FISCAL YEAR	AGENCY NAME	AGENCY ACRONYM
2027	Health and Human Services	HHS

EVIDENCE PLAN

LETTER FROM THE SECRETARY

The Department of Health and Human Services (HHS) mission is rooted in a simple promise: to safeguard the health and well-being of the American people. The Fiscal Year 2027 Evidence Plan advances that promise by committing us to building and applying evidence that supports sound decisions, responsible stewardship of public resources, and better outcomes for the people we serve. This plan fulfills our agency's statutory obligations under the Foundations for Evidence-Based Policymaking Act of 2018, Title I – Federal Evidence-Building Activities, Section 312 (a) and (b)(5 USC § 312).

The Evidence Plan addresses five priority evidence questions reflecting urgent national needs. We are expanding meaningful access to health data, strengthening the foundations of our health system, examining the forces driving chronic illness, improving conditions for children and families, and evaluating how evolving technologies, including artificial intelligence, can advance program integrity and performance.

These priorities reflect a commitment to rigor and courage: rigor to pursue sound findings, and courage to change course when necessary. In the Trump Administration, the work of HHS is rooted in this disciplined approach, grounded in transparency and accountability, and guided by Gold Standard Science.

We do not undertake this work alone. State, local, territorial, and Tribal partners — along with researchers, clinicians, service providers, families, and community leaders — contribute knowledge drawn from personal experience and frontline practice. Their partnership strengthens our ability to serve.

What we learn through this work will directly inform how we improve our programs and deliver results. Guided by strong science and our duty to build a healthier nation, HHS will deliver results that strengthen families and communities nationwide and Make America Healthy Again.

Sincerely,

Robert F. Kennedy, Jr.,
U.S. Secretary of Health and Human Services

SECTION I | EVIDENCE PLAN SUMMARY

This section provides a snapshot of the agency's Priority Questions, evidence activities to answer them, and the alignment of each Priority Question to relevant Administration priorities.

	PRIORITY QUESTION	KEY EVIDENCE ACTIVITIES	RELATED ADMINISTRATION PRIORITIES
1	Which HHS strategies and approaches contribute to identifying, preventing, or addressing root causes of chronic disease, and which improve the effectiveness of care for those with chronic or complex conditions?	▪ Outcome Evaluation: Environmental Influences on Child Health Outcomes (ECHO) Program (NIH)	▪ Executive Order 14212: Establishing the President's Make America Healthy Again Commission
2	What changes in patient and provider access and use of health data and information for decision-making have occurred as HHS advances efforts to use data and technology (e.g. Health IT systems) to give patients greater access to and control over their health information?	▪ Enhancing patient access to electronic health information (ONC) ▪ Assessment of Certified Community Behavioral Health Clinics Expansion (CCBHC-E) Grant Program (SAMHSA)	▪ ONC Mission and Strategic Goals ▪ Executive Order 14212: Establishing the President's Make America Healthy Again Commission ▪ Executive Order 14321: Ending Crime and Disorder on America's Streets
3	To what extent are HHS capacity-building initiatives and investments address present and emerging needs, including strengthening program integrity and reducing fraud, waste, and abuse?	▪ Evaluation of a Moratorium on Enrollment of Home Health Agencies (HHAs) (CMS) ▪ Evaluation of a Moratorium on Enrollment of Hospices (CMS) ▪ Evaluation of a Moratorium on Enrollment of Suppliers of Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) (CMS) ▪ Assessment of Certified Community Behavioral Health Clinics Expansion (CCBHC-E) Grant Program (SAMHSA)	▪ Executive Order 14395: Establishing the Task Force to Eliminate Fraud ▪ Executive Order 14212: Establishing the President's Make America Healthy Again Commission Priority ▪ Executive Order 14321: Ending Crime and Disorder on America's Streets ▪ President's Management Agenda
4	Which HHS investments, programs, or services lead to improved outcomes for families and children, including stable families and economic self-sufficiency?	▪ Testing Identified Elements for Success in Fatherhood Programs (ACF) ▪ Assessment of Certified Community Behavioral Health Clinics Expansion (CCBHC-E) Grant Program (SAMHSA)	▪ ACF Strategic Plan ▪ Executive Order 14303: Restoring Gold Standard Science ▪ Executive Order 14321: Ending Crime and Disorder on America's Streets
5	To what extent is HHS adoption and use of enhanced technologies (e.g. AI) and improved data systems and analytics achieving improvements in organizational performance, efficiency, and cost savings?	▪ Evaluation of a Moratorium on Enrollment of Home Health Agencies (HHAs) (CMS) ▪ Evaluation of a Moratorium on Enrollment of Hospices (CMS) ▪ Evaluation of a Moratorium on Enrollment of Suppliers of Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) (CMS) ▪ Analysis of NIH's AI Use Case Inventory (NIH)	▪ CMS Strategic Plan ▪ Executive Order 13960: Promoting the Use of Trustworthy AI in the Federal Government ▪ Winning the Race, America's AI Action Plan, July 2025 ▪ White House focus issue of Government Accountability

SECTION II | EVIDENCE ACTIVITIES

This section details the key evidence activities being undertaken to answer the agency's Priority Questions, including evaluations. Evaluation, as defined under requirements of the Foundations for Evidence-Based Policymaking Act of 2018, is an assessment using systematic data collection and analysis of one or more programs, policies, and organizations intended to assess their effectiveness and efficiency.

Activity	**A**	**Evaluation**	Outcome Evaluation: Environmental Influences on Child Health Outcomes (ECHO) Program (NIH)			
Supports Priority Question(s)…	1	2	3	4	5	
	☒	☐	☐	☐	☐	
Evaluation Question(s)	1. How and to what extent has ECHO's efficiency-focused structures (inputs) influenced program-wide processes like participant recruitment, protocol implementation, analysis proposal, and manuscript development? 2. How and to what extent have the data collection and analysis processes worked to enhance efficiency of manuscript development and publications? 3. How and to what extent has ECHO achieved the cross-cutting outputs (e.g., enhancements in team science and interested party engagement)? 4. How and to what extent has ECHO achieved program outcomes like influencing knowledge about children's health (e.g., literature with high potential impact)? 5. How and to what extent has ECHO achieved its program outcomes like generating research that informs programs, policies, practices (e.g., citations in clinical practice guidelines)?					
Description	The ECHO External Scientific Board will draw on the findings to make key decisions about how ECHO develops, enhances, and implements its collaborative scientific inquiries, methods, clinical study protocols, data analyses, and scientific publications. The findings, anticipated in December 2026, will also inform strategies for engaging with end users, such as scientists, professional societies, think tanks, Congress, local legislators, participants, etc., to drive the application of scientific results to inform programs, policies, and practices that influence children's health. ECHO collects much of the data (e.g., study metadata) for this evaluation in the normal course of the program's administration. These data are related to enrollment and retention information; study protocol development and implementation; study data collection and analysis; biospecimen collection processing, storage, and use; and processes for the publication of research results. Regarding new data collection, the program's Coordinating Center award site has contracted with the external evaluator to develop surveys and interviews for collecting new data related to quality improvement and effectiveness of program infrastructure, resources, and processes from personnel at all ECHO cores, centers, and clinical sites. An institutional review board oversees these new data collection activities. These data collection activities are in late stages, with the evaluator administering surveys to remaining sites in early 2026. Interviews begin in January 2026 and extend through May 2026. The external evaluation of ECHO is a mixed-methods design that employs both a quantitative and qualitative synthesis to address the primary evaluation questions. Quantitative data that the evaluator will collect and analyze include surveys of program core, center, and clinical site teams, bibliometrics, and social network data. Qualitative data will include interviews with investigators, administrative records, research publications, and policy documents. Both types of data will provide information on ECHO processes, outputs, outcomes, and impacts to assess ECHO successes and identify areas for quality improvement.					

	The evaluator will use a mixed-method approach to analyze data by the end of Summer 2026. Quantitative analytic approaches include: 1) descriptive and inferential statistics to underscore and visualize survey results; 2) bibliometrics of publication data such as relative citation ratios and field citations to measure impact of scholarly literature; 3) social network analysis to visualize the relationship between individuals and the nature of team science across ECHO; and 4) meta-analysis of publications to assess heterogeneity of ECHO cohorts. Qualitative analytic approaches include: 1) content analysis of a sample of ECHO publications to assess key publication outcomes; 2) content analysis of policy-related documents to understand policy impacts; and 3) thematic coding of interviews with cohort and clinical site investigators to investigate evaluation questions in-depth. Analysis tools include R, Power BI, Excel, and Dedoose. The evaluator will synthesize an aggregate report of the quantitative and qualitative analyses. The evaluator plans to complete the evaluation by late 2026. Launched in 2016, the NIH ECHO Program integrates observational research with pediatric clinical trials to study how early-life environmental factors influence child health. The program makes its study data from over 71,000 participants available to the broader scientific community to enable large-scale analyses by its funded investigators and beyond. The purpose of this evaluation is to help the ECHO Program understand whether the program is achieving its goal to influence knowledge to ultimately enhance the health of children. An external evaluator is conducting the evaluation to enhance methodological expertise and help minimize bias. The evaluator will collaborate with Program staff and ECHO's investigator-led governance bodies to assess the program's inputs, processes, outputs, and outcomes and continuously improve the Program's scientific and operational quality. The evaluator plans to complete the evaluation by late 2026. Results from this work will inform enhancements in the translation of research findings into actions that enhance child health outcomes. Program Name: Trans-NIH Research Support FPI #: 93.310
Alignment to Priority(ies)	The Environmental Influences on Child Health Outcomes (ECHO) Program Office at NIH will use the findings from the program's outcome evaluation to improve the quality and efficiency of program infrastructure, processes, outputs, and outcomes. Results will offer critical insights for increasing the transparency, accessibility, and use of funded research for those who determine programs, policies, and practices to enhance children's health.
Collection / Acquisition	ECHO collects much of the data (e.g., study metadata) for this evaluation in the normal course of the program's administration. These data are related to enrollment and retention information; study protocol development and implementation; study data collection and analysis; biospecimen collection processing, storage, and use; and processes for the publication of research results. Regarding new data collection, the program's Coordinating Center award site has contracted with the external evaluator to develop surveys and interviews for collecting new data related to quality improvement and effectiveness of program infrastructure, resources, and processes from personnel at all ECHO cores, centers, and clinical sites. An institutional review board oversees these new data collection activities. These data collection activities are in late stages, with the evaluator administering surveys to remaining sites in early 2026. Interviews begin in January 2026 and extend through May 2026.
Topics	Capacity Building, Children's Health

Activity	B	Enhancing Patient Access to Electronic Health Information (ONC)				
Supports Priority Question(s)…		1	2	3	4	5
		☐	☒	☐	☐	☐
Description		Research Question: 1. To what extent have HHS policies and programs contributed to patients' ability to access, use, and share their health data? Data are expected to be available in late 2026 and 2027, available for use in FY27. Results from this activity will be used to inform potential updates to ONC's Health IT Certification Program, which ensures certified health information technology meets the technological, capability, functionality, and security requirements adopted by HHS. The information will also be used to inform information network implementation and updates, ongoing grants and cooperative agreements, and messaging and engagement efforts with the patient and patient advocacy community. Administrative data come from the ONC Health IT Certification Program (available on an ongoing basis). Quantitative survey data come from the 2026 National Cancer Institute Health Information National Trends Survey (HINTS) (data expected spring 2027), the 2027 ONC National Survey of Health Information Exchange Organizations (HIOs) (OMB Control #0955-0019; data expected summer 2027), the 2026 and 2027 American Hospital Association Information Technology Supplement (data expected fall 2026 and summer 2027), and the ONC National Survey of Digital Health Companies (pending OMB review; data expected fall 2026). Other quantitative data will come from Trusted Exchange Framework and Common Agreement (TEFCA) program data, including exchange metrics. Qualitative data come from interviews with health IT developers and standards development organizations (SDOs). Administrative data are available on a regular basis as products become certified. Survey data collections are supported in whole or in part by ONC and will be collected through contracts and inter-agency agreements that are already funded with prior year funds. Interviews with developers and SDOs can take place, as needed, through structured and unstructured interviews. Descriptive analysis of administrative, survey, and qualitative interview data will be performed to generate evidence for the key question and related measures specified above. Survey data will be available in late 2026 and early 2027, available for use in FY27; foundational fact-finding and policy analyses will be ongoing and available for immediate use during FY27. **Foundational fact-finding:** ONC will assess what standards, standards updates, and implementation guides are critical to enable more patient-centered health IT certification and health technology. ONC will assess which advanced API and other information exchange capabilities can enable greater device and app interoperability with certified health IT. **Policy analysis:** ONC will study information blocking complaints and enforcement approaches. **Performance measurement:** ONC will survey: (1) SDOs, Health Level 7 (HL7) and other SDO working groups and committees; (2) patients and caregivers to track individuals' access, use, and contribution to their electronic health information; (3) providers and health information networks about patient access and engagement efforts; (4) digital health companies and app developers to report on progress related to the use of FHIR-based APIs that enable patient access.				
Alignment to Priority(ies)		This activity helps meet the MAHA objective of combatting critical health challenges facing American citizens by ensuring patients have easy access to the information they need to make informed decisions about their health and care. This aligns with ONC's commitment to enabling patients to access, use, and share their health data, at no cost, using a method of their choice.				
Topics		Empowering Patients, Health Information Exchange				

Activity	C	Evaluation	Assessment of Certified Community Behavioral Health Clinics Expansion (CCBHC-E) Grant Program (SAMHSA)			
Supports Priority Question(s)…	1	2	3	4	5	
	☐	☒	☒	☒	☐	
Evaluation Question(s)	1. Which services required to be provided by Certified Community Behavioral Health Clinics (CCBHCs) are effective in providing clients with substance use disorders, mental health disorders, and co-occurring disorders with comprehensive, integrated care that addresses their prevention, treatment, and recovery needs?					
Description	The findings will support SAMHSA's work to improve access to high-quality community-based care, identify best practices to support implementation and adoption of the CCBHC model, and provide actionable information to help SAMHSA, Congress, and state and community leaders guide decisions about future investments in the model. Evidence generated through this activity will inform certification criteria, reimbursement, and clinical standards in general. The evaluation will focus on helping AHA/SAMHSA 1) understand how alternative sources of funding and state/community support for the model can influence implementation and outcomes; 2) provide insights into establishment of sustainable financing of CCBHC services as well as how clinics with existing financial support for the CCBHC model can effectively expand care and build capacity; and 3) assess changes in quality of care and longitudinal client-level health, behavioral health, and functional outcomes. The evidence activity will use multiple sources and types of data. Existing administrative data that grantees already submit to SAMHSA include various documents (applications, attestation documents, and mid-year and annual reports), and client-level National Outcome Measures (NOMs) and service use information. SAMHSA also plans to require grantees to submit a subset of clinical quality measures used in the CCBHC demonstration. Other existing data sources that will inform the evaluation include the National Substance Use and Mental Health Services Survey (N-SUMHSS), and Medicaid claims (Transformed Medicaid Statistical Information System Files - T-MSIS Analytic Files) in addition to a Grantee Web Survey, Client Wellness Interview Questions Tool (CWIQ), Group Purchasing Organization (GPO) Focus Groups, and Grantee Site Visits. Data is quantitative, qualitative, and administrative. Performance measurement data are collected by grantees on an ongoing basis and made available in SAMHSA's Performance Accountability & Reporting System (SPARS) which includes structured reports. CCBHC-E Improvement & Advancement (IA) and Planning, Development and Implementation (PDI) grantees use a random sampling approach to select people receiving services for baseline NOMs assessments, then collect follow-up assessment and discharge data from this same group. Grantees have some flexibility in the random sampling approach they implement, which could result in data that vary across grantees in their representativeness of all clients who receive CCBHC services. SAMHSA also requires IA and PDI grantees to submit a subset of clinical quality measures used in the CCBHC demonstration. These data sources will be supplemented by surveying a sample of grantee project directors and conducting qualitative interviews and/or focus groups with state officials, community stakeholders, grantees and their partners, and people receiving CCBHC services, including youth and parents/caregivers starting in the end of FY2025 (OMB approved tool number 0930-0402). We also ask all grantees to collect additional client-level data and submit existing client-level data from specific instruments commonly used by grantees to assess improvements in outcomes not measured by NOMs (for example, substance use, mental health symptoms, and recovery outcomes). Specific analytic approaches will be applied to each data source and will synthesize findings across data sources. For example, a univariate and bivariate statistical analyses will be used for Grantee survey and document data, while a thematic analysis will be used for interviews. Analyses of these different data sources and synthesis of findings across them will provide SAMHSA with a comprehensive understanding of how the implementation of each component of the CCBHC model in this grant program contributes to outcomes. We will leverage the strengths of each data source and apply appropriate					

	methods to address limitations. Every evaluation question will be answered using multiple data sources to mitigate the limitations of any single data source. Evidence will be available in Fall 2026. The CCBHC evidence activity and evaluation questions are categorized in three levels of measurements, which include Organizational infrastructure changes, Service-level changes and Client-level changes. The CCBHC evidence activity will assess the degree to which activities at the clinic level and systems level affect the development, implementation, and sustainment of CCBHCs consistent with the certification criteria, and the impacts of the model on outcomes. The evaluation will yield new insights into how clinics (1) develop, improve, implement, and sustain the CCBHC model in alignment with the certification criteria and (2) impact the health, behavioral health, and functional outcomes of people who receive CCBHC services. The evaluation will also identify the state- and community-level inputs that supported clinics' efforts to transform into CCBHCs and sustain the model. The project includes primary and secondary data collection, analysis, and reporting for the benefit of multiple stakeholders and audiences. It provides training and technical assistance (TA) to grantees and their local lead evaluators to help them overcome data collection and submission challenges, conduct rigorous local evaluations, and provide high-quality data to support the evaluation. Program Name: Certified Community Behavioral Health Clinic Expansion Grants FPI #: 93.696
Alignment to Priority(ies)	This activity is directly responsive to EO 14321, "Sec. 4. Redirecting Federal Resources Toward Effective Methods of Addressing Homelessness. (a) The Secretary of Health and Human Services shall take appropriate action to: ...(iii) ensure that Federal funds for Federally Qualified Health Centers and Certified Community Behavioral Health Clinics reduce rather than promote homelessness by supporting, to the maximum extent permitted by law, comprehensive services for individuals with serious mental illness and substance use disorder, including crisis intervention services." This activity is also responsive to Section 223 of the Protecting Access to Medicare Act of 2014 (PAMA), which authorized the Certified Community Behavioral Health Clinic (CCBHC) demonstration, allowing states to test a different strategy for delivering and reimbursing a comprehensive array of services provided in community behavioral health clinics. The CCBHC model is intended to expand access to care for all adults and children/adolescents with behavioral health conditions and to improve outcomes.
Collection / Acquisition	The evidence activity will use multiple sources and types of data. Existing administrative data that grantees already submit to SAMHSA include various documents (applications, attestation documents, and mid-year and annual reports), client-level National Outcome Measures (NOMs) and service use information. SAMHSA also plans to require grantees to submit a subset of clinical quality measures used in the CCBHC demonstration. Other existing data sources that will inform the evaluation include the National Substance Use and Mental Health Services Survey (N-SUMHSS), and Medicaid claims (Transformed Medicaid Statistical Information System Files - T-MSIS Analytic Files) in addition to a Grantee Web Survey, Client Wellness Interview Questions Tool (CWIQ), Group Purchasing Organization (GPO) Focus Groups, and Grantee Site Visits. Data are quantitative, qualitative, and administrative. Performance measurement data are collected by grantees on an ongoing basis and made available in SAMHSA's Performance Accountability & Reporting System (SPARS) which generates structured reports. CCBHC-E Improvement & Advancement (IA) and Planning, Development and Implementation (PDI) grantees use a random sampling approach to select people receiving services for baseline NOMs assessments, then collect follow-up assessment and discharge data from this same group. Grantees have some flexibility in the random sampling approach they implement, which could result in data that vary in their representativeness of all clients who receive CCBHC services. SAMHSA also requires IA and PDI grantees to submit a subset of clinical quality measures used in the CCBHC demonstration. These data sources will be supplemented by surveying a sample of grantee project directors and conducting qualitative interviews and/or focus groups with state officials, community stakeholders, grantees and their partners, and people receiving CCBHC services, including youth and parents/caregivers starting in the end of FY2025 (OMB approved tool number 0930-0402). We also ask

	all grantees to collect additional client-level data and submit existing client-level data from specific instruments commonly used by grantees to assess improvements in outcomes not measured by NOMs (for example, substance use, mental health symptoms, and recovery outcomes).
Topics	Capacity Building, Empowering Patients, Mental Health

Activity	**D**	**Evaluation**	Evaluation of a Moratorium on Enrollment of Home Health Agencies (HHAs) (CMS)			
Supports Priority Question(s)…	1	2	3	4	5	
	☐	☐	☒	☐	☒	
Evaluation Question(s)	1. Per CMS' data analytics, to what degree did the imposition of the nationwide moratorium reduce Fraud, Waste, and Abuse (FWA) among HHAs in general, and in historically high-growth areas such as Los Angeles County, California, in particular? 2. How did the moratorium impact beneficiary access to home health services and, if it had an impact, to what extent and in which geographic locations, including rural areas? 3. How have HHA enrollment trends changed since the imposition of the moratorium?					
Description	Information resulting from this evaluation of the moratorium will be used to determine the degree to which a nationwide moratorium is effective in reducing HHA Fraud, Waste, and Abuse (FWA), and whether it should be extended or supplemented with further program integrity measures. This evidence activity will utilize quantitative administrative data from multiple CMS systems. The primary data sources include: (1) Medicare claims data — transactional records capturing HHA service utilization, payment amounts, and billing patterns by geographic location, enabling analysis of beneficiary service volume before, during, and after the moratorium; (2) Enrollment data — Provider Enrollment, Chain, and Ownership System (PECOS) records tracking new HHA and branch location applications, approvals, denials, and active HHA counts with particular attention to historically volatile markets; (3) Program integrity data — revocation rates and payment suspension metrics and (4) Beneficiary access metrics — service availability, utilization rates, and geographic distribution of active HHAs derived from claims analysis. This evaluation will employ a quasi-experimental design using interrupted time series analysis. We will compare FWA metrics, enrollment patterns, and beneficiary access indicators across three periods: pre-moratorium baseline, the 6-month moratorium, and 120 days post-moratorium. Statistical analyses will include trend analysis of FWA indicators (revocations, payment suspensions) by supplier type, geographic analysis of beneficiary access patterns, and comparative analysis of enrollment applications and approvals. We expect initial evidence of any reduction in HHA FWA by the end of the 120-day period following the moratorium's effective date.					
Alignment to Priority(ies)	HHA FWA has been a severe Medicare program integrity problem for over two decades, driven by low start-up costs and the largely unsupervised, home-based nature of services. HHAs are one of only six provider/supplier types assigned to the "high" screening risk category and are the only provider/supplier type subject to minimum capitalization requirements — underscoring their uniquely elevated risk. This evaluation will assess the nationwide HHA enrollment moratorium effective May 13, 2026, for a minimum of six months, which followed a sudden, unexplained 40-plus percent increase in Los Angeles County HHA enrollments between 2019 and 2023 as well as emerging clusters of co-located HHAs in Ohio, Texas, Michigan, and Nevada. Prior localized moratoria (2013–2019) in Florida, Illinois, Michigan,					

	and Texas were considered successful, but CMS determined that the migratory nature of fraud schemes warranted a nationwide approach this time. The evaluation will follow a three-phased approach: (1) pre-moratorium baseline establishment — collecting and analyzing FWA metrics, enrollment patterns, and beneficiary access data; (2) moratorium implementation and monitoring — tracking FWA indicators, new enrollment applications, and beneficiary service utilization during the 6-month (minimum) moratorium period; and (3) post-moratorium assessment — analyzing data for 120 days following the moratorium's end to measure changes in FWA rates, enrollment trends (including any rebound or migration to new geographic areas), and beneficiary access patterns. This evaluation will generate evidence on FWA reduction, beneficiary access impacts, and enrollment trends to inform whether the moratorium should be extended, modified, or applied as a model for future provider-type moratoria.
Collection / Acquisition	This evidence activity will utilize quantitative administrative data from multiple CMS systems, including Medicare claims data, PECOS enrollment data (new HHA and branch applications, approvals, denials), program integrity data (revocations, payment suspensions), and beneficiary access metrics, compared across pre-moratorium, moratorium, and post-moratorium periods and across both nationwide and historically high-growth geographic areas.
Topics	Preventing Fraud (Program Integrity)

Activity	**E**	**Evaluation**	Evaluation of a Moratorium on Enrollment of Hospices (CMS)			
Supports Priority Question(s)…	1	2	3	4	5	
	☐	☐	☒	☐	☒	
Evaluation Question(s)	1. Per CMS' data analytics, to what degree did the imposition of the nationwide moratorium reduce Fraud, Waste, and Abuse (FWA) among hospices in general, and in disproportionate-growth states such as Arizona, California, Nevada, Texas, Georgia, and Ohio in particular? 2. How did the moratorium impact beneficiary access to hospice care and, if it had an impact, to what extent and in which geographic locations? 3. How have hospice enrollment trends changed since the imposition of the moratorium, and is there evidence that fraudulent activity shifted to states not previously identified as high-risk?					
Description	Information resulting from this evaluation of the moratorium will be used to determine the degree to which a nationwide moratorium is effective in reducing hospice Fraud, Waste, and Abuse (FWA), and whether it should be extended or supplemented with further program integrity measures. This evidence activity will utilize quantitative administrative data from multiple CMS systems. The primary data sources include: (1) Medicare claims data — hospice service utilization, payment amounts, and billing patterns by geographic location; (2) Enrollment data — Provider Enrollment, Chain, and Ownership System (PECOS) records tracking new hospice applications, approvals, denials, active hospice counts, and attempted re-enrollments (3) Program integrity data — revocation and payment suspension metrics, including outcomes from CMS's existing PPEO in Arizona, California, Nevada, and Texas and (4) Beneficiary access metrics derived from claims analysis. This evaluation will employ a quasi-experimental design using interrupted time series analysis, comparing FWA metrics, enrollment patterns, and beneficiary access indicators across a pre-moratorium baseline, the 6-month moratorium period, and 120 days post-moratorium, including comparisons between PPEO-covered states and the nationwide trend. Statistical analyses will include trend analysis					

	of FWA indicators (revocations, payment suspensions) by supplier type, geographic analysis of beneficiary access patterns, and comparative analysis of enrollment applications and approvals. We expect initial evidence of any reduction in hospice FWA by the end of the 120-day period following the moratorium's effective date.
Alignment to Priority(ies)	Hospice fraud, waste, and abuse (FWA) has escalated sharply over the past seven years to levels comparable with HHAs and DMEPOS suppliers, prompting CMS to elevate hospices to the "high" screening risk category in 2024. Between CY 2019 and CY 2023, enrolled hospices grew far faster than the beneficiary population in several states — Arizona (+105 percent), California (+126 percent), Nevada (+151 percent), and Texas (+51 percent) — accompanied by "churn and burn" schemes, kickbacks for false terminal-illness certifications, and enrollment clusters concentrated in small geographic areas such as Los Angeles County. This evaluation will assess the nationwide hospice enrollment moratorium effective May 13, 2026, for a minimum of six months, which CMS imposed after determining that targeted measures (the "high" risk classification, the 36-month Change in Majority Ownership rule, and a four-state PPEO) reduced new enrollments in Arizona, California, and Texas but did not stop fraud from migrating — notably a 151 percent rise in Nevada hospices since 2019 and emerging single-location enrollment clusters in Ohio and Georgia. This evaluation will generate evidence on FWA reduction, beneficiary access impacts, and enrollment trends to inform whether the moratorium should be extended or whether migratory fraud patterns require further nationwide program integrity measures.
Collection / Acquisition	This evidence activity will utilize quantitative administrative data from multiple CMS systems, including Medicare claims data, PECOS enrollment data (new hospice applications, approvals, denials), program integrity data (revocations, payment suspensions, PPEO medical review outcomes), and beneficiary access metrics, compared across pre-moratorium, moratorium, and post-moratorium periods and across both nationwide and historically high-growth geographic areas.
Topics	Preventing Fraud (Program Integrity)

Activity	**F**	**Evaluation**	Evaluation of a Moratorium on Enrollment of Suppliers of Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) (CMS)			
Supports Priority Question(s)…	1	2	3	4	5	
	☐	☐	☒	☐	☒	
Evaluation Question(s)	1. Per CMS' data analytics, to what degree did the imposition of the moratorium reduce Fraud, Waste, and Abuse (FWA) among DMEPOS suppliers in general and medical supply companies in particular? 2. How did the moratorium impact beneficiary access to medical supplies and, if it had an impact, to what extent and in which geographic locations? 3. How have DMEPOS enrollment trends changed since the imposition of the moratorium?					
Description	Information resulting from this evaluation of the moratorium will be used to determine the degree to which moratoria are effective in reducing DMEPOS supplier Fraud, Waste, and Abuse (FWA).					

	This evidence activity will utilize quantitative administrative data from multiple CMS systems. The primary data sources include: (1) Medicare claims data - quantitative transactional records capturing DMEPOS service utilization, payment amounts, billing patterns by supplier type and geographic location; (2) Enrollment data - quantitative administrative records from the Provider Enrollment, Chain, and Ownership System (PECOS) tracking new supplier applications, approvals, denials, and active supplier counts for medical supply companies and other DMEPOS supplier types; (3) Program integrity data - quantitative metrics measuring fraud, waste, and abuse indicators like revocations and payment suspensions; and (4) Beneficiary access metrics - quantitative measures derived from claims analysis showing service availability, utilization rates, and geographic distribution of suppliers. These administrative datasets will enable CMS to conduct comparative analysis across pre-moratorium, moratorium, and post-moratorium periods to assess both program integrity outcomes and beneficiary access impacts. This evaluation will employ a quasi-experimental design using interrupted time series analysis to isolate the moratorium's causal impact. We will compare FWA metrics, enrollment patterns, and beneficiary access indicators across three distinct time periods: pre-moratorium baseline, during the 6-month moratorium, and 120 days post-moratorium. Statistical analyses will include trend analysis of FWA indicators (revocations, payment suspensions) by supplier type, geographic analysis of beneficiary access patterns, and comparative analysis of enrollment applications and approvals. We expect to have initial evidence of any reduction in medical supply company FWA by the end of the 120-day period following the effective date of the moratorium. This evidence activity will evaluate the effectiveness of a temporary moratorium on enrollment of new medical supply companies in the Medicare DMEPOS program. The evaluation will follow a three phased approach for data collection of all enrolled medical supply companies and other DMEPOS supplier types (1) Pre-moratorium baseline establishment - collecting and analyzing FWA metrics, enrollment patterns, and beneficiary access data; (2) Moratorium implementation and monitoring - tracking FWA indicators, enrollment applications, and beneficiary service utilization during the 6-month (minimum) moratorium period; (3) Post-moratorium assessment - analyzing data for 120 days following the moratorium's end to measure changes in FWA rates, enrollment trends, and beneficiary access patterns. The evaluation will compare medical supply companies to other DMEPOS supplier types across all three time periods to isolate the moratorium's impact on program integrity and beneficiary access. Program Name: Medicare Supplementary Medical Insurance (Medicare Part B) Part B FPI #: 93.774
Alignment to Priority(ies)	Medicare fraud, waste, and abuse (FWA) within the DMEPOS sector has remained a persistent program integrity challenge for many years. This evaluation will assess the DMEPOS moratorium effective February 27, 2026 through August 27, 2026 that temporarily prohibited the enrollment of new medical supply companies—an entity type historically associated with higher rates of FWA compared to other DMEPOS suppliers, such as pharmacies—for a minimum period of six months will provide critical evidence to inform program integrity strategies by measuring the moratorium’s impact on fraud, waste and abuse rates among medical supply companies, assessing effects on beneficiary access to necessary medical equipment, and analyzing enrollment patterns to determine whether temporary moratoria should be extended or expanded to other supplier categories. By focusing on this higher-risk segment of the supplier community, the moratorium is intended to mitigate vulnerabilities and reduce overall FWA in the DMEPOS program.
Collection / Acquisition	This evidence activity will utilize quantitative administrative data from multiple CMS systems. The primary data sources include: (1) Medicare claims data - quantitative transactional records capturing DMEPOS service utilization, payment amounts, billing patterns by supplier type and geographic location; (2) Enrollment data - quantitative administrative records from the Provider Enrollment, Chain, and Ownership System (PECOS) tracking new supplier applications, approvals, denials, and active supplier counts for medical supply companies and other DMEPOS supplier types; (3) Program integrity data - quantitative metrics measuring fraud, waste, and abuse indicators like revocations and payment

	suspensions; and (4) Beneficiary access metrics - quantitative measures derived from claims analysis showing service availability, utilization rates, and geographic distribution of suppliers. These administrative datasets will enable CMS to conduct comparative analysis across pre-moratorium, moratorium, and post-moratorium periods to assess both program integrity outcomes and beneficiary access impacts.
Topics	Preventing Fraud (Program Integrity)

Activity	**G**	**Evaluation**	Testing Identified Elements for Success in Fatherhood (ACF)				
Supports Priority Question(s)…		1	2	3	4	5
		☐	☐	☐	☒	☐
Evaluation Question(s)		1. Do individualized services offered to fathers, in addition to services as usual in responsible fatherhood programs, significantly improve outcomes for fathers and their children in key areas such as fathers' positive engagement in their children's lives and economic self-sufficiency? 2. What is the impact of offering cash disbursements, financial coaching, or both on fathers' depression, anxiety and indicators of their economic stability? 3. What is the impact of offering one-on-one parent coaching to address fathers' specific goals related to parenting skills, father-child relationship quality, and time spent with children? 4. What is the impact of offering one-on-one parent coaching on quality of co-parenting relationship, father well-being, successful execution of steps to navigate systems, and economic well-being? 5. What is the impact of offering one-on-one systems navigation support to address fathers' specific goals related to time spent with child(ren), co-parenting relationships, and parental rights, financial support, and child-related agreements? 6. What is the impact of offering one-on-one systems navigation support on father-child relationship quality and parenting skills, father well-being and economic well-being?				
Description		By the end of FY27 results of the impact and implementation studies of the individualized services implemented in five Responsible Fatherhood programs will be available. If any of the strategies significantly enhance father outcomes, the findings will be incorporated, as appropriate, into relevant program policies and practices, including Notices of Funding Opportunities (NOFOs) for future grant cohorts and ongoing guidance and technical assistance for existing grant recipients. This will help ensure funding decisions and program activities are aligned with evidence produced by gold standard science and utilize evidence-based strategies to improve economic and family relationship outcomes for fathers and their children. **Impact Study**: (1) Applicant Characteristics Survey (ACS), an existing survey administered to all fatherhood program participants at enrollment using nFORM, which is the performance measures data collection system used by all grant recipients (Quantitative); (2) Community Fathers Entrance Survey (ES) an existing survey administered to all fatherhood program participants at enrollment using nFORM. An existing survey given to all fatherhood program participants (Quantitative); (3) Baseline survey (BS) collected from all fathers at enrollment: This is a supplement to the ACS and ES, given to study participants. (Quantitative); (4) Father-reported follow-up survey: Fathers will be asked to complete a 9-month follow-up survey and to report on the targeted set of outcomes. (Quantitative); (5) nFORM data assessing program implementation. The impact study will leverage information on program participation and engagement by accessing programs' administrative data available for all study enrollees through nFORM. (Administrative) **Implementation Study:** (6) Staff Interviews: Implementing program staff will be asked to participate in a semi-structured interview at 12 months after the intervention start. Interviews will be conducted in-person, by phone, or by video call. (Qualitative); (7) Staff Reflection: Program staff complete a short				

electronic, Qualtrics-based survey approximately once per quarter. (Quantitative); (8) Father Reflection: Program participants are asked to complete a short electronic, Qualtrics-based survey once during their workshop participation period. (Quantitative); (9) Co-parent interviews: Co-parents of fathers receiving the core components at select sites will be asked to participate in a semi-structured interviews conducted by the research team in-person or by phone or video conference. Interviews will assess co-parent perspectives on fathers' involvement with children, parenting, and co-parenting as it relates to the core component intervention being tested. (Qualitative); (10) Father Focus Groups: A subset of fathers participating in the study will be asked to participate in focus group discussions that will be co-facilitated by the research team and Father Advisors (alumni fathers hired by program sites for the Fatherhood TIES study). Focus groups will be conducted in-person or by phone or video conference. (Qualitative); (11) Photo voice: Photo voice is a visual participatory action research tool. A subset of fathers at select sites will be trained and asked to take weekly photos in response to a research question prompt and then participate in a focus group discussion to collaboratively analyze the photos with the research team. Over a three-week period, photos will be submitted through an electronic link using Qualtrics. After submitting photos, the research team will facilitate group or individual conversations with fathers to collaboratively discuss and analyze the photos. Findings will be discussed to identify themes. (Qualitative); (12) Audio Journaling: Audio journaling is an auditory participatory research approach in which fathers will be asked to make audio recordings in response to a weekly prompt about how they are applying knowledge and skills gained through their participation in the fatherhood program and its effect on their economic stability, experiences navigating systems, or on relationships with their children and co-parents. Audio recordings in response to weekly prompts will be made by a subset of fathers at select sites. Audio recordings will be made to a secure ZoomGov 1-800 line set up by MDRC. Recordings will be transcribed and analyzed to identify themes within and across sites/tests. (Qualitative)

The Applicant Characteristics Survey and Community Fathers Entrance Survey are programmed and collected within nFORM, the information management system used by fatherhood grant recipients. The baseline survey is programmed in Qualtrics and accessed directly through a link provided to fathers. The follow-up survey is collected 9 months after completion of the baseline survey. It is programmed in Qualtrics with a survey link sent to participants by email. If they do not complete the online survey, interviewers will attempt to locate them and complete the surveys over the phone or in person, using a computer-assisted personal interviewing (CAPI) system.

Information collections related to this project have been reviewed and approved by the Office of Management and Budget (OMB) Office of Information and Regulatory Affairs under OMB #0970-0622. Related materials are available at Testing Identified Elements for Success in Fatherhood Programs page on RegInfo.gov.

The Fatherhood TIES study uses a randomized controlled experiment design to assess whether the delivery of the individualized interventions, in addition to business as usual, improved fatherhood outcomes including parenting skills, father-child relationships, time spent with child, co-parenting relationships, economic stability, and father well-being. Each of the three individualized program components being tested has an impact analysis plan. The impact estimates will be derived from Ordinary Least Squares regression models. For all primary and secondary outcomes, the study team plans to use a fixed set of covariates collected at the time of random assignment via the Applicant Characteristics Survey and Baseline Survey and the baseline equivalent of the outcome, whenever available. This plan follows best practices including identifying outcomes before analysis begins and grouping outcomes into domains so that a single test of significance can be conducted on each primary outcome domains, which increases power to detect impact at the domain level.

A final report with results is expected no later than June 2027. The report will describe the interventions that were tested and their estimated effect in the outcome domains of parenting skills, father-child relationships, time spent with child, co-parenting relationships, economic stability, and father well-being.

	Testing Identified Elements for Success in Fatherhood Programs (Fatherhood TIES) is an impact study occurring across five fatherhood programming sites. All study participants must first be eligible for the Responsible Fatherhood grant funded program in which they are seeking to enroll. At each of the participating programs, fathers will be randomly assigned to either receive business-as-usual fatherhood services or one of the individualized support interventions. Participants complete a series of surveys to provide data for analysis by the study team. Analyses of these data will determine whether fathers who received the individualized service component in addition to the usual services had better outcomes than those who received usual services only. In addition, the study team will be conducting an implementation study to better understand how programs integrated each core component within existing program services and the key factors that were critical for successful implementation throughout the study period. Program Name: Healthy Marriage Promotion and Responsible Fatherhood Grants FPI #: 93.086
Alignment to Priority(ies)	The aim of the Fatherhood TIES impact study design is to generate evidence on the core components that are most strongly associated with impacts of Responsible Fatherhood programs on father outcomes related to economic self-sufficiency and family relationships. A rigorous, multi-method approach that involved a literature review of qualitative analyses, meta-analysis of published quantitative studies, secondary analysis of grant award documentation, and engagement with experts including practitioners, academics, and fathers led to the identification of individualized supports as a promising core component for improving outcomes. Rigorously designed randomized controlled trials are testing whether individualized supports for fathers delivered in five fatherhood programs can improve fathers' economic self-sufficiency and relationships with his children and partners.
Collection / Acquisition	Impact Study: (1) Applicant Characteristics Survey (ACS), an existing survey administered to all fatherhood program participants at enrollment using nFORM, which is the performance measures data collection system used by all grant recipients. (Quantitative); (2) Community Fathers Entrance Survey (ES) an existing survey administered to all fatherhood program participants at enrollment using nFORM. An existing survey given to all fatherhood program participants (Quantitative); (3) Baseline survey (BS) collected from all fathers at enrollment: This is a supplement to the ACS and ES, given to study participants. (Quantitative); (4) Father-reported follow-up survey: Fathers will be asked to complete a 9-month follow-up survey and to report on the targeted set of outcomes. (Quantitative); (5) nFORM data assessing program implementation. The impact study will leverage information on program participation and engagement by accessing programs' administrative data available for all study enrollees through nFORM. (Administrative) Implementation Study: (6) Staff Interviews: Implementing program staff will be asked to participate in a semi-structured interview at 12 months after the intervention start. Interviews will be conducted in-person, by phone, or by video call. (Qualitative); (7) Staff Reflection: Program staff complete a short electronic, Qualtrics-based survey approximately once per quarter. (Quantitative); (8) Father Reflection: Program participants are asked to complete a short electronic, Qualtrics-based survey once during their workshop participation period. (Quantitative); (9) Co-parent interviews: Co-parents of fathers receiving the core components at select sites will be asked to participate in a semi-structured interviews conducted by the research team in-person or by phone or video conference. Interviews will assess co-parent perspectives on fathers' involvement with children, parenting, and co-parenting as it relates to the core component intervention being tested. (Qualitative); (10) Father Focus Groups: A subset of fathers participating in the study will be asked to participate in focus group discussions that will be co-facilitated by the research team and Father Advisors (alumni fathers hired by program sites for the Fatherhood TIES study). Focus groups will be conducted in-person or by phone or video conference. (Qualitative); (11) Photo voice: Photo voice is a visual participatory action research tool. A subset of fathers at select sites will be trained and asked to take weekly photos in response to a research question prompt and then participate in a focus group discussion to collaboratively analyze the photos with the research team. Over a three-week period, photos will be submitted through an electronic link using Qualtrics. After submitting photos, the research team will facilitate group or individual conversations with fathers to collaboratively discuss and analyze the photos. Findings will be discussed to identify themes. (Qualitative); (12) Audio Journaling: Audio journaling is an auditory participatory research approach in which fathers will be asked to make audio recordings in response to a weekly prompt about how they

	are applying knowledge and skills gained through their participation in the fatherhood program and its effect on their economic stability, experiences navigating systems, or on relationships with their children and co-parents. Audio recordings in response to weekly prompts will be made by a subset of fathers at select sites. Audio recordings will be made to a secure ZoomGov 1-800 line set up by MDRC. Recordings will be transcribed and analyzed to identify themes within and across sites/tests. (Qualitative) The Applicant Characteristics Survey and Community Fathers Entrance Survey are programmed and collected within nFORM, the information management system used by fatherhood grant recipients. The baseline survey is programmed in Qualtrics and accessed directly through a link provided to fathers. The follow-up survey is collected 9 months after completion of the baseline survey. It is programmed in Qualtrics with a survey link sent to participants by email. If they do not complete the online survey, interviewers will attempt to locate them and complete the surveys over the phone or in person, using a computer-assisted personal interviewing (CAPI) system.
Topics	Marriage and Family Formation

Activity	**H**	Analysis of NIH's AI Use Case Inventory (NIH)				
Supports Priority Question(s)…		1	2	3	4	5
		☐	☐	☐	☐	☒
Description		Research Questions: 1. How is AI being used in operations across NIH? 2. What are the types of AI applications being built and who is building them? 3. What opportunities exist for improving resourcing for AI projects that would benefit the NIH enterprise? The NIH Office of the Chief Information Officer (OCIO) will use the evidence to identify which tools NIH staff and programs are using to improve services and operations, share best practices and lessons learned to promote transparency and peer to peer learning, and identify co-investment opportunities to ensure efficient allocation of resources. Additionally, the NIH Chief AI Officer may use the information to develop an evaluation framework and to develop metrics that can be used to monitor and track successful implementation of the NIH AI Strategic Plan and assess its outcomes over time. This activity will use qualitative and quantitative data to analyze NIH AI use cases from FY 2024-2027. The Inventory organizes data into five categories: (1) Use Case Identifiers such as development stage, high-impact status, and R&D designation; (2) Use Case Summary including use-case purpose, AI type, problem addressed, and expected benefits; (3) Documentation such as implementation details including development approach and authorization status; (4) Data and Code characteristics such as data sources, use of personally identifiable information (PII), custom or open-source code, and impact assessment completion; and (5) Risk Management practices, including potential harms, monitoring, fail-safes, and stakeholder feedback. Overall, the Inventory data provides information on organizational AI maturity, risks, benefits, high-impact or sensitive systems, compliance with federal AI standards, and activities used to minimize risks to end users. To address the research questions, a descriptive analysis of the NIH AI Use Case Inventory will be conducted for data collected between FY 2024-2027. The analysis will use methods such as data aggregation and summarization, data visualization, and frequency analysis to identify and track use cases and describe changes and trends over time. Data collected across the five Inventory categories will inform the descriptive analysis and be used to develop metrics for assessing how NIH implements				

	operational AI initiatives per the pending NIH AI Strategic Plan. For example, Documentation data supports metrics for operational readiness (e.g., average time from development to operational start) and acquisitions (e.g., number of in-house vs. vendor-developed solutions), and Risk Management supports metrics for ethical and safe AI deployment (e.g., percentage with ongoing monitoring plans). The descriptive analysis and developed metrics will allow NIH to monitor progress, identify gaps, determine resource allocations, and guide continuous improvement across the AI Strategic Plan. Since FY 2024, NIH has conducted an annual data call for the NIH AI Use Case Inventory. In FY 2027, internal NIH staff will review and clean data collected from FY 2024-2027, and will conduct an analysis of the resulting Inventory. The analysis will provide descriptive information about NIH AI use cases in pre-deployment, pilot, deployed, or retired status, and include use cases for business/mission support and intramural research projects. Intramural research projects may include cases using AI for basic and applied research (e.g., using AI for medical diagnosis and in clinical settings). Data will be analyzed to describe and track use cases, identify commonalities and differences in use cases, particularly as they may align with and/or impact each other, and determine changes and trends over time. Data is expected to be available for analysis in August 2027; data will be analyzed and generate actionable evidence in September 2027. The data will be collected from a data call request to all NIH Institutes, Centers, and Offices (ICOs). Designated representatives from each NIH ICO will have approximately two weeks to complete a standardized webform that is hosted on a secure NIH platform. The data will be downloaded into an Excel file and cleaned for analysis.
Alignment to Priority(ies)	By providing information on NIH's AI use cases, this foundational fact-finding activity contributes to advancing the priorities of Executive Order 13960: Promoting the Use of Trustworthy AI in the Federal Government and aligns with the Administration's AI Action Plan. The NIH AI Use Case Inventory includes business/mission support AI use cases and intramural research projects using AI, including conducting research about using AI for medical diagnosis and in clinical settings (e.g., basic or applied research). This inventory does not include information on any NIH funding awarded to extramural research institutions. Analysis of information collected through the inventory may be used to identify promising applications of AI that may be replicated, reduce redundant efforts across NIH, enhance peer to peer learning, and identify co-investment opportunities to ensure efficient use of resources. The findings from this activity may also be used to identify and develop metrics and an evaluation framework to assess the implementation and outcomes of the NIH AI Strategic Plan.
Topics	Artificial Intelligence/Technology, Streamlining Government

SECTION III | CHALLENGES

This section details any challenges to developing evidence as part of answering the Priority Questions, including any statutory or other restrictions to accessing relevant data.

A common challenge across multiple evidence activities is data readiness and availability under uncertainty, including delays in data collection, reliance on older or incomplete data, and constraints created by evolving IT systems. Some activities face challenges stemming from small sample sizes that could affect the statistical power of the analyses, potentially due to uncertain timing of program applications and reduced or delayed enrollment. In these instances, analyses may need to rely more heavily on pooled analyses, process-focused findings, or qualitative perspectives rather than robust quantitative estimates. Evidence activities that depend on data collections face challenges in balancing the burden imposed on program staff and sites with meeting data needs, requiring careful use of existing data sources and streamlined data collection approaches to minimize disruption. Additional challenges include ensuring the feasibility of collecting key performance indicator data amid evolving IT landscapes, isolating specific populations or outcomes within complex service environments, and interpreting outcomes (e.g., recovery) that may be ill-defined, non-linear, or sensitive to the timeframe used for assessment.

APPENDIX | HHS DIVISION ACRONYMS

DIVISION NAME	ACRONYM
Administration for Children and Families	ACF
Centers for Medicare and Medicaid Services	CMS
National Institutes of Health	NIH
Office of the National Coordinator for Health Information Technology	ONC
Substance Abuse and Mental Health Services Administration	SAMHSA