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Strengthening the other two sides of the fraud, waste, and abuse triangle

Paul Houchens, FSA, MAAA, Principal and Consulting Actuary
Tyler Schulze, FSA, MAAA, Principal and Consulting Actuary
Stefany Ross, MHA, Healthcare Management Consultant
Adam Hearn, MS-DSPP, Consulting Data Scientist

Milliman

At-a-glance

Fraud, waste, and abuse are often presented together and matched with a single response. This paper presents the three components as a triangle, where each side carries its own definition and the corners function as handoffs from one component to the next. With federal healthcare fraud enforcement at its highest level on record, now is the right time to prioritize waste and abuse reduction in partnership with providers.

Federal healthcare fraud enforcement is having a milestone year: Fiscal year 2025 produced the largest False Claims Act (FCA) recoveries in the statute's history and the Department of Justice's (DOJ's) June 2026 National Health Care Fraud Takedown charged 455 defendants and included more participating state Medicaid Fraud Control Units than any prior DOJ fraud initiative. Yet published estimates have found that fraud accounts for a modest share of total wasted healthcare spending. This paper examines the composition of that spending waste, considers why healthcare industry attention concentrates on fraud more than waste and abuse, and describes five practical, evidence-based approaches for reducing waste and abuse in partnership with providers.

A high-water mark on fraud enforcement

By many measures, the fraud side of healthcare program integrity is generating much attention and producing record recoveries.

- In January 2026, the DOJ announced that FCA settlements and judgments exceeded $6.8 billion in fiscal year 2025, the highest single-year aggregate volume in the statute's history, with more than $5.7 billion arising from healthcare matters and a record 1,297 whistleblower suits filed.[1,2]
- Six months later, the 2026 National Health Care Fraud Takedown charged 455 defendants, the most in takedown history, in connection with more than $6.5 billion in alleged false claims and included the largest Medicaid fraud enforcement action ever conducted.[3]
- These efforts occurred only one year after 2025's record takedown (by dollar volume) of $14.6 billion in alleged intended loss.[4]

The infrastructure that seeks to produce these results is expanding as well. The DOJ created a National Fraud Enforcement Division in April 2026 and highlighted a multiagency Data Fusion Center that pairs claims analytics with financial intelligence.[5] In connection with the 2026 DOJ action, the Centers for Medicare and Medicaid Services (CMS) suspended 1,079 providers and revoked billing privileges for 1,403 more.[6]

The enforcement community itself is emphasizing prevention. CMS Administrator Dr. Mehmet Oz framed the 2026 takedown by observing that prosecuting those who steal from patients is necessary but that stopping them "before a single dollar leaves the building" is smarter.[7] Enforcement is not only a stated priority; it is described by federal agencies as becoming faster, more data driven, and more preventive.

These results deserve recognition, and the work behind them reflects a core underpinning of government health programs: Program integrity obligations are embedded in federal regulation, state contracts, and accreditation requirements.[8] However, fraud, waste, and abuse are three distinct problems, and the evidence suggests that the problem that receives the most concentrated attention accounts for the smallest share of overspend.[9] Applying the same fraud enforcement toolkit to the other two sides is not just a poor fit; if done in an adversarial manner, it can generate the very overspend it aims to eliminate. This paper contends that the waste and abuse sides respond to a different toolkit that includes **education, transparency, and payment policy design executed in collaboration with providers**. The opportunity in front of the healthcare industry is to build the other two sides of the triangle to the same or better standard as the fraud side.

Distinguishing the three sides of the triangle

CMS's own training materials draw the distinctions cleanly.[10]

- **Fraud** is knowing and willful deception or misrepresentation intended to obtain unauthorized payment.
- **Waste** is the overutilization of services and other practices that, directly or indirectly, result in unnecessary cost, generally caused not by criminally negligent action but by the misuse of resources.
- **Abuse** occupies the middle ground: practices inconsistent with sound fiscal, business, or medical practice that produce unnecessary cost or payment for services failing to meet professionally recognized standards, distinguished from fraud chiefly by the absence of demonstrated intent.

Intent is the primary distinction between the problems.

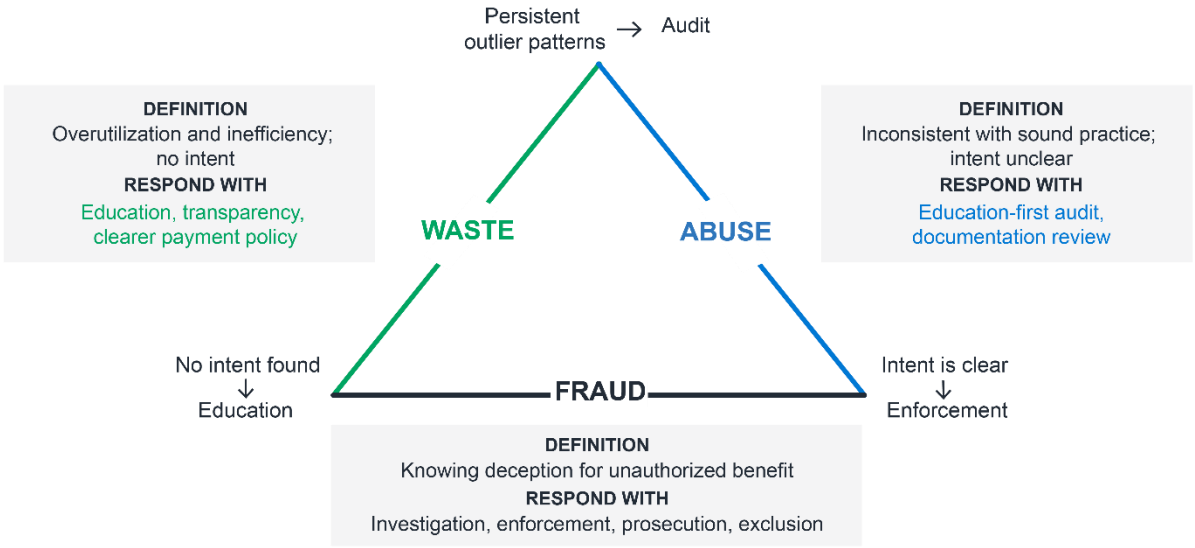
FIGURE 1: DISTINGUISHING FRAUD, WASTE, AND ABUSE

PROBLEM TYPE	EXPLANATION	EXAMPLE
Fraud is a legal problem.	Fraud has a perpetrator, and it is properly addressed with investigative tools, prosecutorial discretion, and recoveries that carry deterrent weight.	A provider knowingly bills for laboratory tests that were never provided.
Waste is an operational and clinical-economics problem.	Waste may be driven by organizational or departmental culture and not a single perpetrator. "Resolving" it means changing practices, rules, habits, and education strategies rather than levying legal action against a person.	A provider routinely orders duplicate lab tests because prior results are unknown or not available.
Abuse is a behavioral practice problem.	Abuse consists of patterns that may be inappropriate, excessive, or inconsistent with accepted practice, but without demonstrated intent to deceive. The appropriate organizational response follows the intent.	A provider consistently bills components of a laboratory panel separately rather than using the single panel code, resulting in higher payment, but with no evidence the practice is deliberate.

A concern with the acronym for fraud, waste, and abuse (FWA) is that it often fuses the three into a single workflow, which invites one toolkit to address all three. The typical program integrity toolkit of detect, audit, and recover is then applied uniformly across three very different problems that require unique solutions. Fraud enforcement approaches are generally a poor fit for lawful errors, particularly those that are unintentional. The approaches are often slower, more expensive, and more abrasive than the underlying problem requires, in addition to being largely incapable of changing the behavior that produced the errors in the first place.

The fraud, waste, and abuse triangle in Figure 2 untangles the acronym. Each side of the triangle carries its own definition and its own matched response. As important as the distinctions are the corners, which function as handoffs: Education that fails to change a persistent pattern escalates to targeted review; review that surfaces indicators of intent escalates to investigation and referral; and closed cases feed back into payment policy and edit design so enforcement lessons harden the prevention layer.

FIGURE 2: THE FRAUD, WASTE, AND ABUSE TRIANGLE: THREE SIDES, THREE TOOLKITS

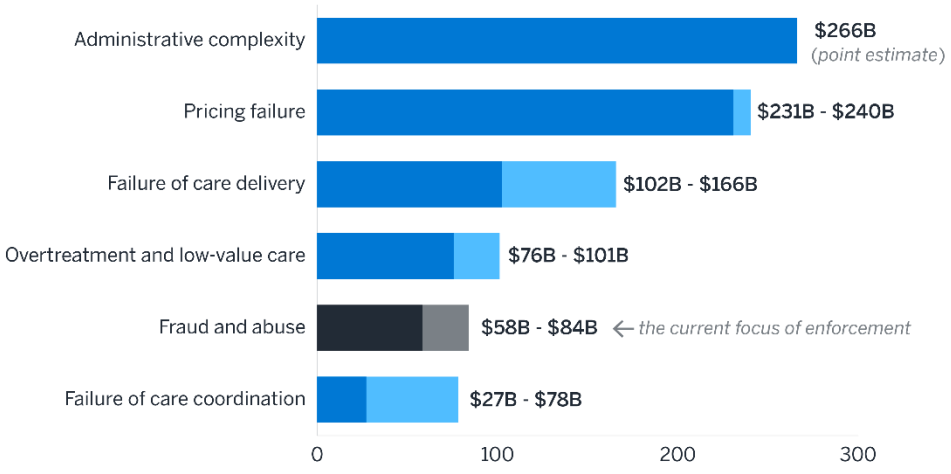


Note: Definitions adapted from CMS's Medicare Learning Network.[11]

Sizing the sides

An often-cited estimate of health system overspend continues to be the 2019 analysis by Shrank and colleagues in the Journal of the American Medical Association (JAMA), which placed total annual overspend at $760 billion to $935 billion, roughly 25% of U.S. health spending in 2019, across six domains.[12] Figure 3 shows the six domains at relative scale with their associated overspend. Based on the analysis, waste accounts for approximately $701.6 billion to $851.2 billion of the overspend, while fraud and abuse account for approximately $58.5 billion to $83.9 billion.

FIGURE 3: ESTIMATED ANNUAL OVERSPEND IN U.S. HEALTHCARE, BY DOMAIN IN 2019



Source: Shrank, W. H., Rogstad, T. L., & Parekh, N. (2019). Waste in the US health care system: Estimated costs and potential for savings. JAMA, 322(15), 1501–1509. Retrieved August 13, 2026, from https://jamanetwork.com/journals/jama/article-abstract/2752664.

Fraud and abuse, two sides of the triangle combined, represented roughly 6% to 11% of estimated total overspend, less on a percentage basis than the 15% to 20% earlier 2011 estimate by Berwick and Hackbarth.[13] The figures shown in Figure 3 were published relative to national health spending of roughly $3.6 trillion. With national health expenditures now estimated to eclipse $6 trillion, the absolute dollars are likely understated relative to today.[14]

Fraud-specific estimates vary widely. The National Health Care Anti-Fraud Association conservatively estimates losses at 3% of total health expenditures, while noting that some government and law enforcement agencies place the figure as high as 10%.[15] Definitional differences explain part of the gap between such estimates and the narrower JAMA fraud-and-abuse domain. Regardless of the source of the estimate, the majority of the estimated overspending pool lies outside fraud entirely.

The federal government's own payment measurement points in the same direction. For fiscal year 2025, CMS reported a Medicare fee-for-service improper payment rate of 6.55% ($28.8 billion), the ninth consecutive year below the 10% statutory threshold, and a Medicaid rate of 6.12% ($37.4 billion).[16,17] Of the Medicaid improper payments, 77.2% resulted from insufficient documentation, which CMS describes as generally not indicative of fraud or abuse. The corresponding figure for Children's Health Insurance Program (CHIP) was 56.1%.[18] CMS has plainly stated that improper payment measurement is not a measure of fraud. Therefore, the bulk of measured payment errors profile as documentation and administrative issues, which fit on the waste side of the triangle.

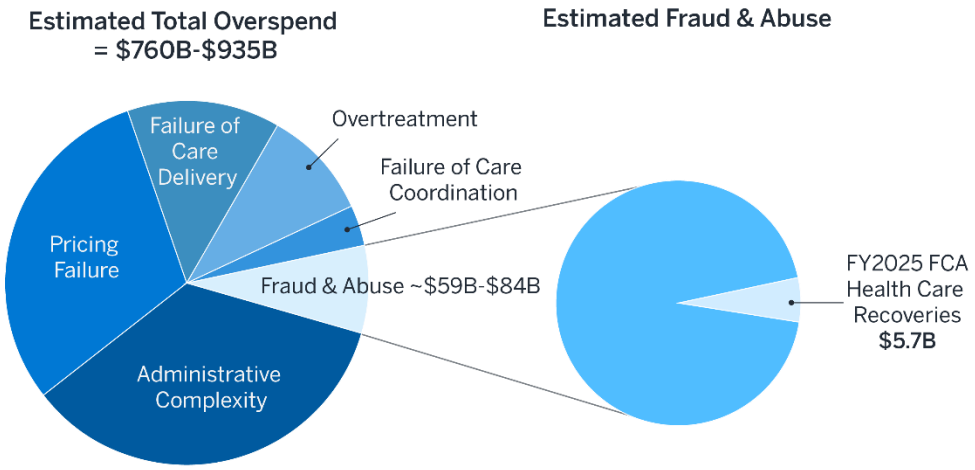
IMPROPER PAYMENTS TYPICALLY INDICATE COMPLIANCE ISSUES OR WASTE, NOT FRAUD OR ABUSE

Improper payments are payments that did not meet program requirements: overpayments, underpayments, or payments that could not be verified from available documentation. CMS is explicit that improper payment measurement is not a measure of fraud. A rising improper payment rate may therefore be better interpreted as a documentation and administration signal than as a fraud signal. Addressing improper payment rates requires different remedies because improper payments can result from a variety of circumstances like:

- Services with insufficient or no documentation
- Services with documentation that does not substantiate the payment
- Services with the right payment recipient and amount, but the payment process did not comply with regulatory payment requirements
- Services with respect to Medicaid/CHIP where there is no record of the required verification of an individual's eligibility factors

Recent federal fraud enforcement results reconcile with the proportions cited in this section. The largest FCA year in history recovered $5.7 billion from healthcare matters, well under 1% of estimated total annual overspend, and cumulative FCA recoveries since 1986, at more than $85 billion, amount to roughly one-tenth of a single year's estimated overspend.[19,20] None of this implies that enforcement underperforms. The more appropriate reading is that enforcement addresses the side of the triangle for which it was designed. The larger sides require different approaches, and Figure 4 puts that into perspective.

FIGURE 4: PUTTING ENFORCEMENT RECOVERIES IN PERSPECTIVE OF TOTAL OVERSPEND (IN BILLIONS)



Figures represent annual values and are derived from separate JAMA and FCA sources/analyses. The recoveries portion is shown within the fraud and abuse domain for illustrative purposes. FCA settlement and judgment amounts can include multiplied damages and penalties and are not a one-to-one measure of underlying improper payments.

Why attention concentrates on the fraud side

Focusing on fraud is a rational response to well-demonstrated features of the problem. Fraud work is mandated by statute, regulation, and contracts in ways waste and abuse reduction are not.[21] Fraud results are measurable: A recovered dollar is auditable, attributable, and reportable, and the return-on-investment story is clean and easy to quantify. Fraud enforcement also offers a clear narrative: A scheme has a perpetrator, a method, and an ending. Documentation friction has none of these; after a fraud problem is identified, there tends to be clearer actions and outcomes.

Structural economics reinforce this further. A meaningful share of recovery work is compensated on contingency, which rewards findings rather than prevention:

- A vendor paid on recoveries has no mechanism to be paid for the error that never occurred.
- A prevented dollar is a counterfactual; no check is cut, no press release is issued, and no line item captures it.
- Budgets follow measurability, and the available instruments quietly shape which problems get worked. Organizations, like people, tend to search where the reward is highest and the story is told more easily.

The other two sides of the triangle are more difficult to solve. Provider payment models play a role because, when providers are rewarded for volume versus outcomes and appropriate utilization, it may incentivize overutilization. Reducing waste and abuse requires clinical judgment and payment-policy fluency, not just anomaly detection. Findings typically produce interventions that reduce waste and abuse prospectively, over an extended period of time. This makes the value of such findings and interventions, as well as the distribution of credit to all the parties involved, subjective and difficult to quantify. Once an issue is detected, the solution is often unclear, and there could be numerous root causes driving the outcomes. The value of addressing waste and abuse is distributed across thousands of small decisions rather than concentrated in cases, and the savings appear as a curved trend line rather than a recovered check.

The hidden costs of a single-sided strategy

An integrity strategy built mainly on audit and recovery carries hidden costs that rarely appear in reported findings. Every disputed healthcare claim carries two costs, one inside the payer and one inside the provider. Record pulls, audit responses, appeals, and rework land on top of an operational billing cost base that is already substantial. One accounting study estimated billing and insurance-related costs of roughly $20 per primary care visit and more than $200 per inpatient surgical stay.[22] Audit-heavy strategies raise these base costs on both sides of the transaction.

An adversarial approach to payment integrity brings a somewhat hidden and important cost to consider. It directly contributes to administrative complexity, which as mentioned previously is the largest domain of healthcare overspending.[23] An integrity program run in an adversarial manner can therefore generate the very category of waste it exists to reduce. This is not to say that the audits themselves are waste, as targeted review is indispensable and the corners of the triangle depend on it. However, an audit approach that does not strategically consider intent and education produces administrative cost on both sides of the claim without changing the behavior that caused the error.

Finally, payer-provider relationships must be considered. Friction from false positives and slow resolution spills into contracting, network participation, provider abrasion surveys, and, most importantly, the member/patient experience. Because most healthcare fraud is committed by a small number of dishonest providers, unrefined fraud, waste, and abuse approaches burden the broader provider community to find the rare bad actors.[24]

Strengthening the waste and abuse sides: Five practical levers

While the modernization of the fraud side is well underway and well chronicled, the waste and abuse sides are less so. Following are five practical levers to consider for enhancing the other two sides. Each one is supported by federal precedent or research evidence. The levers concentrate on the waste and abuse that payer payment integrity programs can reach directly. Each also includes a path for escalation because partnership is appropriate, and often necessary, for unintentional errors—not for intentional fraud.

1. **Publish the rules.** Prevention begins with legibility and clarity. Plain-language payment policy, published edit logic, and advanced notice of edit changes convert denials into predictable outcomes. Therefore, predictable denials become rare ones because providers correct upstream behavior they can see. Transparency of this kind costs little, typically requires no new authority, and directly reduces the documentation ambiguity that drives most measured improper payments.

2. **Teach before you audit.** CMS's Targeted Probe and Educate program offers a federal template: small probes of 20 to 40 claims, one-on-one education tailored to the errors found, a re-probe, and release from review for providers who improve, with escalation reserved for persistent outliers.[25] The design includes a foundational premise that traditional audit programs often do not, which is that most errors are a correctable knowledge failure, not intent. Payers and state agencies can adapt the same architecture to their own high-error service categories and then rely on providers to do the heavy lifting.

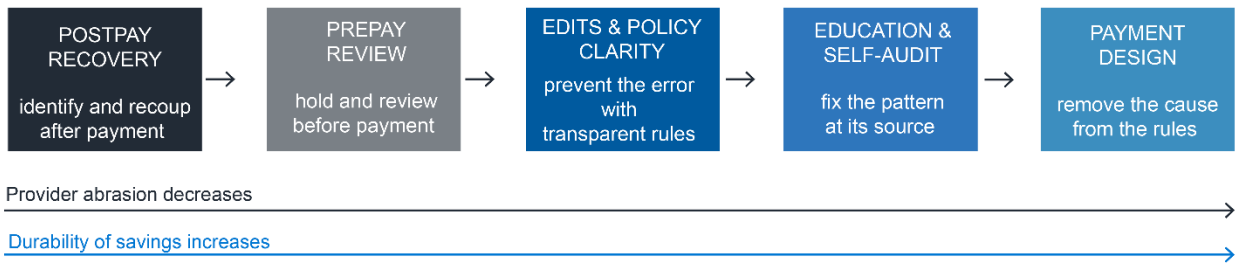
3. **Share the mirror.** Peer comparison shared with providers has a mixed evidence base that is worth considering closely. In a randomized trial, letters from CMS to outlier prescribers of quetiapine reduced their prescribing by roughly 11% over nine months, with effects that persisted for two years.[26] However, an earlier letter campaign found no detectable effect, which may indicate that the message design and credibility of the payer matter.[27] The broader audit-and-feedback literature finds modest median improvements in professional practice, with larger impacts when feedback is specific, repeated, delivered by a credible source, and paired with an explicit action plan.[28] Peer comparison can be inexpensive, scalable, and dignity-preserving because it starts by treating the outlier as a professional who would rather not be one and gives them a chance to demonstrate that this is the case.

4. **Simplify what you can.** Documentation-driven error is the largest measured slice of improper payments, 77% in Medicaid in fiscal year 2025.[29] Payment policy clarification attacks that error at the source: fewer bespoke documentation requirements, rules aligned across products and programs, standardized forms, and sunsetting edits whose yield no longer justifies their friction. Policy clarification (and often, simplification) reduces improper payments without touching a single claim after submission. Its savings accrue to payers via claim savings and to providers via administrative savings.
5. **Make it easy to give money back.** When providers self-identify overpayments, the resolution path should be predictable and proportionate. The Department of Health and Human Services (HHS) Office of Inspector General's self-disclosure protocol demonstrates this by applying reduced multipliers on damages relative to litigated outcomes, faster resolution, and a baseline stance against imposing integrity sanctions on those who come forward.[30] Payers can use this logic via published self-disclosure pathways and extended repayment options.

Administrative complexity, the largest overspend domain in Figure 3, is largely a system-level problem that no single program can eliminate. However, levers 1 and 4 target the share of it that payment policy and integrity operations themselves generate. At industry scale, the Healthcare Fraud Prevention Partnership (HFPP) demonstrates that collaboration is already part of the federal program integrity architecture. The HFPP brings together payers, federal and state agencies, and law enforcement to share data, methods, and emerging schemes in a structured partnership model.[31] That same premise supports each of the five levers. Publishing rules gives providers a shared understanding of expectations; teaching before auditing converts findings into behavior change; peer comparison depends on credible feedback; simplification requires payers and providers to identify where administrative friction is avoidable; and self-disclosure only works when providers believe repayment pathways will be predictable and proportionate.

Payment integrity is strongest when detection, prevention, education, and resolution are treated as shared infrastructure rather than one-sided enforcement activity. Figure 5 illustrates the payment integrity continuum into which these levers fit. As effort shifts left to right, provider abrasion falls and the long-term durability of savings rises.

FIGURE 5: ILLUSTRATIVE PAYMENT INTEGRITY CONTINUUM



Conclusion

The record-setting era of fraud enforcement is an achievement, and it is what makes this the right time to look at the rest of the triangle. The fraud side has never been stronger, better resourced, or more technologically capable. The open question is whether the waste and abuse sides are built to the same standard, with capabilities matched to problems that are more complex with no clear perpetrator, but rather patterns.

To understand whether waste and abuse capabilities are impactful, an organization must assess its own triangle. Not only does this include evaluating the maturity of its payment integrity program, but also measuring sustained changes in portfolio mix, provider experience, transparency, and overall program economics like the total administrative cost trend rather than relying on short-term recoveries. Organizations that bring the same rigor to waste and abuse by measuring net value rather than gross findings, preventing rather than chasing, and engaging providers as partners in the work may find the larger and more durable share of savings.

Caveats and limitations

This paper relies on published estimates and public agency reporting; the authors have not independently audited the underlying data. Estimates of healthcare overpayments, fraud, waste, and abuse vary materially by methodology, definition, and time period, and the figures cited here should be read as orders of magnitude rather than precise measurements. Enforcement statistics describe alleged and recovered amounts, which are not equivalent to proven losses. Nothing herein constitutes legal advice, and nothing herein should be read as a recommendation to reduce statutorily or contractually required program integrity activity.

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CONTACT

Paul Houchens
paul.houchens@milliman.com

Tyler Schulze
tyler.schulze@milliman.com

Stefany Ross
stefany.ross@milliman.com

Adam Hearn
adam.hearn@milliman.com

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