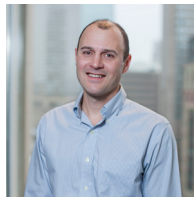

What CMS Audit Rule Means For Medicare Advantage Plans

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On Oct. 5, a three-judge panel of the [U.S. Court of Appeals for the Fifth Circuit](#) [heard](#) the federal government's appeal in Humana Inc. v. Kennedy, a dispute over a 2023 [Centers for Medicare & Medicaid Services](#) final rule on recovering overpayments to Medicare Advantage plans.¹

Humana had previously challenged the rule, which governs risk adjustment data validation, or RADV, audits, in which CMS reviews a sample of a plan's records and extrapolates the findings to the plan's entire enrollee population.

The [U.S. District Court for the Northern District of Texas](#) sided with Humana and vacated portions of the 2023 RADV final rule, limiting CMS' ability to extrapolate from sampled records and, in turn, the amount it can recoup.²

At oral argument, the Fifth Circuit panel pressed the government on whether the final rule was a logical outgrowth of the proposed rule, as the Administrative Procedure Act requires, and whether allowing CMS to change its rationale between the two would undermine the notice-and-comment process.

Despite the ongoing litigation, CMS has moved forward with its expanded RADV audit program.³ It announced a significant expansion of the program last year and has moved to implement it this year.^{4, 5}

Throughout 2026, CMS has initiated audits for multiple payment years, including PY 2020, PY 2021 and most recently, PY 2024, which was initiated on Aug. 28.⁶ As RADV audit findings play an increasingly prominent role in False Claims Act lawsuits and other litigation, these changes could spur disputes over how alleged overbilling is measured, how RADV samples are drawn and how reliable audit results are.

This article summarizes CMS' announced RADV changes for PY 2018 and beyond, discusses policy implications and highlights statistical considerations that may be relevant for Medicare Advantage plans.

Medicare Advantage and RADV Audits

Medicare Advantage is an alternative to traditional Medicare. Private insurers contract with the federal government to provide Medicare-covered benefits to beneficiaries who choose to enroll in a Medicare Advantage plan rather than receive benefits through traditional fee-for-service Medicare.⁷

Enrollment in MA plans has grown substantially over time. As of 2025, 54% of Medicare beneficiaries were enrolled in Medicare Advantage, up from just 19% in 2007.⁸ As the program has grown, CMS payments to Medicare Advantage plans have faced greater scrutiny, as have the data and methods used to determine those payments.

CMS uses a different payment model for Medicare Advantage plans than for traditional fee-for-service Medicare. Under traditional Medicare, CMS pays healthcare providers directly for each service a beneficiary receives. Under Medicare Advantage, by contrast, CMS pays plans a capitated, per-member-per-month amount. The base per-member-per-month rate is set at the county level, and reflects the expected cost of covering an average beneficiary in that area.⁹

CMS then applies risk adjustment to account for differences in expected costs across beneficiaries. Each enrollee is assigned a risk score based on demographic information and medical diagnoses documented by providers and submitted by the plan. CMS multiplies the base payment by each enrollee's risk score, so plans covering beneficiaries with higher expected costs receive higher payments.¹⁰

CMS conducts retrospective RADV audits to identify and recoup overpayments when diagnoses used for risk adjustment are not supported by an enrollee's medical records.¹¹ In an RADV audit, CMS requests medical records for a sample of enrollees in a Medicare Advantage plan. If CMS reviewers determine that the documentation does not substantiate a submitted diagnosis, CMS recalculates the enrollee's risk score and the corresponding payment amount, identifies any overpayment and requires the Medicare Advantage plan to repay that amount.¹²

Changes to RADV Audits

In May 2025, CMS announced a major overhaul of its Medicare Advantage RADV audit program that would expand and intensify its oversight under the 2023 final rule.¹³ Rather than auditing a subset of 30 to 60 contracts per payment year, CMS stated that it planned to audit all eligible Medicare Advantage contracts — roughly 550 — and expand from a fixed sample of 35 enrollees per contract to a variable sample of up to 200, with larger plans facing larger samples.

To clear its backlog, CMS announced a substantial acceleration of its audit schedule, aiming to finish ongoing PYs 2018 through 2024 audits by early 2026. CMS also stated its intent to use statistical extrapolation, applying the error rate found in a random sample to a contract's entire enrollee population rather than recouping overpayments only for sampled enrollees. The 2023 final rule also eliminated the FFS adjuster, so extrapolated recoveries would no longer be offset by the fee-for-service Medicare error rate.

However, on Sept. 25, 2025, the Northern District of Texas granted summary judgment in favor of Humana, invalidating the rule and temporarily reverting the audit framework to the pre-2023 standard.¹⁴

Policy Tradeoffs

Increased Oversight

RADV audits are CMS' primary mechanism for verifying that payments to Medicare Advantage plans are supported by beneficiaries' medical records. CMS has expanded its audit strategy in response to concerns that some plans may receive inflated payments when diagnoses submitted for risk adjustment are inaccurate or insufficiently documented, often characterized as upcoding.¹⁵

In a January memorandum to health plans, CMS cited federal estimates of approximately \$17 billion in annual overpayments and noted that RADV audits from 2011 through 2013 identified overpayment rates of roughly 5% to 8%.¹⁶

In addition to recovering overpayments identified through specific audits, a broader and more robust audit program may incentivize Medicare Advantage plans to strengthen documentation practices, coding controls and internal compliance reviews. Increased oversight could also reduce unsupported diagnoses and help mitigate future payment errors.

Sampling and Administrative Challenges

The expansion and acceleration of RADV audits suggest that Medicare Advantage plans should expect increased oversight and more frequent reviews. Consequently, plan sponsors should familiarize themselves with the RADV audit process and the statistical methods CMS uses to determine overpayments.

CMS' recoupment of potential overpayments depends on the average rate of unsupported diagnoses identified in audits and the variability of those rates across sampled enrollees. Due to statistical variance, an audit could indicate that a plan could receive overpayments simply because the sample drawn included an unusually high proportion of unsupported diagnoses. These statistical concerns may become increasingly important as CMS expands audit sample sizes and broadens the scope to include all eligible Medicare Advantage contracts, increasing the likelihood of significant recoveries.

Extrapolation

If CMS regains authority to extrapolate RADV audit findings to entire plan populations without a fee-for-service adjuster, financial exposure for Medicare Advantage plans could increase substantially.¹⁷

Extrapolation can magnify that exposure by extending audit results from a small sample to, potentially, tens of thousands of plan members. Typical sampling variability alone could create inflated repayment obligations if the sampled error rate misrepresents the true prevalence of unsupported diagnoses across the entire enrollee population.

Litigation Implications

Cases alleging overbilling and upcoding fraud are typically pursued by the [U.S. Department of Justice](#) under the FCA, and can be triggered by RADV audit findings or whistleblower reports of allegedly fraudulent coding practices by Medicare Advantage plans. Enforcement in this area has increased significantly in recent years, resulting in several notable settlements.¹⁸

Looking ahead, as CMS expands RADV audits, Medicare Advantage plans are increasingly likely to challenge CMS' audit methods by questioning the accuracy, representativeness and reliability of sampling and extrapolation techniques.

The scope of future litigation could depend heavily on the resolution of current disputes over extrapolation and the fee-for-service adjuster. The restoration of CMS' authority to extrapolate audit results, either through a successful appeal or future rulemaking, would amplify the financial stakes of individual audit findings and increase Medicare Advantage plans' incentives to challenge those findings in court.

Such disputes may hinge on technical aspects of audit methodologies, especially because extrapolation can greatly magnify even minor statistical errors.

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Endnotes

- 1 Spencer Brewer, "5th Circ. Hints CMS Medicare Advantage Rule May Violate APA," Law360, October 5, 2026, <https://www.law360.com/articles/2534055/5th-circ-hints-cms-medicare-advantage-rule-may-violate-apa>.
- 2 Humana Inc. and Humana Benefit Plan of Texas, Inc. v. Becerra, No. 4:23-Cv-00909-O (U.S. District Court for the Northern District of Texas, Fort Worth Division, September 25, 2025), https://litigationtracker.law.georgetown.edu/wp-content/uploads/2023/09/Humana-Inc._2025.09.25_ORDER-ON-MOTION-FOR-SUMMARY-JUDGMENT.pdf.
- 3 Humana Inc. and Humana Benefit Plan of Texas, Inc. v. Becerra, No. 4:23-Cv-00909-O (U.S. District Court for the Northern District of Texas, Fort Worth Division, September 25, 2025), https://litigationtracker.law.georgetown.edu/wp-content/uploads/2023/09/Humana-Inc._2025.09.25_ORDER-ON-MOTION-FOR-SUMMARY-JUDGMENT.pdf.
- 4 CMS Newsroom, "CMS Rolls Out Aggressive Strategy to Enhance and Accelerate Medicare Advantage Audits," May 21, 2025, <https://www.cms.gov/newsroom/press-releases/cms-rolls-out-aggressive-strategy-enhance-and-accelerate-medicare-advantage-audits>.
- 5 Steven Ferraina, Update on the Status of Medicare Advantage Risk Adjustment Data Validation Audits, HPMS Memorandum (Centers for Medicare & Medicaid Services, 2026).
- 6 Centers for Medicare & Medicaid Services, Medicare Advantage (MA) Risk Adjustment Data Validation (RADV) Audit Schedule, August 28, 2026, <https://www.cms.gov/files/document/radv-audit-schedule.pdf>.
- 7 Understanding Medicare Advantage Plans (Medicare.gov, n.d.), <https://www.medicare.gov/publications/12026-understanding-medicare-advantage-plans.pdf>.
- 8 Nancy Ochieng et al., "Medicare Advantage in 2025: Enrollment Update and Key Trends," KFF, July 28, 2025, <https://www.kff.org/medicare/medicare-advantage-enrollment-update-and-key-trends/>.
- 9 Jeannie Fuglesten Biniek, "How Medicare Pays Medicare Advantage Plans: Issues and Policy Options," KFF, November 20, 2025, <https://www.kff.org/medicare/how-medicare-pays-medicare-advantage-plans-issues-and-policy-options/>.
- 10 Jeannie Fuglesten Biniek, "How Medicare Pays Medicare Advantage Plans: Issues and Policy Options," KFF, November 20, 2025, <https://www.kff.org/medicare/how-medicare-pays-medicare-advantage-plans-issues-and-policy-options/>; Boynton et al., "Decision Vacating CMS Rule Governing RADV Audits Has Important Implications for Medicare Advantage Organizations," WilmerHale, October 2, 2025, <https://www.wilmerhale.com/en/insights/client-alerts/20251002-decision-vacating-cms-rule-governing-radv-audits-has-important-implications-for-medicare-advantage-organizations>; Sabrina Skeldon, "A Discussion of Risks Posed by the 2023 CMS Final RADV Audit Rule," The American Bar Association, February 15, 2024, https://www.americanbar.org/groups/business_law/resources/business-law-today/2024-february/risks-posed-by-2023-cms-final-radv-audit-rule/.
- 11 Centers for Medicare & Medicaid Services, "Medicare Advantage Risk Adjustment Data Validation Program," July 21, 2025, <https://www.cms.gov/data-research/monitoring-programs/medicare-risk-adjustment-data-validation-program>.
- 12 Centers for Medicare & Medicaid Services, "Medicare Advantage Risk Adjustment Data Validation Program," July 21, 2025, <https://www.cms.gov/data-research/monitoring-programs/medicare-risk-adjustment-data-validation-program>; Sabrina Skeldon, "A Discussion of Risks Posed by the 2023 CMS Final RADV Audit Rule," The American Bar Association, February 15, 2024, https://www.americanbar.org/groups/business_law/resources/business-law-today/2024-february/risks-posed-by-2023-cms-final-radv-audit-rule/; Boynton et al., "Decision Vacating CMS Rule Governing RADV Audits Has Important Implications for Medicare Advantage Organizations," WilmerHale, October 2, 2025, <https://www.wilmerhale.com/en/insights/client-alerts/20251002-decision-vacating-cms-rule-governing-radv-audits-has-important-implications-for-medicare-advantage-organizations>.

- 13 CMS Newsroom, "CMS Rolls Out Aggressive Strategy to Enhance and Accelerate Medicare Advantage Audits," May 21, 2025, <https://www.cms.gov/newsroom/press-releases/cms-rolls-out-aggressive-strategy-enhance-accelerate-medicare-advantage-audits>.
- 14 Humana Inc. and Humana Benefit Plan of Texas, Inc. v. Becerra, No. 4:23-Cv-00909-O (U.S. District Court for the Northern District of Texas, Fort Worth Division, September 25, 2025), <https://litigationtracker.law.georgetown.edu/wp-content/uploads/2023/09/Humana-Inc.-2025.09.25-ORDER-ON-MOTION-FOR-SUMMARY-JUDGMENT.pdf>; Boynton et al., "Decision Vacating CMS Rule Governing RADV Audits Has Important Implications for Medicare Advantage Organizations," WilmerHale, October 2, 2025, <https://www.wilmerhale.com/en/insights/client-alerts/20251002-decision-vacating-cms-rule-governing-radv-audits-has-important-implications-for-medicare-advantage-organizations>; Rob Pipich, "Federal Court Vacates 2023 CMS Final Rule on RADV Audits, Citing Procedural Flaws," Milliman, September 30, 2025, <https://www.milliman.com/en/insight/federal-court-vacates-2023-rule-cms-radv-audits>.
- 15 Fuglesten Biniek, "How Medicare Pays Medicare Advantage Plans: Issues and Policy Options," November 20, 2025, <https://www.kff.org/medicare/how-medicare-pays-medicare-advantage-plans-issues-and-policy-options/>.
- 16 Steven Ferraina, Update on the Status of Medicare Advantage Risk Adjustment Data Validation Audits, HPMS Memorandum (Centers for Medicare & Medicaid Services, 2026).
- 17 If the Department of Health and Human Services' (HHS) appeal is successful, HHS could reinstate the 2023 rule, greatly increasing repayment liabilities. Additionally, CMS could still reintroduce extrapolation in a future rule if it meets procedural requirements given that the court did not rule extrapolation itself illegal. CMS has also explicitly reserved the right to apply extrapolation-based recoveries if legally authorized later in its PY 2020 RADV Audit Methods and Instructions.
- 18 "Aetna Agrees to Pay \$117.7 Million to Resolve False Claims Act Allegations," U.S. Department of Justice, March 11, 2026, <https://www.justice.gov/opa/pr/aetna-agrees-pay-1177-million-resolve-false-claims-act-allegations>; "Kaiser Permanente Affiliates Pay \$556M to Resolve False Claims Act Allegations," U.S. Department of Justice, January 14, 2026, <https://www.justice.gov/opa/pr/kaiser-permanente-affiliates-pay-556m-resolve-false-claims-act-allegations>; "Medicare Advantage Provider Independent Health to Pay Up To \$98M to Settle False Claims Act Suit," U.S. Department of Justice, December 20, 2024, <https://www.justice.gov/archives/opa/pr/medicare-advantage-provider-independent-health-pay-98m-settle-false-claims-act-suit>; "Cigna Group to Pay \$172 Million to Resolve False Claims Act Allegations," U.S. Department of Justice, September 30, 2023, <https://www.justice.gov/archives/opa/pr/cigna-group-pay-172-million-resolve-false-claims-act-allegations>.