Top Management & Performance Challenges Facing HHS



2026

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 report is intended to help the Department improve the effectiveness and efficiency of its programs and operations.

Fraud is a serious threat to HHS's effectiveness and efficiency. It wastes taxpayer dollars and can put people in harm's way. In 2026, HHS took new actions to fight fraud in its programs. However, program integrity risks continue to make it harder for the Department to carry out its mission.

Program integrity concerns play a role in each of the Department's five top management and performance challenges. The sections below summarize each challenge and why addressing them matters. OIG's website offers additional resources, including all reports and enforcement actions mentioned here, OIG recommendations to improve Department programs and strengthen their integrity, and actions taken to address those recommendations.

1 | Medicare and Medicaid

Elements of the Challenge

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

HHS must ensure that Medicare and Medicaid deliver high-quality, cost-effective care to the millions of Americans who rely on these programs.

Combating Fraud, Waste, and Abuse

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. The Centers for Medicare & Medicaid Services (CMS) partnered effectively with OIG to suspend billions of dollars in payments to suspected fraud perpetrators as part of the 2026 National Health Care Fraud Takedown, continued to build the Fraud Defense Operations Center to combat fraud in Medicare, and established the Medicaid Fraud War Room to combat fraud in Medicaid. 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, prepayment review, data analysis), and administrative enforcement actions (e.g., payment suspension, recovery of overpayments, termination, revocation). CMS should consider additional program-specific safeguards (e.g., including ordering providers' National Provider Identifiers on managed care claims). CMS should also ensure that States and Medicaid managed care organizations identify and report suspected fraud.

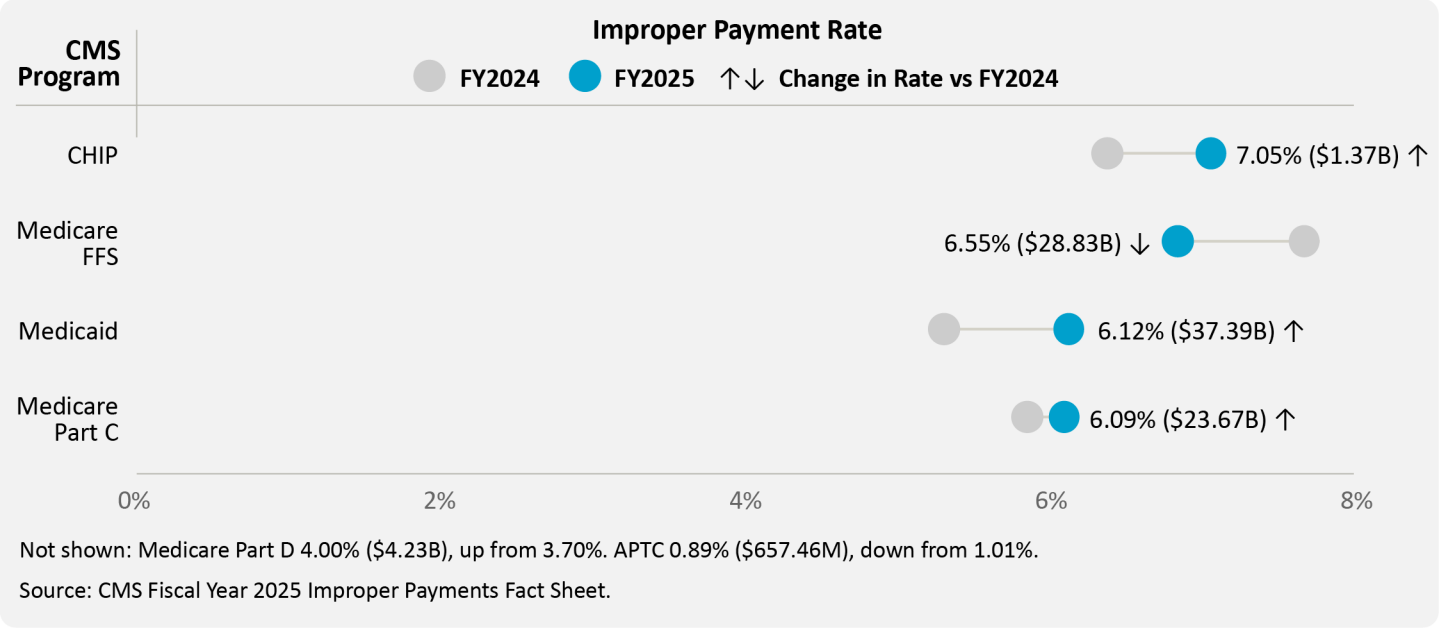
Health care fraud schemes are increasingly complex and global in scope, often migrating from one medical item or service to another. Items and services at high risk of fraud include durable medical equipment, prescription drugs, hospice care, genetic and clinical laboratory testing, wound care, and treatment for substance use disorder. 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.



Improper Payments in Medicare and Medicaid

HHS measures programwide improper payment rates annually for Medicare and Medicaid. In fiscal year (FY) 2025, improper payments for Medicare, Medicaid, and the Children's Health Insurance Program were estimated at $95.49 billion. An improper payment is any payment that does not meet legal requirements or is made in an incorrect amount. However, although all fraudulent payments are improper, not all improper payments indicate fraud. HHS must be vigilant in identifying and recovering improper payments promptly and continue developing actions to prevent improper payments from being made.

The Medicare Fee-for-Service improper payment rate was the only one of four programs to improve in FY 2025.



Not shown: Medicare Part D 4.00% ($4.23B), up from 3.70%. APTC 0.89% ($657.46M), down from 1.01%.

Source: CMS Fiscal Year 2025 Improper Payments Fact Sheet.

Ensuring That Medicare Advantage Delivers Value

Medicare Advantage has become the primary method through which Medicare enrollees receive care. Administering a program with 35 million enrollees and $522 billion in Federal spending in calendar year 2025 presents challenges in ensuring that payments are accurate and people enrolled in these plans have access to needed care that plans are being paid to provide. In FY 2025, improper payments reported for the program, based on errors in diagnoses information submitted for risk-adjusted payment for 2023, totaled $23.67 billion, or 6.09 percent of program outlays. CMS must strengthen program oversight to ensure that plans do not upcode to receive increased risk-adjusted payments. Rigorous oversight by CMS is needed to ensure that enrollees receive appropriate care without undue administrative or financial burden and that plans deliver

value to the taxpayers funding this care. CMS also needs to ensure that plans do not inappropriately deny payment to providers and do not engage in misleading and deceptive marketing or enrollment practices. Finally, CMS must ensure 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

OIG work has identified vulnerabilities in the Medicaid program related to payment accuracy, eligibility determinations, provider taxes, and service delivery. The largest portion of the Medicaid improper payment measure relates to eligibility, with errors due to insufficient documentation. Ensuring accuracy of enrollment data is a particular challenge in the Medicaid program. OIG audits have shown that some individuals are concurrently enrolled in Medicaid programs in two States and found payments made to Medicaid plans for individuals who are deceased. Other risk areas include timely return of overpayments and access to covered care, particularly in rural areas. CMS has taken steps to address some of these risks, and as it does so, must ensure effective coordination and communication between the Federal Government and States.

Examples of OIG's Related Work

- *States Have Missed Some Opportunities To Improve Medicaid Managed Care Organizations' Provider Fraud Referrals*
- *Medicare Payments for Continuous Glucose Monitors and Supplies Exceeded Supplier Costs and Retail Market Prices, Indicating Medicare Can Save at Least Tens of Millions of Dollars in One Year*
- *Medicaid Agencies Made Millions in Unallowable Capitation Payments to Managed Care Organizations on Behalf of Deceased Enrollees*
- *CMS Potentially Overpaid Medicare Advantage Organizations $462 Million Based on Certain Unsupported Acute Stroke Diagnosis Codes*
- *Medicare Advantage Industry Segment-Specific Compliance Program Guidance*
- *Utilization Trends and Medicare Part B Billing for Office-Based Peripheral Vascular Procedures Raise Questions About Program Integrity*

2| Grants and Contracts

Elements of the Challenge

- Ensuring program integrity and recipient compliance
- Managing complex risks and exploitation

Given HHS's significant expenditures through grants, contracts, and other transaction agreements, the Department must ensure sound financial stewardship and work to combat fraud, waste, and abuse.

Ensuring Program Integrity and Recipient Compliance

Combating fraud, waste, and abuse in HHS's grants and contracts is imperative to ensure that every taxpayer dollar is used effectively to advance research, public health, and human services. As the largest grant-making agency in the Federal Government and one of its largest contracting entities, HHS awards billions of dollars annually to States, territories, Tribes, local governments, community organizations, educational institutions, and for-profit businesses. These awards support programs and services essential to HHS achieving its mission, including supporting health centers, biomedical research, child care, and preparedness for public health emergencies. The scale and importance of these programs highlight the urgency of ensuring that Federal funds are well spent and protected from misuse and other risks.

HHS must prioritize rigorous operational oversight throughout the contract and grant life cycles to ensure that the Department enforces compliance from initial award through final closeout. Administering a diverse portfolio of Federal awards presents persistent challenges in ensuring that taxpayer resources are utilized efficiently and lawfully, including securing qualified partners, tracking performance, and ensuring compliance with recipient reporting requirements to support timely action. To mitigate upfront risks, the Department must enforce contracting requirements to prevent non-compliant award terms and conduct intensive financial and performance risk assessments on grant applicants. During the post-award phase, continuous vigilance is required to track deliverable milestones, review billing, and deploy real-time electronic reporting systems to audit the flow of funds and prevent improper drawdowns. Finally, additional administrative attention must be paid to closeout deadlines, including the 120-day grant reconciliation window, to audit final costs, promptly deobligate unused balances, and recover disallowed payments.



Managing Complex Risks and Exploitation

Just as health care fraud schemes grow increasingly complex, threats to grants, contracts, and non-traditional funding awards are expanding in scope and sophistication, necessitating agile and targeted safeguards to address evolving risks. The Department must protect federally funded research from foreign government interference, academic espionage, and the unauthorized misappropriation of U.S. research. Simultaneously, accountability must also be reinforced at the subrecipient level, ensuring that prime awardees are accountable for the oversight and integrity of subrecipients. The rapid growth of flexible mechanisms, such as the National Institutes of Health's use of "Other Transactions," which ballooned from under $900 million in 2020 to $1.9 billion by 2024, requires specialized oversight to ensure that these tools deliver on clinical promises. Finally, HHS must better detect and address vulnerabilities in human service programs, such as those exposed in child care assistance programs where weak attendance tracking and self-certification were exploited.

Examples of OIG's Related Work

- *CMS Put $11.2 Billion at Risk of Fraud, Waste, and Abuse by Not Properly Closing Contracts*
- *ACF's $529 Million Sole Source Contract Award for Unaccompanied Alien Children Services Was Based on an Unsolicited Proposal, Double the Cost Estimate, and Noncompliant With Pre-Award Requirements*
- *Gaps in NIH's Oversight Put Millions in Funding for Other Transactions at Greater Risk of Fraud, Waste, or Abuse*
- *The Office of Refugee Resettlement Needs To Improve Its Monitoring of Unlicensed Unaccompanied Alien Children Program Care Providers' Compliance With Background Check Requirements*
- *ACF Did Not Monitor States' Compliance With All American Rescue Plan Child Care Stabilization Grant Provisions*
- *NIH Recipients Conducting Biospecimen Research: Gaps in Emergency Planning and Reporting*

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 (FDA)
- Ensuring preparedness for and response to disasters and public health emergencies

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 among the top 10 leading causes of illness, death, and disability in the United States. Chronic diseases are also leading drivers of the Nation's estimated $5.7 trillion in annual health care costs. Approximately three in four American adults have at least one chronic condition, and more than half have two or more chronic conditions. Rates of chronic disease in children are rising. HHS launched a Take Back Your Health campaign, emphasizing the importance of nutrition's role in preventing disease and the benefits of physical activity, and issued an advisory on the harms of screen use. 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 2025, adolescents and young adults showed downward or stable trends across several behavioral health indicators, including depression, suicidal thoughts, and the use or initiation of alcohol, nicotine/vaping, marijuana, and other illicit drugs. Still, the overall burden of mental illness and substance use disorders remains substantial. Anxiety symptoms remained a notable concern among adolescents and adults. Many Americans continue to face difficulty obtaining timely, high-quality care for mental health and substance use conditions, which impedes improvement. Confronting the Nation's ongoing behavioral health challenges remains a priority.



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

The FDA regulates a broad range of crucial consumer products, including foods; human and veterinary drugs—including compounded drugs; biological products; medical devices; cosmetics; radiation-emitting products; tobacco products; and infant formula. Collectively, these products account for approximately 21 cents of every dollar spent by American consumers. The FDA faces a range of vulnerabilities and challenges including reliance on overseas manufacturing, increasingly complex and interconnected supply chains, cybersecurity threats, and other security risks. For example, the globalization of food supply chains has made food safety oversight increasingly complex, while inspection capacity remains under strain. Despite these challenges, the FDA must continue to ensure the safety, effectiveness, quality, security, and availability of the products it regulates. Doing so is essential to strengthening domestic resilience, mitigating vulnerabilities, and safeguarding the public.

Ensuring Preparedness for and Response to Disasters and Public Health Emergencies

The Administration for Strategic Preparedness and Response's FY 2026–FY 2029 strategic plan emphasizes resilience before, during, and after crises and a rapid, efficient Federal response supported by secure medical supply chains. HHS faces the ongoing challenge of providing and scaling Federal support that is responsive to the needs of States, territories, Tribes, and local health partners while ensuring that data systems and supply chains reflect operational realities on the ground and enabling timely, locally informed guidance and transparent communication that strengthens public trust. HHS must continue to prioritize readiness—preparing for, responding to, and recovering from public health emergencies and disasters—to build resilience and deliver meaningful results for the American people.

Examples of OIG's 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 Health and Safety

Elements of the Challenge

- Safeguarding appropriate access to necessary care
- Delivering care and services in safe settings
- Ensuring care and services by qualified staff

People receiving HHS-funded care and services should be able to trust they will be protected from preventable harm.

Safeguarding Appropriate Access to Necessary Care

Timely access to care is essential for maintaining health and preventing unnecessary suffering. HHS must address concerns that eligible individuals experience improper delays or restrictions in receiving needed services. This includes building on efforts to better protect Medicare beneficiaries from problematic patterns of denials for necessary care. It also requires ensuring that Federal health care network directories are accurate, so that patients can efficiently locate in-network providers. Barriers to appropriate and necessary care can mean eligible individuals delay or forgo treatment and suffer adverse health outcomes.

Delivering Care and Services in Safe Settings

Adverse health outcomes may also be the result of errors, substandard care, and inappropriate treatment in hospitals and other care facilities. HHS must continue strengthening its oversight to ensure that all funded care settings meet required standards. For example, nursing home residents with dementia must be better protected from being given antipsychotic drugs for staff convenience, despite warnings that these drugs may increase the risk of death. HHS has made important progress in improving nursing home safety, but continued attention and action are necessary.

Vulnerable Americans face health and safety risks in other HHS-funded settings as well. Without effective preparedness and response, these risks are exacerbated in emergency situations. HHS must do more to ensure that these settings, including child and adult care facilities and foster care placements, follow health and safety requirements and identify and quickly remediate weaknesses that put individuals at risk. A recent HHS initiative, *A Home For Every Child*, seeks to ensure that all children in foster care have a safe, permanent home. This initiative has the potential to reduce many of the preventable risks faced by children in foster care, including when they go missing from care or are placed in unlicensed settings that do not have the resources or accommodations needed to care for them safely.



Ensuring Care and Services by Qualified Staff

Many HHS-funded providers and program staff hold positions of significant trust and frequently work closely with individuals in private settings. Although the vast majority of these professionals uphold that trust and strive to deliver high-quality services, some may pose risks if not properly screened. Background checks are essential for identifying individuals who are disqualified from service or who may otherwise present a threat to people served by HHS programs.

However, gaps in compliance with background check requirements are an ongoing concern in HHS-funded programs. These gaps increase the potential for preventable harms, particularly among populations at greatest risk, including children, older Americans, and people with intellectual disabilities. The Department must remain vigilant in continuous efforts to ensure that all HHS-funded providers and other staff, in all program and service settings, meet established criteria for vetting and training.

Examples of OIG's Related Work

- *Medicare Advantage Organizations Overturned Nearly All Appealed Prior Authorization Denials for Skilled Nursing Facility Admission, Raising Concerns About Initial Denials*
- *The Three Largest Medicare Advantage Organizations Denied Requests for Long-Term Acute Care and Inpatient Rehabilitation at Some of the Highest Rates*
- *Inaccurate Medicaid Managed Care Provider Directories May Limit Enrollees' Access to Maternal Health Care*
- *Nursing Homes' Inappropriate Use of Antipsychotic Drugs Poses a Risk to Residents*
- *National Overview of State-level Challenges and Efforts To Minimize or Eliminate Temporary Emergency Placements in Foster Care*
- *The Indian Health Service Did Not Ensure That Commissioned Corps Officers' Background Investigations Complied With Federal Requirements*

5 | Technological Advancement and Cybersecurity

Element of the Challenge

- Managing risks from rapid technological innovation
- Improving cybersecurity for HHS programs, related industry sectors, and individuals

As HHS leverages technological advancements, it must ensure that people, data, and operations are protected from evolving cyber risks.

Managing Risks From Rapid Technological Innovation

Super intelligence (SI) (previously termed "artificial intelligence"), large language models, and other technologies offer meaningful opportunities to gain efficiency and improve decision making across HHS programs and operations. Rapid evolution and adoption create pressure to advance quickly, although some risks may not be fully understood or tested. HHS must ensure thoughtful adoption of technology that benefits HHS programs and their mission. Responsible adoption requires clear governance, disciplined implementation, and continuous oversight so decisionmakers can weigh benefits and risks without compromising the people served by HHS or statutory obligations. HHS's 2025 Artificial Intelligence Use Case Inventory identifies 446 use cases, some of which relate to core program responsibilities. HHS is establishing policy and Department-wide training to support secure, approved use of SI tools. Maintaining human oversight of technology choices, the risks and impacts they may introduce, and the steps to mitigate those risks will remain a continuing challenge as tools and threats evolve.

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. Varying approaches to cybersecurity across divisions and programs can complicate efforts to prevent or respond to cybersecurity risks. Although HHS has taken steps to modernize and strengthen its cybersecurity posture, implementation varies across programs and HHS's overall enterprise information security program has not yet reached the desired level of effectiveness. To improve, HHS must ensure consistent implementation of strong safeguards across operating divisions.



Effective cybersecurity must also extend to the thousands of HHS contractors, grantees, and other external entities engaged by HHS programs. For many HHS programs, effective cybersecurity will depend on these parties implementing solutions that mitigate cybersecurity threats specific to their operations. Protecting technology and data requires broader efforts beyond technical fixes, such as clear expectations, modernized program rules, and effective oversight. The health care industry remains a prime target as bad actors continue to threaten patient care and critical operations. Limited resources, reliance on legacy technology, and the need to recruit and retain a skilled workforce remain constraints. HHS must maintain vigilance, rapidly communicate vulnerabilities, and help the health care industry adapt to evolving threats. Working within existing Health Insurance Portability and Accountability Act authorities, HHS must adapt oversight and enforcement to contemporary risks to the privacy and security of protected health information.

Examples of OIG's 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*
- *Settlement to Resolve False Claims Act Allegations Arising from Cybersecurity Vulnerabilities in Genomic Sequencing Systems*
- *A Large Southeastern Hospital Could Improve Certain Security Controls to Enhance Its Ability To Prevent and Detect Cyberattacks*
- *The National Institutes of Health Needs To Improve the Cybersecurity of the All of Us Research Program to Protect Participant Data*
- *HHS Office of the Secretary Needs To Improve Key Security Controls to Better Protect Certain Cloud Information Systems*

Conclusion

HHS has taken steps to address its top management and performance challenges, but further progress is needed. Leveraging its resources and opportunities for collaboration across Government and with other sectors to solve these challenges is vital to Americans' health and well-being.

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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

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 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 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.