AMERICAN SPEECH & DEBATE ASSOCIATION

2026-2027
Team Policy Debate
Sourcebook Case 1

Resolved: The United States Federal Government should significantly reform one or more of the following entitlement programs: Social Security, Medicare, Medicaid, SNAP, TANF.

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Affirmative Case: Expand RAC Audits

If you bought a basic minivan from a car dealership and they charged you for a Ferrari, you would call that fraud. Unfortunately, patients using Medicare and Medicaid are often charged for more expensive services than were provided. Because of this, my partner and I stand

Resolved: The United States Federal Government should significantly reform one or more of the following entitlement programs: Social Security, Medicare, Medicaid, SNAP, TANF.

Today, my partner and I will be focusing on Medicare and Medicaid specifically. Before we go any deeper, there are several key terms that need to be defined, beginning with

Definition 1: Upcoding

The law firm, Phillips & Cohen LLP, explained that

"'Upcoding' occurs when a healthcare provider submits codes to Medicare, Medicaid, or private insurers for more serious (and more expensive) diagnoses or procedures than the provider actually diagnosed or performed."[1]

To put it simply, upcoding is like that dealership charging for a luxury sports car while only providing a beat-up minivan. It inflates the cost to the consumer, to the insurer, and to the taxpayer without providing any additional benefit to the patient's care. The next definition is

Definition 2: RAC Audits

Healthcare Operations Strategist, Awais Afzal, explained in 2026 that

"A Recovery Audit Contractor (RAC) audit is an examination of Medicare claims conducted by contractors hired by the Centers for Medicare & Medicaid Services (CMS). The primary goal of these audits is to identify improper payments to healthcare providers, which may include both overpayments and underpayments. RAC audits focus on ensuring that Medicare claims submitted by healthcare providers are compliant with the relevant regulations and guidelines."[2]

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[1] No Author Listed. Published by Philips & Cohen LLP (Phillips & Cohen LLP is a prominent law firm that specializes in whistleblower cases, particularly those involving fraud against the government). No date given.
Accessed August 8, 2026. "https://www.phillipsandcohen.com/upcoding-unbundling-fragmentation/" What is Upcoding and Unbundling Fraud in Healthcare?

[2] Authored by Awais Afzal (Healthcare Operations Strategist at RCM Finder). Published by RCM Finder (RCM Finder is a platform that provides end-to-end solutions including medical billing, coding, denial management, and administrative support to maximize cash flow and reduce accounts receivable). June 15, 2026.
Accessed August 8, 2026. "https://rcmfinder.com/rac-audits-healthcare-guide-2025/" Comprehensive Guide to RAC Audits in Healthcare.

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Essentially, a RAC Audit is when a third-party contractor brought in by CMS examines claims for improper payments, including upcoding.

Fact 1: Upcoding is Prevalent

Upcoding is an inherently harmful practice. It makes healthcare more expensive and less accessible without any improvement in quality. To make matters worse, upcoding is widespread in our medical system and is only growing. The Office of the Inspector General of the United States Department of Health and Human Services reported in 2021 that

"Hospitals are increasingly billing for inpatient stays at the highest severity level, which is the most expensive one. The number of stays at the highest severity level increased almost 20 percent from FY 2014 through FY 2019, ultimately accounting for nearly half of all Medicare spending on inpatient hospital stays. The number of stays billed at each of the other severity levels decreased. At the same time, the average length of stay decreased for stays at the highest severity level, while the average length of all stays remained largely the same. Stays at the highest severity level are vulnerable to inappropriate billing practices, such as upcoding-the practice of billing at a level that is higher than warranted. Specifically, nearly a third of these stays lasted a particularly short amount of time and over half of the stays billed at the highest severity level had only one diagnosis qualifying them for payment at that level."[3]

The prevalence of upcoding contributes to a broken medical billing system. However, there is a solution. RAC Audits can combat upcoding as seen in

[3] No Author Listed. Published by the Office of the Inspector General of the United States Department of Health and Human Services (The Office of Inspector General of the United States Department of Health and Human Services (HHS-OIG) is the internal oversight office for the United States Department of Health and Human Services). February 19, 2021.
Accessed August 8, 2026. "https://oig.hhs.gov/reports/all/2021/trend-toward-more-expensive-inpatient-hospital-stays-in-medicare-emerged-before-covid-19-and-warrants-further-scrutiny/" Trend Toward More Expensive Inpatient Hospital Stays in Medicare Emerged Before COVID-19 and Warrants Further Scrutiny

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Fact 2: RAC Audits are effective

Awais Afzal writing for RCM Finder in 2026

"RAC audits play a vital role in ensuring that healthcare providers are reimbursed accurately. According to CMS, the RAC program has recovered over $11 billion in improper payments since its inception. By identifying and recovering funds that were incorrectly distributed, RAC audits promote a culture of compliance within the healthcare system. They also encourage providers to adopt better billing practices, ultimately benefiting patient care."[4]

While currently limited in scope, RAC audits are actively countering upcoding. RAC audits reclaim billions of federal funding while incentivizing better compliance, better billing practices, and better patient care. This shows that they are an effective tool for improving financial integrity and protecting CMS resources. However, the current system shows that RAC audits are an underutilized tool in CMS's financial toolbox, as seen in

Harm 1: Waste of Taxpayer Dollars

Judge, a portion of your paycheck goes to funding Medicare and Medicaid. When you receive your W-2 form from your employer, in boxes five and six you will see what portion of your earnings went to Medicare specifically. Unfortunately, upcoding inflates the cost of medical care, which makes the amount in those boxes higher than they need to be. A 2024 study from Health Economics Review aimed to quantify those costs. It found that

"The estimated combined financial impact of upcoding [for Medicare Parts A and B], on average over the period 2010-2019, is approximately $3.48 billion per year, predominantly due to upcoding in Medicare Part B. This value is substantially lower than the estimates of $9-12 billion for years for Medicare Advantage."[5]

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[4] Authored by Awais Afzal (Healthcare Operations Strategist at RCM Finder). Published by RCM Finder (RCM Finder is a platform that provides end-to-end solutions including medical billing, coding, denial management, and administrative support to maximize cash flow and reduce accounts receivable). June 15, 2026.
Accessed August 8, 2026. "https://rcmfinder.com/rac-audits-healthcare-guide-2025/" Comprehensive Guide to RAC Audits in Healthcare.

[5] Authored by Keith A. Joiner, Jianjing Lin, and Juan Pantano (Keith A. Joiner, M.D., M.P.H, is Professor of Medicine, Economics, Cellular and Molecular Medicine and Public Health at the University of Arizona; Jianjing Lin is an assistant professor of economics at Rensselaer Polytechnic Institute; Juan Pantano, Ph.D., M.A, B.A is an associate professor of economics at the University of Arizona's Eller College of Management). Published by Health Economics Review (Health Economics Review is an open-access, international journal that publishes research on all aspects of health economics, ranging from microeconomic to macroeconomic perspectives). January 2, 2024.
Accessed August 8, 2026. "https://pmc.ncbi.nlm.nih.gov/articles/PMC10759668/" Upcoding in medicare: where does it matter most?

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As this study demonstrates, upcoding creates up to $15 billion in additional costs to Medicare programs without any added benefit to patient care. Unfortunately, those costs are only ticking upwards. Further research from Health Affairs in 2024 found that

"During this period, the number of discharges with the highest MS-DRG coding intensity increased by 41 percent. Adjusting for changes in patient characteristics, length-of-stay, and hospital characteristics, we estimated that the increase would have been 13 percent in the absence of changes in coding behavior. We estimated that in 2019, the increase in upcoding (relative to 2011 coding practices) was associated with $14.6 billion in hospital payments, including $5.8 billion from private health plans, $4.6 billion from Medicare, and $1.8 billion from Medicaid."[6]

Almost two-thirds of the increase in high-intensity billing came from upcoding. Substantial funds are lost through upcoding annually. That money does not contribute to improved outcomes in medical care or a higher quality of service; it merely lines the pockets of specific parties in the medical community while burdening taxpayers. To solve this problem, we need the Affirmative plan.

Plan: Expand RAC Audits.

Mandate – Require quarterly RAC audits of diagnosis groups that have an elevated risk of upcoding. These groups will be selected using the preexisting CMS CERT program.

Enforcement – This plan will be enforced through preexisting RAC enforcement mechanisms administrated by the CMS.

Funding – Any necessary funding will be allocated through regular appropriations processes. This plan is expected to result in a net gain to federal funds as it will save on waste in Medicare and Medicaid.

Timeline – This plan will go into effect one year after an Affirmative ballot to allow relevant parties to implement changes.

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[6] Authored by Daniel Crespin, Michael Dworsky, Jonathan Levin, Teague Ruder, and Christopher M. Whaley (Crespin, Dworsky, Levin, & Ruder are researcher from the RAND Corporation; Christopher M. Whaley is the Associate Director of the Center for Advancing Health Policy through Research as well as an Associate Professor of Health Services, Policy and Practice). Published by Health Affairs (Health Affairs is a monthly, peer-reviewed health and health care policy journal published by Project HOPE). December 3, 2024.
Accessed August 8, 2026. "https://www.healthaffairs.org/doi/10.1377/hlthaff.2024.00596" Upcoding Linked To Up To Two-Thirds Of Growth In Highest-Intensity Hospital Discharges In 5 States, 2011–19

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Advantage: Decreased Waste

By recovering funds lost to upcoding, we can strike a blow against wasteful financial practices in Medicare and Medicaid. An analysis of expanding RAC audits in Texas for Medicaid alone found that

"The agency also assumes there will be significant recovered Medicaid revenue to the state as a result of the audits of overpayments in managed care. The analysis assumes that by FY 2029, the recoveries could reach approximately $88.48 million/year."[7]

From this we can see that RAC audits will effectively prevent waste. By scaling up RAC audits, we will be able to save billions in wasted taxpayer dollars. Now, it is because we can no longer support the wasteful and fraudulent status quo that I urge you to vote Affirmative.

[7] Authored by Jerry McGinty (Director of the Texas Legislative Budget Board). Published by the Texas Legislature (The lawmaking body of the state of Texas). April 21, 2025.
Accessed August 8, 2026. "https://capitol.texas.gov/tlodocs/89R/fiscalnotes/html/HB03984I.htm" FISCAL NOTE, 89TH LEGISLATIVE REGULAR SESSION

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Affirmative Backup: Expand RAC Audits

Strategy Guide

At first glance, this case appears to be about medical billing. It is not. This case is fundamentally about government accountability and oversight. Medicare and Medicaid lose billions of dollars annually to upcoding. This inflates costs without improving patient care and diverts government resources away from other beneficial uses. In round, the discussion may begin to stray into the weeds. A good affirmative team will be aware of this and keep the discussion focused on the need for greater oversight rather than coding and billing methodologies.

The plan to address upcoding is the expansion of Recovery Audit Contractor (RAC) audits. These audits already exist within Medicare and have recovered billions in improper payments. The affirmative plan merely expands a preexisting policy by requiring more frequent audits of diagnosis groups that CMS has already identified as high-risk through the Comprehensive Error Rate Testing program (CERT). This is an important point. RAC audits have already demonstrated effectiveness, meaning the debate will largely center on whether more audits will produce more recoveries. This is where the Office of the Inspector General's (OIG) recommendation will play a meaningful role. Following an evaluation of CMS payment integrity, OIG determined that there was a lapse in oversight. To correct this lapse, RAC audits are required. Negative teams may dispute the efficacy of RAC audits. However, such arguments will focus on blanket auditing. Emphasizing that this case is more limited in scope and will avoid the issues associated with blanket auditing.

There are two important themes for the affirmative to center argumentation on. The first is financial waste. The affirmative should argue that Medicare and Medicaid are paying more than necessary because of improper coding practices. Greater oversight is needed to correct these practices. The second theme is program integrity. RAC audits should be presented as a mechanism that not only recovers improper payments but also encourages providers to maintain accurate billing practices (as evidenced by Afzal, 2026).

There are also two pitfalls to be wary of. First, the case does not require the affirmative to prove that all upcoding is fraudulent. Instead, the argument should be that audits help distinguish legitimate claims from improper ones. Do not claim that every provider is committing fraud, nor that every coding error is intentional. Rather, claim that the scope of improper billing is significant enough to warrant greater oversight. Second, this case can contain incredibly complex or technical language. The debaters that have researched the case may understand all of the intricacies of RAC audits and upcoding, however the average person cannot be expected to. In front of lay judges, the case should be simplified as much as possible. Terms such as "coding intensity," and "CERT indicators" will be less persuasive than straightforward language about

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waste and accountability. A lay judge will understand and internalize the analogy about being charged Ferrari prices for a minivan. They will remember that billions of taxpayer dollars are being lost. Wherever possible, use similar analogies or examples to demonstrate what your statistics and evidence claim.

Ultimately, this case comes down to a simple question: if Medicare and Medicaid are currently losing billions to improper payments, and RAC audits have already proven they can recover those funds, why should the government not do more auditing?

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Definition: Comprehensive Error Rate Testing Program (CERT)

No Author Listed. Published by the Center for Medicare and Medicaid Services (The Centers for Medicare & Medicaid Services (CMS) is a federal agency within the United States Department of Health and Human Services (HHS) that administers the Medicare program and works in partnership with state governments to administer Medicaid). January 16, 2026.

Accessed August 13, 2026. "https://www.cms.gov/data-research/monitoring-programs/improper-payment-measurement-programs/comprehensive-error-rate-testing-cert" Comprehensive Error Rate Testing (CERT)

"The Centers for Medicare & Medicaid Services (CMS) estimates the Medicare Fee-for-Service (FFS) program improper payment rate through the Comprehensive Error Rate Testing (CERT) program. Each year, the CERT program reviews a statistically valid stratified random sample of Medicare FFS claims to determine if they were paid properly under Medicare coverage, coding, and payment rules."

Definition: RAC Audits

Authored by Awais Afzal (Healthcare Operations Strategist at RCM Finder). Published by RCM Finder (RCM Finder is a platform that provides end-to-end solutions including medical billing, coding, denial management, and administrative support to maximize cash flow and reduce accounts receivable). June 15, 2026.

Accessed August 8, 2026. "https://rcmfinder.com/rac-audits-healthcare-guide-2025/" Comprehensive Guide to RAC Audits in Healthcare.

"A Recovery Audit Contractor (RAC) audit is an examination of Medicare claims conducted by contractors hired by the Centers for Medicare & Medicaid Services (CMS). The primary goal of these audits is to identify improper payments to healthcare providers, which may include both overpayments and underpayments. RAC audits focus on ensuring that Medicare claims submitted by healthcare providers are compliant with the relevant regulations and guidelines."

Definition: Upcoding

No Author Listed. Published by Philips & Cohen LLP (Phillips & Cohen LLP is a prominent law firm that specializes in whistleblower cases, particularly those involving fraud against the government). No date given.

Accessed August 8, 2026. "https://www.phillipsandcohen.com/upcoding-unbundling-fragmentation/" What is Upcoding and Unbundling Fraud in Healthcare?

"'Upcoding' occurs when a healthcare provider submits codes to Medicare, Medicaid, or private insurers for more serious (and more expensive) diagnoses or procedures than the provider actually diagnosed or performed."

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Upcoding is Widespread

Authored by Awais Afzal (Healthcare Operations Strategist at RCM Finder). Published by RCM Finder (RCM Finder is a platform that provides end-to-end solutions including medical billing, coding, denial management, and administrative support to maximize cash flow and reduce accounts receivable). June 15, 2026.

Accessed August 8, 2026. "https://rcmfinder.com/rac-audits-healthcare-guide-2025/" Comprehensive Guide to RAC Audits in Healthcare.

"Frequent use of incorrect billing codes is a major red flag. For example, a provider consistently using high-cost procedure codes without justification may lead to increased scrutiny. According to a study by the Office of Inspector General (OIG), up to 40% of Medicare claims contain some form of billing error."

Impact: Upcoding is not an occasional occurrence. It is a systemic issue that affects about 40% of Medicare claims.

Upcoding is Widespread – OIG Findings

No Author Listed. Published by the Office of the Inspector General of the United States Department of Health and Human Services (The Office of Inspector General of the United States Department of Health and Human Services (HHS-OIG) is the internal oversight office for the United States Department of Health and Human Services). February 19, 2021.

Accessed August 8, 2026. "https://oig.hhs.gov/reports/all/2021/trend-toward-more-expensive-inpatient-hospital-stays-in-medicare-emerged-before-covid-19-and-warrants-further-scrutiny/" Trend Toward More Expensive Inpatient Hospital Stays in Medicare Emerged Before COVID-19 and Warrants Further Scrutiny

"Hospitals are increasingly billing for inpatient stays at the highest severity level, which is the most expensive one. The number of stays at the highest severity level increased almost 20 percent from FY 2014 through FY 2019, ultimately accounting for nearly half of all Medicare spending on inpatient hospital stays. The number of stays billed at each of the other severity levels decreased. At the same time, the average length of stay decreased for stays at the highest severity level, while the average length of all stays remained largely the same. Stays at the highest severity level are vulnerable to inappropriate billing practices, such as upcoding-the practice of billing at a level that is higher than warranted. Specifically, nearly a third of these stays lasted a particularly short amount of time and over half of the stays billed at the highest severity level had only one diagnosis qualifying them for payment at that level."

Impact: While OIG noted that upcoding is already widespread, it is important that it is "increasingly" occurring.

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Specific Instances of Upcoding

No Author Listed. Published by Philips & Cohen LLP (Phillips & Cohen LLP is a prominent law firm that specializes in whistleblower cases, particularly those involving fraud against the government). No date given.

Accessed August 8, 2026. "https://www.phillipsandcohen.com/upcoding-unbundling-fragmentation/" What is Upcoding and Unbundling Fraud in Healthcare?

(**Strategy Note:** This piece of evidence works well as an opener for a speech or as a more concrete example of the harm that exists in the status quo. It functions best when framed as a single instance of a more widespread problem.)

"CareAll Management LLC, a Tennessee home health provider, paid $25 million to the United States and the state of Tennessee to settle allegations that it upcoded home health billings to Medicare and Medicaid. According to the complaint, CareAll exaggerated the severity of its patients' conditions in order both to increase billings and to bill for medically unnecessary services. EndoGastric Solutions, Inc., a Washington-based medical device manufacturer, returned $5.25 million to the federal government to settle upcoding allegations. EndoGastric's device could be implanted through two procedures, one more invasive and more expensive than the other. When promoting its device, EndoGastric advised providers to bill for the more expensive procedure, causing federal healthcare programs to pay more than needed. NextCare Inc., an Arizona urgent care provider, paid $10 million to the federal government and several states, settling allegations that its employees inflated billings for a variety of urgent care procedures. The complaint also alleged that NextCare performed unnecessary medical procedures, such as redundant allergy testing."

Impact: Upcoding is not some abstract problem. It is a real problem that affects real people every day.

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Upcoding is Expensive

Authored by Keith A. Joiner, Jianjing Lin, and Juan Pantano (Keith A. Joiner, M.D., M.P.H, is Professor of Medicine, Economics, Cellular and Molecular Medicine and Public Health at the University of Arizona; Jianjing Lin is an assistant professor of economics at Rensselaer Polytechnic Institute; Juan Pantano, Ph.D., M.A, B.A is an associate professor of economics at the University of Arizona's Eller College of Management). Published by Health Economics Review (Health Economics Review is an open-access, international journal that publishes research on all aspects of health economics, ranging from microeconomic to macroeconomic perspectives). January 2, 2024.

Accessed August 8, 2026. "https://pmc.ncbi.nlm.nih.gov/articles/PMC10759668/" Upcoding in medicare: where does it matter most?

"The estimated combined financial impact of upcoding, on average over the period 2010-2019, is approximately $3.48 billion per year, predominantly due to upcoding in Medicare Part B. This value is substantially lower than the estimates of $9-12 billion for years for Medicare Advantage."

Impact: Upcoding results in substantial losses to welfare programs. Those losses are ultimately born by taxpayers.

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Upcoding is Expensive – United, Anthem, Cigna, and SCAN

Authored by Juan Siliezar (Juan Siliezar is the Associate Director of Media Relations and Leadership Communications at Brown University's School of Public Health). Published by the Brown University School of Public Health (The Brown University School of Public Health is the public health school of Brown University, a private research university in Rhode Island). June 9, 2025.

Accessed August 13, 2026. "https://sph.brown.edu/news/2025-06-09/medicode" New interactive tool explores billions in excess payments to Medicare Advantage plans

"'The main finding we see is that there are just a couple of companies accounting for much higher spending—billions of dollars in additional payments due to how they code—while many other companies are not getting paid that much at all,' Meyers said. UnitedHealth Group alone receives an estimated $12 billion annually in additional payments due to higher coding intensity, according to the data. Humana, which is now planning to revise how it adds diagnoses that boost payments in response to scrutiny over aggressive billing practices, follows with $6 billion. Smaller insurers like Anthem, Cigna and SCAN code even more aggressively, but their impact is smaller due to fewer enrollees. Along with showing the average annual differential payments to the 10 largest Medicare Advantage parent companies, MediCode also breaks down coding differences at the state level. The hope is to give local stakeholders an understanding of what upcoding costs the federal government in their area. For example, health plans in Rhode Island may be overpaid approximately $53 million annually due to coding differences. The tool also includes an interactive section on potential policy solutions, including estimates on the cost of several alternative strategies that could be used to address inflated coding practices."

Impact: This evidence demonstrates that upcoding results in billions of dollars in excess federal payments, excess payments that are ultimately born by the American taxpayer.

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Price of Upcoding Increasing

Authored by Daniel Crespin, Michael Dworsky, Jonathan Levin, Teague Ruder, and Christopher M. Whaley (Crespin, Dworsky, Levin, & Ruder are researcher from the RAND Corporation; Christopher M. Whaley is the Associate Director of the Center for Advancing Health Policy through Research as well as an Associate Professor of Health Services, Policy and Practice). Published by Health Affairs (Health Affairs is a monthly, peer-reviewed health and health care policy journal published by Project HOPE). December 3, 2024.

Accessed August 8, 2026. "https://www.healthaffairs.org/doi/10.1377/hlthaff.2024.00596" Upcoding Linked To Up To Two-Thirds Of Growth In Highest-Intensity Hospital Discharges In 5 States, 2011–19

"During this period, the number of discharges with the highest MS-DRG coding intensity increased by 41 percent. Adjusting for changes in patient characteristics, length-of-stay, and hospital characteristics, we estimated that the increase would have been 13 percent in the absence of changes in coding behavior. We estimated that in 2019, the increase in upcoding (relative to 2011 coding practices) was associated with $14.6 billion in hospital payments, including $5.8 billion from private health plans, $4.6 billion from Medicare, and $1.8 billion from Medicaid."

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OIG Recommends Increased Oversight

No Author Listed. Published by the Office of the Inspector General of the United States Department of Health and Human Services (The Office of Inspector General of the United States Department of Health and Human Services (HHS-OIG) is the internal oversight office for the United States Department of Health and Human Services). February 19, 2021.

Accessed August 13, 2026. "https://oig.hhs.gov/reports/all/2021/trend-toward-more-expensive-inpatient-hospital-stays-in-medicare-emerged-before-covid-19-and-warrants-further-scrutiny/" Trend Toward More Expensive Inpatient Hospital Stays in Medicare Emerged Before COVID-19 and Warrants Further Scrutiny

"Oversight is essential to ensuring that Medicare dollars are spent appropriately. Inpatient hospital billing in the years leading up to the pandemic indicates that some stays at the highest severity level could be susceptible to inappropriate billing. Accordingly, we recommend that CMS conduct targeted reviews of Medicare Severity Diagnosis-Related Groups (MS-DRGs) and stays that are vulnerable to upcoding, as well as the hospitals that frequently bill them. CMS did not concur but acknowledged that there is more work to be done to determine conclusively which changes in billing are attributable to upcoding. We also think more work needs to be done; therefore, we continue to recommend that CMS conduct targeted reviews to identify stays involving upcoding and hospitals with patterns of upcoding."

Impact: The Affirmative plan is modeled off of policy analyses and recommendations developed by the governmental entity that would have the greatest insight into the state of upcoding within CMS programs.

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RAC Audits are Effective

Authored by Awais Afzal (Healthcare Operations Strategist at RCM Finder). Published by RCM Finder (RCM Finder is a platform that provides end-to-end solutions including medical billing, coding, denial management, and administrative support to maximize cash flow and reduce accounts receivable). June 15, 2026.

Accessed August 8, 2026. "https://rcmfinder.com/rac-audits-healthcare-guide-2025/" Comprehensive Guide to RAC Audits in Healthcare.

"RAC audits play a vital role in ensuring that healthcare providers are reimbursed accurately. According to CMS, the RAC program has recovered over $11 billion in improper payments since its inception. By identifying and recovering funds that were incorrectly distributed, RAC audits promote a culture of compliance within the healthcare system. They also encourage providers to adopt better billing practices, ultimately benefiting patient care."

Impact: RAC Audits are an effective tool for reducing waste in Medicare and Medicaid. Furthermore, they incentivize providers to adapt their billing practices which will provide long term benefits to patients.

RAC Audits are Effective – Texas Example

Authored by Jerry McGinty (Director of the Texas Legislative Budget Board). Published by the Texas Legislature (The lawmaking body of the state of Texas). April 21, 2025.

Accessed August 8, 2026. "https://capitol.texas.gov/tlodocs/89R/fiscalnotes/html/HB03984I.htm" FISCAL NOTE, 89TH LEGISLATIVE REGULAR SESSION

(**Strategy Note:** Be careful with this card. When presented without proper context it can make the Affirmative advantages appear insignificant. This piece of evidence will work best when it is emphasized that the $88 million is from one of the fifty states. Expanding RAC Audits in all fifty states would likely yield greater recoveries.)

"The agency also assumes there will be significant recovered Medicaid revenue to the state as a result of the audits of overpayments in managed care. The analysis assumes that by FY 2029, the recoveries could reach approximately $88.48 million/year."

Impact: Even an incredibly limited implementation of the Affirmative plan has the potential to yield significant savings.

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Negative Case: Expand RAC Audits

Strategy Guide

Upon first inspection, the Affirmative plan seems perfect. It claims that it can decrease fraud while saving taxpayer dollars. However, a closer look reveals a complexity that a cursory inspection would fail to find. While RAC audits are purported to be beneficial, there is substantial evidence to suggest that they come at a serious cost. In round, the Negative team's goal will be to reveal the costs associated with RAC audits and demonstrate that the detriments outweigh the benefits.

In 2023, the Government Accountability Office researched the expansion of RAC audits. Their findings were inconclusive as most states do not participate in the RAC program due to alternative enforcement mechanisms (Padilla, 2023). There are two flaws to the Affirmative proposal that can be deduced from this information. First, if states have their own program integrity initiatives that they can tailor to their specific needs, why should RAC audits be thrusted upon them? And second, if most states are exempted from RAC audits, what benefit would come from expanding audits while leaving the exemptions in effect? By answering these questions, we find that the Affirmative plan would be a nonstarter.

Furthermore, there is evidence to suggest that RAC audits harm compliant providers and noncompliant providers in equal measure (Emmanuel, 2025). In its current incarnation, the RAC program incentivizes auditors to forgo accuracy for volume. This causes providers to fight costly legal battles that often cripple them financially. The Affirmative side's rhetoric will center on the ideals of oversight and accountability; However, a good Negative team will shift the debate to focus on governmental overreach and the toll that a poorly designed program exacts.

Arguing that the status quo encourages predatory auditing practices can provide a stepping point for the Negative side to expand argumentation. There are numerous avenues to pursue, ranging from the increased administrative burden's effect on rural care to the money diverted from patient care to cover legal expenses. Once the Negative establishes the perverse incentives associated with RAC audits, it is then critical to show the judge what the real-world impacts of those incentives are. A strong Negative presentation will use a mixture of stories and statistics to establish these disadvantages.

One example impact that is presented in this brief is that of a healthcare system at its breaking point (American Hospital Association, 2026). The US healthcare system is already under serious pressure due, in part, to current RAC audits. The expansion of RAC audits threatens to increase that pressure and push small healthcare providers towards bankruptcy (Neubert, Pepe & Monteith, 2026). This has the potential to jeopardize patient care across the

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United States. This example is one of many that Negative teams may use to drive home the importance of their position.

The second example impact found in this case regards the potential for an administrative backlog. Medicare and Medicaid have limited resources, thus there is a limit to how many appeals they can process in a timely manner. The expansion of RAC audits would inevitably lead to an increase in appeals as providers contest claims denials related to the audits. As appeals increase without any plan to increase capacity, it is highly likely that an appeals backlog will form (AllZone, 2023; Emmanuel, 2021). Such a backlog would exacerbate the risks of predatory auditing as providers would have no timely manner of recouping unjustly taken funds. By properly emphasizing this concept, the Negative side can demonstrate that the Affirmative plan is not the panacea that it is presented as.

Ultimately, the Negative team's goal is not to deny all the Affirmative side's claims. Rather, it is to show that the risks associated with the plan far outweigh any economic benefit that it may bring about. By showing judges the harsh reality of a well-meaning plan, a good negative team can dismantle the Affirmative team's plan.

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RAC Audit Exemptions

Authored by M. Hannah Padilla (Director of Financial Management and Assurance at the Government Accountability Office). Published by the Government Accountability Office (The United States Government Accountability Office (GAO) is a federal agency within the legislative branch of the United States government that provides auditing, evaluative, and investigative services for the United States Congress in an independent and nonpartisan capacity). June 28, 2023.

Accessed September 8, 2026. "https://www.gao.gov/products/gao-23-106025#summary_recommend" CMS Oversight and Guidance Could Improve Recovery Audit Contractor Program.

"The Patient Protection and Affordable Care Act established the Medicaid Recovery Audit Contractor (RAC) program to identify overpayments and underpayments and recoup overpayments. The act allowed the Centers for Medicare & Medicaid Services (CMS) to permit exceptions and exemptions to Medicaid RAC program requirements. GAO's review found that 34 states and the District of Columbia did not participate in this program during fiscal year 2021. Most states cited having other program-integrity initiatives as the reason for requesting an exemption, as shown in the table."

Impact: RAC Audits can only be effective if they occur. Without revoking exemptions, the Affirmative plan would not apply to over half of the United States.

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RAC Audits Becoming Predatory

Authored by Knicole C. Emmanuel Esq. (Lawyer with over 20 years in health care litigation with a focus on Medicare and Medicaid litigation). Published by MedLearn Publishing (US-based healthcare education provider focused on coding and compliance education). September 10, 2025.

Accessed September 8, 2026. "https://medlearn.com/racmonitor/when-audits-become-ambushes-the-perils-of-financially-incentivized-medicare-investigations/" When Audits Become Ambushes: The Perils of Financially Incentivized Medicare Investigations.

"We all know that Recovery Audit Contractors (RACs), Unified Program Integrity Contractors (UPICs), and other Centers for Medicare & Medicaid Services (CMS)-hired entities are financially incentivized to find alleged wrongdoing. The more "improper payments" they identify, the more money they stand to make. This structure creates a system in which neutrality takes a back seat to profit, and providers are left to defend themselves against allegations that often collapse under scrutiny. The problem compounds when audit findings are funneled into False Claims Act (FCA) cases or criminal prosecutions. What should be a compliance check too often becomes an ambush. RACs are explicitly paid a contingency fee, often between 9 and 12.5 percent of the "overpayments" they recover. While this model is meant to incentivize detection of true fraud, in practice, it incentivizes volume over accuracy. In 2016, the American Hospital Association (AHA) reported that 66 percent of appealed RAC denials were ultimately overturned in favor of hospitals. Yet providers had already spent millions on legal fees and staff time to fight those denials – costs that cannot be recovered."

Impact: The current implementation of RAC audits incentivizes auditors to identify as many improper payments as possible without regards to accuracy. This causes healthcare providers to face costly legal battles against baseless accusations.

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RAC Audits Becoming Predatory – AseraCare, Inc. & Hernandez
Authored by Knicole C. Emmanuel Esq. (Lawyer with over 20 years in health care litigation with a focus on Medicare and Medicaid litigation). Published by MedLearn Publishing (US-based healthcare education provider focused on coding and compliance education). September, 10, 2025.
Accessed September 8, 2026. "https://medlearn.com/racmonitor/when-audits-become-ambushes-the-perils-of-financially-incentivized-medicare-investigations/" When Audits Become Ambushes: The Perils of Financially Incentivized Medicare Investigations.

(**Strategy Note:** This piece of evidence works well as an opener for a speech or as a more concrete example of the harm that exists in the status quo. It functions best when framed as a single instance of a more widespread problem.)

"Take *United States v. AseraCare, Inc.,* 938 F.3d 1278 (11th Cir. 2019). In that case, DOJ pursued a massive FCA action based on hospice eligibility determinations. The government relied heavily on RAC-like reviews of medical necessity. Ultimately, the Eleventh Circuit rebuked the prosecution, holding that a "reasonable difference of opinion" among physicians is not enough to prove falsity under the FCA. Yet providers spent years – and millions – defending themselves against allegations that boiled down to subjective medical judgment. That is the cost of a system in which bounty-hunters supply the evidence. Another example is *United States v. Hernandez,* in which a Florida nurse practitioner received a 20-year sentence tied to a $200 million telehealth/genetic testing scheme. Reports suggest that early investigative findings from contractors were used to frame the case, while exculpatory evidence was sidelined. Similar to *AseraCare,* questions of regulatory interpretation and medical judgment were cast as fraud. Unlike *AseraCare,* the defendant here lost her liberty."

Impact: RAC audits incentivize predatory practices that have a significant toll on healthcare practitioners and providers.

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RAC Audits Increase Administrative Burden

Authored by Sarah N. Smeriglio (Member of NPM Law's Healthcare Law and Professional Malpractice & Insurance Defense practice). Published by Neubert, Pepe & Monteith (Neubert, Pepe & Monteith, P.C. is a general practice law firm located in New Haven and Hartford, Connecticut). March 25, 2026.
Accessed September 9, 2026. "https://npmlaw.com/article/are-rac-auditors-abusing-incentives-to-recovery-fees/" Are RAC Auditors Abusing Incentives to Recovery Fees?

"There is no question that the high volume of audits and the lengthy appeals process are a significant drain on administrative resources and staff time within physician practices and networks. In addition to internal costs, many providers hire legal counsel, billing and coding experts, and other specialists to address the notice of a RAC audit. Aside from the substantial price of appealing a RAC audit, there is uncertainty from multi-year lookback periods, which can negatively impact financial planning, as well as a more immediate financial setback: A RAC audit often claws back money allegedly overpaid before the provider has a chance to appeal, recovering those alleged overpayments from ongoing reimbursements. Some providers believe RAC auditors are disincentivized to limit their audits and/or increase accuracy because RAC auditors can keep their fees unless and until an overpayment is overturned on appeal, often years after the original "take back" of monies has occurred."

Impact: RAC audits place a significant strain on healthcare providers' resources. By increasing the number of audits performed, the Affirmative plan will increase the administrative burden borne by healthcare providers.

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High Strain on Healthcare Providers

No Author Listed. Published by the American Hospital Association (The American Hospital Association (AHA) is a health care industry trade group. It includes nearly 5,000 hospitals and health care providers). 2026.
Accessed September 9, 2026. "https://www.aha.org/aha-center-health-innovation-market-scan/2025-12-09-health-care-workforce-system-under-pressure-poised-reinvention" Health Care Workforce: A System Under Pressure, Poised for Reinvention

(**Strategy Note:** This piece of evidence is intended to be used in tandem with Smeriglio, 2026.)

"Hospitals and health systems head into 2026 facing familiar but intensifying headwinds. High labor costs, inflation, supply chain volatility and financial pressures continue to squeeze operating budgets. At the same time, demand for care is rising as the U.S. population ages and patient needs grow more complex. Layer onto that an exhausted workforce still carrying the weight of years of strain. Burnout, vacancies and administrative burden remain top concerns for health care leaders across the country."

Impact: The US healthcare system is already under substantial pressure. The intensification of RAC audits will only serve to add to that pressure.

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Medicare and Medicaid Appeals Backlog

No Author Listed. Published by AllZone Management Services Inc. (US-based healthcare outsourcing company specializing in medical billing, medical coding, and revenue cycle management). December 15, 2023.

Accessed September 9, 2026. "https://www.allzonems.com/evolution-and-challenges-of-recovery-audit-contractor-audits/" Evolution of Recovery Audit Contractor (RAC) Audits: Challenges, Changes, and Current Landscape

"As the RAC program expanded across the nation, it posed three significant challenges that providers struggled to surmount: Providers encountered a trio of formidable hurdles with the nationwide rollout of the RAC program:

(1) Overly aggressive RACs: RAC audit fees, funded by the Centers for Medicare & Medicaid Services (CMS), operated on a contingency fee basis. This setup meant that the higher the amount denied and "recovered," the greater the fees collected by the RACs. Consequently, this incentivized RACs to adopt an assertive audit stance, particularly targeting hospitals with high-value claims.

(2) More paperwork, less time: The sudden influx of medical record requests caught most providers unprepared, leading to delayed or denied submissions due to the inability to respond promptly. This inundation resulted in a shortfall in meeting submission deadlines.

(3) Overwhelmed appeals process: The surge in provider claims inundated the Medicare appeals process across all levels, causing significant delays in response times. The appeals system struggled to keep pace with the rapid increase in appeals, resulting in prolonged waiting periods for resolution."

Impact: When RAC audits were initially implemented, there was a sudden surge in Medicare and Medicaid claims appeals. This sudden influx of appeals created a backlog that took years to resolve.

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Medicare and Medicaid Appeals Backlog – Past Precedent

Authored by Knicole C. Emmanuel Esq. (Lawyer with over 20 years in health care litigation with a focus on Medicare and Medicaid litigation). Published by MedLearn Publishing (US-based healthcare education provider focused on coding and compliance education). April 15, 2021.

Accessed September 9, 2026. "https://medlearn.com/racmonitor/the-alj-backlog-dissolves-and-smrc-audits-escalate/" The ALJ Backlog Dissolves – and SMRC Audits Escalate.

"Now, the bad news. Remember when the Recovery Audit Contractor (RAC) program was first implemented, and the RACs were zealously auditing, which is the reason that the backlog exists in the first place? RACs were given free rein to audit whichever types of service providers they chose to target. Once the backlog got out of hand, CMS restricted the RACs. They only allowed a three-year lookback period, whereas other auditors can go back six years, as with the Supplemental Medical Review Contractor (SMRC) audits. CMS also mandated that the RACs slow down their audits, and put other restrictions on RACs. Now that the Office of Medicare Hearings and Appeals (OMHA) has the capacity to adjudicate 300,000 Medicare appeals per year, however, expect that those reins that have been holding the RACs back will by 2021 or 2022 be fully loosened for a full gallop."

Impact: While we may have overcome the initial backlog caused by RAC audits, recent changes already threaten to create another backlog. Increasing RAC audits now will only heighten that risk.

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