Guide

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Future-Proofing MA Plans: Essential Strategies for Year-Round MA RADV Audit Readiness

This guide will help you achieve continuous readiness and protect your plan from today's toughest CMS audits.

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Audit Readiness: The Make-or-Break Moment for MA Plans

With CMS raising the stakes for Medicare Advantage plans, audit readiness is no longer optional. Only those organizations that prepare early and stay vigilant will avoid significant financial risks.

Medicare Advantage (MA) enrollment is rising at nearly 8% annually, with per-enrollee spending now at 122% of traditional Medicare.[1] To control costs and address overpayments, CMS has introduced significant changes to Risk Adjustment Data Validation (RADV) audits, affecting audit methods, extrapolation, and timelines.

These changes could make or break the future of many plans. Now, MA plans may be on the line for millions of dollars of payment recoupment should these broader, deeper audits find evidence of overpayment.
The focus on overpayments is unlikely to be temporary. CMS's announcement in May[2] represents another initiative by the agency as it prioritizes program integrity.

Medicare Advantage plans should begin preparing for audits by systematically retrieving historical medical records, identifying any evidentiary deficiencies, and familiarizing themselves with recent updates to the submission process. Taking concrete actions to respond to audits more thoroughly and promptly is already a major priority for many organizations. Additionally, working closely with providers proactively helps reduce financial disruption and enhance care quality.

In this guide, discover the audit-readiness steps all MA plans should prioritize. Then, develop a strategy that weaves together organizational preparedness, advanced technology, and provider engagement to make more regular and intensive audits seamless with minimal disruption to operations or financial performance.

Medicare Advantage began in 1997 (as Medicare Part C) to give seniors more choices, more coverage, and better care. Introducing private insurers to Medicare, MA was an early attempt to catalyze value-based care with the underlying hypothesis that increased innovation and care management would drive quality improvement and cost savings.[3] The program has grown at a rapid pace—in 2025, there were over 3,700 MA contracts available, and federal spending on quality bonus payments will be four times higher than a decade ago.[4]

Over the past 30 years, the MA program has been under scrutiny due to concerns about fraud, waste, and abuse. The Government Accountability Office has labeled the Medicare Program, including MA, "high risk" due at least in part to improper payments.[5] Some estimates indicate that MA may be overspending by 22-35%. Audits as far back as 2011 have indicated that roughly up to a quarter of diagnoses were not documented.[6]

Understanding MA RADV: What CMS is looking for

The Medicare Advantage Risk Adjustment Data Validation (RADV) Program, administered by CMS, is the principal mechanism for addressing overpayments to MA plans. During a RADV audit, CMS coders will request a targeted selection of a health plan's medical records pertaining to a specific case. The coders then examine the documentation to verify that the evidence substantiates the diagnoses that have been billed.

CMS generally focuses on records that include these diagnoses of interest:

- Acute heart attack
- Breast cancer
- Acute stroke
- Colon cancer
- Embolism
- Lung cancer
- Major depressive disorder
- Prostate cancer
- Vascular claudication7

CMS then estimates overpayments and the resulting recoupment amount by first calculating the difference in the sample between payments and accurate, risk-adjusted payments. Finally, it uses a statistically valid extrapolation method to estimate total overpayments to the plan.

What CMS's new audit mandate means for MA plans

In May 2025, CMS made a major move toward increasing MA program integrity, drastically increasing its resources to broaden the scope of RADV audits and recoup more overpayments. Specifically, CMS has announced that:

- All MA plans will be audited on an annual basis, not just a subset of plans.
- The number of records audited per health plan will increase from 35 to 200.
- The agency's goal is to complete audits for seven years' worth of payments by the end of 2026, representing a significant operational and financial risk for all MA plans.
- To support the expansion, CMS will rapidly scale its audit workforce from 40 to 2,000 medical coders and deploy advanced technology to flag suspicious diagnoses and collect overpayments.[1]

The era of the "audit lottery" is over. Instead of rushing every year to meet audit deadlines and respond to auditor queries, every MA plan must take proactive steps to stay audit-ready throughout the year.

RADV by the numbers: The new reality of CMS enforcement

Metric	Previous approach	New CMS strategy	Change
Plans audited annually	~60 plans	All 550+ plans	+10X
Sample size per plan	35 members	Up to 200 member	+5.7X
Audit frequency	Sporadic selection	Every plan, every year	100% coverage
CMS coding staff	40 coders	2,000 coders	+5X
Estimated annual overpayments	$15.34B	$17B-$43B	Accelerating
Extrapolation applied	Limited to sample	All PY 2018+ audits	Universal
Submission time	20 weeks	12 weeks	-40%
Medical record support	5 per member HCC	2 per member HCC	-60%

With recent CMS estimates citing up to $43 billion a year in overpayments, the agency is looking to use RADV audits to recoup the difference. In 2023, as part of the RADV final rule, CMS decided to extrapolate overpayment findings from as far back as 2018. This would result in an estimated $4.7 billion in additional recoupment. For MA plans, that means that every dollar of overpayment found in a RADV audit sample would lead to an additional $55 of overpayment by way of extrapolation.[6]

Previously, when CMS was looking at 35 records, overpayments were estimated by extrapolating to that disease-specific population. Now, looking at a broader swath of up to 200 records could lead to broader extrapolation and significantly higher recoupment. MA plans need to consider these potential costs across seven years of payments.

Beyond the potential costs of overpayment recoupment are additional penalties from the False Claims Act and Department of Labor for findings of non-compliance. Non-compliant plans also risk reputational damage, challenging their ability to attract new members and retain existing ones, jeopardizing their financial sustainability.

> “*Its really important to reconcile your inputs, coding results and outputs to your EDL every step along the way"*
>
> Roxanna Cross,
> *Solutions Architect at Reveleer*

MA plans will need to devote resources to remaining audit-ready to prevent costly non-compliance issues. By following the strategies below, these plans can improve workflow flexibility, safeguard data integrity, and better prepare for increasingly frequent, detailed audits.

1. Dedicate financial and staff resources to compliance

To meet the demands of yearly audits that investigate a higher number of member records, plans will have to allocate additional resources including budget and staff time. All MA plans should develop dedicated internal response teams to stay accountable for audit readiness year-round.

Team composition:

- Dedicated representation from health plan leadership
- Compliance staff
- Legal staff
- Clinical documentation integrity (CDI) professional
- Physician, nurse, or another clinician

Team responsibilities:

- Develop a good internal understanding of coding guidelines and how they've changed over the years
- Educate staff about coding guidelines to ensure compliance with evolving models
- Work with CDI specialists to engage providers on clinical documentation best practices
- Ensure the plan has a legal strategy in place should audit methodologies or extrapolation logic come under dispute
- Investigate, recommend, and oversee the implementation of technology to aid in audit readiness processes including medical record retrieval and clinical coding

2. Prioritize provider engagement

As healthcare focuses more on value, it's vital for plans and providers to work together. Health plans rely on providers to deliver high-quality care and document it accurately, while providers count on payers to allocate the necessary financial resources to treat their patients and tom make timely reimbursements. Both payers and providers are at risk if CMS finds evidence of overpayments, and this shared concern should drive closer partnership to adopt better risk adjustment strategies for audit readiness.

As healthcare focuses more on value, it's vital for plans and providers to work together.

Working in tandem to close documentation gaps offers both payers and providers stronger protection to prevent errors and reduce the risk of inaccurate payments. To protect both revenue and care outcomes, MA plans and providers must work in lockstep to maintain data integrity and meet member needs.

Every health plan can benefit from taking concrete steps to increase provider engagement, including:

- Clarifying contractual language with providers to support audit needs so that expectations are clear and providers and payers can both plan ahead
- Automating the provider attestation process to make it simpler and less time-consuming to make requests, send reminders, and track attestation status
- Using multi-channel retrieval tools—including email, fax, portal, and phone—to improve medical record collection
- Integrating provider engagement metrics into dashboards and project tracking for visibility into pursuit status, bottlenecks, and areas for intervention

3. Stay up to date with coding changes

Updates to RADV mean payers must validate records going back multiple years with multiple coding models. Coding teams must be familiar with historical HCC models and CMS guidelines as they have evolved since 2018.

One major evolution has been the transition to Risk Adjustment Model V28 from V24. This transition has been one of CMS's efforts to increase the accuracy of risk adjustment data and reduce overpayments. Any software system that a health plans uses will need to have historical payment models.

About the transition to V28

- The transition to V28 has been a major effort by CMS with a three-year phase-in: 2023 through 2025.
- The transition aims to increase the accuracy of risk adjustment data and reduce overpayments.
- V28 reflects the increased detail in ICD-10 codes and increases the number of Hierarchical Condition Categories (HCCs) from 86 to 115.
- V28 also shifts the focus away from the volume of a patient's diagnoses to their severity to get a more precise measurement of member health.
- As a result of increased specificity and a focus on severity, CMS projects overall risk scores will decrease, possibly resulting in lower reimbursement rates.[4]

4. Invest in cleaner, centralized, accessible data

CMS's new RADV audit strategy demands that plans aggregate all risk adjustment data starting in payment year 2018. To do this, it might be necessary to work with previous vendors and even contact providers that have closed their doors to ensure access to all relevant medical records.
Powerful technology can support large-scale data management by:

- Ingesting enrollee data lists (EDLs) and aggregating medical records from a broad range of sources including legacy systems, former vendors, and even closed provider offices
- Automating multi-channel retrieval from EHRs, HIEs, and cloud repositories
- Implementing digital workflows to secure and link missing provider attestations as well as manage daily status reporting and evidence tracking
- Digitizing disparate formats and reconciling records across contracts, sources, and EDLs
- Validating all imported medical record data, applying the appropriate historical coding logic for each audit year, and flagging discrepancies or documentation gaps in real time

5. Stay ahead of deadlines and accelerate audit readiness processes

Seamless workflows and excellent time management are critical to ensuring year-round audit readiness. First, the internal response team must be prepared to move quickly and set aside other priorities when the time comes to respond to RADV audits.

Then, implementing advanced technology, powered by AI, can help to expedite medical record retrieval. Retrieval technology should be able to securely pull records electronically or via email, fax, or mail, centralize and integrate the data.

6. Stay prepared: run audit simulations before CMS does

At least once a year, health plans should conduct audit simulations to work out any issues in the process including submission times, accuracy, necessary staff resources, and more. The dry run should consist of a random sample of medical records and include their retrieval and coding.

During this process, plans should get a good idea of what their error rate looks like. Then, using financial forecasting, they should run various extrapolation models to understand the impact of potential overpayments or errors in terms of CMS recoupment or estimated penalties.

Audit readiness, reinvented with technology

Audit preparation no longer must consume vast amounts of time and resources. Advances in AI-powered technology can power audit preparation by analyzing clinical data and surfacing relevant evidence, helping payers boost the accuracy of risk adjustment data and reclaim valuable staff time.

Powerful audit preparation technology should include:

Automated CMSenrollee data management
For ingesting and reconciling enrollee data lists from multiple vendors and sources.

AI-driven coding and evidence validation
Score evidence and conduct quality assurance, even as HCC models shift year to year.

Real-time reporting
Including real-time dashboards for retrieval, coding, QA, and submission.

Automated provider attestation and pursuits
Streamlining provider outreach and tracking including for hard-to-reach providers.

Submission package builder
Documentation for every member that's validated, ranked, and securely delivered.

Faster and more accurate: A new era of audit readiness

84%

reduction in manual chart reviews

Using AI models that continuously improve as they learn, one health plan saved over 1,000 hours of staff time and reduced errors by reducing manual review of charts

3X

increase in coding speed

AI-powered technology also facilitates collaboration among plan coding teams, increasing productivity and accelerating audit readiness.

40%

more accurate charts

Finally, advanced technology for audit readiness helps validate existing diagnoses and uncover potential missed conditions, increasing the accuracy of each chart.

Audit readiness is a mindset: make it a year-round priority

Audit readiness is no longer optional for MA plans—it's essential. With CMS ushering in a new era of oversight through its expanded RADV audit strategy, plans must act now to strengthen workflows, upgrade technology, and minimize compliance risks.

Success in this high-stakes environment hinges on having the right technology partner, one that delivers the data infrastructure and advanced analytics to streamline audits and prevent costly findings.

Do more with Reveleer

For over 15 years, Reveleer has empowered healthcare organizations with a purpose-built platform for value-based care. Our team understands the intricacies of value-based care workflows including RADV and IVA audits. Our solutions provide intelligent data acquisition, centralized member views, and AI-powered insights to ensure you're always audit-ready.

Don't wait for CMS to come knocking. Prepare now to meet compliance requirements and drive better outcomes year-round. Schedule a demo to see how the Reveleer Platform accelerates the success of your audit readiness program.

REQUEST A DEMO

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As the industry's pioneering value-based care enablement platform, Reveleer is purpose-built to solve the most pressing real-world challenges faced by provider and health-plan organizations today. By unifying retrieval, clinical intelligence, risk adjustment, quality improvement, and member management solutions into one intelligent, AI-powered system, Reveleer streamlines fragmented workflows to supercharge productivity, enhance care quality, and optimize performance on high-priority value-based initiatives. To learn more about Reveleer's value-based care platform, visit us at Reveleer.com.

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