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Client Alert: Health Care Hot Summer Schemes, Errors, and Side Hustles Part 1

The federal government publishes various press releases regarding actions it has taken against health care providers. These items provide insight into its strategy, perspective, and opinions regarding the applicable laws. Legal and compliance professionals should review the latest settlements and cases to increase their knowledge and ability to forecast the government's future activities.

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It should be noted that in today's world, one person's scheme may be another person's side hustle. The following information is according to the United States Attorney's Office and represents its statement of the issue or perspective. The other party to each matter may disagree. With those factors in mind, we present some of the notable recent activities:

Department of Justice Releases First-Ever Corporate Enforcement Policy for All Criminal Cases

On March 10, 2026, the Department of Justice (DOJ) released the first-ever department-wide corporate enforcement policy for criminal matters, promoting uniformity, predictability, and fairness in how it pursues white-collar cases to protect the American people. The department-wide Corporate Enforcement Policy (CEP) is intended to provide concrete benefits to incentivize companies to voluntarily disclose discovered misconduct, cooperate with DOJ investigations, and timely and appropriately remediate the wrongdoing. For companies that do, absent certain limited aggravating circumstances, the department will decline to prosecute the company. Incentivizing corporate self-disclosures—while still permitting prosecutions in appropriate circumstances—allows the department to quickly pursue culpable individuals, secure justice for victims, and deter white-collar crime, all while not unduly burdening American businesses. The CEP also intends to provide predictability for companies and their counsel that approach these issues as it applies to all corporate criminal cases across the department (aside from those relating to antitrust), superseding all component-specific or U.S. Attorney's Office-specific corporate enforcement policies currently in effect. The CEP can be found at https://www.justice.gov/dag/media/1430731/dl?inline.

Florida Nursing Assistant Sentenced to Nine Years in Prison for $11.4M Health Care Fraud Scheme Targeting

Medicare Beneficiaries

A Florida nursing assistant was sentenced to nine years in prison and two years of supervised release for his role in an $11.4 million health care fraud and wire fraud conspiracy in which hundreds of Medicare beneficiaries were sent thousands of orthotic braces they did not need. The nursing assistant was also ordered to pay $3,712,345.70 in restitution and $724,871 in forfeiture. According to court documents and evidence presented at trial, the nursing assistant owned and operated a durable medical equipment (DME) supplier based in Florida through which he submitted millions of dollars in false claims to Medicare for medically unnecessary orthotic braces. He and his co-conspirator paid illegal kickbacks and bribes to obtain signed doctors' orders. They used these orders to ship orthotic braces to Medicare beneficiaries nationwide and then claim payment from Medicare, including to beneficiaries who neither requested nor needed the braces. He allegedly lied to Medicare, claiming that he was the sole owner and operator of the company, when in fact he shared ownership in the company with his co-conspirator, a convicted felon. Medicare would not have allowed the company to enroll with Medicare if it had known about his co-conspirator. The co-conspirator has been charged but remains at large. The nursing assistant received several hundred thousand dollars to his personal bank account from the fraudulent scheme that he frequently withdrew in cash on consecutive days at different bank branches in Florida, often in amounts just under the bank reporting threshold of $10,000.

California Man Pleads Guilty to Orchestrating $270M Medication Reimbursement Fraud Scheme

A California man pleaded guilty to submitting nearly $270 million in fraudulent claims over an 11-month span to California's Medicaid program (Medi-Cal) for expensive prescription drugs that were medically unnecessary and, in many instances, not provided to the purported recipients. According to court documents, this resident of Orange, along with pharmacist and pharmacy owner of Moreno Valley, and nurse practitioner of West Hills, exploited Medi-Cal's suspension of its requirement that health care providers obtain prior authorization before providing certain medications at the beginning of 2022. Medi-Cal temporarily suspended the requirement as part of a transition to a new payment system. Using a business which the pharmacist owned, the Orange resident and his co-schemers billed Medi-Cal tens of millions of dollars per month for purportedly dispensing high-reimbursement drugs containing cheap, generic ingredients that were manufactured in unique dosages, combinations or package quantities and were not included in the applicable maximum price lists that cap Medi-Cal reimbursements. In furtherance of the scheme, the Orange resident paid illegal kickbacks to patient marketers in exchange for Medi-Cal beneficiary information and thereafter paid illegal kickbacks to the Advanced Practice Registered Nurse (APRN) to sign pre-filled prescriptions for 19 high-reimbursement, non-contracted, generic drugs. The APRN never met the patients, reviewed their medical records or otherwise determined that the medications were medically necessary before signing the prescriptions. The medications, which included pain creams and Folite tablets, a vitamin available over the counter, were billed for thousands of dollars each, including approximately $13,424 for one prescription of meloxicam 5 mg, a generic drug that typically costs between $5 and $25 for a 30-day supply in larger dosages. The Orange resident received a portion of the pharmacy's reimbursements from Medi-Cal, at times equaling approximately 40 percent of its profit from the false and fraudulent claims. The Orange resident admitted in his plea agreement that he caused at least $269,120,829 in false and fraudulent claims to Medi-Cal from May 2022 to April 2023, of which Medi-Cal paid at least approximately $178,746,556. He also admitted that he committed the offense while on release in another criminal case. The Orange resident and others laundered their illicit proceeds by transferring the money to a third party to pay kickbacks to APRN in an attempt to conceal the crime from law enforcement. In his plea agreement, the Orange resident agreed to forfeit property obtained from the fraud, including bank account balances exceeding $17 million, three vehicles, seven real properties, and sports memorabilia. To date, the government has seized approximately $126.5 million in assets that he and his co-schemers accumulated

from the scheme, including $111 million in bank funds and securities, nine luxury vehicles totaling approximately $1 million, nine luxury real properties totaling approximately $13.5 million, and more than $1 million worth of sports memorabilia. The Orange resident pleaded guilty to one count of wire fraud. He is scheduled to be sentenced on August 3 and faces a maximum penalty of 30 years in prison. A federal district court judge will determine any sentence after considering the U.S. Sentencing Guidelines and other statutory factors.

The new DOJ enforcement policy could signal an upcoming trend to push for disclosures to aid DOJ in civil matters. Additionally, the above matters indicate that DME providers and prescription drugs are still in the center of the regulators' radar. It should be noted that these actions involved separately a Medicare provider and a Medicaid provider. These cases are varied but do show trends that are likely to continue.

For more information, please contact Grant Dearborn, Ginny Dailey, or another member of Shumaker's Health Law Team.

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