CAPITOL STREET

November 23, 2025

# Government Appeals MA RADV District Ct Decision

## Audits Likely On Hold For Now as CMS Assesses Next Steps

Relevant Companies

## Our Take & Next Up

**Late Friday Nov. 21, the government appealed the District Courts RADV ruling, tossing out the 2023 RADV guidance.** The defendants have appealed to the US Court of Appeals (5th Circuit). An appellate court will take weeks to months for briefing and a decision.

**As a reminder, CMS initiated aggressive RADV (Risk Adjustment Data Validation) audits of all MA plans for PY (Payment Year) 2019 in two tranches, early and late June 2025 (here).** The first batch of MA audits included 45 contracts, and was supposed to begin on June 12, while the second batch of 310 contracts announced on June 25 here.

**CMS will likely have to re-write the MA rules for audits to begin.** CMS had announced in June changes to its Risk Adjustment Data Validation (RADV) audits in 2025, signaling a shift to more intense plan oversight. CMS intended to extrapolate results from these audits; the 2019 audits use small samples (n=35) to calculate overpayments on a large scale. Audited MA plans would have had three months to collect and submit medical records from providers; for the 2018 audit, plans had five months to collect and submit these records. We said in June (here) that this truncated timeline could result in provider friction as they are asked to submit medical records in a short timeframe.

## Key Points

**HHS will appeal the lower court's Sept 25 ruling on RADV, which threw out the audit rules on procedural grounds (versus actual substance).** On September 25, 2025, a federal court issued a ruling that directly impacts the landscape of Risk Adjustment Data Validation (RADV) audits for Medicare Advantage Organizations (MA plans). In the case of *Humana Inc. v. Xavier Becerra*, Judge Reed O'Connor's ruling did not address the substance of the 2023 final rule itself, but dismissed the rule on procedural grounds under the Administrative Procedure Act (APA), creating immediate uncertainty for audits covering payment years 2018 and beyond (here).

**What's at issue? The FFS adjuster.** The case centered on the final rule issued by CMS on February 1, 2023 (here). This rule formalized a policy allowing CMS to audit a small sample of a Medicare Advantage (MA)

contract's enrollees and then use statistical extrapolation to calculate alleged overpayments across the entire contract population, which CMS could then pursue for recovery.

**We had said that CMS was careless with these rules: The agency did not collect stakeholder comments.** The government also argued that agencies "did not have 'an obligation to seek comment on [their] statutory interpretations.'" The court commented that the argument "plainly fails. Defendants' assertion is based on the premise that interpretive rules, unlike legislative rules, need not be subjected to notice and comment." The requirement for actuarial equivalence in the MA payment model is legislated and "[i]t is a longstanding principle that actuarial equivalence applies to RADV audits.

**Now what? The appellate court proceedings will start and RADV audits are unlikely to commence for 6-12 months, as CMS will likely have to rewrite the rules.** The grounds for the appeal will become apparent in subsequent filings. We will provide more color as we have it. We had said that the mid 2025 rules around RADV were aggressive with tight timelines (see background below), and that legal challenges are likely.

**BACKGROUND**

**The agency quietly announced June 25 (here) will audit all MA plans for PY 2019-2024 using enhanced extrapolation and sampling methods, modern technologies, increased staffing, and coordination with the OIG (Office of Inspector General)** We believe this is an aggressive timeline, with CMS' audit methodology, and lack of an adjustment for errors in the underlying risk adjustment model (also known as the 'Fee-for-Service adjuster') being questioned and likely challenged by the plan community, using *Azar vs. Allina* as one of several arguments. Humana has filed suit against CMS on the final RADV rule.

**By early 2026, CMS aims to complete all PY 2019-2024 audits.** Key dates for first batch of PY 2019 Audits (45 contracts, initiated June 12): June 20: Medical record (MR) submission window for PY2019 begins. September 15: Deadline for PY 2019 medical record submission. Key dates for the second batch of PY 2019 Audits (310 contracts, initiated June 25) are as follows.

- July 7, 2025: Medical record submission window opens
- September 29, 2025: Deadline for MR submission.

**We had said at the time that this was an aggressive task for the agency: the CMS Center for Program Integrity is significantly understaffed.** CMS notes it will bring in the use of AI and contractors to complete the audits. CMS has stated its intent to audit all MA plans-not just high-risk ones-prompting debate about their authority and discretion in implementing these sweeping, system-wide audits.

**We had said this summer (here) that the 2019 *Allina* ruling may present a legal obstacle to CMS's new RADV audit strategy — particularly its methodology and lack of an application of a Fee-for-Service adjuster — by reinforcing that substantive policy changes affecting reimbursement require formal notice-and-comment rulemaking.** In *Allina*, the court struck down HHS's 2014 changes to DSH payments for bypassing this process. Similarly, CMS's methodology in their audit announcements, without new rulemaking, could be seen as a violation of the Medicare Act. CMS cites its 2023 Final Rule as legal justification, which authorizes extrapolation from PY 2018 onward and would not apply a Fee-for-Service Adjuster, boosting the amount it would recoup from RADV audits. CMS also has argued that these changes do not harm small providers, anticipating *Allina*-based critiques. Still, CMS's audit methods may face legal challenges.

**METHODOLOGY**

**CMS's expanded use of extrapolation in RADV audits this year -- prior to the District Court decision -- marked a shift in strategy, raising concerns of statistical reliability and legal validity**. Under CMS' methodology for PY 2019, they use a small sample of enrollees to estimate the change in risk score, extrapolate overpayment based on the average change in risk scores, and then take back the overpayment. CMS will extrapolate results only if the lower bound of the 90% confidence interval of the change in risk score (where the change in risk score is calculated as the pre-RADV risk score minus the post-RADV risk score) exceeds zero.

**A sample size of 35 would be used, which is lower than the size used in 2011, 2012, and 2013 audits**. CMS now uses predictive models to target high-risk enrollees, allowing smaller samples (as few as 35 enrollees). On June 25, CMS released the recent PY 2019 MA RADV Audit Methods and Instructions document, detailing its use of a 35-enrollee random sample from high-risk enrollees. Given the small sample size, one large change in risk score for one or two sampled members can have a disproportionate impact on the average change in risk score for the 35 person sample.

**AUDIT SCHEDULE**

**CMS had previously stated it will complete all outstanding audits for PY 2019-2024 by early 2026.** The agency plans to modernize its tech systems for flagging unsupported diagnoses, expand its audit workforce from 40 to 2,000 coders by September 1, 2025, and coordinate with HHS-OIG for validation support.

**The CMS PY 2019 contracts were released in two stages, first on June 12, and then on June 25: CMS selected 45 MA contracts in the first batch of audits, and 310 in the second batch,** including parent organizations that include Elevance, Humana, UnitedHealth, WellCare, InnovaCare, Molina, Cambia, & Alignment Health.

**OIG AUDITS (STILL ONGOING)**

**The Office of Inspector General (OIG) conducts independent audits, typically focused on high-risk enrollees, and is collaborating with CMS on overpayment recovery**. Unlike CMS, OIG does not have authority to directly recover funds—it can only recommend action by CMS.

**OIG is still reviewing some of the same contracts**. CMS is increasingly relying on OIG findings and both agencies share a goal of curbing overpayments. In its 2024 report, OIG flagged plans' misuse of unsupported diagnoses—particularly from in-home Health Risk Assessments—and urged CMS to impose stricter audit and repayment controls on MAOs.

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