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CMS Makes Significant Updates to and Expands Scope of Medicare Advantage RADV Audits

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On May 21, 2025, the Centers for Medicare & Medicaid Services (CMS) announced a significant expansion of its primary auditing tool used for Medicare Advantage (MA) plans or contracts.[1] CMS conducts Risk Adjustment Data Validation (RADV) audits to help ensure the accuracy of payments

based on the health status of Medicare beneficiaries in the MA program. These audits involve reviews of enrollee medical records to determine if diagnoses submitted for payment purposes have the appropriate documentation support in accordance with industry guidelines.

In MA, private health insurers (Medicare Advantage Organizations or MAOs) contract with CMS to offer managed Medicare benefits to Medicare-eligible enrollees through MA plans. The MAOs receive capitated monthly payments from CMS to care for individually enrolled Medicare beneficiaries based on the particular set of diagnosis codes submitted on encounters by the MAO to CMS for that enrollee (i.e., higher payments for patients with more severe or chronic conditions that cost more to manage), among other enrollee characteristics such as age, gender, and Medicaid eligibility status. The enrollee characteristics and diagnosis codes submitted on encounters in the year of service are used to calculate a risk adjustment factor or risk score (RAF) for each enrollee. The RAF score is used to determine the monthly payment amounts for each enrollee in the following year, known as the payment year. This methodology is known as risk adjustment. In an effort to improve accuracy of these payment amounts, CMS created RADV audits to verify the accuracy of MA plans' diagnosis code submissions by confirming that diagnoses that factor into the risk adjustment model for calculating payments are supported by medical records.

RADV Background

Originally implemented for 2007, CMS RADV audits were developed to serve as the primary audit tool to identify potential errors and overpayments to MAOs within the MA program. The purpose of RADV audits is to identify discrepancies in payments by comparing diagnosis data submitted by an MAO against medical record documentation MAOs provide during the audit to support conditions that affect enrollee risk scores, which drive the capitated payments from CMS to the MAO. Regulations mandate that diagnosis codes must be supported in the medical record to be submitted for risk adjustment purposes.[2]

This was accomplished through CMS selecting a sample of enrollees from a limited number of plans chosen through an undisclosed selection process. CMS would review medical records for these sampled enrollees to determine if any payment-related diagnoses were unsupported. CMS then calculated payment adjustments for potentially unsupported diagnoses for the sampled enrollees. The process by which enrollees were selected for the audit sample was intended to form a statistically valid sample that could support an extrapolated recovery to other eligible enrollees in the plan.

CMS has not collected extrapolated recoveries to date but intends to do so for the audits related to payment years 2018 and forward, which were initiated in November 2024[3] and are currently in process.

What Did CMS Announce?

In May 2025, CMS announced its intention to materially increase its RADV audit efforts. CMS acknowledges it is several years behind and has not recovered any significant MA overpayments since 2007. Instead of selecting a limited list of MA plans as has been the historical pattern, CMS announced that it will invest additional resources through enhanced technology and an increased team of medical coders to (1) audit all eligible MA plans for each payment year and (2) work through its backlog of

RADV audits for payment years 2018-2024 by early 2026. CMS did not indicate with which payment year the expansion to all eligible plans will begin although many more plans were selected for 2019 compared to 2018 to date. Notably, payment year 2018 is the first year that CMS' related final rule permits the extrapolation of RADV audit sample overpayments outside of the sampled enrollees to a broader sampling frame population[4] within the MA plan.[5]

What Else Do We Know About CMS' New RADV Methodology?

Along with the May 2025 announcement, CMS has also released a "Questions and Answers" document for both payment years 2018[6] and 2019[7] that includes a list of selected contracts under audit to date for each year. CMS has also released additional details regarding its updated RADV audits through an "Audit Methods and Instructions" document for 2018[8] and 2019.[9] These documents communicate CMS' audit methods and instructions to an MAO selected for audit in the year, including information related to the following important components of the audit:

- Statistical Sampling Methodology
- Sampling Frame Discussion
- Sample Selection Method
- Medical Record Requirements and Submission Instructions
- Payment Error Calculation and Extrapolation Methodology

What Are the Key Takeaways from CMS' Updated RADV Methodology and Announcement?

Plan Selection and Sampling Frame

For payment year 2018, CMS utilized two different plan and sampling frame selection criteria to select 58 total contracts for audit and the sampling frames for each. The first utilizes two MA improper payment prediction models to select certain contracts that have a higher likelihood of a RADV audit identifying overpayments. The second attempts to isolate and include contracts due to a higher use of chart review-related records[10] (i.e., a large number of enrollees with only chart review-related diagnoses submissions contributing to portions of their risk score). For payment year 2019, CMS does not include this second approach related to chart review diagnoses but instead selected 355 MA plans (45 initially, followed by second batch of 310) and each plan's related sampling frame solely using the improper payment prediction model approach.

CMS' methodology of selecting the sampling frame using an improper payment prediction model differs from its previously discussed methodology in 2012.[11] That methodology did not leverage an improper payment prediction model and sampled all RADV eligible enrollees. **Table 1** below contains a comparison between CMS' new sampling methodologies for payment years 2018 and 2019 as well as a comparison to CMS' previous discussion of the sampling process for RADV audits of MA contracts from 2012.

Table 1

Methodology	PY 2018	PY 2019	2012 Methodology
Plan Selection	58 contracts	355 contracts (45 initially, followed by second batch of 310)	Historically 30 contracts audited per year
Sampling Frame	*Historical RADV Eligibility:* 1. Continuous enrollment in the audited contract from January of the data collection year through January of the payment year 2. Enrolled in Medicare Part B coverage for all 12 months during the data collection year 3. At least one diagnosis in the data collection year that led to at least one CMS-HCC assignment for the payment year 4. Not in an End Stage Renal Disease or Hospice status from January of the data collection year through January of the payment year 5. Not part of any OIG audit or other pertinent settlement that included data from January of the data collection year through January of the payment year		
Sampling Frame (Cont'd)	Version A Ranked in the top decile of RADV eligible enrollees in RADV eligible MA contracts by one or both of CPI's MA improper payment prediction models *Or* Version B All Encounter Data System (EDS) CMS-HCCs are based on diagnoses submitted by the audited MAO to the EDS derived only from linked or unlinked chart review records 35 enrollees randomly selected from sampling frame	Ranked in the top decile of RADV eligible enrollees in RADV eligible MA contracts by one or both of CPI's MA improper payment prediction models 35 enrollees randomly selected from sampling frame	201 sample members randomly selected from three strata determined by risk score (67 members each for members with the lowest, medium, and highest risk scores)

Extrapolation Methodology

CMS indicates that extrapolation is expected to be the standard practice with CMS RADV audits of MA plans beginning with payment year 2018. When extrapolation is utilized, CMS will extrapolate the estimated payment error only to enrollees within the sampling frame.

For payment years 2018 and 2019, CMS will utilize a 90% confidence interval to determine a "lower bound" around a "point estimate" of the average drop in risk score derived from its sample audit results. For payment year 2018, CMS will look to recoup this *lower bound* estimate of extrapolated overpayments within the sampling frame. This differs from the methodology announced by CMS for payment year 2019, for which CMS has stated that it will look to recoup the *point estimate* of extrapolated overpayments within the sampling frame. CMS will only use the lower bound to determine if the lower bound is above zero. In cases where the lower bound estimate of overpayments is at or below zero, CMS indicates that it will not extrapolate the sample results to the sampling frame and will only look to recoup any sample-related overpayments for that MA plan.

This methodology of extrapolation differs from CMS' previously discussed methodology from 2012, [12] which indicated that the lower bound of a 99% confidence interval (a larger or wider interval that would result in a lower "lower bound" compared to a 90% confidence interval—see an example comparison depicted in **Figure 1** below) would be used as the estimate of overpayments for the sampling frame prior to the final rule restricting extrapolation from RADV audits to payment years

2018 forward. As can be seen in **Figure 1**, these changes are significant for MA plans as the lower bound of a 90% confidence interval is higher than that of a 99% confidence interval, while the point estimate is higher than either of the lower bounds.

Figure 1

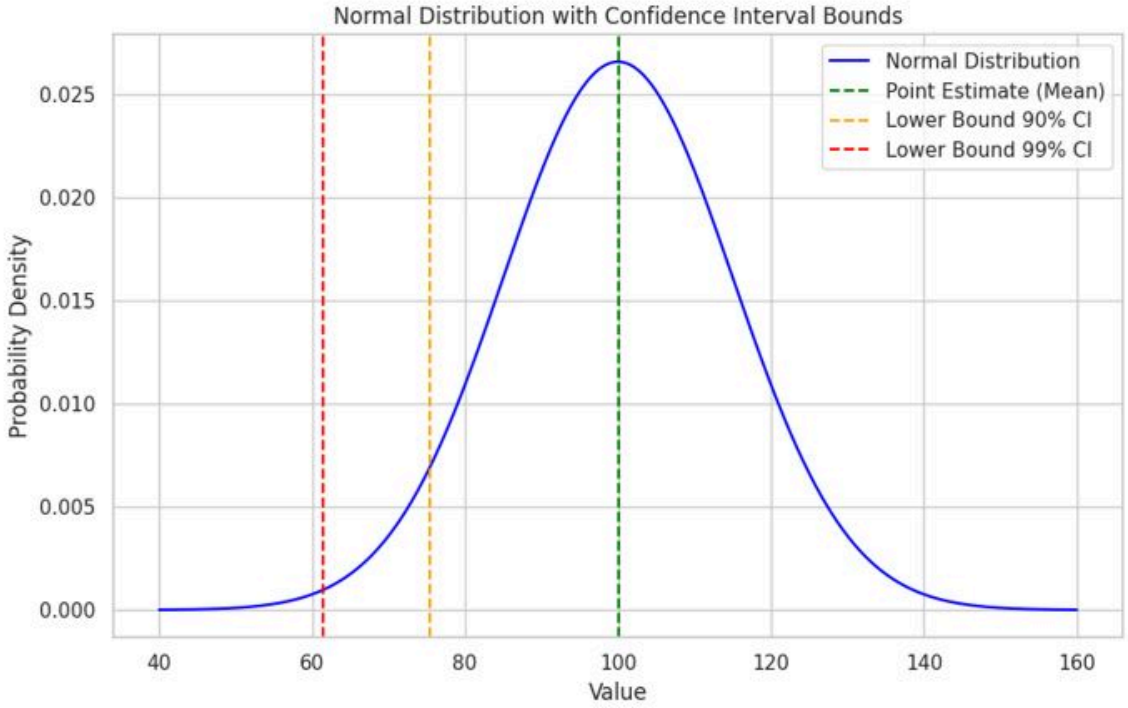

Table 2 below contains a comparison between CMS' new extrapolation methodologies for payment years 2018 and 2019 as well as a comparison to CMS' previous discussion of the extrapolation of audit results from RADV audits of MA contracts from 2012.[13]

Table 2

Methodology	PY 2018	PY 2019	2012 Methodology
Extrapolation	• Calculate the average change in risk score for the sampled enrollees to get the "point estimate" • Use the estimate of the variance of the average change in risk score for the sampling frame to determine the lower bound of a **90%** confidence interval • CMS indicates that the **lower bound of a 90%** confidence interval is the audit recoupment amount (capping the recoupment amount at $0 in the case of any potential underpayment)	• Calculate the average change in risk score for the sampled enrollees to get the "point estimate" • Use the estimate of the variance of the average change in risk score for the sampling frame to determine the lower bound of a **90%** confidence interval • CMS indicates that when the lower bound of a 90% confidence interval is greater than $0, the audit recoupment amount is the **point estimate** (when the lower bound is $0 or less, CMS will not extrapolate)	• Calculate the annual payment error across all sampled enrollees and multiply it by the enrollee's sampling weight to get the "point estimate" • Use the estimate of the variance of the payment error for the sampling frame to determine the lower bound of a **99%** confidence interval • CMS indicates that the **lower bound of a 99%** confidence interval would be the preliminary audit payment recovery amount (capping the amount at $0 in the case of any potential underpayment)*

* To determine the final payment recovery amount, CMS indicated that it would apply a Fee-for-Service Adjuster amount as an offset to the preliminary recovery amount. If the FFS Adjuster amount is greater than the preliminary recovery amount, the final recovery amount is equal to zero. The FFS adjuster accounts for the fact that the documentation standard used in RADV audits to determine a contract's payment error (medical records) is different from the documentation standard used to develop the Part C risk-adjustment model (FFS claims). CMS found more recently in its RADV-related final rule that a FFS Adjuster is not appropriate and would not be applied during further RADV extrapolations. The removal of the FFS Adjuster has been widely criticized by MAOs.

Summary

CMS has recently increased its focus on ensuring MAOs "are billing the government accurately for the coverage they provide to Medicare patients."[14] To do so, CMS has begun to implement a "significant expansion of its auditing efforts"[15] for MA plans through its RADV audit program by looking at an increased number of eligible MA plans for each payment year and investing in additional resources to expedite the completion of audits for payment years 2018 through 2024.

CMS' methodology for conducting these audits and determining what amounts to attempt to recoup from MAOs appears to be evolving through this expedited process. Importantly, as it relates to extrapolation, CMS plans to recoup extrapolated overpayments starting with payment year 2018 and then plans to increase the extrapolated overpayment estimates for 2019 compared to 2018 and earlier methodologies by (1) auditing far more contracts than historically done, (2) targeting the point estimate instead of the lower bound of a confidence interval, and (3) using a narrower 90% confidence interval instead of the 99% confidence interval described in the 2012 methodology.

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[1] CMS, *CMS Rolls Out Aggressive Strategy to Engage 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.

[2] CMS, Medicare Managed Care Manual Chapter 7–Risk Adjustment (Feb. 28, 2014), https://www.cms.gov/regulations-and-guidance/guidance/transmittals/downloads/r116mcm.pdf. Per CMS, as it relates to Risk Adjustment Data Submission Requirements, MAOs must: "Ensure the accuracy and integrity of risk adjustment data submitted to CMS. All diagnosis codes submitted must be documented in the medical record and must be documented as a result of a face-to-face visit."

[3] CMS, *Payment Year 2018 Contract-Specific Risk Adjustment Data Validation Questions and Answers* (last updated June 13, 2025), https://www.cms.gov/files/document/py2018-radv-questions-and-answers.pdf.

[4] HHS OIG, Statistical Sampling: A Toolkit for MFCUs (accessed on Aug. 25, 2025), https://oig.hhs.gov/documents/medicaid-fraud-control-units/10385/Statistical%20Sampling:%20A%20Toolkit%20for%20MFCUs.pdf. "The database from which a sample is drawn is known as the Sampling Frame."

[5] CMS, Medicare and Medicaid Programs; Policy and Technical Changes to the Medicare Advantage, Medicare Prescription Drug Benefit, Program of All-Inclusive Care for the Elderly (PACE), Medicaid Fee-For-Service, and Medicaid Managed Care Programs for Years 2020 and 2021, 88 Fed. Reg. 6643 (Feb.1, 2023).

[6] CMS, *Payment Year 2018 Contract-Specific Risk Adjustment Data Validation Questions and Answers* (last updated June 13, 2025), https://www.cms.gov/files/document/py2018-radv-questions-and-answers.pdf.

[7] CMS, *Payment Year 2019 Contract-Specific Risk Adjustment Data Validation Questions and Answers* (last updated June 25, 2025), https://www.cms.gov/files/document/payment-year-2019-radv-questions-and-answers-6-26-25.pdf.

[8] CMS, *Payment Year 2018 Medicare Advantage Contract-Specific Risk Adjustment Data Validation (RADV) Audit Methods and Instructions* (last updated July 21, 2025), https://www.cms.gov/files/document/payment-year-2018-ma-radv-audit-methods-instructions.pdf.

[9] CMS, *Payment Year 2019 Medicare Advantage Contract-Specific Risk Adjustment Data Validation (RADV) Audit Methods and Instructions* (last updated June 25, 2025), https://www.cms.gov/files/document/payment-year-2019-radv-audits-methods-and-instructions-6-26-25.pdf.

[10] Dep't of Health and Human Servs. Office of Inspector Gen., *Billions in Estimated Medicare Advantage Payments From Chart Reviews Raise Concerns* (Dec. 2019), https://oig.hhs.gov/documents/evaluation/2792/OEI-03-17-00470-Complete%20Report.pdf. "Chart reviews can be a tool to improve the accuracy of risk-adjusted payments by allowing MAOs to add and delete diagnoses in the encounter data based on reviews of patients' records."

[11] CMS, *Notice of Final Payment Error Calculation Methodology for Part C Medicare Advantage Risk Adjustment Data Validation Contract-Level Audits* (Feb. 24, 2012), https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/recovery-audit-program-parts-c-and-d/Other-Content-Types/RADV-Docs/RADV-Methodology.pdf.

[12] CMS, *Notice of Final Payment Error Calculation Methodology for Part C Medicare Advantage Risk Adjustment Data Validation Contract-Level Audits* (Feb. 24, 2012), https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/recovery-audit-program-parts-c-and-d/Other-Content-Types/RADV-Docs/RADV-Methodology.pdf.

[13] CMS has continued to change and evolve the MA RADV audit process and its methodology over time including a different methodology for 2014 and 2015 payment years. However, CMS did not release a specific extrapolation methodology for these years (for example, *see* https://downloads.regulations.gov/CMS-2018-0133-0267/attachment_7.pdf).

[14] CMS, *CMS Rolls Out Aggressive Strategy to Engage 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.

[15] *Id.*

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