A R C L I G H T I N S I G H T S ™

Policy White Paper

Upstream Denials, Downstream Costs:

Hidden Systemic Costs and Measurement Failure in Medicare Unified Program Integrity Contractor (UPIC) Determinations

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Executive Summary

Medicare's Unified Program Integrity Contractors generate substantial downstream economic costs that current program reporting cannot measure, attribute, or manage. This paper estimates the annual hidden systemic cost of UPIC-related audit determinations that are reversed on appeal or likely reversible at $49 million to $250 million under conservative-to-high assumptions. Even under the most favorable interpretation of available data — treating every documentation-driven reversal as pure provider omission, leaving no role for structural process effects — direct adjudication and administrative costs attributable to ultimately reversed determinations are estimated at $29 million to $65 million annually: 17 to 38 percent of the estimated current UPIC program budget.

These costs do not appear in any program integrity report — not because the data does not exist, but because the data architecture was never built to see them. Official reversal data appear to exonerate contractors: CMS-authorized quarterly reconsideration reports show that 76 to 95 percent of Level 2 reversals are attributed to "new documentation/evidence persuasive," which suggests providers simply failed to submit complete records. This paper argues that interpretation is structurally incomplete. A documented feature of the appeals cascade — which the companion peer-reviewed analysis terms rationale drift (i.e., the shift in the operative basis for denial across appeal levels without advance notice) — produces documentation responses the classification system cannot distinguish from genuine omissions, systematically misattributing a portion of structural process costs to provider behavior.

The result is a self-reinforcing measurement gap. The program is generating material costs it cannot observe because the classification system it relies on conflates two causally distinct phenomena under a single label. This paper names the mechanism, documents its regulatory basis, bounds the cost in three scenarios, and proposes six reforms — including a foundational data infrastructure change that is the necessary prerequisite for all the others.

CENTRAL THESIS

A performance evaluation framework that rewards investigative output without measuring determination accuracy creates a structural incentive to overproduce audit findings. Because the appeals process — not the contractor — corrects those findings, the true cost of UPIC activity is materially understated in current reporting. This paper estimates annual hidden systemic costs at $49 million to $250 million — an order-of-magnitude approximation at approximately 60 to 70 percent confidence. Even the most conservative scenario, assuming zero contribution from structural process effects, yields direct costs of $29 million to $65 million that are currently invisible in program integrity reporting. The central constraint on precision is straightforward: CMS does not publish contractor-level appeal outcome data. These estimates would narrow substantially if it did.

Core Structural Issue

1	UPICs self-direct data mining and claim selection
2	UPICs generate their own investigative leads and case volume
3	CMS evaluates UPICs on workload volume, not determination accuracy
4	Incorrect determinations are corrected downstream through appeals
5	Correction costs fall on providers and government — not on the UPIC

The cycle above represents the structural incentive misalignment at the center of this paper's argument. Each step is documented in Sections I through V.

Key Findings at a Glance

~$168M	Estimated midpoint of current annual CMS UPIC spending ($101M confirmed in 2019; $120M–$180M estimated range based on $1.52B in total IDIQ obligations over 9 years).
11–28%	UPIC Level 2 favorable reversal rate, Q4 2024–Q4 2025 (Q2A quarterly reconsideration data). RAC Level 2 rates over the same period ranged from 36 to 50 percent — a 20-percentage-point gap that cannot be explained by available public data.
$29M–$65M	Direct cost floor under zero-drift assumption — the scenario most favorable to the current evaluation framework. Under base-case assumptions, total system costs reach $99M–$120M annually. These costs are currently invisible in program reporting because the classification system cannot distinguish structural process costs from provider documentation failures.
93–95%	Share of Part B Level 2 reversals classified as "new documentation/evidence persuasive" (Q2A). This figure appears to exonerate contractors but cannot alone be used to conclude that all costs are attributable to provider behavior — a classification problem with direct consequences for cost measurement and contractor accountability.

1 Report	The HHS-OIG's September 2022 report (OEI-03-20-00330) — analyzing 2019 data — is the only comprehensive public evaluation of UPIC performance since program unification. As of April 2026, the data analyzed is approximately seven years old.
11–17 Months	Estimated timeline from initial UPIC determination to ALJ hearing decision. Under current regulations (42 CFR §405.379), recoupment resumes and continues throughout this period once QIC review is complete — before any independent adjudication has occurred.

I. Background: The UPIC Program and Its Oversight Framework

A. Program Origins and Structure

Beginning in 2016, CMS consolidated its Medicare and Medicaid program integrity activities under a new contractor model — the Unified Program Integrity Contractor. UPICs replaced earlier Zone Program Integrity Contractors (ZPICs), Program Safeguard Contractors (PSCs), and Medicaid Integrity Contractors, integrating their functions into a single unified contractor per geographic jurisdiction.

The consolidation was designed to enhance cross-program fraud detection by eliminating silos between Medicare and Medicaid oversight. By June 2018, fully operational UPICs covered all five jurisdictions. Three companies currently operate those jurisdictions: Qlarant Integrity Solutions (Western and Southwestern, covering Texas and surrounding states), SafeGuard Services (Northeastern and Southeastern), and CoventBridge (Midwestern).

The program operates under a $2.5 billion IDIQ contract vehicle with an ordering period of May 2016 through May 2025. Total obligations reached approximately $1.52 billion, implying average annual obligations of approximately $168 million across the full contract lifecycle. CMS publicly confirmed $101 million in 2019 funding; actual annual figures were likely lower in the program's early ramp-up years and higher as operations matured.

B. What UPICs Actually Do

UPICs conduct a broad range of program integrity activities within their assigned jurisdictions, including:

- Screening and prioritizing leads — suspected instances of fraud, waste, or abuse — from proactive data mining and external referrals
- Opening and conducting investigations into providers
- Performing data analysis projects on Medicare and Medicaid claims and encounter data
- Conducting pre- and post-payment medical record reviews
- Identifying and referring overpayments to Medicare Administrative Contractors or States for collection
- Recommending administrative actions: provider revocations, payment suspensions, civil monetary penalties, and exclusions
- Making case referrals to law enforcement, including OIG, the Department of Justice, and Medicaid Fraud Control Units

Critically, CMS instructs UPICs to proactively identify leads through their own data analysis — meaning the volume of cases generated is substantially within the contractor's own control. This self-directed workload generation is central to the incentive misalignment problem explored in Section V.

C. The Performance Evaluation Framework

CMS evaluates UPIC performance primarily through the Unified Case Management (UCM) system and through an award fee structure. According to the OIG's 2022 evaluation, CMS determines award fees based on performance, quality, timeliness, and coordination with other program integrity contractors.

THE CRITICAL GAP

Neither the award fee criteria nor CMS's public performance reporting includes systematic evaluation of determination accuracy as measured by downstream appeal outcomes. UPICs are evaluated on how much they do — not on whether what they do is correct. Most mature audit and oversight systems — including Recovery Audit Contractors, Supplemental Medical Review Contractors, and private-sector audit programs — incorporate outcome-based accuracy metrics as a core performance dimension. The UPIC framework is a structural outlier in its exclusive reliance on output volume.

II. What the OIG Found — And What It Didn't

A. One Evaluation. Seven-Year-Old Data.

In September 2022, the HHS Office of Inspector General released OEI-03-20-00330, "UPICs Hold Promise To Enhance Program Integrity Across Medicare and Medicaid, But Challenges Remain" — explicitly characterized as the first evaluation of program integrity activities since CMS unified Medicare and Medicaid program integrity under UPICs.

A point that warrants direct statement: the report published in September 2022 analyzes program integrity activities conducted in calendar year 2019. As of April 2026, the underlying data is approximately seven years old. The UPIC program has now operated for a full decade, cost CMS an estimated $1.2 to $1.5 billion in total obligations, and been subject to exactly one comprehensive, publicly released independent evaluation — covering a single pre-pandemic year.

A PROPORTIONALITY PROBLEM

A provider operating in any UPIC jurisdiction may face audit activity annually — prepayment reviews, post-payment record requests, investigations, and administrative actions that can overlap and accumulate across years. Over that same decade, the UPIC contractor conducting that activity has been the subject of one public independent evaluation analyzing data that is now seven years old. We do not suggest that provider oversight should be reduced. We suggest that contractor oversight should be held to a comparable standard.

B. OIG's Key Findings

Wide, unexplained variation across UPICs. Even after adjusting for jurisdiction size, OIG found that the UPIC opening the most investigations opened three times as many as the UPIC opening the fewest, per $100 billion in spending. One UPIC completed more than three times as many data analysis projects as another. The OIG flagged this as an unresolved governance question. There is no public record indicating it has been resolved since.

Disproportionate Medicare focus despite higher Medicaid spending. UPICs conducted substantially more program integrity activities for Medicare than for Medicaid, even though Medicaid spending exceeded Medicare fee-for-service spending by $147 billion in 2019.

Minimal Medicaid managed care oversight. Although 83 percent of Medicaid enrollees received services through managed care in 2019, UPICs estimated that only 11 percent of their Medicaid activities focused on managed care. UPICs reported zero data analysis projects and zero vulnerabilities identified for Medicaid managed care that year.

Systemic UCM reporting limitations. All five UPICs reported that the UCM system does not capture all information they must track, forcing parallel internal databases. CMS is now migrating to UCM NexGen, but neither the legacy system nor its successor appears designed to capture appeal outcomes as a performance variable.

UPIC Activity Type (CY2019)	Medicare	Medicaid
Leads Screened	5,868	1,178
Investigations Opened	3,586	960
Cases Referred	794	163
Overpayments Referred for Recovery	$329M	$44M
Administrative Actions Recommended	624	0
Data Analysis Projects Completed	345	195
Claims Denied	96,586	20,161
Vulnerabilities Identified	10	2

Source: HHS-OIG, OEI-03-20-00330, September 2022. Data reflects calendar year 2019 operations — approximately seven years prior to the date of this paper.

C. What the OIG Report Did Not Measure

The evaluation contains no systematic analysis of: redetermination overturn rates (Level 1); QIC reconsideration overturn rates (Level 2); ALJ reversal rates by contractor or jurisdiction (Level 3 — the first independent adjudication); net economic impact of reversed determinations; or any

correlation between audit volume and determination accuracy. Without outcome data, the award fee system can only reward process compliance and volume — regardless of whether the underlying determinations were correct.

III. The Appeals System as the Primary Error-Correction Mechanism

A. Structure of the Medicare Appeals Process

Providers who receive adverse UPIC determinations — overpayment demands, prepayment review restrictions, or payment suspensions — may appeal through a five-level process. The regulatory treatment of recoupment at each level is essential to understanding where the accountability gap creates the most acute harm.

1. MAC Redetermination (Level 1): The Medicare Administrative Contractor reviews the initial determination. Recoupment is paused while a timely request for redetermination is pending.
2. **QIC Reconsideration (Level 2):** A Qualified Independent Contractor conducts a second review. Under 42 CFR §405.379, recoupment must cease upon receipt of a valid QIC reconsideration request and must not be initiated if it has not yet begun. After QIC action, however, recoupment may resume.
3. **ALJ Hearing (Level 3):** OMHA assigns an Administrative Law Judge who conducts a de novo — fresh, independent — review of the case. Under 42 CFR §405.373(e), recoupment resumes after QIC action and remains in effect throughout the ALJ process, which takes an estimated 11 to 17 months from initial determination to hearing decision.
4. Medicare Appeals Council (Level 4): A further administrative review if the ALJ decision is unfavorable.
5. Federal Court Review (Level 5): Final judicial review, requiring a minimum amount in controversy ($1,840 in 2024; $200 threshold for ALJ-level entry in 2026).

> **REGULATORY CONTEXT**
>
> Current regulations stop recoupment during QIC reconsideration (Level 2) but explicitly allow it to resume after QIC action and continue through ALJ proceedings (Level 3) and beyond. Providers are therefore repaying money — often under duress — throughout the period when they are statistically most likely to have that money returned by an independent adjudicator. This is the regulatory foundation of Recommendation 5.

B. The ALJ as the True Accuracy Signal

The ALJ level is analytically significant for a specific reason: it is the first point in the process at which the case is evaluated by an adjudicator with no connection to the initial determination or the contractor ecosystem that produced it. ALJ outcomes therefore represent the most reliable available signal of whether the underlying determination was justified. When an independent adjudicator with clinical context reviews the full record and finds in the provider's favor, the most defensible interpretation is that the initial determination did not align with the final adjudicated standard.

C. The Reversal Rate Evidence: New Data and an Important Qualification

The most current publicly available contractor-specific reversal data comes from Q2A, the CMS-authorized contractor managing Medicare reconsideration workload reporting. Across Q4 2024 through Q4 2025, UPIC Level 2 combined favorable and partially favorable rates ranged from 11 to 28 percent. RAC Level 2 rates over the same period ranged from 36 to 50 percent — a difference of roughly 20 percentage points at the midpoint. This gap is large enough to warrant examination, though case-mix differences and enforcement-category composition may contribute.

OMHA decision statistics (updated January 29, 2026) show all-Medicare merits reversal rates — favorable and partially favorable decisions divided by total decisions excluding dismissals — of approximately 42 percent in FY2022, declining to 27 percent in FY2025, and partially recovering to 30 percent year-to-date in FY2026. A 2013 OIG evaluation (OEI-02-10-00340) found that hospitals achieved fully favorable outcomes in approximately 72 percent of contested appeals, while practitioners saw approximately 60 percent. These earlier figures predate the UPIC program and should be understood as historical context rather than a current operational estimate.

IMPORTANT QUALIFICATION

The 60–72% favorable rate figures are drawn from data now more than a decade old. The more current OMHA merits rates (27–42%) are the appropriate anchor for cost modeling. No publicly available statistic specifically measures UPIC-originating case reversal rates by contractor or jurisdiction. All figures should be interpreted as indicators of how frequently determinations are modified or reversed under independent adjudication, not as direct measures of UPIC contractor error rates.

D. The Iceberg Problem: Unappealed Cases

The ALJ reversal rate almost certainly understates the frequency of initial determination error. Approximately 5 to 10 percent of nonfavorable Part B QIC determinations and 12 to 16 percent of Part A determinations proceed to ALJ review; the remainder never reach independent adjudication. The appeals process imposes real costs at every level: staff time required to compile, review, organize, summarize, and formally submit medical records and responses; coordination with outside consultants or legal representatives that providers often — though are not required to — retain; and the cumulative timeline that stretches 11 to 17 months before independent review occurs. Industry practitioners consistently estimate 4 to 8 hours of administrative burden per case at each level of appeal. Any estimate of the total cost of UPIC determination error that excludes unappealed incorrect cases is, by definition, an understatement of unknown magnitude.

E. A Complicating Factor: The Documentation-Driven Reversal Finding and Its Limits

This section addresses a critical limitation in how official reversal outcomes are currently interpreted — one that directly affects the credibility and scope of the cost estimates that follow.

Q2A data reveal a finding that appears, on its face, to exonerate audit contractors: 93 to 95 percent of Part B Level 2 reversals and 76 to 85 percent of Part A reversals are classified as "new documentation/evidence persuasive." If reversals happen because providers submitted records they initially failed to include, the denial may have been justified with the evidence available at the time — a narrative that shifts responsibility for system costs to provider behavior.

This interpretation is incomplete for a structural reason that the companion peer-reviewed analysis documents formally. The Medicare appeals cascade contains a feature — termed rationale drift (i.e., the shift in the operative basis for denial across appeal levels without prior notice to the provider) — in which the QIC may shift the dispositive denial theory at the reconsideration stage. Under 42 CFR §405.968(b)(5), QICs have authority to raise entirely new issues not present in the UPIC's denial rationale. When a QIC shifts the operative legal theory — converting a documentation-sufficiency denial into a categorical non-coverage determination under a different regulatory framework — the provider must submit qualitatively different evidence at the ALJ level to respond to the new theory.

WHY THIS MATTERS FOR COST MEASUREMENT

Scientific literature, regulatory analysis, and coverage arguments submitted at the ALJ level to address a shifted QIC theory appear in Q2A's classification system as "new documentation/evidence persuasive" — identical to the classification for clinical records the provider simply forgot to submit. The classification system alone cannot be used to conclude that all or most reversal costs are attributable to provider behavior. It conflates two causally distinct phenomena under a single label, systematically attributing a portion of structural process costs to providers.

The cost model in Section IV explicitly accounts for this uncertainty through scenario-based weighting, with a zero-drift sensitivity floor providing the most conservative lower bound under the assumption that provider omission alone explains all documentation-driven reversals.

IV. Economic Cost of Overturned Determinations: Scenario Analysis

A. Methodology

Quantifying the total economic cost of UPIC-generated determinations that are ultimately reversed requires combining estimates of appeal volumes, reversal rates, and per-case costs. Because CMS does not publish contractor-level accuracy or appeal outcome data, the following analysis is an order-of-magnitude approximation based on Q2A quarterly reconsideration data, OMHA decision statistics, CMS Recovery Audit Contractor program reports, Premier Inc. provider survey data, and external comparators from Medicare Advantage and Marketplace denial research. Results are presented in three scenarios with an estimated confidence of approximately 60 to 70 percent. These estimates would become substantially more precise if CMS required annual public reporting of contractor-level appeal outcomes — as recommended in Section VII.

B. Documentation-Decomposition Approach

Given the documentation-driven reversal finding discussed in Section III.E, the model explicitly decomposes documentation-driven reversals into two components: those attributable to provider omission and those attributable to structural process effects such as rationale drift. Three scenario weights are applied:

- Conservative: 20 percent of documentation-driven reversals treated as drift-attributable
- Base Case: 45 percent drift-attributable (neutral prior given regulatory pervasiveness of the QIC new-issue authority)
- High: 70 percent drift-attributable (consistent with enforcement environments featuring systematic categorical coverage theories)

These weights are analytical assumptions intended to bound the policy-relevant cost range, not empirical estimates of how often rationale drift occurs. A zero-drift sensitivity run — treating all documentation-driven reversals as pure provider omission — represents the lower bound under the assumption most favorable to the current evaluation framework.

C. Three-Scenario Cost Model

Table 1. Three-Scenario Cost Model: Estimated Annual Hidden Systemic Cost of UPIC-Related Audit Determination Reversals

Model Component	Conservative Scenario	Base Case Scenario	High Scenario
PANEL A: VOLUME INPUTS			
Annual OMHA new filings (post-backlog)	25,000	30,000	40,000

UPIC-attributable share (estimated)	20%	25%	30%
UPIC cases at ALJ (derived)	5,000	7,500	12,000
Merits reversal rate (OMHA, excl. dismissals)	27%	35%	42%
Reversed UPIC cases at ALJ (derived)	1,350	2,625	5,040
PANEL B: DOCUMENTATION DECOMPOSITION			
Documentation-driven reversal share (Q2A)	93%	93%	93%
Drift-attribution weight	20%	45%	70%
Drift-attributable reversed cases	252	1,099	3,296
PANEL C: COST LAYERS			
Layer 1: Provider burden pre-ALJ ($44–$57/claim × denial base)	~$5M	~$9M	~$18M
Layer 2: Direct adjudication ($12k–$15k/reversed case)	~$16M	~$35M	~$76M
Layer 3: Recoupment financing cost (11–17 months)	~$8M	~$15M	~$30M
Layer 4: Unappealed loss imputation (bounded)	~$20M	~$40M	~$80M
Total estimated annual system cost	**~$49M–$56M**	**~$99M–$120M**	**~$204M–$250M**
Zero-drift sensitivity floor (all doc-driven = provider omission)	**~$29M–$35M**	**~$54M–$65M**	**~$104M–$126M**

Sources: Q2A quarterly reconsideration reports (Q4 2024–Q4 2025) for Level 2 rates and documentation-driven shares; OMHA Decision Statistics (updated January 29, 2026) for merits reversal rates; AHA v. Becerra litigation workload exhibits for UPIC attribution; Premier Inc. (2023) survey for Layer 1 per-claim burden; OMHA FY2017 budget data, CPI-U-adjusted, for Layer 2 government cost; KFF (2024–2025) Medicare Advantage and Marketplace data for Layer 4 calibration. Documentation-decomposition weights are analytical assumptions. Zero-drift sensitivity (highlighted) is the lower bound assuming no structural process contribution to reversals — the scenario most favorable to the current evaluation framework. Confidence approximately 60–70%.

D. From Direct Costs to Total System Cost

The cost layers capture four distinct categories of harm. Layer 1 applies the Premier Inc. estimate of $44 to $57 in provider administrative burden per denied or reworked claim to the estimated full population of UPIC-attributed unfavorable initial determinations, capturing minimum cost at the point of denial before any appeal activity. Layer 2 covers combined provider and government adjudication costs for reversed ALJ cases, using approximately $1,300 per appeal in inflation-adjusted government adjudication costs. Layer 3 estimates the recoupment financing cost during the 11-to-17-month ALJ processing period for cases ultimately reversed. Layer 4 uses the Q2A non-escalation rate (90 to 95 percent of nonfavorable Part B QIC determinations never reach OMHA) as a bounded imputation for unappealed losses, calibrated against KFF's finding that 80.7 percent of appealed Medicare Advantage prior authorization denials were overturned.

Because the appeals process is publicly funded, these costs represent direct expenditures of taxpayer resources — OMHA adjudication costs, interest on returned recoupments, and the administrative overhead of a multi-level appeals system operating at scale to correct upstream errors.

CONFIDENCE AND PRECISION

These estimates carry approximately 60 to 70 percent confidence. The zero-drift floor — $29 million to $65 million under conservative-to-base volume assumptions — is the most defensible figure and establishes that costs are material relative to UPIC program spending even if structural process effects contribute nothing to reversals. The ranges would narrow substantially if CMS published annual UPIC-specific appeal outcome data. The uncertainty is itself an argument for the data transparency reforms recommended in Section VII.

V. Structural Analysis: Misaligned Incentives and Negative Externalities

A. The Self-Directed Workload Problem

Unlike Recovery Audit Contractors, which are paid on contingency, UPICs are compensated on a cost-plus basis: reimbursed for operating costs plus a fixed fee. This removes the most direct financial incentive to maximize findings volume. But it creates a subtler version of the same problem: activity-based performance metrics reward generating leads, opening investigations, and completing reviews — regardless of whether those activities produce accurate outcomes.

Because UPICs proactively generate many of their own leads through data mining, they have substantial control over the volume of cases they initiate. A contractor that mines data aggressively and opens many investigations demonstrates high performance by the metrics currently tracked. A contractor that mines data selectively and prioritizes high-confidence cases may appear less productive under the same metrics, even if its determinations are substantially more accurate. The evaluation framework provides no mechanism to distinguish these two contractors. This is a textbook misaligned incentive: the behavior rewarded by the performance framework (volume) diverges from the behavior that produces the desired social outcome (accuracy).

B. The Negative Externality Structure

The economic concept of a negative externality describes a cost imposed on parties not involved in the transaction that generated it. The UPIC determination system exhibits this structure clearly: the contractor makes a determination, the cost of an incorrect determination is borne primarily by the provider and the government, and the contractor does not internalize that cost in its performance evaluation or compensation. Standard economic analysis predicts that negative externalities lead to overproduction of the activity that generates them. The burden-shifting is documented across every stage of the process:

Cost Type	Who Bears It
UPIC generates an audit determination	Covered by CMS contract (public funds)
Determination is incorrect; provider does not appeal	Full cost borne by provider — unjust loss, uncompensated
Provider challenges the determination through appeals	Primarily borne by provider: 4–8 hrs per level, consultant/legal costs
Case adjudicated at ALJ level	Government (OMHA adjudication) + continued provider burden
ALJ reverses; recoupment refunded + interest	Government bears refund + interest; provider never compensated for burden

Reputational or performance consequence to UPIC	Minimal to none: not tracked, not published, not used in award fee scoring

C. The UCM Accountability Deficit

The Unified Case Management system, which CMS describes as the tool used to "continuously monitor and evaluate UPIC performance," has been identified by OIG as structurally deficient. All five UPICs reported that the UCM does not capture all information they must track, forcing parallel internal databases. CMS is migrating to UCM NexGen, but neither the legacy system nor its successor appears designed to capture appeal outcomes as a performance feedback variable. A monitoring system that cannot close the loop between initial determination and final adjudication outcome cannot support outcome-based performance evaluation.

D. The Oversight Frequency Asymmetry

A provider in any UPIC jurisdiction may face audit activity annually — prepayment reviews, post-payment record requests, investigations, and administrative actions can overlap and accumulate. Over the UPIC program's decade of operation, the contractor conducting that activity has been subject to one comprehensive public evaluation, analyzing data that is now approximately seven years old. Robust program integrity requires accountability flowing in both directions: rigorous oversight of providers, and rigorous oversight of those doing the overseeing.

VI. Additional Dimensions of the Accountability Deficit

A. The Extrapolation Problem

When UPICs identify billing irregularities through medical record review, they frequently employ statistical extrapolation to project the identified error rate across a larger universe of claims — dramatically amplifying the financial exposure of the provider. Extrapolation is a legitimate audit technique when applied to statistically valid samples and when the underlying determination is correct. When the underlying determination does not survive independent adjudication, extrapolation compounds the harm proportionally. Documented provider cases have shown extrapolated demands of $400,000 being reduced to under $3,000 following full ALJ adjudication — a reduction of more than 99 percent that illustrates the potential scale of divergence between initial UPIC findings and adjudicated reality.

B. The Wound Care Provider Experience

Wound care illustrates the structural problem with particular clarity. Post-acute wound care services — advanced dressings, negative pressure wound therapy, cellular and tissue-based products — involve complex medical necessity determinations requiring evaluation of clinical documentation, treatment history, and the progression of care over time. The appropriateness of an advanced therapy depends on whether conservative treatment has been adequately tried and documented — a judgment that requires longitudinal clinical context a billing-pattern-focused audit may not capture.

When those determinations are challenged with complete clinical records and appropriate expert context, reversal rates are high. But many wound care providers — particularly smaller practices and rural providers serving elderly, diabetic, and post-surgical patients — lack the resources to mount a full appeal. The losses they absorb from incorrectly reversed determinations are real, and so are the downstream effects on patients when providers limit services or exit markets to reduce audit exposure.

C. The Oversight Gap in Context

CMS concurred with all four recommendations in the OIG’s September 2022 report. Follow-up on implementation is not publicly available. There is no public record indicating whether CMS has addressed the unexplained variation across UPICs, improved UCM reporting, or introduced any outcome-based element into UPIC award fee criteria. In most regulated industries, a government contractor managing $150 million or more annually with identified governance weaknesses would face more frequent, more rigorous, and more public performance review. The absence of that review here is a structural design gap, not a criticism of any individual contractor or CMS official.

VII. Policy Recommendations

The following six recommendations address the structural accountability deficit identified in this paper. They range from administrative actions CMS can take under existing authority to reforms that would benefit from Congressional action. All are compatible with robust, effective program integrity enforcement.

Recommendation 1: Mandate Annual Public Reporting of ALJ Outcomes by Contractor

CMS should require OMHA and relevant administrative contractors to compile and publicly report appeal outcomes for UPIC-attributable cases by jurisdiction, annually. Published data should include: total UPIC-attributable cases reaching ALJ review; fully favorable, partially favorable, and unfavorable outcomes; dollars at issue in reversed determinations; and average time from initial determination to ALJ decision. This data exists within existing case management systems. Making it public requires direction, not new data infrastructure.

Recommendation 2: Integrate Outcome-Based Accuracy Metrics Into UPIC Award Fee Criteria

CMS should amend UPIC award fee plans to incorporate ALJ reversal rates as a meaningful scoring component. Contractors whose UPIC-originated determinations are reversed at rates materially above the program-wide average should receive reduced award fee scores. Contractors with consistently low reversal rates should receive credit. This creates a financial consequence for generating incorrect determinations, partially internalizing the externalized cost of error. The specific threshold and methodology should be developed through notice-and-comment rulemaking to ensure stakeholder input.

Recommendation 3: Require Issue Disposition Tables in QIC Decisions and UCM Integration of Reversal Data

This recommendation has two components that address the same underlying data problem from different directions.

First, QIC decisions should include a standardized issue disposition table documenting: (a) each issue identified in the UPIC's denial rationale; (b) whether the QIC sustained, rejected, or declined to reach each UPIC issue; (c) any new issues introduced by the QIC and the basis for their introduction; and (d) the dispositive issue(s) on which the decision rests. This is the foundational data infrastructure reform that makes the classification problem in Section III.E solvable. Without a record of whether the QIC's sustaining theory differed from the UPIC's denial theory, no subsequent data collection effort can distinguish rationale-drift-attributable costs from provider-omission costs. Implementation pathway: MPIM Chapter 4 revision and QIC contract performance standards, without requiring legislation.

Second, CMS should require the UCM system — including UCM NexGen — to capture appeal outcomes and reversal reasons as mandatory data fields for every UPIC-initiated case entering the appeals process. Once issue disposition tables create the underlying record, the UCM should flag cases in which the QIC's sustaining theory differed materially from the UPIC's initial denial theory. Together, these two changes close the information loop that currently prevents outcome-based evaluation.

Recommendation 4: Establish Independent Periodic Evaluation on a Three-Year Cycle

Congress and CMS should establish a requirement for independent, periodic external evaluation of UPIC performance — on a cycle not to exceed three years — including analysis of determination accuracy as measured by appeals outcomes. These evaluations should be publicly released and structured to enable longitudinal comparison across cycles. A single evaluation analyzing pre-pandemic data is not an adequate oversight record for a program that has cost taxpayers over a billion dollars and audited tens of thousands of providers.

Recommendation 5: Extend Recoupment Suspension Through ALJ-Level Review

Under current regulations (42 CFR §405.379), recoupment pauses during QIC reconsideration (Level 2) but resumes after QIC action and continues through ALJ proceedings (Level 3) and beyond. Because the ALJ represents the first independent adjudication, continuing recoupment through this period systematically extracts money from providers who will frequently be found to have owed less or nothing. CMS should pursue regulatory amendment to extend the recoupment suspension through the ALJ hearing decision. This would:

- Align financial exposure with adjudicated liability rather than contractor determination
- Reduce coercive pressure to settle meritorious appeals rather than pursue independent review
- Preserve interest accrual provisions: if the ALJ affirms the determination, recoupment proceeds with appropriate interest from that point

This reform does not eliminate recoupment. It delays recoupment until an independent adjudicator has evaluated the determination that triggered it.

Recommendation 6: Pilot Independent AI-Assisted Claim Selection

CMS should explore, through a structured pilot in a single jurisdiction, the use of CMS-operated or CMS-directed AI-assisted claim analysis tools for the initial identification and selection of claims warranting UPIC review. Under this model:

- An AI system under the direct control of CMS — not the UPIC contractor — performs initial data analysis and claim flagging
- The UPIC receives a defined referral list for investigation, rather than self-generating that list
- UPIC award fees reflect the accuracy of investigations of referred cases, not the volume of cases the UPIC chose to initiate

- The AI system's selection criteria, training data, and performance metrics are publicly documented and subject to independent audit

This approach separates claim selection — where the incentive problem is most acute — from claim investigation, where UPIC expertise remains valuable. Implementation should be phased, beginning with a single-jurisdiction pilot with transparent, published evaluation criteria, and designed to preserve full due process rights for providers at every stage.

VIII. Conclusion

Medicare program integrity is not optional. The fraud, waste, and abuse that UPICs exist to detect and deter represent a genuine threat to the financial sustainability of programs that serve tens of millions of Americans. The goal of this paper is not to weaken UPIC authority or diminish the importance of their function.

The goal is to insist that the function be performed accurately — and that accuracy be measured.

Medicare program integrity reporting documents what the system does. It does not document what the system costs. This paper has estimated that the annual hidden systemic cost of reversed or likely-reversible UPIC audit determinations ranges from $29 million to $250 million depending on assumptions, with the zero-drift floor — even granting every favorable assumption to the current framework — consuming 17 to 38 percent of the UPIC program's own budget. These costs are real. They fall on providers, on OMHA, and on taxpayers. They do not appear in any program integrity report because the data architecture governing UPIC performance evaluation was not designed to reveal them.

The documentation-driven reversal classification that accounts for 93 to 95 percent of Part B reversals accurately reflects what was classified. What it cannot do — alone — is establish that all or most reversal costs are attributable to provider behavior. Rationale drift produces documentation responses indistinguishable from provider omissions in the current data architecture. That is not a minor technical limitation. It is the mechanism by which structural process costs are attributed to providers, insulating their source from detection and preventing the program from learning from its own outcomes.

The six recommendations in this paper — and particularly the issue disposition table reform in Recommendation 3 — provide a path from this equilibrium to one in which contractor determination accuracy is measurable, comparable across jurisdictions, and consequential for contractor compensation. The data needed to build this picture already exists, embedded in the written decisions that QICs issue in every reconsideration. Making it systematic, structured, and public is a straightforward administrative act.

The program is measuring the wrong things and cannot know it.

CALL TO ACTION

Providers affected by UPIC audit activity, healthcare associations, policy organizations, Congressional oversight committees, and the HHS Office of Inspector General are encouraged to: (1) request that CMS disclose UPIC award fee plans and evaluation criteria; (2) direct OMHA to publish annual, contractor-attributed appeal outcome statistics; (3) require issue disposition tables in QIC decisions as a foundational data infrastructure reform; (4) commission a new, comprehensive OIG evaluation of UPIC performance incorporating outcome-based accuracy metrics; (5) initiate a pilot program for CMS-

directed independent AI-assisted claim selection; and (6) cite the companion peer-reviewed analysis (Arclight Action, forthcoming) when engaging CMS, OIG, or Congressional offices — the journal manuscript provides the rigorous methodological foundation supporting the arguments and estimates in this paper.

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This white paper was produced for informational and policy advocacy purposes.

Nothing herein constitutes legal advice. Providers facing UPIC audit activity should consult qualified healthcare counsel.

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