No. 25-11293

IN THE UNITED STATES COURT OF APPEALS

FOR THE

FIFTH CIRCUIT

HUMANA INCORPORATED, ET AL,

Plaintiffs-Appellees,

-v.-

ROBERT F. KENNEDY JR., SECRETARY OF HEALTH AND HUMAN SERVICES, IN HIS OFFICIAL CAPACITY, ET AL,

Defendants-Appellants.

On appeal from a final judgment of the
United States District Court for the Northern District of Texas
Case No. 4:23-cv-00909-O (Chief District Judge Reed O'Connor)

BRIEF OF ECONOMISTS AND HEALTH POLICY SCHOLARS AS AMICUS CURIAE IN SUPPORT OF DEFENDANTS-APPELLANTS

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CERTIFICATE OF INTERESTED PARTIES

The undersigned certifies that the following listed persons and entities as described in the fourth sentence of Rule 28.2.1 and 29.2 have an interest in the outcome of this case.

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CORPORATE DISCLOSURE STATEMENT

Pursuant to Federal Rule of Appellate Procedure 26.1(a) and Fifth Circuit Rule 29.2, the undersigned counsel for amici curiae hereby makes the following disclosures:

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No amicus curiae in this case is a publicly held corporation or other publicly held entity. No publicly held corporation or other publicly held entity has a direct financial interest in the outcome of this litigation. No amicus curiae has issued shares to the public.

Dated: March 30, 2026

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I. INTEREST OF AMICI CURIAE

Amici curiae[1] are health policy experts with extensive expertise and knowledge of the Medicare program, including the Medicare Advantage ("MA") program design, risk adjustment methodology, and healthcare payment systems, who submit this brief to provide the Court with the background necessary to understand the context in which the Centers for Medicare & Medicaid Services' ("CMS") enhanced its risk adjustment data validation ("RADV") audit process ("Final Rule").[2]

Amici curiae have a substantial interest in ensuring that the Court understands the importance of the RADV audit process as a fundamental tool necessary for CMS to recover improper payments and combat fraud, waste, and abuse in the MA program—not only to ensure the sustainability of the healthcare system, but to protect American taxpayers and keep Medicare coverage affordable for beneficiaries. This brief additionally demonstrates that stakeholders understood—

[1] *Amici Curie* are Matthew Fiedler Ph.D., Carrie Graham Ph.D., Jack Hoadley Ph.D., David Meyers Ph.D., M.P.H., J. Michael McWilliams, Ph.D., M.D., Neil Patil M.P.P., and Rachel Schmidt Ph.D.

[2] *See* Medicare & Medicaid Programs; Policy and Technical Changes to the Medicare Advantage, Medicare Prescription Drug Benefit, and Medicare Cost Plan Programs, 88 Fed. Reg. 6,643 (Feb. 1, 2023), (hereinafter "Final Rule"), at https://www.federalregister.gov/documents/2023/02/01/2023-01942/medicare-and-medicaid-programs-policy-and-technical-changes-to-the-medicare-advantage-medicare.

and indeed commented on and meaningfully engaged with—the agency's common-sense proposals to strengthen its approach to RADV audits.

II. INTRODUCTION

More than half of American seniors and younger individuals with disabilities currently receive their Medicare coverage through a private insurer like Humana. These Medicare Advantage Organizations ("MAOs") contract with CMS to provide Medicare beneficiaries with coverage that meets or exceeds the benefits available under traditional Medicare Parts A and B. Unlike traditional Medicare's fee-for-service ("FFS") model, in which CMS reimburses providers for each service rendered, CMS pays MAOs a fixed, prospective monthly rate for each beneficiary that is based on estimated average spending in the FFS program. To account for differences in the expected healthcare costs of individual beneficiaries, CMS must "risk adjust" payments to MAOs in a manner that "ensure[s] actuarial equivalence" between MA payments and estimated FFS expenditures. This risk adjustment process relies on information on the health status of MA enrollees that CMS collects from MAOs themselves, so ensuring the accuracy of the information submitted by MAOs is of paramount importance.

But CMS's efforts to ensure the accuracy of these data have not kept pace with MAO's efforts to manipulate them for financial gain. The Medicare Payment Advisory Commission ("MedPAC"), the independent congressional agency that

advises the U.S. Congress on issues affecting the Medicare program, has explained how this payment structure creates a direct financial incentive for MAOs to document as many diagnosis codes as possible for their enrollees.[3] Among the 20 most common conditions, each additional diagnosis documented for an enrollee generates an average additional payment of approximately $3,400 per year.[4] MAOs' efforts have pushed MA coding intensity (i.e., the rate at which diagnoses are reported) far above its level in traditional Medicare. As a result between 2007 and 2026, MedPAC estimates that higher MA coding intensity generated *$233 billion in higher aggregate payments* to MA plans.[5] Higher payments translate to both higher government spending on Medicare by taxpayers and higher Part B premiums paid by Medicare beneficiaries. Part B premiums are calculated to cover 25 percent of Medicare Part B program costs (and greater shares for higher-income beneficiaries).

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[3] Medicare Payment Advisory Commission, *The Medicare Advantage Program: Status Report*, in Report to the Congress: Medicare Payment Policy Ch. 11, at 324 (Mar. 2025) ("MA plans have a financial incentive to ensure that their providers record all possible diagnoses because adding new risk-adjustment-eligible diagnoses raises an enrollee's risk score and results in higher payments to the plan.") (hereinafter "MedPAC 2025 Report"), at https://www.medpac.gov/wp-content/uploads/2025/03/Mar25_Ch11_MedPAC_Report_To_Congress_SEC.pdf.

[4] Medicare Payment Advisory Commission, The Medicare Advantage Program: Status Report, in Report to the Congress: Medicare Payment Policy Ch. 12, at 388 (Mar. 2026) (hereinafter "MedPAC 2026 Report"), at https://www.medpac.gov/wp-content/uploads/2026/03/Mar26_Ch12_MedPAC_Report_To_Congress_SEC.pdf.

[5] *Id.* at 392.

RADV audits are the agency's principal tool and "main corrective action" for identifying and recovering the improper payments that occur when MAOs report unsupported diagnoses.[6] Following years of concerns about improper payments—and a decade of debate over whether and how the actuarial equivalence standard should be accounted for in the RADV process, CMS proposed in 2018 and finalized in 2023 a rule to revise and strengthen the RADV audit process for MAOs such as Humana.

The Court's decision will have a lasting impact on the overall sustainability of the Medicare program, the federal government's ability to recover improper payments, and the fiscal burden imposed on American taxpayers and millions of senior citizens who have enrolled in MA plans or traditional Medicare.

III. BACKGROUND

A. CMS Calculates Risk Scores Using the CMS-HCC Model, and Federal Regulations Require That All Submitted Diagnosis Codes Be Supported by Medical Records.

CMS implements the statutory risk-adjustment requirement through the CMS Hierarchical Condition Category ("CMS-HCC") risk-adjustment model, which uses demographic information and medical diagnosis codes grouped into HCCs to

[6] Medicare Advantage Risk Adjustment Data Validation (RADV) Final Rule (CMS-4185-F2) Fact Sheet, Ctrs. for Medicare & Medicaid Servs., at 1–2 (hereinafter "Final Rule Fact Sheet"), at https://www.cms.gov/newsroom/fact-sheets/medicare-advantage-risk-adjustment-data-validation-final-rule-cms-4185-f2-fact-sheet.

calculate a risk score for each enrollee.[7] Higher risk scores yield higher monthly payments to MAOs.[8] Federal regulations require that all diagnosis codes submitted for risk adjustment be supported by evidence in the beneficiary's medical record from a qualifying face-to-face encounter.[9]

B. In 2012, CMS Introduced the FFS Adjuster, but the Adjuster Was Never Applied in an Issued RADV Audit and its Adoption Delayed Recovery of Hundreds of Millions in Identified Overpayments.

In 2012, CMS announced that it would revise its RADV methodology by adding an "FFS Adjuster"—which would have reduced RADV recoveries on the premise that the documentation standards that apply to MAO-submitted diagnoses are different from those that apply to traditional FFS claims in ways that might systematically bias RADV findings against MAOs.[10] In effect, the FFS Adjuster would determine an allowable baseline level of payment error attributable to unsupported diagnosis codes in FFS, and MA organizations would owe repayments only to the extent their extrapolated RADV error exceeded that baseline level.[11]

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[7] MedPAC 2026 Report at 356–57.
[8] *Id.*
[9] *See* 42 C.F.R. § 422.310(d)(1); Medicare Managed Care Manual, Ch. 7, § 40.
[10] Notice of Final Payment Error Calculation Methodology for Part C Medicare Advantage Risk Adjustment Data Validation Contract-Level Audits, Ctrs. for Medicare & Medicaid Servs. (2012).
[11] CMS, Fee for Service Adjuster and Payment Recovery for Contract Level Risk Adjustment Data Validation Audits (Oct. 26, 2018), https://www.cms.gov/research-statistics-data-and-systems/monitoring-programs/medicare-risk-adjustment-data-validation-program.

Although CMS has never applied the FFS Adjuster in an issued RADV audit,[12] its adoption delayed the finalization of RADV audits for payment years 2011 through 2013—audits that had already been conducted at a cost of approximately $150 million to the agency and that identified an estimated $683.2 million in extrapolated improper payments.[13] As of the Final Rule, those audits had never been finalized, and CMS had not recovered any of the identified overpayments.[14] In the Final Rule, CMS stated that it "did not intend the 2012 methodology to suggest that contract-level RADV audits create a different 'documentation standard' for MAOs than the standard that applies to traditional Medicare providers."[15]

C. In 2018, CMS Proposed Several Changes to RADV, Including Eliminating the FFS Adjuster, Extended the Comment Period Multiple Times, and Separately Requested Comment on Whether the Actuarial-Equivalence Statute Requires the FFS Adjuster.

On November 1, 2018, CMS published a proposed rule that

included several provisions aimed at strengthening the RADV program. Especially important, CMS proposed to begin calculating audit recoveries by "extrapolating" from the random sample of an MAO's enrollees included in the audit

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[12] Final Rule at 6,647 (ROA.17073).
[13] *Medicare and Medicaid Programs; Policy and Technical Changes to the Medicare Advantage and the Medicare Prescription Drug Benefit Programs*, 83 Fed. Reg. 54,982, at 55,038 (Nov. 1, 2018), (hereinafter "Proposed Rule"), at https://www.govinfo.gov/content/pkg/FR-2018-11-01/pdf/2018-23599.pdf; Final Rule at 6,664 (Table 3).
[14] Final Rule at 6,655.
[15] Final Rule at 6,644.

to the full set of enrollees covered under the audited contract. This change was intended to ensure that the amount the federal government recovered following an audit was commensurate with the magnitude of the improper payments demonstrated by the audit findings. Previously, CMS had only attempted to recover overpayments for the enrollees actually included in the audit sample and, as such, systematically recovered far less than the amount justified by the audit findings.

As part of this broader set of changes, CMS proposed to eliminate the FFS Adjuster from the methodology used to calculate audit recoveries ("Proposed Rule").[16] The proposal rested on two grounds. First, CMS released a study indicating that diagnosis errors in FFS claims data do not lead to systematic payment error in the MA program.[17] CMS later abandoned reliance on the study after commenters challenged its methodology.[18] Second, CMS stated that a payment adjustment would be inconsistent with the purpose of the RADV program. CMS explained that "RADV audits are used to recover payments based on diagnoses that are not supported by medical record documentation. … If a payment has been made to an MA organization based on a diagnosis code that is not supported by medical record documentation, that entire payment is in error and should be recovered in full. … Consequently, an adjustment to RADV recoveries to remedy payment accuracy

[16] Proposed Rule at 55,037–41.
[17] *Id.* at 54,995–99.
[18] *See* Final Rule at 6,659.

concerns is inappropriate."[19] Over the following months, CMS extended the comment period twice and released multiple rounds of underlying data.[20]

On June 28, 2019—two months before the close of the extended comment period—CMS published a separate notice in the Federal Register requesting additional public comment on whether 42 U.S.C. § 1395w-23(a)(1)(C), the statutory provision requiring actuarial equivalence, "mandates an FFS Adjuster, prohibits an FFS Adjuster, or should otherwise be read to inform [CMS's] proposal not to apply an FFS Adjuster in any RADV extrapolated audit methodology."[21] This request expressly put stakeholders on notice that CMS was evaluating whether the actuarial-equivalence provision of the Medicare statute required, prohibited, or was otherwise relevant to the application of an FFS Adjuster in RADV audits.

D. In 2023, CMS Finalized Important Changes to RADV, Including Eliminating the FFS Adjuster, Concluding That Actuarial Equivalence Governs Rate-Setting, Not Overpayment Recovery.

On February 1, 2023, CMS published the Final Rule which finalized several significant changes to the RADV program, including adopting extrapolation for

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[19] Proposed Rule at 55,041.

[20] *See* 83 Fed. Reg. 66,661 (Dec. 27, 2018)(CMS extended the comment period for the RADV provisions from its original close date until April 30, 2019, and announced the release of data underlying the FFS Adjuster Study); 84 Fed. Reg. 8,069 (Mar. 6, 2019)(CMS released the study's underlying data); 84 Fed. Reg. 18,215 (Apr. 30, 2019)(CMS extended the comment period a second time until August 28, 2019, and announced the release of additional data, including data containing Protected Health Information).

[21] 84 Fed. Reg. 30,983 (June 28, 2019).

payment year 2018 and later. With respect to the FFS Adjuster, CMS adopted the same core policy proposed in 2018: the elimination of the FFS Adjuster in RADV audits.[22] In the Final Rule, CMS grounded its decision on two bases: (1) the actuarial-equivalence requirement of 42 U.S.C. § 1395w-23(a)(1)(C) governs how CMS calibrates MA payment rates prospectively—not how CMS recovers identified overpayments for unsupported diagnoses through retrospective RADV audits; and (2) the existing coding pattern adjustment—a separate, statutorily mandated reduction in MA payments to account for coding differences between MA and FFS—already addresses the concern that the FFS Adjuster was designed to remedy, making an additional offset in RADV audits unnecessary.[23] The Final Rule also provided that, for payment years 2018 and forward, CMS would extrapolate the error rate of audited enrollees to a larger population of audit-eligible enrollees in each contract. The Final Rule eliminated the use of extrapolation for RADV audits of 2017 and earlier, limiting overpayment recovery for those years to the audit sample only.

E. Humana files suit in the United States District Court for the Northern District of Texas challenging the Final Rule under the Administrative Procedure Act.

On September 25, 2025, the district court granted summary judgment for Humana, holding that the Final Rule was procedurally invalid because CMS shifted

[22] *See* Final Rule.
[23] Final Rule at 6,644.

its reasoning for eliminating the FFS Adjuster between the Proposed Rule and Final Rule without adequate notice.[24] The government timely appealed, and the case is now pending before this Court. [25]

IV. ARGUMENT

A. The Sheer Size of the MA Program Underscores the Importance of Combatting Fraud, Waste, and Abuse

The sheer scale of the Medicare Advantage program makes robust oversight of fraud, waste, and abuse indispensable. MedPAC reports that in 2025, 55 percent of eligible Medicare beneficiaries enrolled in MA plans, up from 54 percent in 2024 and 37 percent in 2018.[26] In 2025 alone, the MA program enrolled about 34.9 million beneficiaries, and paid MA plans an estimated $537 billion.[27] In 2026, Medicare will pay MA plans 14 percent more—about $76 billion in additional spending—than it would spend if those same beneficiaries remained in traditional FFS Medicare.[28] MedPAC attributes $22 billion of the $76 billion to higher coding intensity. These costs are borne both by taxpayers and by Medicare beneficiaries through the Part B premium.

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[24] *See* Compl., *Humana Inc. v. Becerra*, No. 4:23-cv-00909-O (N.D. Tex. Sept. 1, 2023), ECF No. 1 (ROA.19); Mem. Order & Op. at 5, ECF No. 76 (ROA.26918); *id.* at 1–16 (ROA.26912–27); Final J., ECF No. 77 (ROA.26928).
[25] Notice of Appeal, Humana Inc. v. Kennedy, No. 4:23-cv-00909-O (N.D. Tex. Nov. 21, 2025), ECF No. 78 (ROA.26929); see No. 25-11293 (5th Cir.).
[26] MedPAC 2026 Report at 343.
[27] *Id.*
[28] *Id.* at 346.

In a program of this magnitude, even relatively modest levels of improper payments, lax oversight, or abusive practices can translate into tens of billions of dollars in losses borne by the federal government and by Medicare beneficiaries who finance the program through premiums and cost-sharing, underscoring the critical need for rigorous oversight of the MA program and MAOs. And recent developments underscore the urgency of meaningful oversight today. As HHS has noted: "Fraud schemes are increasingly complex and global in scope," and "[c]ombating fraud, waste, and abuse in Medicare and Medicaid is imperative to ensure that every dollar invested in these programs is used to provide high-quality health care."[29]

Federal oversight and accountability are even more critical because some MAOs have exploited the MA program to increase the payments they receive. MAOs have powerful financial incentives to maximize federal payments, and official oversight bodies have repeatedly found that many MAOs have exploited the program's payment rules and the limited scope of existing RADV audits to increase their revenues at the expense of the Medicare program and its beneficiaries—often through submitting unsupported diagnostic data.[30] MedPAC reports that "MA plans

[29] Department of Health and Human Services, Office of Inspector General, *Top Management & Performance Challenges Facing HHS*, at 169 (2025), at https://www.hhs.gov/sites/default/files/fy-2025-hhs-agency-financial-report.pdf.
[30] MedPAC 2025 Report at 319–21, 323–25.

have a financial incentive to ensure that their providers record all possible diagnoses because adding new risk-adjustment-eligible diagnoses raises an enrollee's risk score and results in higher payments to the plan."[31] Higher diagnostic coding intensity in MA, compared with traditional FFS Medicare, increases payments to MA plans by tens of billions of dollars each year, and even after CMS's across-the-board coding adjustment, overall MA coding still generates substantial extra payments to MA plans.[32] Bipartisan members of Congress have also weighed in on this issue—expressing "grave concern" that MAOs are endangering the solvency of the Medicare Trust Funds through "tremendously wasteful practices"[33] and underscoring the concerning nature of coding intensive MAOs "in light of the high degree of market concentration that currently exists in MA."[34] Such members of Congress urged CMS to make changes to implement processes to eliminate

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[31] *Id.* at 324.

[32] *Id.* at 323–26 (explaining that coding intensity and favorable selection cause MA payments to exceed FFS and estimating that, even after a coding adjustment, MA risk scores remain higher, projecting roughly $40 billion in additional payments in 2025).

[33] *See* Ltr. from U.S. Rep. P. Jayapal et al. to CMS (March 27, 2025), at 1 (hereinafter, "Jayapal Ltr."), at https://jayapal.house.gov/wp-content/uploads/2025/03/25.03.27-2025-Letter-to-CMS-HHS-on-Medicare-Advantage-Final.pdf.

[34] United States Senate Committee on the Judiciary, Charles E. Grassley, Chairman, How UnitedHealth Group Puts the Risk in Medicare Advantage Risk Adjustment: Majority Staff Report, at 1 (Jan. 12, 2026) (hereinafter "Grassley Report"), at https://www.grassley.senate.gov/imo/media/doc/uhg_report_-_final.pdf.

diagnosis codes frequently used for fraud and abuse,[35] and noted that "risk adjustment in MA has become a business in itself—by no means should this be the case."[36] The Congressional Budget Office has estimated the Medicare Hospital Insurance Trust Fund will be exhausted by 2040, placing undue strain on traditional Medicare and medical providers administering important services.[37] Reducing and recouping improper payments to MAOs remains an essential element of preserving the Medicare Trust Funds and combatting the fraud, waste, and abuse plaguing the Medicare program in recent years.

B. The RADV Program Is an Essential Tool for Recovering Improper Payments Remitted to MAOs

1. The RADV Program, as Improved by the Final Rule, Protects Federal Medicare Dollars and Beneficiaries

CMS conducts RADV audits to verify the accuracy of the diagnosis codes that MAOs submit. Pursuant to Congress's mandate to adopt a risk-adjustment methodology, CMS designed the RADV program as the primary mechanism for ensuring that risk-adjusted payments to MAOs are not distorted by unsupported

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[35] Jayapal Ltr. at 1.
[36] Grassley Report at 104.
[37] Congressional Budget Office, *CBO's Updated Projections of the Hospital Insurance Trust Fund's Finances*, (Feb. 23, 2026) ("If the balance of the fund was exhausted and the fund's spending continued to outstrip its income, total payments to health plans and providers for services covered under Part A would be limited by law to the amount of income credited to the fund."), at https://www.cbo.gov/publication/62165.

diagnoses.[38] CMS explains that RADV audits are "the main corrective action" for improper MA payments, because they allow CMS to review underlying medical records, identify diagnoses that are not supported, and recoup overpayments from MAOs.[39] CMS further notes that "[r]isk adjustment strengthens the MA program by ensuring that accurate payments are made to MAOs based on the health status and demographic characteristics of their enrolled beneficiaries, and that MAOs are paid appropriately for their plan enrollees."[40]

The available results from RADV audits reveal significant problems with the accuracy of MAO-submitted diagnoses. Historically, RADV audits have uncovered substantial payment errors and generated meaningful recoveries. For example, audits of 2007 risk-adjustment data found that average overpayment rates were well over 10 percent for most contracts under audit.[41] The HHS Office of Inspector General has conducted RADV-like audits of high-risk diagnoses for at least 30 MA contracts and found that 70 percent of all diagnosis codes audited were not supported by medical records, and that some diagnoses were unsupported over 90 percent of the time.[42] For payment years 2011–2013, RADV audits found between five and

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[38] *Recovering Improper Payments in Medicare Advantage – Fast Facts*, Ctrs. for Medicare & Medicaid Servs., at 1, (hereinafter "Fast Facts") at https://www.cms.gov/files/document/cpi-radvfact-sheet.pdf.
[39] Final Rule Fact Sheet at 1–2.
[40] *Id.*
[41] MedPAC 2026 Report at 402–03.
[42] *Id.* at 402.

eight percent in overpayments to audited MAOs, and unsupported diagnoses are estimated to result in roughly $17 billion in overpayments to MAOs each year.[43] For payment years through 2017, CMS used a protocol that audited roughly five percent of MA contracts per year using a sample of 201 enrollees per contract.[44] CMS's most recent improper payment data show that MA had an estimated improper payment rate of 6.09 percent in Fiscal Year 2025—about $23.7 billion in improper payments—most of which were attributable to MAOs' failure to substantiate submitted diagnosis data with adequate documentation.[45]

Because RADV audits can target exactly this type of unsupported diagnosis through retrospective chart review and record validation, the RADV program is an essential tool for protecting the Medicare Trust Funds and safeguarding beneficiaries from the growing costs that flow from widespread overpayments. The provisions of the Final Rule, especially CMS' decision to begin extrapolating from audit findings when calculating recoveries, greatly improved the RADV program's ability to achieve that objective by ensuring that the amounts recovered from MAOs were consistent with the magnitude of the improper payments reflected in audit findings.

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[43] Fast Facts at 1.
[44] MedPAC 2026 Report at 402.
[45] Fiscal Year 2025 Improper Payments Fact Sheet, Ctrs. for Medicare & Medicaid Servs., at 2 (Jan. 14, 2026), at https://www.cms.gov/newsroom/fact-sheets/fiscal-year-2025-improper-payments-fact-sheet.

2. The Introduction of the FFS Adjuster Frustrated the Purpose of the RADV Program.

By design, RADV audits are supposed to identify and correct overpayments stemming from unsupported MAO diagnosis coding—but layering an FFS Adjuster on top of those findings dilutes recoveries and frustrates RADV's central purpose of protecting federal Medicare dollars. Instead of requiring MAOs to return the full amount of identified overpayments tied to unsupported diagnoses, the design of the FFS Adjuster effectively grants plans a "free pass," even when RADV audits show that MAOs had, in fact, been paid for diagnoses they could not prove. As CMS itself noted in its 2018 proposed rule, "[t]he FFS Adjuster was never intended to set a permissible rate for the submission of erroneous diagnosis codes."[46]

Additionally, the RADV program is only one part of the system used to pay MAOs. While CMS must ensure that its MAO payment methods, taken as a whole, achieve the statutory goal of "actuarial equivalence," the agency has other tools for doing so even as the RADV program focuses on ensuring that MAOs' diagnosis data meets CMS standards. Particularly relevant here, CMS makes a Coding Pattern Adjustment to the risk scores used to determine payments to MAOs that is intended to adjust for the overall difference in coding intensity between MA and traditional Medicare. This involves accounting both for factors that cause MA coding intensity

[46] Proposed Rule at 55,038.

to be higher than traditional FFS Medicare (e.g., MAOs' aggressive diagnosis coding efforts) and for factors that could, in principle, cause MA coding intensity to be lower than traditional FFS Medicare (e.g., differences in documentation standards for MAO diagnosis submissions versus FFS claims, the issue that originally motivated creation of the FFS adjuster). For that reason, including an FFS Adjuster in the RADV methodology is not necessary to achieve "actuarial equivalence." Moreover, an FFS Adjuster is not an effective tool for achieving actuarial equivalence since, unlike the Coding Pattern Adjustment, an FFS Adjuster only affects MAO contracts that are actually audited, a point CMS emphasized in the Proposed Rule.

C. CMS's Final Rule Was a Logical Outgrowth of Its Proposed Rule.

As the Appellants argue, the Administrative Procedure Act requires only that a final rule be a logical outgrowth of the agency's proposal and the comments received, not that the agency's legal reasoning remain static from proposal to finalization—a standard that CMS satisfied in the present case. In 2018, CMS proposed to eliminate the FFS Adjuster in RADV audits, explained that its internal analysis showed that errors in FFS claims data do not systematically bias MA risk scores or payments, and noted that the use of an FFS Adjuster would be inconsistent with the RADV program's purpose of identifying and recovering MA overpayments, and invited comment on whether the Medicare statute requires, permits, or prohibits the FFS Adjuster in the RADV context. CMS then finalized the same core policy—

no FFS Adjuster in RADV audits—and grounded that policy in its initial premise that RADV audits exist to identify and recover MA overpayments based on medical record review, not to adjust for differences in documentation standards and practices between MA and traditional FFS Medicare. The Final Rule's conclusion that the actuarial-equivalence concept governs how CMS calibrates MA payment rates, rather than how it recovers identified overpayments, is the type of explanation that falls squarely within the range of positions reasonably anticipated from CMS's proposal and the public comments.[47]

1. CMS Provided Ample "Fair Notice" of Its Rationale for Abandoning the FFS Adjuster.

CMS gave fair notice of both the policy change and the rationales it ultimately adopted. The 2018 proposed RADV rule informed stakeholders that CMS's internal study found that unsupported FFS diagnoses do not introduce systematic bias into MA risk scores and, on that basis, proposed to stop applying an FFS Adjuster when extrapolating RADV audit findings.[48] CMS then issued a separate request for comment on its RADV methodology that expressly asked whether the statutory risk-adjustment provisions—including the actuarial-equivalence and

[47] Final Rule Fact Sheet at 1–2 (announcing that "CMS will not apply an adjustment factor (known as an FFS Adjuster) in RADV audits" and explaining that the actuarial-equivalence requirement applies to how CMS risk-adjusts MA payments, not to the obligation to return overpayments for unsupported diagnosis codes identified in RADV).

[48] *See* Proposed Rule at 54,995–54,999.

coding-intensity clauses —"mandate[], prohibit[], or otherwise inform[]" use of an FFS adjustment in RADV audits.[49] That request, which CMS released in 2019, two months prior to the close of the comment period on the proposed rule, explicitly asked for comment on whether the statute requires CMS to offset proven MA overpayments with a hypothetical FFS-based adjustment.[50] In light of this notice—of the empirical findings, the proposed elimination of the FFS Adjuster, and the specific statutory issues CMS was considering—MAOs and other stakeholders had every opportunity to comment on CMS's proposal to abandon the FFS Adjuster.

2. Stakeholders Anticipated the Elimination of the FFS Adjuster

The comment record confirms that stakeholders not only understood that CMS might eliminate the FFS Adjuster but actively engaged with that possibility and CMS's reasoning. In its 2019 comment letter, MedPAC expressly supported

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[49] MedPAC, *Comment Letter on Risk Adjustment Data Validation*, at 1–3, 5–7 (Aug. 12, 2019) (hereinafter, "MedPAC Comment Letter") (describing CMS's study showing that unsupported FFS diagnoses introduce no systematic bias on MA risk scores, noting CMS's proposal not to apply an FFS Adjuster in extrapolated RADV audits, and referencing CMS's request for comment on whether the risk-adjustment statute mandates or prohibits use of an FFS Adjuster), at https://www.medpac.gov/wp-content/uploads/import_data/scrape_files/docs/default-source/comment-letters/08122019_medpac_ma_radv_comment_v3_sec.pdf.

[50] Medicare & Medicaid Programs; Risk Adjustment Data Validation, Request for Comment, 84 Fed. Reg. 34,148 (June 28, 2019) (indicating that CMS would continue to take public comment until August 28, 2019), at https://www.federalregister.gov/documents/2019/06/28/2019-13891/medicare-and-medicaid-programs-risk-adjustment-data-validation.

CMS's proposal not to apply an FFS Adjuster in extrapolated RADV audits, agreeing with CMS's study that unsupported FFS diagnoses do not systematically bias MA risk scores and concluding that no adjustment to the risk-adjustment system is warranted on that basis.[51] CMS additionally issued multiple *Federal Register* notices extending the comment period on the RADV provisions and releasing additional underlying data precisely because MA plans and other stakeholders were vigorously contesting the proposed elimination of the FFS adjuster.[52] Notably, multiple MAOs, including Humana, commented on the proposed elimination of the FFS Adjuster—signaling that they understood CMS was reconsidering the application of actuarial equivalence to RADV audits.[53] In particular, during the relevant comment period, Humana fully acknowledged that:

> [T]he Agency recently updated its original request for comments to indicate that the Agency generally is seeking input on whether its proposal 'not to apply an FFS Adjuster in any RADV extrapolated audit methodology' comports with the Medicare Act's (the 'Act')

[51] *See* MedPAC Comment Letter.

[52] U.S. Dept. of Health & Human Services, *NPRM 4185-P RADV Provision Data Release File Summaries* (May 28, 2019) (describing extensions of the RADV comment period and release of additional data requested by commenters), at https://www.hhs.gov/guidance/document/nprm-4185-p-radv-provision-data-release-file-summaries.

[53] In addition to Humana, the comment record includes, for example, comments from Anthem, Blue Cross Blue Shield Association, Innovacare Health, and AHIP—all indicating that such entities were well aware of the actuarial equivalence issue that partially helped inform the Final Rule. *See* CMS, Comment Docket, *Advance Notice of Methodological Changes for Calendar Year (CY) 2020 for Medicare Advantage (MA) Capitation Rates, Part C and Part D Payment Policies and 2020 Call Letter*, at https://www.regulations.gov/docket/CMS-2018-0154/comments.

> requirement that CMS risk adjust payments to MA plans in a manner that 'ensure[s] actuarial equivalence' between the MA program and the Medicare FFS program.[54]

This comment, along with several other stakeholder comments, undercut the arguments raised by Humana that the industry was not on fair notice of CMS's reasoning in its Final Rule.

Further, there has been a longstanding dispute over the appropriateness of applying the FFS Adjuster to RADV audits. For more than a decade, CMS, MAOs, and other stakeholders have been engaged in ongoing disagreement about whether the FFS Adjuster is necessary to achieve actuarial equivalence and whether it produces fair results in RADV audits, with CMS both defending and then empirically and legally re-examining that premise. CMS's conclusion that actuarial equivalence does not compel an FFS Adjuster in RADV audits is best understood as a refinement of an issue that has long been open for comment and is not an unforeseeable shift.

D. Invalidation of the RADV Rule Will Harm Medicare Beneficiaries and Incentivize Continued Bad Faith Conduct.

Invalidation of the Final Rule will entrench the already unsustainable status quo; exacerbate fraud, waste, and abuse in the MA program; and leave beneficiaries to bear higher costs, especially through higher Part B premiums. MA plan enrollees

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[54] *Id.*

are not the only ones affected. MedPAC makes clear that "higher payments to MA plans are financed by the taxpayers and beneficiaries who fund the Medicare program," and "Part B premium payments will be about $11 billion higher in 2026 because of higher Medicare payments to MA plans (equivalent to roughly $175 per beneficiary per year)."[55] A recent congressional analysis, echoed by AARP, found that MA overpayments increased the Part B premium by nearly $18 per month per enrollee in 2025—about $13.4 billion in the aggregate—and that roughly $6 billion of that burden fell on people who chose to enroll in traditional Medicare.[56] For taxpayers and Medicare beneficiaries, higher premiums mean less money for basic necessities like housing, food, and medications, and they magnify the financial strain on beneficiaries with chronic conditions who rely most on Medicare coverage.

Recent enforcement actions confirm that these risks are not hypothetical. In January 2026, five Kaiser Permanente affiliates paid $556 million — the largest MA False Claims Act settlement to date — to resolve allegations that they systematically added unsupported diagnoses to inflate risk-adjusted payments over a nine-year

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[55] MedPAC 2026 Report at 346.

[56] Senate Joint Economic Committee, The Part B Premium Pass-Through: Medicare Advantage Overpayments Inflate Premiums for All (March 10, 2026), https://www.jec.senate.gov/public/vendor/_accounts/JEC-R/issue-briefs/The%20Part%20B%20Premium%20Pass-Through.pdf; *See also* AARP, *Medicare Advantage Overpayments Increase Premiums, Erode Social Security Benefits for All, Lawmakers Say* (Mar. 11, 2026), at https://www.aarp.org/medicare/medicare-advantage-overpayments-premiums/.

period.[57] In February 2026, CMS sanctioned Elevance Health for knowingly submitting unverifiable diagnosis codes for seven years and refusing to correct them through required electronic systems.[58] And in March 2026, Aetna agreed to pay $117.7 million to resolve allegations that it operated a one-directional chart review program that added diagnosis codes to increase payments while ignoring results showing codes were unsupported; HHS-OIG placed Aetna under heightened scrutiny for 10 years after it refused to enter a Corporate Integrity Agreement.[59] RADV audits are the principal check on this conduct, and vacating the Final Rule would weaken that check when the evidence shows it is most needed.

Vacating the RADV Final Rule would remove one of the few effective checks that CMS has on MAOs' ability to collect inflated payments by submitting erroneous diagnoses. In short, gutting RADV would leave MA overpayments unchecked, reward plans that game the system, burden taxpayers, and force millions of older adults and people with disabilities to pay higher premiums for their Medicare coverage—all outcomes that policymakers have been appropriately working to avoid.

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[57] Press Release, U.S. Dep't of Justice, Kaiser Permanente Affiliates Pay $556M to Resolve False Claims Act Allegations (Jan. 14, 2026).
[58] Letter from Ctrs. for Medicare & Medicaid Servs. to Elevance Health, Inc., Re: Notice of Intermediate Sanctions and Civil Money Penalties (Feb. 27, 2026).
[59] Press Release, U.S. Dep't of Justice, Aetna Agrees to Pay $117.7 Million to Resolve False Claims Act Allegations (Mar. 11, 2026).

V. CONCLUSION

This Court should reverse the district court's judgment.

Dated: March 30, 2026

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CERTIFICATE OF SERVICE

I certify that I electronically filed the foregoing with the Clerk of the Court for the United States Court of Appeals for the Fifth Circuit by using the appellate CM/ECF system. I further certify that all participants in the case are registered CM/ECF users and that service will be accomplished by the appellate CM/ECF system.

Dated: March 30, 2026

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CERTIFICATE OF COMPLIANCE

This brief complies with the type-volume limitation of Fed. R. App. P. 32(a)(7)(B) because it contains 5,345 words, excluding the parts of the brief exempted by Fed. R. App. P. 32(f). This brief also complies with the typeface requirements of Fed. R. App. P. 32(a)(5)(A) and the type style requirements of Fed. R. App. P. 32(a)(6) because it has been prepared in a proportionally spaced typeface using Microsoft Word in Times New Roman font size 14.

Dated: March 30, 2026

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