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Turning Up the Heat: What DOJ's New Corporate Fraud Directive and CMS's Expanding Enforcement Toolkit Mean for Providers in 2027

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In a span of just two weeks this fall, federal health care fraud enforcement took several significant turns. On October 1, 2026, the Department of Justice's ("DOJ") newly created National Fraud Enforcement Division (the "Fraud Division") issued Directive 26-12, Corporate Enforcement in the Fight Against Fraud (the "Directive"), naming health care fraud as the first of its four corporate enforcement priorities.[1] On October 5, 2026, the Centers for Medicare & Medicaid Services ("CMS") released a Request for Information ("RFI") proposing a new fraud defense contracting model in which CMS, rather than its contractors, would drive fraud investigations.[2] And on October 14, 2026, the Secretary of the Department of Health and Human Services ("HHS") formally delegated permissive exclusion authority under Section 1128(b) of the Social Security Act to the CMS Administrator.[3] These developments build on CMS's ongoing Comprehensive Regulations to Uncover Suspicious Healthcare ("CRUSH") initiative. Taken together, they signal that providers of every size and type, not just hospitals and large health systems, should expect more fraud enforcement activity in 2027.

DOJ Directive 26-12: Aggressive Enforcement, With a Promise to Guard Against Overreach

The Directive instructs Fraud Division prosecutors to "take an aggressive, all-tools approach to investigating and prosecuting our health care, government, tax, and trade fraud priorities."[4] In opening and conducting corporate investigations, prosecutors are to prioritize, first, "[f]raud schemes involving the health care industry, including health care fraud, distribution of controlled substances, and violations of the Federal Food, Drug, and Cosmetic Act."[5] The Directive also requires prosecutors to work with the Fraud Division's Corporate Enforcement Section "at all phases of corporate investigations, from case intake through completion of any corporate resolution or litigation," and to report all ongoing corporate investigations to the Section Chief within seven days.[6]

[1] Memorandum from Colin M. McDonald, Assistant Att'y Gen., Nat'l Fraud Enf't Div., U.S. Dep't of Justice, to All Fraud Division Personnel, Directive 26-12: Corporate Enforcement in the Fight Against Fraud 3 (Oct. 1, 2026) [hereinafter Directive 26-12].
[2] CMS, Request for Information – Fraud Defense Contracts, SAM.gov Notice ID 270536 (Oct. 5, 2026, amended Oct. 13, 2026) [hereinafter Fraud Defense RFI].
[3] Statement of Delegation of Authority, 91 Fed. Reg. 65,219 (Oct. 14, 2026); see 42 U.S.C. § 1320a-7(b).
[4] Directive 26-12, supra note 1, at 1.
[5] Id. at 3.
[6] Id. at 2–3.

Importantly for providers, the Directive lists ten factors on which prosecutors "must place great weight" in deciding whether to bring charges and in negotiating resolutions. Several are directly relevant to health care organizations, including: (1) knowledge of or involvement in the fraud scheme by corporate management; (2) efforts to conceal fraud from government agencies or auditors; (3) conduct lasting three years or more; (4) conduct that causes substantial financial hardship to a taxpayer-funded program; (5) conduct that affects multiple taxpayer-funded programs (for example, both Medicare and Medicaid); and (6) conduct resulting in harm to 25 or more victims or $25 million or more in loss.[7]

At the same time, the Directive commits that the Fraud Division will "firmly guard against overbroad corporate enforcement—rightly dividing between shades of corporate malfeasance—lest we interfere with legitimate business operations," and that the Department will "appropriately credit those that demonstrate a willingness to disclose misconduct, cooperate, and remediate."[8] Prosecutors remain bound by the Principles of Federal Prosecution of Business Organizations and the Department-wide Corporate Enforcement and Voluntary Self-Disclosure Policy.[9] The Directive further directs Fraud Division leadership to design programs that "appropriately incentivize whistleblowers," including those "who participated in the criminal conduct."[10] One week later, Directive 26-12 called for prosecutors to use the full range of criminal authorities and to deploy "early, pre-indictment asset seizures."[11] For providers, the message is twofold: a well-designed, functioning compliance program and a credible record of disclosure and remediation are likely to matter more than ever, and insiders will have growing incentives to report concerns to the government first.

CMS Now Holds Permissive Exclusion Authority

Effective October 14, 2026, the HHS Secretary delegated to the CMS Administrator "the authorities vested in the Secretary of Health and Human Services under section 1128(b) of the Social Security Act."[12] Permissive exclusion authority had previously been exercised by the HHS Office of Inspector General ("OIG"). The notice explains that CMS, as the agency administering Medicare and Medicaid, "is uniquely positioned to investigate, identify, and develop the evidentiary basis underpinning permissive exclusion determinations," and that the delegation "aligns investigative and enforcement responsibilities within a single operating division." The delegation does not include authority to conduct hearings or issue regulations.[13]

This shift is significant for both entities and individuals operating within the health care space. Permissive exclusion can reach owners of a sanctioned entity who knew or should have known of the conduct, as well as officers and managing employees based on their status alone.[14] "Managing employee" includes individuals exercising operational or managerial control "whether or not the individual is a W-2 employee."[15] With the agency that also controls enrollment, payment

[7] Id. at 4.
[8] Id. at 1–2.
[9] Id. at 2 (citing Justice Manual § 9-28.000).
[10] Id. at 5.
[11] Press Release No. 26-1160, U.S. Dep't of Justice, Assistant Attorney General Colin M. McDonald Issues Memorandum on the National Fraud Enforcement Division's Comprehensive Approach in the Fight Against Fraud (Oct. 8, 2026); see Memorandum from Colin M. McDonald, Directive 26-12: A Comprehensive Approach in the Fight Against Fraud (Oct. 7, 2026).
[12] 91 Fed. Reg. at 65,219 (revising Delegation of Authority, 76 Fed. Reg. 13,618 (Mar. 14, 2011)).
[13] Id.
[14] 42 U.S.C. § 1320a-7(b)(15)(A)(i)–(ii); 42 C.F.R. § 1001.1551.
[15] 42 C.F.R. § 455.101.

suspension, and revocation now able to exclude, providers should expect these administrative tools to be used in closer coordination, and should assess individual exposure early in any investigation.

The Fraud Defense Contracts RFI: CMS Takes the Wheel

The RFI, posted on SAM.gov, includes a draft Statement of Objectives for the contracts which would succeed today's Unified Program Integrity Contractors ("UPICs"). Under the draft model, CMS would become "the primary driver of proactive data analysis, lead generation, prioritization, and law enforcement vetting," while contractors would primarily build the cases CMS assigns, including through medical review, interviews, onsite visits, and support for rebuttals, appeals, hearings, and litigation.[16] CMS has stated the new framework "enhances CMS' role in directing investigations" and invited proposals "without being bound by current UPIC policies or the Medicare Program Integrity Manual." Responses were due November 4, 2026.[17]

Although the RFI does not itself change any provider obligations, it points toward investigations which begin earlier in the payment cycle, move faster, and are integrated across Medicare fee-for-service, Medicare Advantage, Part D, and Medicaid.[18] Providers should also assume that early correspondence and productions in a contractor review may become part of a broader enforcement record.

CRUSH: The Numbers Behind the Push

CMS launched CRUSH in February 2026 with an RFI seeking comment on, among other things, expanded payment suspension authority, enhanced enrollment screening and revocation, and heightened scrutiny of high-risk Medicaid services, including housing stabilization, behavioral health, personal care, and non-emergency medical transportation.[19] A CRUSH proposed rule is currently under review at the Office of Management and Budget.[20] CMS's own figures for January 1 through June 30, 2026, show the scale of activity: $1.8 billion in Medicare overpayments identified through medical review; $378 million collected through post-payment review; $539 million in payment suspensions affecting 1,095 providers and suppliers; 153 law enforcement referrals accepted, encompassing $1 billion in billing; and 1,625 revocations, a 15% increase over the same period in 2025.[21] CMS's Medicaid Fraud War Room, launched in April 2026, reported more than $203 million in net savings across 50 providers in its first 88 days.[22]

Enforcement momentum is also evident on the Medicaid side. In 2026, CMS deferred federal Medicaid payments to Minnesota and California pending review of high-risk claims, including $259.5 million from Minnesota in February.[23] OIG also suspended funding for New York's Medicaid Fraud Control Unit ("MFCU") from July 1 through September 30,

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[16] Fraud Defense RFI, supra note 2 (draft Statement of Objectives).
[17] CMS, Crushing Fraud, Waste, & Abuse, https://www.cms.gov/fraud (last modified Nov. 2, 2026).
[18] See Fraud Defense RFI, supra note 2 (seeking comment on integration of Medicare Advantage, Part D, and Medicaid investigations and on the speed of administrative action).
[19] Request for Information (RFI) Related to Comprehensive Regulations to Uncover Suspicious Healthcare (CRUSH), 91 Fed. Reg. 9803, 9807 (Feb. 27, 2026).
[20] Comprehensive Regulations to Uncover Suspicious Healthcare (CRUSH) (CMS-6098), RIN 0938-AV97, Office of Info. & Regulatory Affairs, Executive Order Submissions Under Review, RegInfo.gov (accessed Nov. 12, 2026).
[21] CMS, Crushing Fraud | 2026: CMS Facts & Figures, January 1, 2026 – June 30, 2026, at 1–2 (Aug. 2026).
[22] Id.
[23] Press Release, CMS, Trump Administration Prioritizes Affordability by Announcing Major Crackdown on Health Care Fraud (Feb. 25, 2026).

2026.[24] The 2026 National Health Care Fraud Takedown charged 455 defendants in schemes involving more than $6.5 billion in alleged false claims, with all 50 MFCUs participating.[25] Fiscal Year 2025 False Claims Act recoveries reached $6.8 billion, the highest in the statute's history, with more than $5.7 billion from health care.[26]

What Providers Should Do Now

As 2026 winds down, providers should consider the following steps to prepare for this enforcement environment:

• **Assess and invest in the compliance program.** DOJ evaluates compliance programs under its Evaluation of Corporate Compliance Programs guidance, and the Directive's "great weight" factors reward early detection and penalize management involvement and concealment.[27] An independent compliance program assessment can identify gaps before the government does.

• **Audit your own data.** Government analytics flag outliers in high-value and high-volume services. Conduct privileged internal reviews that reconcile the claim, time records, service documentation, authorization, credentials, and exclusion screening for a sample of claims.

• **Screen for exclusions monthly.** Check the LEIE (using the online verification tool) and SAM at engagement and monthly thereafter, and audit any vendor to which screening has been delegated. Liability for employing an excluded individual whose work is not separately billable can be assessed at three times total compensation.[28]

• **Treat potential overpayments with urgency.** Identified overpayments must be reported and returned within 60 days, and retention can support reverse false claims liability.[29]

• **Evaluate self-disclosure options.** DOJ credits timely disclosure, cooperation, and remediation, and HHS maintains its own self-disclosure channels.[30] Where a problem is identified, counsel can help evaluate whether and through which channel to disclose.

• **Build a response plan before the letter arrives.** Train mailroom and front-desk staff to escalate audit and investigation correspondence, designate who will coordinate productions and communications, and make the first production organized and complete. Do not alter documentation.

• **Consider individual exposure early.** Owners, officers, and managing employees may face exclusion and prosecution separate from the entity, which can affect whether separate counsel is appropriate.[31]

How Hancock Daniel Can Help

[24] Letter from HHS Office of Inspector Gen. to N.Y. Medicaid Fraud Control Unit (June 30, 2026).
[25] U.S. Dep't of Justice & HHS, Press Releases (June 16, July 2, and July 21, 2026).
[26] Press Release, U.S. Dep't of Justice, False Claims Act Settlements and Judgments Exceed $6.8B in Fiscal Year 2025 (Jan. 16, 2026).
[27] See Directive 26-12, supra note 1, at 4; Justice Manual § 9-28.800.
[28] 42 C.F.R. §§ 455.436, 1003.210(b)(2)(ii); OIG, Updated Special Advisory Bulletin on the Effect of Exclusion (May 8, 2013).
[29] 42 U.S.C. § 1320a-7k(d); 31 U.S.C. § 3729(a)(1)(G).
[30] See Directive 26-12, supra note 1, at 1–2, 4.
[31] See 42 U.S.C. § 1320a-7(b)(15); Directive 26-12, supra note 1, at 1.

Hancock Daniel assists hospitals, health systems, physician practices, post-acute and behavioral health providers, and other health care organizations with compliance program assessments and investments, privileged internal audits, overpayment analyses, self-disclosures, settlement negotiations, and responses to audits and investigations by MACs, UPICs, RACs, MCO special investigations units, OIG, and DOJ. If you have questions regarding these developments or would like assistance preparing for 2027, please contact a member of the Compliance or Fraud & Abuse teams.

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