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How Medicare Advantage Health Plans Can Prepare for RADV Audits

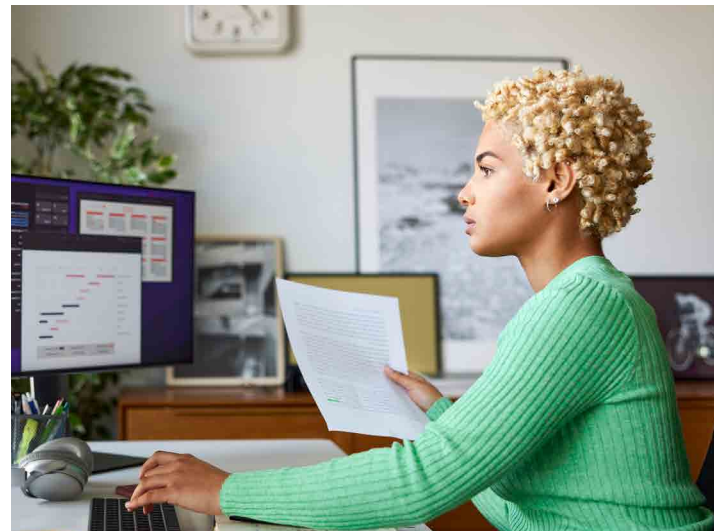


Introduction

On February 1, 2023, the Centers for Medicare & Medicaid Services (CMS) unveiled its approach to Risk Adjustment Data Validation (RADV) audits through the publication of a **final rule**. CMS's approach had serious operational and financial implications for Medicare Advantage (MA) plans, as it allowed for the extrapolation of audit findings for payment years 2018 and beyond. Errors found in a sample of member records from a RADV audit could be applied to a plan's entire MA contract, with recoveries expected to rise significantly in the years ahead. As discussed in its final rule, CMS estimated recoveries to be \$4.7 billion across the MA Program from 2023-2032.¹

In the years that followed, the extrapolation rule was heavily contested. In September 2025, the Federal District Court vacated the rule, and CMS appealed the rule less than two months later. This decision is still being litigated. In the meantime, CMS plans to comply with the vacated ruling but intends to pursue its stated strategy, per a **January 2026 memo**.

MA plans should proactively prepare for RADV audits. These tasks could include additional monitoring activities and reviewing their compliance programs to respond to changes in the population served, regulatory requirements, and industry best practices. Additionally, MA plans can implement operational best practices, such as data accuracy checks, staff training, and internal data audits to identify and address gaps. By choosing a strategic partner and integrating surveillance technology, MA plans can further enhance compliance and audit readiness, reduce financial risk, and even ensure better care for their members.



1. "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," Centers for Medicare & Medicaid Services, February 1, 2023, <https://www.federalregister.gov/documents/2023/02/01/2023-01942/medicare-and-medicare-programs-policy-and-technical-changes-to-the-medicare-advantage-medicare>

Rise of Medicare Advantage and Oversight

54%

Of those eligible for Medicare were participants in MA plans in 2025

For more than 25 years, MA plans have been the preferred choice of many Medicare-eligible beneficiaries, and payments to these plans now account for the majority of federal spending on Medicare.

According to the [Kaiser Family Foundation](#), 54% of those eligible for Medicare were participants in MA plans in 2025. This represents a significant increase in enrollment, given that only 19% of those eligible for Medicare chose MA plans in 2007.

MA growth has attracted increased attention from government agencies, which are tasked with auditing federal programs to prevent fraud and abuse, and ensure the financial integrity of Medicare. [The Government Accountability Office](#) has labeled the Medicare Program, including MA, “high risk” due at least in part to improper payment risk. [CMS](#) estimates the improper payment rate in MA for Fiscal Year 2023 was 6.01% of total payments or \$16.6 billion.

CMS is required to risk adjust payments to MA organizations under Section 1853(a)(1)(C) of the Social Security Act. CMS introduced the Medicare RADV audit program to ensure the accuracy of payments to MA plans based on members’ health status and to recoup possible overpayments. CMS has used pilot audits to refine its approach over the years and respond to legal challenges.

Following the 2023 final rule’s publication, CMS finalized policies related to the RADV audit program, applying extrapolation for payment years 2018 and beyond (but not for payment years 2011 through 2017). As of January 2026, MA plans should expect expedited audits for PY 2018-24, and all RADV-eligible contracts will be audited on a recurring basis.

Impact on Estimated Collections of Improper Payments per Year from RADV Rule

[\$ in millions]

	2023	2024	2025	2026	2027	2028	2029	2030	2031	2032	Total
Estimated Non-Extrapolated Collections Assumed Without RADV Final Rule Changes	13.1	28.0	11.6	10.9	12.7	13.5	14.4	15.4	16.4	17.5	153.5
Estimated Collections from Audits Completed in Prior Years with RADV Final Rule Changes	13.1	28.0	497.4	447.5	522.6	557.2	594.0	633.2	675.0	719.5	4,669.5
Additional Estimated Collections as a Result of RADV Final Rule	0.0	0.0	467.8	436.6	509.9	543.7	579.6	617.8	658.6	702.0	4,516.0

Source: "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." Centers for Medicare & Medicaid Services, Feb. 1, 2023. www.federalregister.gov/d/2023-01942

\$4.7 Billion

The estimated
recovery amount
from 2023
through 2032

By applying extrapolation to the audit findings from the 2018 payment year, CMS predicts a net recovery of \$428.4 million in 2025 – the difference between the projected recovery of \$479.4 million and the annual \$51 million cost of the RADV program. The federal agency estimates an average recovery of \$8.2 million per audited year without extrapolation. The estimated recovery amount from 2023 through 2032 is \$4.7 billion. According to CMS officials in the final rule, the RADV rule is crucial to yielding positive net recoveries.

The onus is on MA plans to ensure that data on their members' risk scores are adequately supported by properly documented diagnoses from face-to-face encounters, which are then mapped into hierarchical condition categories (HCCs). Proper coding will ensure accurate payment adjustments and help MA plans avoid repayments for risk-adjustable conditions which are not supported by medical records.



Understanding RADV Audits

A CMS RADV audit verifies whether the diagnosis codes submitted by MA plans are supported by medical record documentation. These codes reflect enrollees' health status and, together with other factors, determine the payment level from CMS to MA organizations. Since payments are higher for enrollees with diagnoses that are expected to require more intensive healthcare services, CMS is focused on ensuring the diagnoses are accurately coded.

RADV audits help CMS identify diagnosis codes not properly supported in medical records, as well as identify payment errors to MA organizations. In recent years, CMS has changed the particulars of its sampling and extrapolation audit methodology.

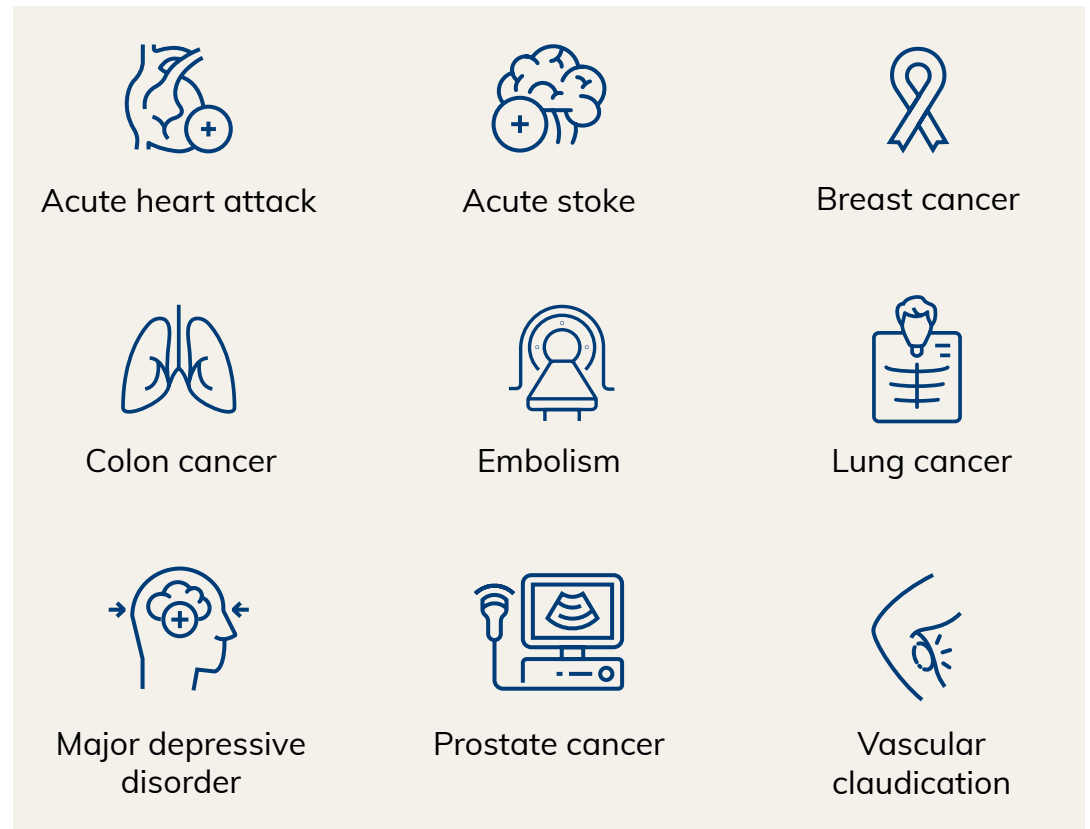
During a RADV audit, CMS will identify a sample of enrollees, or possibly health conditions, consistent with the methodology that CMS is using for that audit. CMS or its contracted auditors will request medical records from the selected MA organizations to support the sampled selection. The medical records will be reviewed to determine whether the diagnoses included in the audit sample are supported.

As stated in the [2026 Advanced Notice](#) for methodology changes, CMS seeks to refine the types of diagnosis submissions that will be considered for risk score calculation. This includes the exclusion of audio-only telehealth services and unlinked chart review records (CRRs) starting in 2027.

Audio-only telehealth appointments do not meet the "face-to-face" requirement for risk adjustment and will be excluded from both model calibration and risk score calculation. CMS also proposes to exclude all diagnoses submitted via CRRs that are not linked to a previously accepted Encounter Data Record (EDR). This move addresses data integrity concerns where diagnoses were submitted without an associated record of service.

Also in the January 2026 memo, CMS indicates it will reduce the maximum number of medical records allowed per audit Hierarchical Condition Categories (HCC) from five to two. This places higher stakes on the quality of each record submitted for review during an audit.

CMS may use a sub-cohort methodology in some RADV audits as an alternative to other sampling methods. While CMS has not specified which diagnosis codes the RADV program may focus on, a review of certain published audits conducted by the U.S. Department of Health and Human Services' Office of Inspector General (OIG) may indicate particular diagnosis groups of interest:



With spending on MA only increasing, MA plans need to be ready for what has changed and what will change in the years to come by having a sustainable RADV audit strategy to support the proposed quarterly audit schedule.



Preparation Steps for RADV Audits

For MA plans, properly preparing for RADV audits is strategically important. MA plans should consider adopting practices to mitigate the risk of financial recoupments and maintain the integrity of their risk adjustment data submissions.

“MA plans need to be ready for an audit at any time,” says Kathryn Eshelman, M.D., MPH, Vice President of Medical Informatics at Inovalon. “If a health plan fails to substantiate the diagnoses in even a small percentage of cases, the financial repercussions can be substantial, with potential losses amounting to a significant slice of their revenue. Beyond the financial impact, there is the risk of reputational damage and the potential of reducing the quality of care for members due to inaccurate documentation of diagnoses.”

For Eshelman, MA plans need to establish a compliance program because it serves as a system of checks and balances to ensure the accuracy and integrity of coding and billing practices.

“Every health plan needs a compliance program and a dedicated coding team,” she maintains. “CMS expects plans to actively look for and fix coding errors. The goal is to prevent incorrect codes from being used from the start, which is better than trying to correct them later. This means focusing on the most relevant data and avoiding unnecessary or incorrect information that some others might include.”

According to Eshelman, MA plans should also consider directly engaging providers and deliver clear guidance on proper documentation and adherence to coding guidelines before submitting claims — all while simultaneously reviewing past claims to identify and correct any errors. Technology and analytics can aid in this process by highlighting potential issues early on and supporting ongoing compliance efforts. Collecting thorough documentation to support diagnoses can also be important since patient data is often scattered across various electronic health records.

“Organizations without advanced surveillance technology face a daunting and labor-intensive task akin to finding a needle in a haystack when preparing to respond to RADV audits,” she warns.

“However, by employing sophisticated surveillance analytics, health plans can efficiently and effectively pinpoint areas of concern within their data. For optimal audit preparedness, combining technology-driven internal audits with traditional random sampling methods helps health plans vet their coding practices.”

Eshelman suggests that internal audits should occur multiple times annually, with at least one early in the year for initial assessment. Then, perform additional audits later, particularly in the fall, to ensure any coding errors are corrected before submission to CMS.

Choosing the right technology partner is another factor in ensuring accurate data collection and analysis as well, especially given the evolving nature of RADV audits to date and into the future.

“The ideal technology partner is committed to continuously refining its solutions, utilizing a dedicated clinical team and coding team to ensure all systems and data are accurate,” says Eshelman. “An innovation partner should leverage artificial intelligence (AI) effectively, benefiting from extensive data sets to refine their models while recognizing that AI requires appropriate clinical and coding oversight and cannot yet operate independently. In an evolving healthcare landscape, it’s critical that their systems remain effective, accurate, and trustworthy for health plans preparing for RADV audits.” Rigorous RADV audit preparation ensures compliance and strategic success and requires robust verification, continuous training, and technology integration to safeguard against financial and reputational risks.



Engaging with Providers on Accurate and Complete Documentation

To prepare for RADV audits, MA plans can help their provider partners be successful in completing the documentation required to substantiate the diagnosis codes submitted for risk adjustment.

Potential strategies include:

Standardizing data collection. MA plans should consider conducting regular education sessions for healthcare providers on the importance of data accuracy. During education, highlight the necessity for the data accuracy that's required for risk adjustment and RADV audits.

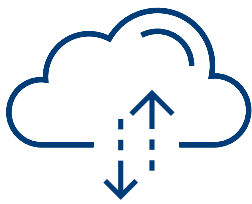
Conducting regular education sessions can also help build relationships between plans and providers, and open further communication around the value of good data practices. Ensuring that everyone is “on the same page” will increase buy-in to data accuracy and decrease error risk as well.

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Providing feedback to providers from internal audits. If an MA plan identifies coding irregularities or errors during an internal audit, the MA plan could develop feedback to providers and/or incorporate such feedback into education sessions.

Leveraging digital tools for data accuracy. health records (EHR) contain essential data that MA plans can use to round out their data collection and compliance. However, ingesting and integrating EHR data into risk adjustment reporting has traditionally been time consuming, manual, and error prone. With the help of AI, plans can transform data extraction and data analysis to better capture, ingest, and apply EHR data in risk adjustment reporting.



How Technological Innovations Help in the Audit Processes

Collecting, cleaning, managing, and maintaining data is thankfully no longer a manual process, and emerging technologies can greatly assist MA plans in the efficiency and accuracy of their RADV audit preparation. The following technologies and advances can help implement increased data management and governance systems:

Artificial intelligence (AI), machine learning (ML), and natural language processing (NLP). MA plans looking to increase their data management and compliance can use AI or ML algorithms to identify unusual patterns or anomalies in their data submissions, potentially flagging inaccuracies or areas requiring further investigation. AI can also automate and speed up various steps of the audit process, from initial data analysis to identifying potential risk areas, **reducing the manual effort required for reviewers**. Additionally, MA plans can use NLP to simplify the review of collected provider documentation, improving the identification of necessary information for validating diagnosis codes. Such use of AI, ML, and NLP should be reviewed by individuals with expertise in risk adjustment and documentation requirements.

Advanced data analytics. Plans can incorporate analysis tools into the audit approach as well, which could include integrated analytics or implementing healthcare-focused analysis software to support accurate risk adjustment and reduce the risks associated with audits. Advanced data analytics and predictive models can forecast future audit risks, enabling a more proactive compliance strategy and earlier recognition of corrective measures.



Choosing the Right Technology Partner

MA plans wanting to create a more robust compliance and data management program may have the willingness, but not the in-house expertise or resources to do so. This is why partnering with a knowledgeable software provider can help increase compliance, decrease costs, and build a foundation for future reduced risk.

Here's what to consider when selecting a strategic technology partner:

- **Experience and Expertise:** Look for vendors with a proven track record in risk adjustment and healthcare analytics, as they'll best know how to guide MA plans..
- **Data Security and Compliance:** Ensure the vendor follows stringent data security practices and complies with healthcare regulations like the Health Insurance Portability and Accountability Act (HIPAA).
- **Integration Capabilities:** The vendor's solutions should integrate seamlessly with your health plan's existing systems, making for a more streamlined, time-saving process.
- **Scalability:** Choose a vendor that can scale solutions to meet growing data and analysis needs. As the amount of data an MA plan needs to manage will only increase, look for scalability options like cloud infrastructure and data lakes.
- **Customer Support:** Assess the vendor's customer service framework so that there's support and guidance available when it's needed.
- **Innovation and Future-Proofing:** Evaluate the vendor's commitment to innovation and their ability to adapt to future industry changes. Considering the changing nature of CMS requirements and the evolving technologies that support data management, determine today whether the vendor will remain at the cutting edge of technology tomorrow.

Having the right partner can bring widespread value to an MA plan. It's not just about having access to a robust technology stack that delivers solutions for data management, analytics, and insights. It's also about having a trusted, knowledgeable, and responsive partner you can turn to help solve your pain points.

Conclusion

With CMS seeking to recover billions in overpayments, MA plans must prioritize RADV audit preparation to avoid financial losses and reputational damage, and ensure their members receive appropriate care.

A compliance program with a dedicated coding team is essential to maintaining the accuracy and integrity of data submissions. Taking proactive measures through provider engagement and advanced surveillance analytics can streamline the audit preparation process. Conducting internal audits throughout the year can further strengthen a health plan's compliance posture.

Partnering with a technology provider committed to ongoing innovation and improvement, particularly one that integrates AI with clinical oversight and coding expertise, will help MA plans keep pace with regulatory changes and safeguard against the risks associated with RADV audits.

For more strategies to prepare for RADV audits, read our blog on [identifying potentially over-coded conditions early on](#).



About us

Inovalon is a leading provider of data and solutions empowering data-driven healthcare. We bring together national-scale connectivity, real-time primary source data access, and advanced analytics into a sophisticated platform empowering improved outcomes and economics across the healthcare ecosystem. The company's analytics and capabilities are used by over 50,000 active, licensed customers. For more information, visit www.inovalon.com.

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