and administrative theories based on the same underlying conduct. As a result, healthcare fraud has become not only a policy priority but also the most durable and versatile enforcement vehicle available to regulators. For companies operating in or adjacent to the healthcare sector, this reality necessitates proactive, documented and self-executing compliance systems.

## The Landscape Hasn’t Shifted, But It Has Intensified

Healthcare fraud is the one major white-collar domain where enforcement intensity has not merely remained constant, but has increased. In early July 2025, the Trump Administration announced the creation of the DOJ-HHS False Claims Act Working Group, a specialized task force dedicated to healthcare fraud enforcement. This initiative is expected to drive an increase in *qui tam* actions brought by whistleblowers, particularly in areas such as Medicare Advantage, network adequacy requirements, drug pricing and materially defective medical devices.

Just days before that announcement, the New York Attorney General's Office publicized a \$13 million enforcement "takedown" targeting transportation companies accused of defrauding Medicaid, underscoring the continued willingness of state AGs to pursue healthcare fraud aggressively at the state level.

## **A Vast Enforcement Toolbox**

Healthcare enforcement teams capitalize on the unusually broad array of tools available to them, including the False Claims Act ("FCA"), healthcare-specific criminal statutes, program-integrity regulations, and extensive administrative remedies at both the federal and state levels. Each mechanism offers distinct advantages; used together, they create a lattice of potential liability that makes healthcare enforcement uniquely efficient, flexible and lucrative for government agencies. Federal prosecutors increasingly partner with AGs, pooling resources and coordinating parallel investigations in ways that significantly heighten exposure for targeted entities.

One defining feature of healthcare fraud enforcement is that a single operational failure can trigger multiple forms of liability. A billing error, documentation deficiency or compliance lapse may simultaneously give rise to:

### **1. Civil Liability Under the False Claims Act**

The FCA remains the government's primary civil enforcement tool. Statutory per-claim penalties combined with mandatory treble damages can produce extraordinary financial exposure. Even modest error rates may result in outsized damages when extrapolated across large datasets or multi-year claims histories.

### **2. Criminal Liability**

The same conduct supporting a civil FCA claim may, with minor factual variation, support criminal charges. The mere possibility of criminal exposure substantially increases settlement leverage and often drives early resolution, without requiring the government to meet the burdens of a criminal trial.

### **3. Administrative and Statutory Penalties**

Agencies such as the Centers for Medicare & Medicaid Services and the Office of the Inspector General may impose exclusions, recoupments, civil monetary penalties or program-participation restrictions based on the same underlying facts. These sanctions can be existential for providers, frequently forcing resolution even where the conduct was unintentional or technical.

This layered enforcement structure virtually guarantees that the government rarely walks away empty-handed. Providers, by contrast, face parallel proceedings, duplicative penalties, and significant litigation costs. For many entities-particularly small and mid-sized providers-settlement is often the only economically viable outcome.

## Why Healthcare Enforcement Will Endure

Healthcare enforcement serves a broader systemic function. The federal government finances, regulates and polices the very healthcare programs through which it later seeks recoveries. The scale of federal healthcare spending enables enforcement to operate in a self-reinforcing cycle:

- Federal agencies fund care and administer benefit programs.
- Those same agencies audit, investigate, and recoup alleged overpayments.
- Recovered funds are returned to federal coffers or used to support further enforcement activity.

This dynamic is not an explicit policy of “enforcement for revenue,” but the fiscal symbiosis is unmistakable. Healthcare fraud enforcement is one of the few areas where regulatory reach, financial interest and enforcement authority fully align, making it uniquely resilient even as other white-collar priorities fluctuate.

## Compliance as a Strategic Imperative

In this environment, robust compliance is no longer optional-it is essential. Healthcare providers can no longer assume that minor operational gaps or benign billing discrepancies will be resolved informally. Regulators increasingly expect proactive, documented, and self-executing compliance programs.

Effective modern compliance rests on three pillars:

### 1. Early Issue Identification

Organizations must deploy internal audits, data analytics, reporting mechanisms and training programs that surface potential violations before regulators do. Early identification narrows exposure and allows providers to control the narrative.

### 2. Timely Evaluation and Return of Overpayments

The 60-day rule and related obligations require prompt investigation and repayment. Delay can transform an overpayment into a “knowing” false claim, exponentially increasing liability. Providers must have processes to quickly assess whether anomalies constitute reportable overpayments.

### 3. Voluntary Self-Disclosure

When undertaken strategically and with counsel, self-disclosure can significantly mitigate penalties and reduce the risk of parallel criminal exposure. Agencies increasingly expect self-correction and transparency-and they reward early engagement. Failure to disclose can convert a manageable compliance issue into a multi-front enforcement action.

Compliance today is not merely defensive; it is strategic. The choice is no longer between disclosure and silence-it is between managed liability and uncontrolled risk.

Healthcare fraud has emerged as the last bastion of federal and state white-collar enforcement because it occupies a unique position at the intersection of regulation, funding and statutory authority. While other enforcement priorities have ebbed and flowed since 2024, healthcare fraud

persists because the system is engineered for maximum accountability, recoverability and optionality for the government.

For healthcare providers, this reality demands rigorous, forward-looking compliance programs that detect issues early, evaluate financial obligations accurately and leverage self-disclosure to mitigate exposure. Enforcement in this space is not receding; organizations cannot afford to wait for it to arrive at their door.