U.S. Department of Health and Human Services

Agency Priority Goal | Action Plan | FY 2026 – FY 2027

Promoting Program Integrity

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Goal Overview

Goal statement

By October 2027, HHS will strengthen program integrity in human services, Medicare, Medicaid, and the Marketplace through enhanced fraud detection, prevention, and enforcement activities.

- **Recovery of Funds -** Increase Medicare savings through fraud, waste, and abuse detection and recovery efforts by 10% by the end of 2026 and a similar percentage in 2027.
- **Improper A/B Activity –** By October 2027, CMS will issue proposals in rulemaking to establish new criteria and processes to suspend or terminate CMS's relationship with agents and brokers who violate CMS Agreements or regulations and ramp up enforcement against noncompliant agents and brokers.
- **Stakeholder Outreach -** By year end 2026, 75% of CMS stakeholder engagements will include messaging on crushing fraud, waste, & abuse, with a similar percentage in 2027.
- **Human Services -** By September 2027, reduce improper payments in ACF Child Care and Development Fund (CCDF) from 4.93% to 4.67% by:
    - Providing 10 targeted training sessions over the course of FY 2026 and FY 2027 for lead agencies around program integrity and error rates.
    - Developing and implementing a new interactive training module on federal/state joint case reviews (JCRs) for improper payment case review staff.

Problem to Be Solved

Health care fraud perpetrators steal billions of dollars each year from the Federal and State governments, private insurance companies, providers, American taxpayers, and some of our most vulnerable citizens. Fraudulent activities threaten the integrity and financial sustainability of CMS programs by diverting program funds from their intended purposes of covering legitimate medical needs.

In addition, improper payments due to overpayments, underpayments, or undocumented payments waste billions of taxpayer dollars intended for those who need it. In fiscal year (FY) 2024, the HHS Office of the Inspector General (OIG) estimated improper payments for Medicare, Medicaid, and the Children's Health Insurance Program at $86.5 billion.[1] Within traditional Medicare, the improper payment rate was 7.66%, while Medicaid reported 5.09% of all payments. This marks the eighth consecutive year this figure has been below the 10% threshold for compliance established by the improper payment statutory requirements.[2]

[1] HHS OIG Top Management & Performance Challenges Facing HHS
[2] Fiscal Year 2025 Improper Payments Fact Sheet

In fiscal year FY 2025, ACF estimated an improper payment rate of 4.93% in the Child Care and Development Fund (CCDF), totaling approximately $921.46 million.[3] As stewards of public funds, CCDF Lead Agencies are responsible for ensuring program accountability, safeguarding funds, maximizing benefits for eligible children and families, and spending tax dollars appropriately. To support this work, the Office of Child Care (OCC): continues to partner with CCDF Lead agencies to strengthen program integrity and internal controls to reduce improper payments and is preparing new accountability plans for states with long-term error rates exceeding 10%. This Agency Priority Goal (APG) will demonstrate the initial improvements achieved by ACF in reducing the national error rate.

What Success Looks Like

For CMS, proactive, data-driven systems prevent payments tied to suspicious activities before they leave the door, through automated pre-payment edits. The utilization of AI, real-time analytics, and stringent provider screening protect billions of taxpayer dollars, safeguard them against harmful schemes, and ensure program integrity across beneficiary care and children and families support programs.

- High-risk bad actors are blocked or privileges revoked from participating in federal health care programs.
- Conducting unannounced site visits ensure providers are legitimate businesses and not “shell” operations.
- Beneficiaries are protected from predatory scams where they are involuntarily enrolled programs that do not provide access to the services they need.
- Beneficiaries are empowered to detect and report fraudulent and inappropriate activities.
- A high percentage of proper CMS payments are made where there is sufficient documentation to support payment in accordance with the program’s payment requirements.
- A high return on investment (ROI) is realized to ensure sustainability and longevity of the vital CMS programs.
- Implement comprehensive training and technical assistance activities to support states implementation of error rate activities to ensure program integrity across states and new accountability plans for states with long-term error rates exceeding 10%.

For ACF, OCC provides comprehensive training and technical assistance to support state CCDF Lead Agencies in strengthening internal controls and implementing CCDF error rate reporting requirements with fidelity. Through targeted federal support, including the development of new accountability plans for states with long-term error rates exceeding 10%, states are better positioned to reduce improper payments and enhance reporting accuracy, ensuring program integrity and safeguarding taxpayer dollars in child care programs.

[3] Fiscal Year 2025 Agency Financial Report

Tracking the goal

Goal Target(s)

The column in **blue** will reflect the quarterly update except for the initial action plan.

	We will…	**Name of indicator** (units in parentheses)	**Start value (Date)**	**Current value**	**Target value**
1	Increase Medicare savings through fraud, waste, and abuse detection and recovery efforts by 10% by the end of 2026 and a similar percentage in 2027.	Recovery of funds (% of Medicare savings)	0%	In progress	10%
2	CMS will issue proposals in rulemaking to establish new criteria and processes to suspend or terminate CMS's relationship with agents and brokers who violate CMS Agreements or regulations and ramp up enforcement against noncompliant agents and brokers.	Improper A/B Activity* (issue proposed rulemaking, regulations, and increase enforcement)	0%	In progress 50%	100% (Achieved)
3	75% of CMS stakeholder engagements will include messaging on crushing fraud, waste, & abuse, with a similar percentage in 2027.	Stakeholder Outreach (% of engagements)	64%	In progress	75%
4	Reduce the CCDF Improper Payment rate	CCDF Improper Payment rate (% of improper payments) reported in the FY26 HHS Agency Financial Report	4.93% (FY 2025)	4.93%	4.67%

* Qualitative progress may be noted as "Yes, we achieved it", "in-progress", or "No, not yet."

Summary of Progress– FY 2026 Quarter 1 & 2

CMS Summary

CMS has demonstrated significant and measurable progress in its Program Integrity (PI) efforts, with results that reflect a strong, multi-pronged strategy to combat fraud, waste, and abuse (FWA) across Medicare, Medicaid, and Marketplace programs. The data presented reflects accomplishments largely through CY 2025 and into early CY 2026, and the overall trajectory indicates the goal of strengthening program integrity is on target — with several milestones not only met but exceeded.

Progress Highlights (Most Recent Period)

Prevention — Strong Results

- The **Medicare FFS improper payment rate dropped to 6.55%** in FY 2025, down from 7.66% in FY 2024[2] — a meaningful **1.11 percentage point reduction**, signaling that enhanced provider screening and oversight are producing measurable results.
- CMS **suspended $5.7 billion in fraudulent Medicare payments**[4] and **prevented $1.5 billion in fraudulent Durable Medical Equipment, Prosthetic Devices, Prosthetics, Orthotics, and Supplies (DMEPOS) billing**[5], demonstrating the effectiveness of pre-payment controls.
- The **Fraud Detection Operation Center (FDOC)**[6] suspended over **$1.8 billion in Medicare payments**[5] across 249 providers/suppliers in 2025, with billing privileges subsequently revoked for 127 of those entities.
- A **6-month nationwide DMEPOS enrollment moratorium**[7] was implemented, targeting historically high-fraud areas — a proactive and targeted intervention.

Detection & Investigation — High Volume Activity

- **7,701 Medicare providers/suppliers**[4] were investigated for potential fraud.
- **122,658 Medicare claims were denied**[4] through pre-payment reviews on high-risk items and services — a strong indicator that front-end controls are functioning effectively.

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[4] Crushing Fraud: Annual Report 2025
[5] The $1.5B DMEPOS and the $1.8B FDOC figures are both subsets of the total $5.7B in suspended Medicare payments. These figures should not be added together.
[6] The Fraud Defense Operations Center Fact Sheet
[7] Trump Administration Prioritizes Affordability by Announcing Major Crackdown on Health Care Fraud

- **537 payment suspensions** were imposed, and **5,586 providers/suppliers were revoked**[4] for inappropriate behavior.
- **372 fraud referrals**[4] were accepted by law enforcement for potential legal action.

Enforcement — Record-Breaking Takedown

- The **2025 National Health Care Fraud Takedown** resulted in **324 defendants criminally charged** for fraudulent billings totaling over **$14.6 billion**[8] — more than **double the size** of the largest prior national health care takedown.
- In FY 2025, HHS-OIG recorded **701 criminal actions** and **876 civil** actions and excluded **2,837 individuals and entities** from Federal health care programs[9].

New Initiatives Launched

- **CRUSH Request for Information (RFI)**[10] — A new regulatory initiative aimed at tightening oversight and detecting fraud through comprehensive regulatory reform.
- **Chilli Cook-Off Competition**[4] — An innovative late-2025 research challenge engaging private industry to leverage **AI and machine learning** to detect anomalies in Medicare claims data — a forward-looking investment in scalable fraud detection technology.
- **CMS-State Tax Fraud Partnership**[4] — Launched with **28 states and the U.S. Virgin Islands** to strengthen state-federal enforcement against healthcare and tax fraud.
- **Improved Hospice Election Process** — Targeted beneficiary messaging launched in August 2025; over **45,000 letters** issued in Nevada and California since inception.
- **Medicaid War Room (Newly Implemented)** — Integrates cross-functional expertise through a specialized team of data analysts, investigators, health policy experts, legal advisors, and law enforcement, primarily focused on **suspensions and exclusions** of Medicaid providers.

Concerns & Challenges

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[8] National Health Care Fraud Takedown
[9] HHS Office of Inspector General Enforcement Actions
[10] CMS Comprehensive Regulations to Uncover Suspicious Healthcare (CRUSH)

While results are strong, a few areas warrant continued attention:

- **$371 million in post-payment overpayments collected**[4] — while audits are ongoing, this figure may reflect the difficulty of recovering funds after payments have already been made, underscoring the importance of continued investment in *pre-payment* controls.
- The **Health Fraud Prevention Partnership (HFPP) 25% increase in fraud alerts**[11] is still a forward-looking target, not yet confirmed as achieved.
- Ongoing **agent/broker fraud in Marketplace plans** remains an active area of investigation, requiring continued vigilance and stricter enrollment verification.

Celebrated CMS Milestones

- **Largest national health care fraud takedown in U.S. history** — $14.6 billion in fraudulent billings charged.
- **Lowest recent Medicare FFS improper payment rate** — down to 6.55%.
- **$5.7 billion in fraudulent payments suspended.**
- **28-state tax fraud partnership** — a landmark expansion of federal-state collaboration.
- **Launch of AI/ML industry research challenge** — positioning CMS at the forefront of technology-driven program integrity efforts.

ACF Summary

OCC has demonstrated progress in its Quarter 1 and Quarter 2 Program Integrity (PI) efforts to deliver consistent and timely training to CCDF Lead Agencies. These efforts emphasize the proper implementation of the improper payment methodology and the critical actions needed to mitigate and reduce payment errors in CCDF. In addition, OCC is taking steps to implement and enforce stronger accountability measures for states that continue to exceed the 10% threshold.

[11] Healthcare Fraud Prevention Partnership 2023-2024 Report to Congress

Goal Strategies

CMS Strategies

CMS's Fraud, Waste, and Abuse Sprint Strategy

CMS is taking decisive action to combat suspected fraud and improper payments by implementing key program integrity initiatives. These initiatives will save taxpayers billions while protecting beneficiary care. The Medicare, Medicaid, and Exchange programs are all supported by Health Care Fraud and Abuse Control (HCFAC) funding, with a FY 2026 discretionary request of $941.0 million (+$0) and mandatory funding of $1,693.5 million (+$44.7M)[12]. These resources are directed toward activities such as prior authorization, artificial intelligence initiatives, provider enrollment modernization, program integrity efforts in the Exchanges, and Medicaid oversight.

The Fraud Defense Operations Center[6]

In March 2025, CMS launched the Fraud Defense Operations Center (FDOC), also known as the Fraud War Room, to integrate cross-functional expertise through a specialized team of data analysts, investigators, health policy experts, legal advisors, and law enforcement. The FDOC safeguards beneficiaries and protects taxpayer resources by using rigorous data analysis to identify investigative leads for prompt engagement with subject matter experts and key stakeholders. The FDOC leverages data-driven analytics to proactively detect, address, and prevent fraud, waste, and abuse in real time. Using this approach, the team coordinates timely interventions to ensure that improper payments are halted before financial loss is incurred by Medicare.

The CRUSH Request for Information (RFI)[10]

The Comprehensive Regulations to Uncover Suspicious Healthcare (CRUSH) RFI, announced on February 27, 2026, seeks input a broad range of stakeholders – including states, providers, suppliers, payers, technology companies, patient advocates, beneficiaries, and others – on ways to strengthen CMS's ability to prevent, detect, and respond to fraud, waste, and abuse, and program inefficiencies in Medicare, Medicaid, the Children's Health Insurance Program (CHIP), and the Health Insurance Marketplace.

The Annual Report of the Departments of Health and Human Services and Justice: HCFAC Program

[12] FY 2026 Justification of Estimates for Appropriations Committees

The CMS HCFAC Report outlines a robust, multi-layered strategy for combating health care fraud, rooted in the legislative authority of Public Law 104-191 (HIPAA, 1996). The program operates under the joint direction of the Attorney General and the HHS Secretary, coordinating efforts across federal, state, and local law enforcement agencies — including the DOJ, FBI, HHS-OIG, and CMS.

- **HHS-OIG** uses CMS HCFAC funding to conduct oversight of the Medicare and Medicaid programs. In FY 2025, HHS-OIG's oversight efforts resulted in 701 criminal actions against individuals or entities that engaged in crimes related to healthcare, and 876 civil actions, which include false claims, unjust enrichment lawsuits filed in Federal district court, and civil monetary penalty settlements. In addition, HHS-OIG excluded a total of 2,837 individuals and entities from participation in Federal health care[9].

- **The United States Attorneys and the Department of Justice's (DOJ)** Civil Division, Criminal Division, and Civil Rights Division receive CMS HCFAC program funds to support civil and criminal health care fraud, by building on those resources by providing dedicated positions for attorneys, paralegals, auditors, investigators, and subject matter experts, as well as funds for electronic discovery, data analysis, and litigation of resource-intensive health care fraud cases. DOJ has a FY 2026 total operating budget of $211.2 million.

- **The Federal Bureau of Investigations (FBI)** is responsible for detecting and investigating health care fraud in the United States and has jurisdiction over crimes targeting Federal health insurance programs and private health insurance plans. Each of the FBI's 56 field offices have personnel assigned to investigate health care fraud matters. The FBI's efforts in combatting health care fraud, in coordination with the efforts of our Federal, state, and local law enforcement, regulatory partners, as well as private sector partners, are crucial to the success and sustainability of the health care system that so many Americans depend upon. The FY 2026 FBI budget includes CMS mandatory funding in the amount of $177.9 million.[12]

CMS Program Integrity Program

CMS has a strong commitment to eliminating fraud, waste, and abuse in federal health care programs by building on the FY 2025 foundation with targeted investments in anti-fraud technologies and oversight. CMS is aggressively modernizing its fraud-fighting capabilities through artificial intelligence, machine learning, and advanced data analytics, including the permanent establishment of the Fraud Defense Operations Center (FDOC) in March 2025, which suspended $1.8 billion in payments in calendar year 2025 alone[6], while also expanding technical assistance to states to promote consistent, scalable best practices in program integrity nationwide.

- **Medicare and Medicaid Program Integrity** are the two largest areas of focus in CMS's budget integrity efforts. Medicare, projected to spend over $1 trillion in CY 2027, faces an estimated $56.7 billion in improper payments across Original Medicare, Part C, and Part D in FY 2025[1]. CMS combats this through provider enrollment and screening, data analyses, investigations, and medical record reviews — generating over $41.9 billion in savings and achieving a $22.3.6 to $1 return on investment in

FY 2025[13]. Medicaid, similarly on the GAO's High-Risk List, in FY 2025 achieved $4.1 billion in savings[13], with CMS and states jointly addressing integrity through oversight, data analytics, and technical assistance.

- **Exchange Program Integrity** focuses on protecting the Health Insurance Exchanges, where individuals access private health insurance and Advance Premium Tax Credits (APTCs)[14]. The primary threat is unauthorized enrollment and plan changes by agents and brokers, which CMS counters through system updates to prevent unauthorized activity, data analytics, cancelation of identified fraudulent policies (and recoupment of APTC), and prioritized investigations to safeguard the Federally-Facilitated Exchange (FFE).

ACF Strategies

The Office of Child Care (OCC) will support CCDF Lead Agencies to strengthen their internal controls around eligibility verification, implement the CCDF error rate reporting requirements with fidelity, and reduce improper payments by providing ongoing training and technical assistance.

Efforts in FY2026 – FY2027 include:

- Providing 10 targeted training sessions over the course of FFY 2026 and FFY 2027 for CCDF Lead Agencies on program integrity and error rate reporting. The training underscores ACF's commitment to reducing high error rates and enforcement of new accountability measures for states that continuously exceed the 10% error rate threshold.
- Developing and implementing a new interactive training module on federal/state joint case reviews (JCRs) for improper payment case review staff.

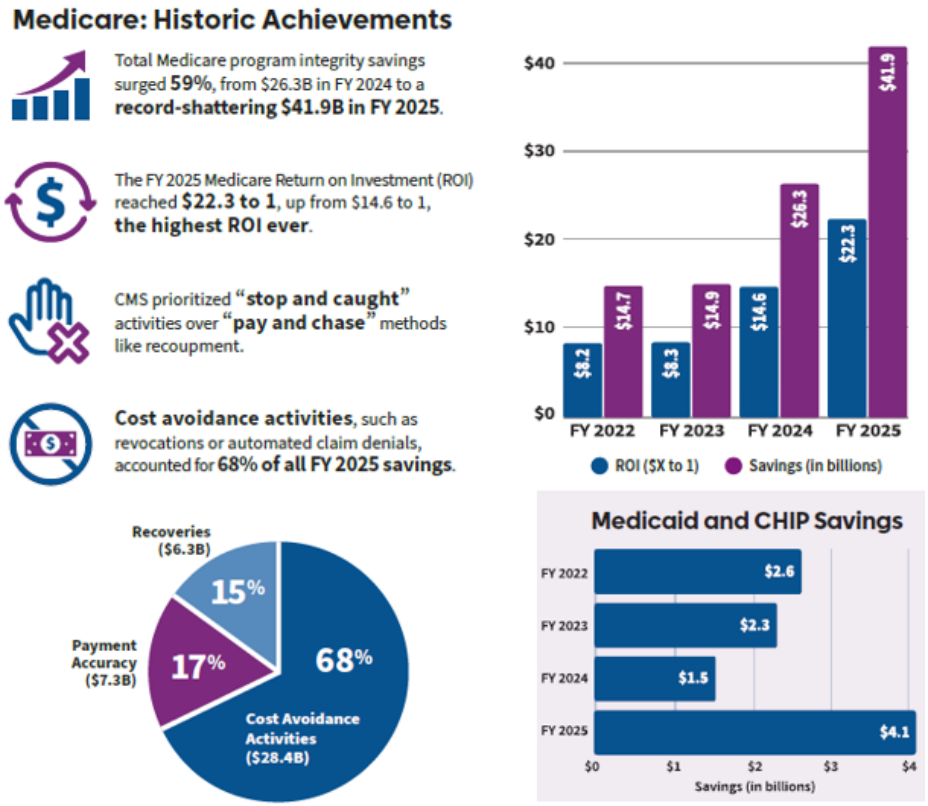
[13] CMS Reports Highest Program Integrity ROI Ever Recorded
[14] CMS Actions to Protect Consumers and Strengthen Exchange Program Integrity

Key Indicators

CMS Reports Highest Program Integrity ROI Ever Recorded

Due to the bold actions this administration has taken to crush fraud, CMS delivered unprecedented results in Fiscal Year (FY) 2025, protecting taxpayer dollars and holding bad actors accountable like never before.

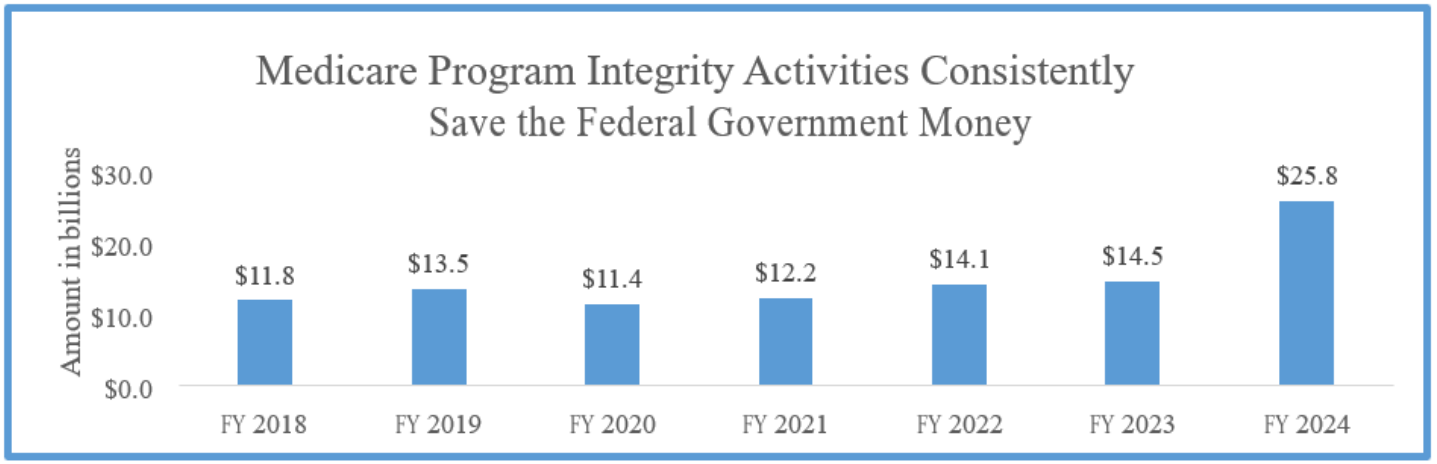
Source: https://www.cms.gov/fraud, May 2026



Key Indicators

Annual Medicare program integrity savings resulting from activities funded with mandatory and discretionary CMS Health Care Fraud and Abuse Control (HCFAC) resources, as well as provider enrollment user fees.[15]

Source: FY 2027 Justification of Estimates for Appropriations Committees



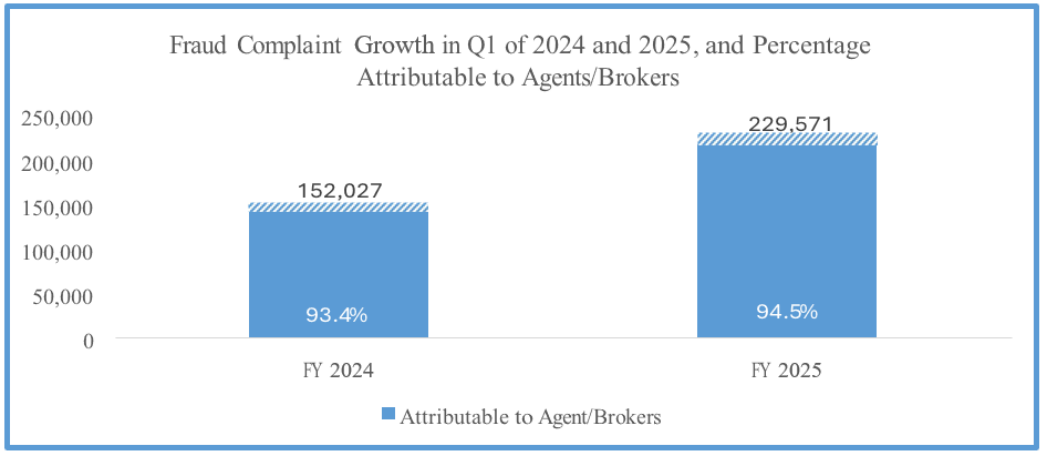
[15] The savings in the chart excludes savings from the Recovery Audit Contractors. Additional detail can be found in the Medicare and Medicaid Integrity Programs Report to Congress (https://www.cms.gov/medicare/medicaid-coordination/center-program-integrity/reports-guidance).

Key Indicators

CMS also aggressively safeguards the Health Insurance Exchanges through data analytics and targeted investigations that proactively prevent, identify, and address fraud allegations. Consumer complaints of fraud undergo rigorous review to determine whether administrative action can be taken. CMS recently introduced a new machine learning-based Exchange consumer complaint categorization process that has reduced complaint resolution timelines by more than 45 days and contractor workload by 85%. These efficiencies have enabled CMS to route consumer complaints to the appropriate entity more quickly to investigate and take action, as appropriate.

After the 2023 open enrollment period, CMS saw an increase in suspected Exchange fraud. The number of complaints in that period notably grew in 2025. Typically, CMS receives the greatest number of complaints in the first quarter of a given year. When the consumer becomes aware of these unauthorized enrollments, particularly after open enrollment and during tax season, they notify CMS.

Source: FY 2027 Justification of Estimates for Appropriations Committees

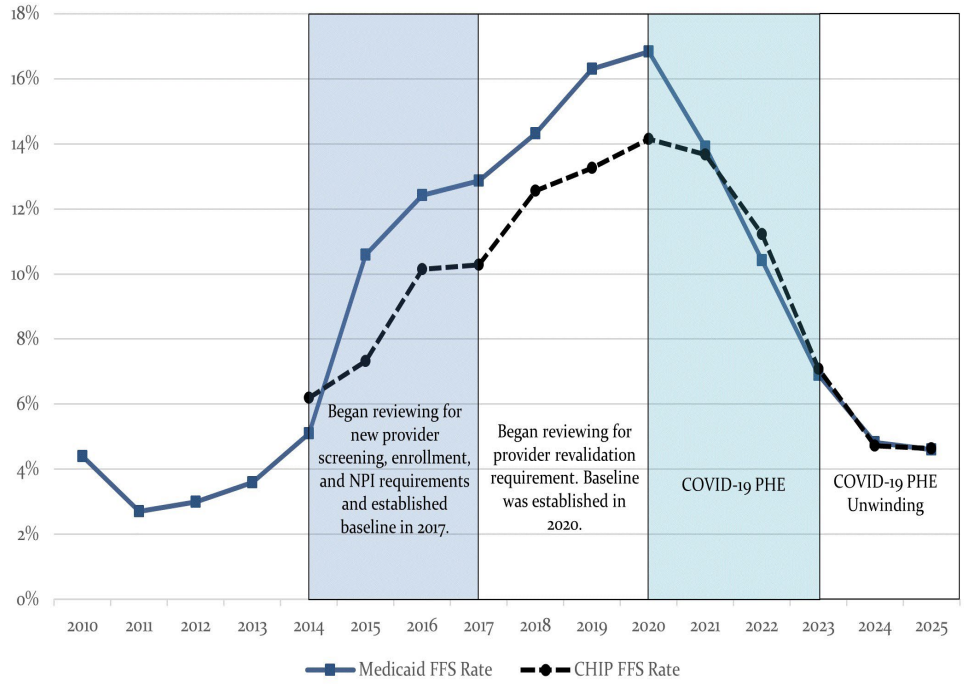


Key Indicators

2025 Fee-for-Service (FFS) Improper Payment Trends

Medicaid and Children's Health Insurance Program (CHIP) FFS Improper Payments Timeline Highlighting Key Review Events[16]

Source: 2025 Medicaid & CHIP Supplemental Improper Payment Data

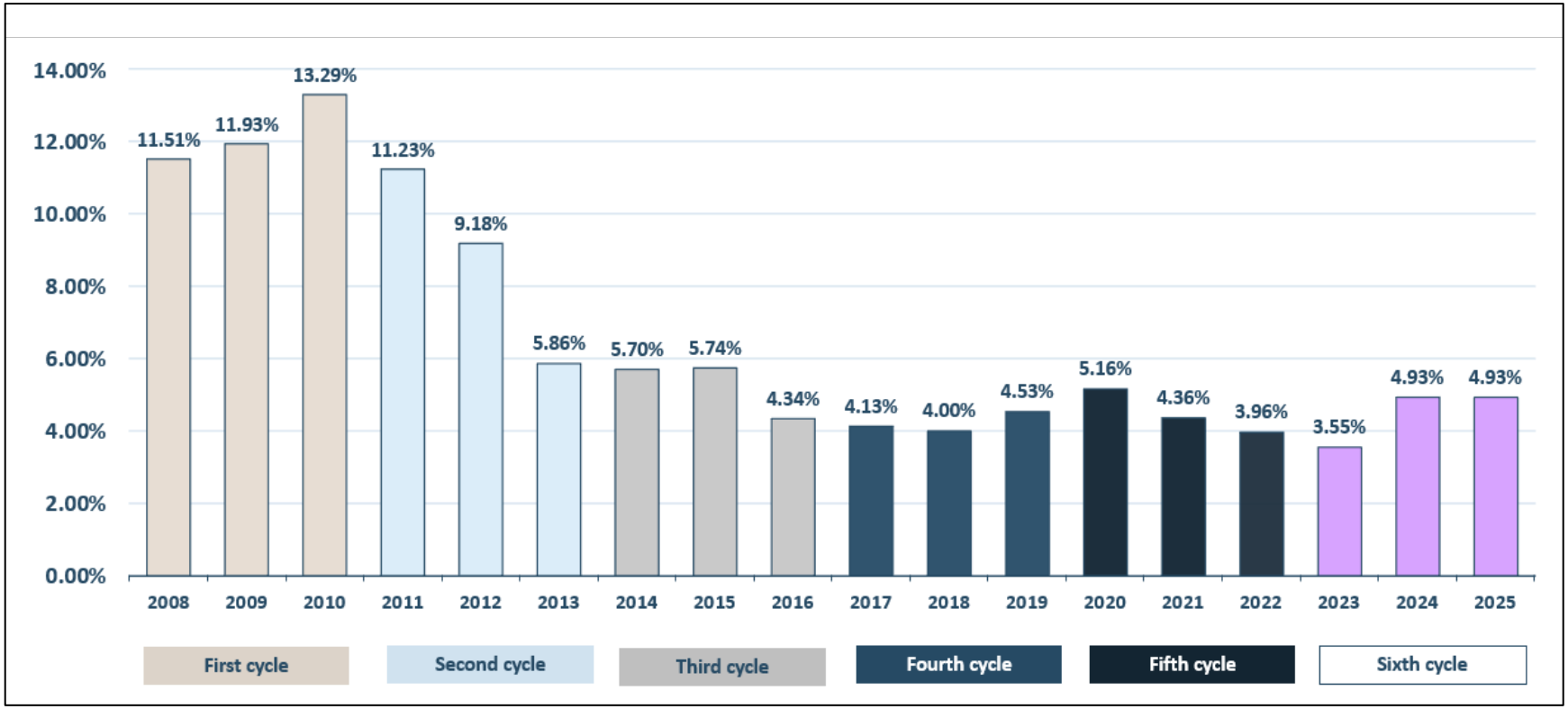


[16] Results reported in 2025 still reflect the effects of the PHE, which ended on May 11, 2023.

Key Indicators

Source: Generated with annual CCDF national error rate percentages from 2008 through 2025.

Child Care and Development Fund (CCDF) Improper Payment Rate Trends



Key Milestones

Key Milestone	Milestone Due Date	Milestone Status	Owner	Comments [Optional]
Implement new automated fraud detection edit rules across Medicare and Medicaid claims processing systems	Q4, CY26	On track	CMS	Supports APG sub-goal to increase Medicare savings
Increase the number of complex medical reviews completed by the Medicare Fee-for-Service Recovery Audit Contractors	Q4, CY26	On track	CMS	Supports APG sub-goal to increase Medicare savings
By year end 2026, build partnerships with all 50 states to build out new FWA capabilities, with a deep dive in 6 high-risk states	Q4, CY26	On track	CMS	
Increase the number of Fraud Defense Operations Center leads identified and evaluated	Q4, CY26	On track	CMS	
Launch and use enforcement tools with zero tolerance to remove providers who are high risk to the Medicare program	Q4, CY26	On track	CMS	
Conduct communications highlighting how CMS is combatting fraud	Q4, CY26	On track	CMS	Supports APG sub-goal to include messaging on crushing fraud, waste, & abuse with stakeholder engagements.

Issue proposals in rulemaking to establish new criteria and processes to suspend or terminate CMS's relationship with agents and brokers who violate CMS Agreements or regulations	Q4, CY26	On track	CMS	Supports APG sub-goal to address improper agent/broker activity
Ramp up enforcement against noncompliant agents and brokers	Q4, CY26	On track	CMS	Supports APG sub-goal to address improper agent/broker activity
Provide targeted training session for Lead Agencies around program integrity & error rate reporting	Q1, FY26	On track	ACF	OCC provided training to **19** Lead Agencies submitting the *ACF-404 State Improper Payments Report* in June 2026 to help them conduct case reviews in accordance with the CCDF methodology and instructions. [Cohort 1 Training: *Conducting Case Record Reviews*; 12-18-25]
Provide targeted training session for Lead Agencies around program integrity & error reporting	FY26: Q2	Complete	ACF	OCC provided training to **16** Lead Agencies submitting the *ACF-404 State Improper Payments Report* in June 2027 to help them prepare for their next error rate review cycle and ensure they create a case record review sampling plan that aligns with the CCDF methodology and instructions. [Cohort 2 Training: *Creating the Sampling Decisions, Assurances, and Fieldwork Preparation Plan;* 3-25-26]
Conduct state/federal joint case reviews	FY26: Q2	Complete	ACF	OCC conducted Joint Case Reviews with **11** Lead Agencies submitting the *ACF-404 State Improper Payments Report* in June 2026 to provide oversight of state implementation of case reviews before they submit final data to OCC and to provide individualized state technical support. [December – March 2026]
Review and approve state improper payments corrective action plans	FY26: Q1 & Q2	Complete	ACF	OCC reviewed corrective action plans (CAPs) for **seven** Lead Agencies with an improper payment rate above the established threshold to ensure states established corrective actions, timelines, and milestones to address root causes of errors,

Conduct meetings with Lead Agencies on corrective action plans	FY26: Q1 & Q2	On track	ACF	OCC held check-in meetings with **six** Lead Agencies to discuss CAP implementation including action step completion, barriers, and progress in measuring error rate reduction progress.

Data Accuracy & Reliability

Please include a brief description of how the team will ensure the accuracy and reliability of the data and will compensate for any data limitations.

Data Source	Accuracy	Reliability	Data Limitations?	Comments
CMS - Fraud Prevention System (FPS)	Accuracy is high - FPS streams claims data and applies analytical models and business rules to validate fraud, waste, and abuse patterns.	Reliability is high – FPS is actively used by Unified Program Integrity Contractors (UPICs) and Medicare Administrative Contractors (MACs) daily and processes millions of Part A, B, and DME claims per day.	Data limitations include: 1) results dependent on quality of incoming claims data and 2) may not capture all fraud schemes in real time. CPI takes these limitations into account when using findings from the FPS for decision making.	
CMS - Provider Enrollment, Chain, and Ownership System (PECOS)	Accuracy is high – PECOS collects structured, standardized provider/supplier enrollment information including ownership, practice locations, and affiliations.	Reliability is high – PECOS is a national database with logging, tracking, and inquiry/reporting capabilities.	Data limitations include: 1) does not contain beneficiary information and 2) limited primarily to Medicare enrollment. CPI does not utilize PECOS data for obtaining beneficiary information, or non-Medicare provider enrollment details.	
CMS - Advanced Provider Screening (APS) system[17]	Accuracy is high – APS validates Medicare provider data against external sources using automated business rules to identify ineligible providers and potential fraud, waste, and abuse.	Reliability is high - APS performs automated pre- and post-enrollment screening on new and existing enrollments.	Data limitations include: 1) APS limited to Medicare provider/supplier screening and 2) dependent on accuracy of external data sources used for validation. CPI does not utilize APS for non-Medicare providers/suppliers and recognizes that the quality of APS results is dependent on the data fed into the system.	
CMS - The Unified Case Management system (UCM)[18]	Accuracy is medium – UCM tracks leads, audits, investigations, and outcomes	Reliability is high – UCM supports multiple programs (Medicare, Medicaid) and	Data limitations include: 1) planned for retirement in Q4 2026 and being replaced by	

[17] Advanced Provider Screening (APS) Fact Sheet
[18] Unified Case Management (UCM) System Fact Sheet

	across Medicare and Medicaid programs, and accuracy is dependent on manual contractor data entry.	captures workflow, metrics, and referrals to law enforcement.	United Case Management Next Generation (UCM-NexGen), 2) data quality dependent on contractor input, and 3) may have legacy data consistency issues. CPI recognizes these limitations and takes them into consideration when using these data to inform decision making.	
CMS - The One Program Integrity (PI) system	Accuracy is high – One PI provides modernized data analysis using multiple Business Intelligence (BI) tools [Snowflake, BusinessObjects, System for Tracking Audit & Reimbursements (STARS)].	Reliability is high – One PI is a centralized, secure portal accessible with role-based security that supports thousands of direct users.	Data limitations include: 1) privacy considerations apply and 2) limited to authorized users via role-based access controls. CPI takes these limitations into consideration when using these data to inform decision making.	
ACF-404 State Improper Payments Report	Accuracy is medium - ACF does not directly collect the data for the ACF-404 - data are reported by states, so accuracy is dependent on state data collection and analysis. However, ACF provides comprehensive training and technical assistance on the error rate methodology, including the review of a sample of cases, to help ensure states address any issues or inaccuracies prior to data submission.	Reliability is medium – ACF does not directly collect the data for the ACF-404 - data are reported by states, so reliability is dependent on state data collection and analysis, However, all states are required to follow reporting instructions and guidance outlined the *Child Care Improper Payments Data Collection Instructions* and receive training prior to data collection, analysis, and submission to help ensure reliable implementation of the methodology.	Data limitations include: States report the aggregate results of their case reviews to ACF. ACF does not directly conduct the review of states' case records to calculate results.	States report the results of case reviews, including errors and improper payments, in the ACF-404 State Improper Payments Report. One-third of states report each year.
HHS Agency Financial Report (AFR)	Accuracy is high - ACF works with a statistician to analyze state report data and calculate the CCDF national measures each year and implements quality control measures to ensure data accuracy.	Reliability is high - The CCDF national error rate methodology and results are reviewed each year as part of the HHS Payment Integrity Information Act of 2019 (PIIA) (Public Law No. 116-117) Compliance Audit.	Data limitations include: Timing - States report data on the ACF-404 from the prior fiscal year case review period. Additionally, ACF updates only one-third of state data each year and combines it with data from the	ACF uses the information reported by states on the ACF-404 to calculate and report national error measures including improper payments for the HHS Annual

			prior two years to calculate the CCDF national error rate. Therefore, the current CCDF national improper payment rate is a “look-back” that includes data that may be 1-3 years old. This lag means recent state improvements may not yet be reflected in the national rate, making it challenging to demonstrate year-over-year progress.	Financial Reports (AFR).

Additional Information

Related Policy and Partners

- President's Management Agenda:
  - Eliminate Woke, Weaponization, and Waste
    - Cease payments to fraudsters and eliminate waste
- Regulations, Executive Orders, and Legislation:
  - Executive Order: Stopping Waste, Fraud, and Abuse by Eliminating Information Silos
  - FY 2026 enacted Labor HHS bill (H.R. 7148)
  - Task Force to Eliminate Fraud (established March 2026, chaired by Vice President Vance)
  - Child Care and Development Fund Regulations (45 CFR Part 98 and 99)
- Policies:
  - Strategic Plan – *not yet available*
  - CMS: Comprehensive Medicaid Integrity Plan for FYs 2024 - 2028
  - CMS: Medicare & Medicaid Program Integrity 2024 Report to Congress
  - CMS: 2025 Medicaid & CHIP Supplemental Improper Payment Data
  - FY2025 HHS Agency Financial Report (AFR)
  - Appendix C to OMB Circular A-123
  - Payment Integrity Information Act of 2019 (PIIA)
- Partners:
  - HHS OIG
  - DOJ
  - FBI
  - ACF
  - CMS
  - UPICs (Unified Program Integrity Contractors) - private entities that conduct audits and investigations to detect and prevent fraud, waste, and abuse in Medicare and Medicaid programs. They are also part of the Major Case Coordination (MCC) initiative, along with the OIG, DOJ, and the CMS Center for Program Integrity, who maximize their efforts to identify, investigate, and pursue providers.

Goal Team

Questions regarding this APG can be directed to performance@hhs.gov

Centers for Medicare and Medicaid Services

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- Jacqueline Wilson (CCIIO)
- Meril Pothen (CCIIO)

Administration for Children, Families, and Community

Deputy Goal Lead: Wendy Horman (OCC)

Implementation Team:

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- Megan Campbell (OCC)
- Toya Bryant (OCC)
- Adie Fatur (OCC)