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Health care fraud is surging, and enforcement is racing to keep up

California has emerged as a major focal point in the healthcare fraud crisis, with regulators targeting a surge of sham hospice and home health care operators and increasing enforcement efforts across the state.

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California has become a major focal point for the healthcare fraud crisis, driven heavily by an epidemic of sham hospice and home health care operators in Southern California. Federal and state regulators have identified Los Angeles County as a uniquely dense hotbed for these illicit schemes.

Recent federal enforcement actions underscore the government's focus on health care fraud in California. In April 2026, authorities announced changes related to alleged hospice billing fraud and a separate Medi-Cal fraud scheme involving unnecessary prescription drugs and kickbacks.

Implications for health care providers in California

The increased law enforcement surveillance, heightened scrutiny and prosecutions in California emphasize the compliance steps California health care providers should consider, including billers and hospice care providers.

Third-party medical billers:

Frequently, the DOJ charges health care fraud cases under the criminal conspiracy law. In other words, multiple parties with alleged roles in health care fraud schemes are charged as agreeing with the criminal objective to submit illegitimate reimbursement requests (i.e., not for medical necessity) to Medi-Cal/Medicaid in furtherance of the fraud. As the party directly submitting the "fraudulent" request, medical billers are low-hanging fruit for the government. Even though a third-party medical biller might be unaware of all parties involved in the scheme, if it is aware of red flags pertaining to the reimbursement request, or has knowledge about a false statement reflected in the reimbursement request, the requisite mindset to participate in the fraudulent scheme can be imputed and established, thus laying a basis for finding that the biller is a co-conspirator. Under federal criminal law, a co-conspirator can be criminally liable for all foreseeable losses in the conspiracy, i.e., damages above and beyond the submissions made by the third-party biller and extending to all financial losses implicated by the conspiracy. In a criminal conspiracy, co-conspirators are jointly and severally liable for all losses.

In the classic model of fraudulent health care billing for durable medical equipment (DME) (e.g., knee, ankle or shoulder braces), the third-party biller receives reimbursement requests from DME companies accompanied by signed patient orders (i.e., prescriptions). However, these putative patient orders have been identified by telemarketers who paid national and international call centers to contact patients to generate "leads" for braces or prescriptions. Those leads may generate patient records through unlawful marketing and kickback arrangements before claims are submitted to Medicare or Medi-Cal. Although billers may not participate in every aspect of the scheme, they often serve as the final checkpoint before reimbursement requests are submitted.

The classic model described here emphasizes that the third-party biller provides a gate-keeping function to potential fraudulent processing activity. Many billers already maintain technology that screens suspicious claims before reimbursement requests are submitted. Such protocols might (i) screen for missing information; (ii) confirm that the patient order is signed by a physician; and (iii) screen against databases verifying that (a) the patient is an actual person, (b) is not deceased, and (c) resides at the requisite ad-

dress. However, these protocols may be insufficient to verify that an order originated from a treating physician or a facility that has a history with the patient.

Hospice care providers:
Hospice care has become a significant focus of health care fraud enforcement. Common schemes involve enrolling patients in hospice without their knowledge and billing Medicare/Medi-Cal for services that never occurred.

Managing the regulatory and law-enforcement scrutiny that hospice facilities in California face requires intense diligence and a proactive compliance infrastructure. The DOJ and the OIG look at live discharge rates and the percentage of patients who do not die while in hospice care to identify potential fraud.

The national average for non-death discharges (patients who leave hospice alive) is approximately 17.2%. A DOJ operation targeting large-scale hospice fraud in Southern California (Operation Never Say Die) reported non-death discharges at rates of more than 85%. Aside from criminal prosecutions, extremely high live discharge rates often, at a minimum, trigger federal audits to determine if a facility is improperly admitting non-terminal patients to Medicare hospice benefits.

Medicare guidelines require a life expectancy of six months or less; however, the median lifetime length of service nationally is only 17 days. Facilities with a disproportionate number of very long-term patients who do not die face scrutiny.

If the hospice facility fails to incorporate these statistical realities into its compliance protocols, the likelihood of a DOJ investigation, including subpoenas to third parties, is an inevitability.

California's enforcement environment reflects a sustained focus on health care fraud. For providers, billers and compliance professionals, the key takeaway is that robust compliance programs, meaningful oversight and ongoing monitoring are no longer best practices alone but essential risk-management tools. Organizations that proactively address compliance vulnerabilities today will be better prepared to withstand the heightened scrutiny that is likely to continue across the state's health care sector.

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