



Executive Briefing: Recent HHS Actions and What They Mean for Healthcare

Impact on Medicare, hospitals, clinics, and clinicians (physicians, NPs, PAs, and RNs)

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Bottom line

In October, HHS Secretary Robert F. Kennedy Jr. made two moves that significantly raise the stakes on Medicare and Medicaid billing compliance. First, CMS now has the power to exclude providers from federal healthcare programs. Second, HHS and the Department of Justice opened a six-month window in which organizations can self-report potential False Claims Act violations in exchange for avoiding exclusion, enrollment revocation, and penalties. Taken together, the message is clear: enforcement is getting faster, and the government is rewarding organizations that come forward early.

1. What Changed

CMS can now exclude providers (effective October 13, 2026)

Secretary Kennedy delegated permissive exclusion authority under Section 1128(b) of the Social Security Act to the CMS Administrator, effective immediately. Until now, only the HHS Office of Inspector General (OIG) held this power, and OIG keeps it. In practice, two agencies can now remove individuals and organizations from Medicare, Medicaid, and other federal programs.

This matters because CMS works from real-time claims and enrollment data, oversees a national network of contractors that audit claims around the clock, and has direct leverage over state Medicaid programs. The grounds for permissive exclusion do not require a criminal conviction. The delegation does not include mandatory exclusion authority, the power to hold exclusion hearings, or the power to issue regulations, and CMS has not yet explained how it will use the new authority.

The broader trend is unmistakable. CMS reported 5,586 billing-privilege revocations in 2025 and 1,413 in the first quarter of 2026 alone, a record 40% quarterly increase.

DOJ–HHS False Claims Act self-disclosure pilot (announced October 22, 2026)

Healthcare companies that voluntarily disclose potential civil False Claims Act violations can resolve them through a single, coordinated settlement. To qualify, an organization must disclose all relevant facts, produce supporting documents, describe the corrective steps it has taken, and repay the amount owed multiplied by a factor of 1.25 to 1.6. The multiplier depends on how quickly the issue was reported, how long and widespread the conduct was, whether senior leaders were involved, and how much the organization benefited.

In return, DOJ releases the disclosed liability, OIG will not impose an exclusion or a Corporate Integrity Agreement, CMS will not revoke Medicare enrollment or billing privileges, and neither agency will impose civil monetary penalties. **Submissions are due by April 22, 2027**, and late or incomplete filings will not be reviewed.

Other October announcements worth noting

- **Insurance price transparency (October 5):** Health plans will report pricing data quarterly instead of monthly and must give members personalized cost estimates by phone as well as online. Separately, hospitals have been subject to stricter price-posting rules since April 1, including actual allowed amounts and a signed accuracy attestation from a senior official.
- **Vaccine injury reporting (October 8):** CMS has proposed paying physicians for the time they spend reporting suspected vaccine injuries to VAERS. This is a proposal, not yet a final rule.
- **Health center nutrition initiative (October 14):** A voluntary commitment encouraging community health centers to make nutrition and prevention part of routine care.

2. Impact by Stakeholder

Stakeholder	What it means
Medicare program	Faster removal of providers with suspicious billing patterns. More recoveries through self-disclosure. Greater price visibility for beneficiaries and employers.
Hospitals and health systems	Exclusion now carries a second enforcement path. Employing or contracting with an excluded person can trigger civil monetary penalties. Price-transparency attestations put senior officials on the record.
Clinics and physician groups	Data-driven audits can flag outlier coding, volume, or ordering patterns sooner. The self-disclosure window offers a defined way to resolve known problems without losing billing privileges.

3. Impact on Individual Clinicians

Exclusion applies to individuals, not just organizations. An excluded clinician cannot be paid by any federal program for services they furnish, order, or prescribe. In practice, that often means the end of employment anywhere that accepts Medicare or Medicaid.

Role	Key exposure
Physicians	Exclusion blocks payment for their own services and for the labs, imaging, and drugs they order. The self-disclosure pilot is designed for companies, so employed physicians are covered only through their employer's filing. Physicians with concerns should seek their own legal counsel.
Nurse practitioners and physician assistants	Similar exposure to physicians, since NPs and PAs bill, order, and prescribe under their own NPIs. Incident-to and split/shared billing are common sources of error, and both the NP or PA and the supervising physician may face scrutiny.
Registered nurses	Lower direct billing exposure, but an excluded RN becomes very difficult to hire. Nursing documentation often supports billed services such as home health, hospice eligibility, and time-based care, so it can become evidence in an audit.

Sources

- HHS press releases: DOJ–HHS False Claims Act Self-Disclosure Pilot (Oct. 22, 2026); Price Transparency Rules (Oct. 5); Vaccine Injury Actions (Oct. 8); Health Center Healthy Lifestyle Commitment (Oct. 14). [hhs.gov/press-room](https://www.hhs.gov/press-room)
- Statement of Delegation of Authority, 91 Fed. Reg. 65219 (Oct. 14, 2026)
- Sidley Austin, HHS Secretary Extends HHS-OIG Exclusion Authority to CMS (Oct. 19, 2026); Alston & Bird, Health Care Week in Review (Oct. 16, 2026); Penn State Office of Rural Health, Hospital Price Transparency Enforcement

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