

# Top Management & Performance Challenges Facing HHS



Department of Health and Human Services  
**Office of Inspector General**

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# Introduction

The Department of Health and Human Services (HHS or the Department), Office of Inspector General (OIG) issues its *Top Management and Performance Challenges Facing HHS* annually as required by statute. This publication is intended to help the Department improve the effectiveness and efficiency of its programs and operations. This past year, the Department has undertaken a sizeable workforce reduction and many program changes are in process. Effectively managing a changing organizational and workforce environment is itself a significant management challenge. Concurrently, the Department faces five top challenges, which are summarized in the sections that follow. While the Department has taken steps to address these five challenges, opportunities exist for further progress.

OIG's [website](#) offers additional oversight resources, including all reports mentioned here, OIG [recommendations](#) to improve Department programs and reduce vulnerabilities, and the status of those recommendations.



# 1 | Financial Integrity

## Elements of the Challenge

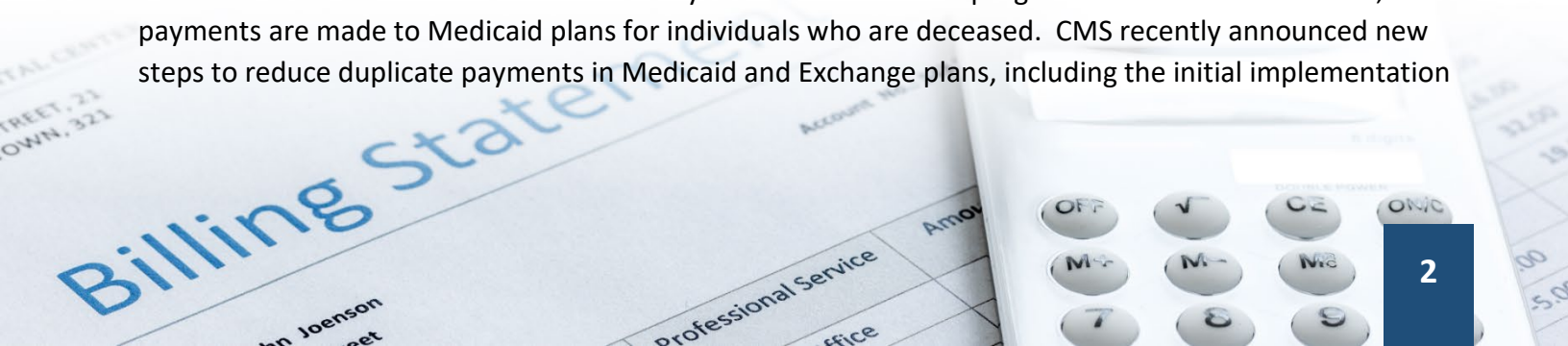
- Preventing, reducing, and recovering improper payments
- Controlling costs by ensuring prudent payments
- Protecting grants and contracts from fraud
- Monitoring and reporting on the integrity of HHS financial management

Given HHS's significant expenditures, the Department must ensure sound financial stewardship and work to combat fraud, waste, and abuse.

## Preventing, Reducing, and Recovering Improper Payments

In fiscal year (FY) 2024, improper payments for Medicare, Medicaid, and the Children's Health Insurance Program were estimated at \$86.5 billion. An improper payment is any payment that does not meet legal requirements or is made in an incorrect amount. Among other harms, improper payments can duplicate other payments, fund ineligible services, enrich ineligible providers, serve ineligible recipients, or violate other program rules. HHS must be vigilant in recovering overpayments promptly.

- Within the Traditional Medicare program, reducing improper payments remains a challenge. The improper payment rate reported in FY 2024, 7.66 percent, has not decreased from the rates reported in FYs 2022 or 2023. The four categories with the largest dollars in improper payments in FY 2024 were claims associated with skilled nursing facilities, hospital outpatient services, inpatient rehabilitation facilities, and hospice care. The Centers for Medicare & Medicaid Services (CMS) has developed multiple corrective actions to address these errors, including audits of high overpayment areas and provider education to reduce claim errors. OIG has identified additional areas of high risk, such as payments to critical access hospitals.
- In the Medicaid program, the improper payment rate reported in FY 2024, 5.09 percent of all payments, was a decrease from 8.58 percent in FY 2023. The rate is based on a rolling average of the three prior payment years. The decrease is likely due to a combination of factors, including improved State compliance and temporary flexibilities from the COVID-19 public health emergency that allowed for suspensions of eligibility checks, eliminating that as a source of error.
- Ensuring accuracy of eligibility and enrollment data is a challenge in the Medicaid program. OIG audits have shown that individuals are concurrently enrolled in Medicaid programs in two different States, and payments are made to Medicaid plans for individuals who are deceased. CMS recently announced new steps to reduce duplicate payments in Medicaid and Exchange plans, including the initial implementation



of some tools provided in the One Big Beautiful Bill Act to prevent duplicate enrollment. Ensuring that all of the new tools established by the One Big Beautiful Bill Act operate effectively will require CMS to coordinate closely with the States over the next several years.

- HHS awards grants and contracts to deliver programs and services. HHS must be vigilant in ensuring that these awards meet their objectives efficiently and effectively and that they comply with Federal requirements. The Department needs to continue its progress to ensure that grant and contract dollars are used for their intended purpose, and recipients properly account for costs and justify expenditures. This includes ensuring sufficient visibility into subawards of grant funds and improving the contract management and closeout processes.

## Controlling Costs by Ensuring Prudent Payments

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HHS must continually assess payment policies to ensure they are structured to curb wasteful spending. OIG work has identified payment policies that create incentives for providers and other stakeholders to behave in ways that increase costs to HHS programs without adding value. For example, for skin substitutes used for wound care, a combination of low barriers to market entry and reimbursement at rates higher than acquisition costs, or spread pricing, drive both higher prices and increased utilization, resulting in higher Medicare costs. Similar issues exist for continuous glucose monitors, creating incentives for increased utilization. CMS has recently proposed regulations to reform payments for skin substitutes and continuous glucose monitors. HHS must continue to pursue cost savings by identifying and correcting misaligned payment policies to ensure that HHS programs are prudent purchasers of items and services.

## Protecting Grants and Contracts From Fraud

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Fraud is a threat to grant and contract awards. HHS must be vigilant in ensuring that taxpayer investments in HHS grants and contracts are not diverted for fraudulent, unauthorized, or illegal purposes. The Department must continue to enhance oversight, internal controls, and fraud detection measures to guard against increasingly complex, technology-driven national and transnational fraud schemes. Key risks include embezzlement, social engineering schemes, identity theft, diversion of funds for personal use, and submission of false information for fraudulent purposes.



# Monitoring and Reporting on the Integrity of HHS Financial Management

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Effective internal controls are needed to prevent fraudulent transactions and prevent bad actors from gaining access to HHS systems. The Department has taken steps to improve its information technology controls within its financial systems, including establishing a governance body over the systems that support financial reporting activities. This has led to improvements in its core financial systems. However, the Department must take additional actions to resolve ongoing issues, including continuing efforts to monitor access to key applications and ensuring appropriate segregation of duties.

## Examples of Related Work

- [Multiple States Made Medicaid Capitation Payments to Managed Care Organizations After Enrollees' Deaths](#)
- [ACF Used Contractor Personnel To Perform Inherently Governmental Functions and Paid Millions in Potentially Unallowable Costs](#)
- [Nearly All States Made Capitation Payments for Beneficiaries Who Were Concurrently Enrolled in a Medicaid Managed Care Program in Two States](#)
- [Medicare Could Save Billions With Comparable Access for Enrollees if Critical Access Hospital Payments for Swing-Bed Services Were Similar to Those of the Fee-for-Service Prospective Payment System](#)
- [Medicare Part B Payment Trends for Skin Substitutes Raise Major Concerns About Fraud, Waste, and Abuse](#)
- [NIH Did Not Close Contracts in Accordance With Federal Requirements, Resulting in the Increased Risk of Fraud, Waste, and Abuse](#)

# 2 | Medicare and Medicaid

## Elements of the Challenge

- Combating fraud, waste, and abuse
- Ensuring Medicare Advantage delivers value
- Ensuring the effectiveness and efficiency of the Medicaid program

Millions of American seniors, individuals with disabilities, people in low-income households, and individuals with disease and other complex health needs rely on Medicare and Medicaid for health care coverage. HHS must ensure that these programs deliver high-quality, cost-effective care.

## Combating Fraud, Waste, and Abuse

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Combating fraud, waste, and abuse in Medicare and Medicaid is imperative to ensure that every dollar invested in these programs is used to provide high-quality health care. CMS partnered effectively with OIG to suspend billions of dollars in payments to suspected fraud perpetrators as part of the [2025 National Health Care Fraud Takedown](#) and launched a Fraud Defense Operations Center. CMS must build on these important steps and continue to improve its ability to stop improper and fraudulent payments. These efforts should focus on fraud prevention (e.g., provider enrollment screening and revalidation), detection (e.g., claims processing, pre-payment review, data analysis), and administrative enforcement actions (e.g., payment suspension, recovery of overpayments, termination, revocation). CMS should consider additional program-specific safeguards, such as including ordering providers' National Provider Identifiers on managed care claims. CMS should continue to work closely with its contractors and with OIG and other law enforcement partners to detect and prevent fraud.

Fraud schemes are increasingly complex and global in scope, often migrating from one item or service to another. Items and services at high risk of fraud include durable medical equipment, prescription drugs, hospice care, genetic and clinical laboratory testing, wound care, and treatment for substance use disorder. In designing safeguards, CMS should also consider the roles of for-profit ownership, vertical integration, and middlemen (e.g., pharmacy benefit managers) in potential fraud, waste, and abuse in health care. Different CMS programs (e.g., managed care, traditional Medicare, value-based care models) have different risks because they pay for services and provide coverage differently. As HHS refines payment policies and incentives, it must anticipate and guard against exploitation of specific payment designs.



# Ensuring Medicare Advantage Delivers Value

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Medicare Advantage has become the primary method through which Medicare enrollees receive care. Administering a program of this size (nearly 33 million enrollees and \$462 billion in Federal spending in calendar year 2024) presents challenges in ensuring that payments are accurate, and people enrolled have access to needed care that plans are being paid to provide. HHS must continue to strengthen protections to ensure that plans are not upcoding to receive increased risk adjustment payments or making it difficult for enrollees to receive covered care by denying claims or implementing excessive prior authorization requirements. HHS recently announced a new initiative to improve prior authorization processes. Rigorous oversight will be needed to ensure that enrollees receive appropriate care without undue administrative or financial burden and that plans are delivering value to the taxpayers funding this care. Oversight is also needed to ensure plans are not inappropriately denying payment to providers and are not engaged in misleading and deceptive marketing or enrollment practices. Finally, additional attention must be paid to ensuring that complete and accurate data about payments are readily available from plans for effective monitoring and oversight of the Medicare Advantage program.

## Ensuring the Effectiveness and Efficiency of the Medicaid Program

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OIG work has identified vulnerabilities in the Medicaid program related to payment accuracy, eligibility determinations, provider taxes, and service delivery. As it plans for and administers significant changes in the Medicaid program under the One Big Beautiful Bill Act, CMS should consider these vulnerabilities and adopt appropriate safeguards to ensure that the program operates as intended. Risk areas include ensuring transparency, accurate data, correct eligibility determinations, timely return of overpayments, and access to covered care, particularly in rural areas. Because Medicaid is jointly administered and financed, effective coordination and communication between the Federal Government and States is especially critical as CMS implements new program requirements. As it implements these requirements, CMS must continue to address vulnerabilities in the current program.

### Examples of Related Work

- [Medicare Advantage: Questionable Use of Health Risk Assessments Continues To Drive Up Payments to Plans by Billions](#)
- [Special Fraud Alert: Suspect Payments in Marketing Arrangements Related to Medicare Advantage and Providers](#)
- [Some Medicare Advantage Organization Denials of Prior Authorization Requests Raise Concerns About Beneficiary Access to Medically Necessary Care](#)
- [CMS Is Not Systematically Tracking Whether States Return Federal Shares of Medicaid Managed Care Remittances](#)
- [Indiana Made at Least \\$56 Million in Improper Fee-for-Service Medicaid Payments for Applied Behavior Analysis Provided to Children Diagnosed With Autism](#)

# 3 | Public Health

## Elements of the Challenge

- Preventing and fighting chronic disease
- Addressing the mental health and substance use disorder crises
- Ensuring the safety, effectiveness, and availability of products regulated by the Food and Drug Administration

HHS must efficiently use public health resources to protect and improve the health of all Americans.

## Preventing and Fighting Chronic Disease

According to the Centers for Disease Control and Prevention, chronic diseases such as heart disease, cancer, and diabetes are the leading causes of illness, death, and disability in the United States. They are also leading drivers of the Nation's \$4.9 trillion in annual health care costs. Approximately 6 in 10 Americans have at least one chronic disease, and 4 in 10 have two or more chronic diseases. Rates of chronic disease in children are rising. HHS has expressed a commitment to getting to the root cause of and combating the chronic disease epidemic. HHS is leading the Make America Healthy Again Commission, which released an assessment of chronic disease in children and its strategy to combat childhood chronic disease. Much remains to be done to address the considerable challenge of preventing and fighting chronic disease.

## Addressing the Mental Health and Substance Use Disorder Crises

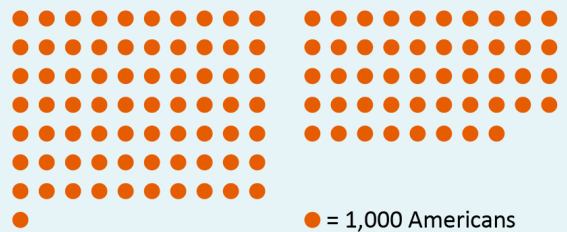
In 2024, 15.4 percent of American adolescents had a major depressive episode, 23.4 percent of American adults experienced mental illness, and 16.8 percent of Americans older than 12 had a substance use disorder. In 2024, an estimated 48,821 Americans died by suicide and an estimated 81,711 Americans died from drug overdoses. While this represents a notable decrease in overdose deaths compared to 2023 when an estimated 106,903 people died, these numbers remain higher than recorded before 2020.

### 2024 Behavioral Health Snapshot

- 15% of adolescents had a major depressive episode
- 23% of adults experienced mental illness
- 17% of people had a substance use disorder

81,000+ people died of drug overdose

48,000+ people died by suicide



Source: Substance Abuse and Mental Health Services Administration

The difficulty in obtaining timely, high-quality care for mental health and substance use remains an obstacle in effectively addressing the Nation’s mental health and substance use disorder crises. As HHS considers changes to programs that provide behavioral health care and support, addressing the substance use disorder and mental health crises is a continuing challenge.

## Ensuring the Safety, Effectiveness, and Availability of Products Regulated by the Food and Drug Administration

The Food and Drug Administration (FDA) regulates crucial consumer products, including foods, human and veterinary drugs, biological products, medical devices, cosmetics, products that emit radiation, tobacco, and infant formula. Twenty-one cents of every dollar American consumers spend goes to these FDA-regulated products. Vulnerabilities facing FDA include reliance on overseas manufacturing, increasingly complex supply chains, and cyberattacks and other security risks. While faced with these challenges, FDA must ensure the safety, effectiveness, quality, security, and availability of FDA-regulated products.

### Examples of Related Work

- [Medicare Part D Spending for 10 Selected Diabetes Drugs Totaled \\$35.8 Billion in 2023, an Increase of 364 Percent From 2019](#)
- [Medicaid Gross Spending on 10 Selected Diabetes and 2 Selected Weight Loss Drugs Totaled More Than \\$9 Billion in 2023, an Increase of 540 Percent From 2019](#)
- [Medicare and Medicaid Enrollees in Many High-Need Areas May Lack Access to Medications for Opioid Use Disorder](#)
- [FDA Food Safety Inspections of Domestic Food Facilities](#)
- [The Food and Drug Administration’s Foreign For-Cause Drug Inspection Program Can Be Improved To Protect the Nation’s Drug Supply](#)
- [The Food and Drug Administration’s Inspection and Recall Process Should Be Improved To Ensure the Safety of the Infant Formula Supply](#)



# 4 | Beneficiary Safety

## Elements of the Challenge

- Protecting the health and safety of those served
- Ensuring qualified providers and other staff

People receiving HHS-funded care should be able to trust that they will be protected from preventable harms.

## Protecting the Health and Safety of Those Served

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HHS-funded programs and services are operated in a variety of different settings, including hospitals, nursing homes, adult day care facilities, hospices, shelters for unaccompanied alien children, child care centers, foster care group homes, and people's own homes, among many others. HHS programs have a role in protecting the health and safety of those served, including protecting against abuse in child care settings, infections in hospitals, misuse of drugs in nursing homes, and hazards in adult day care facilities. To that end, providers and program managers must follow health and safety requirements, appropriately vet and train staff, and identify and quickly remediate weaknesses that put individuals at risk.

Every year, millions of patients served by Federal health programs experience adverse events and temporary harm events as a result of medical care or in a health care setting. Some of these events are the result of errors or substandard care. Although most harm events resolve quickly, some have long-term and serious implications for patient health. HHS has uncovered practices that put organ donors at risk for preventable harm. Despite nationwide efforts to improve patient safety, reducing patient harm remains a challenge for HHS.

People in nursing homes are at increased risks for harm. HHS has taken important steps to improve nursing home safety and must continue to build on this progress, in areas such as infection control, drug misuse, improper facility-initiated discharges, and preventing abuse and neglect.

Emergency situations, often fast moving, uncertain, and complicated, can both introduce new and exacerbate longstanding gaps in safety and put those most vulnerable to harms at greater risk of injury or death. For natural disasters, emerging infectious diseases, bioterrorism, or other life safety events, HHS must strengthen its efforts to protect beneficiaries during and after emergencies.



# Ensuring Qualified Providers and Other Staff

Thousands of HHS-funded providers and program staff hold positions of trust that bring them into close contact with individuals, often behind closed doors. Most providers and other staff earn this trust and work hard to serve people well; however, some cause harm. Thoroughly vetting providers and staff by using background checks helps prevent potential predators, and people otherwise disqualified, from gaining access to individuals in HHS programs. Gaps in compliance with background check requirements in HHS-funded programs remain, increasing the potential for preventable harms, particularly among populations at greatest risk, including children, older Americans, and people with special health care needs. The Department must remain vigilant in continuous efforts to ensure that HHS-funded providers and other staff, in all program and service settings, meet established criteria for vetting and training.

## Examples of Related Work

- [\*Hospitals Did Not Capture Half of Patient Harm Events, Limiting Information Needed To Make Care Safer\*](#)
- [\*Concerns Remain About Safeguards To Protect Residents During Facility-Initiated Discharges From Nursing Homes Many States Lack Information To Monitor Maltreatment in Residential Facilities for Children in Foster Care\*](#)
- [\*2023 Operation Nightingale Enforcement Action\*](#)
- [\*CMS Should Take Additional Actions To Help Hospitals Prepare for a Future Emerging Infectious Disease Outbreak\*](#)
- [\*State Survey Agencies Need Additional Guidance To Assess Nursing Home Emergency Preparedness Programs\*](#)
- [\*Gallup Indian Medical Center—an IHS-Operated Health Facility—Did Not Timely Conduct Required Background Checks of Staff and Supervise Certain Staff\*](#)

# 5 | Cybersecurity

## Element of the Challenge

- Improving cybersecurity for HHS programs, related industry sectors, and individuals

HHS must adapt as risks expand to include social engineering threats, data breaches, and increasingly sophisticated cyberattacks.

HHS faces persistent cybersecurity threats. The large scale of HHS's mission and information technology environments requires that the Department simultaneously address a range of cybersecurity risks along with the specific data and technology needs for each HHS division and program.

## Improving Cybersecurity for HHS Programs, Related Industry Sectors, and Individuals

Cyberattacks and related threats can jeopardize critical HHS operations and programs, potentially compromising the health and welfare of the individuals HHS serves. Disparate organizational approaches to cybersecurity that vary by division and program within the Department and across the Government complicate HHS's preparedness efforts to prevent or respond to cybersecurity risks. The Department has taken steps to consolidate functions related to cybersecurity and improve its cybersecurity overall, but progress is often still dependent on each division and program.

Cybersecurity solutions must be implemented not just within the Department but also by the thousands of HHS contractors, grantees, and other external entities. For many HHS programs, effective cybersecurity will depend on these parties implementing solutions that mitigate cybersecurity threats specific to their operations, which may be more challenging for smaller entities. Protecting technology and data requires broader efforts beyond implementing technical fixes, such as establishing clear expectations; modernizing program rules; and conducting effective oversight of the Department's contractors, grantees, and other external entities.

HHS must also help address significant cybersecurity threats for the industries and other entities it oversees. The health care industry remains a prime target for cyberattacks. Bad actors continue to leverage the threat of interrupting patient care and other critical health care operations to extract ransoms or other value from providers and other entities that play a vital role in the health care industry. The diffuse nature of HHS cybersecurity authorities and responsibilities complicates response efforts.



Although HHS leads a network of Federal agencies to improve the cybersecurity of the health care and public health sectors, challenges remain that the Department has limited authorities or resources to address, including the industry's reliance on legacy technology and workforce challenges. As cybersecurity threats and potential targets increase, HHS must maintain vigilance, expeditiously notify the sector of vulnerabilities, and help the health care industry adapt to evolving threats.

The Department must also work to protect the privacy and security of individual data that is required to receive services, and that must be kept out of the hands of bad actors. HHS's ability to enforce the decades-old Health Insurance Portability and Accountability Act (HIPAA) - Privacy Rule and HIPAA Security Rule - may not be sufficient to address contemporary privacy concerns of protecting health information or increased risks to the security of electronic protected health information. Working within the statutory authorities established by HIPAA in 1996, HHS must adapt as privacy and security needs evolve.

### Examples of Related Work

- [\*HHS's Grant Payment System Lacked Effective Internal Controls To Prevent \\$7.8 Million in Fraud, and HHS Has Begun Taking Corrective Actions To Reduce Fraud Risk\*](#)
- [\*Summary Report of Prior Office of Inspector General Cyber Threat Hunt Audits of Eight HHS Operating Division Networks\*](#)
- [\*Illumina Inc. to Pay \\$9.8M to Resolve False Claims Act Allegations Arising from Cybersecurity Vulnerabilities in Genomic Sequencing Systems\*](#)
- [\*A Large Northeastern Hospital Could Improve Certain Security Controls for Preventing and Detecting Cyberattacks\*](#)
- [\*The Office for Civil Rights Should Enhance Its HIPAA Audit Program To Enforce HIPAA Requirements and Improve the Protection of Electronic Protected Health Information\*](#)
- [\*HHS Office of the Secretary Needs To Improve Key Security Controls To Better Protect Certain Cloud Information Systems\*](#)

# Conclusion

Addressing HHS's top management and performance challenges will support high-quality care and services, ensure careful stewardship of taxpayer dollars, and mitigate fraud and other risks so that programs operate as intended.

## Stay in Touch



**HHS Office of Inspector General**



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# Report Fraud, Waste, and Abuse

OIG Hotline Operations accepts tips and complaints from all sources about potential fraud, waste, abuse, and mismanagement in HHS programs. Hotline tips are incredibly valuable, and we appreciate your efforts to help us stamp out fraud, waste, and abuse.



**[TIPS.HHS.GOV](https://tips.hhs.gov)**

**Phone: 1-800-447-8477**

**TTY: 1-800-377-4950**

## Who Can Report?

Anyone who suspects fraud, waste, and abuse should report their concerns to the OIG Hotline. OIG addresses complaints about misconduct and mismanagement in HHS programs, fraudulent claims submitted to Federal health care programs such as Medicare, abuse or neglect in nursing homes, and many more. [Learn more about complaints OIG investigates.](#)

## How Does It Help?

Every complaint helps OIG carry out its mission of overseeing HHS programs and protecting the individuals they serve. By reporting your concerns to the OIG Hotline, you help us safeguard taxpayer dollars and ensure the success of our oversight efforts.

## Who Is Protected?

Anyone may request confidentiality. The Privacy Act of 1974, the Inspector General Act of 1978, and other applicable laws protect complainants. The Inspector General Act states that the Inspector General shall not disclose the identity of an HHS employee who reports an allegation or provides information without the employee's consent, unless the Inspector General determines that disclosure is unavoidable during the investigation. By law, Federal employees may not take or threaten to take a personnel action because of [whistleblowing](#) or the exercise of a lawful appeal, complaint, or grievance right. Non-HHS employees who report allegations may also specifically request confidentiality.