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Medicare Advantage Under Continued Scrutiny: The Good, the Bad, and the Uncertain

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Summary

- As the Medicare Advantage program grows, so does the federal government's scrutiny of MAOs and downstream providers alike.
- Given recent regulatory and market developments, as well as the increasing availability and use of AI across the MA program, effective and proactive compliance safeguards for stakeholders can significantly limit long-term financial and operational risks.
- This article explores how these ongoing and emerging trends and increased regulatory scrutiny across the MA program—the good, the bad, and the uncertain—can and likely will affect how stakeholders build effective safeguards.

Combating healthcare fraud, waste, and abuse (FWA) remains a top bipartisan enforcement priority. As the Medicare Advantage (MA) program grows, so does the federal government's scrutiny of Medicare Advantage Organizations (MAOs) and downstream providers alike. The U.S. Department of Justice's (DOJ) enforcement efforts addressing alleged FWA in the MA program under the federal False Claims Act (FCA)[1] continue to accelerate. Congress also has been aggressive with its inquiries—sharpening its focus through public investigations of stakeholders and proposed legislation. In response to internal and external pressures, the Centers for Medicare & Medicaid Services (CMS) has enhanced its recovery tools to aggressively tackle its backlog of MAO risk adjustment validation (RADV) audits—all the while defending challenges to its core audit approach. In addition to the MA program, CMS has also created and implemented new models to address potential FWA affecting traditional fee-for-service (FFS) Medicare.

Regulatory scrutiny has not been limited to DOJ enforcement. The Office of Inspector General (OIG) for the U.S. Department of Health and Human Services (HHS) has continued with its own assessments of the efficiency and effectiveness of the MA program's risk adjustment payment model as evidenced by the audits, analyses, and reviews outlined in its work plans. OIG is also becoming increasingly critical of MAOs and downstream providers' compensation arrangements with brokers, agents, and third-party marketing organizations (TPMOs), while CMS has had to defend against challenges to its regulatory authorized payment structure that have been brought under the Administrative Procedure Act (APA).[2] At the same time, certain MAOs are exiting geographic and product markets altogether, and participating providers are leaving MAO networks. Given these regulatory and market developments, as well as the increasing availability and use of artificial intelligence (AI) across the MA program, effective and proactive compliance safeguards for stakeholders can significantly limit long-term financial and operational risks. This article explores how these ongoing and emerging trends and increased regulatory scrutiny across the MA program—the good, the bad, and the uncertain—can and likely will affect how stakeholders build effective safeguards.

Fraud Enforcement Priorities are Targeting the MA Program

Since the MA program's inception in 1997,[3] federal agencies have brought and resolved several enforcement actions—and a few MA-related fraud theories have emerged. Since the introduction of the MA risk adjustment model in 2004, one predominant theory is that MAOs and downstream providers are making beneficiaries appear sicker than they actually are to increase the beneficiaries' risk adjustment factor (RAF) scores and, thus, to increase CMS's payments to MAOs. This theory is familiar, as it tracks with alleged schemes involving FFS Medicare—e.g., providers billing for more items or services than actually provided or for items or services not actually provided at all.

Multiple MAOs and downstream providers have been alleged to increase RAF scores in allegedly inappropriate ways, including focusing on one-way risk adjustment reviews, which have included reviewing medical records and querying providers to add diagnoses on claims but not otherwise assessing whether existing diagnoses should be deleted. Other alleged schemes have included conduct involving providing allegedly medically unnecessary items and services, reducing or limiting medically necessary items and services for purposes of gainsharing, and providing items and services in in-home or other non-provider-based settings.[4]

Civil FCA resolutions with MAOs for allegedly submitting false claims have led to nearly $1 billion in settlements since 2010.[5] Similar resolutions with downstream providers have totaled more than $500 million since 2018.[6] DOJ has also pursued criminal FWA conduct related to the MA program. For example, in 2023, a former executive at HealthSun Health Plans Inc. (HealthSun) was charged with allegedly orchestrating a scheme to submit false claims to increase the amount HealthSun received for its MA enrollees.[7] Notably, while a federal jury found the former executive not guilty in 2025, HealthSun nonetheless refunded $53 million in overpayments to the MA program.[8]

In addition to alleged fraudulent risk adjustment schemes, federal agencies have also focused on and resolved federal anti-kickback statute (AKS) allegations involving MAOs and providers.[9] For example, in 2022, MCS Advantage, Inc. (MCS) paid $4.2 million to resolve allegations that it distributed gift cards to administrative assistants of providers to induce them to refer, recommend, or arrange for the enrollment of beneficiaries in an MA plan, resulting in MCS receiving premiums associated with the new members of the MA plan.[10] In 2024, MMM Holdings, LLC paid $15.2 million to resolve similar allegations.[11] Also in 2024, Oak Street Health (Oak Street) paid $60 million to resolve allegations that it paid third-party insurance agents in exchange for their “warm transfer” of beneficiaries, resulting in a scheme allegedly predicated on Oak Street’s financial motivation rather than the best interests of MA beneficiaries.[12]

Whereas federal agencies have historically worked together to facilitate the resolution of potential violations of certain healthcare FWA laws,[13] including those resolved under the FCA, last summer, DOJ formalized a False Claims Act Working Group to allow more seamless cross-agency collaboration.[14] That working group specifically identified the MA program as a focal point for forthcoming investigation and enforcement under a streamlined approach that emphasizes collaboration through cross-federal agency referrals, leveraging data mining resources, and decision-making about payment suspensions and FCA qui tam dismissals.

Additionally, OIG recently issued guidance about the foregoing areas of scrutiny and to assist MAOs and providers with ensuring compliance and remaining vigilant in their conduct. With respect to participation in the MA program, generally, OIG issued its "Medicare Advantage Industry Segment-Specific Compliance Program Guidance," highlighting ways MAOs and providers can maintain an effective compliance program and can implement certain risk mitigation strategies.[15] And with respect to the AKS, OIG's December 2024 Special Fraud Alert warns about marketing schemes that "involve questionable payments and referrals between [MA] plans, health care professionals, and third-party marketers, such as agents and brokers" because such payments and referrals "can mislead Medicare enrollees into choosing specific MA plans or health care providers that may not meet the enrollees' needs."[16] In its Special Fraud Alert, OIG provided a list of "suspect characteristics" that MAOs and providers can use to fine-tune their compliance programs, including by incorporating them into risk assessments, annual work plans, and auditing and monitoring protocols, and by revising policies and procedures and training and education materials, if and as appropriate.

Together, these FCA resolutions, criminal investigations, and DOJ and OIG activities highlight the ongoing enforcement focus on alleged misconduct in the MA program and evolving theories of liability being advanced by federal agencies. As scrutiny intensifies, both through coordinated enforcement efforts and expanded compliance guidance, MAOs and downstream providers face regulators' increasing expectations to proactively identify and mitigate risk across their operations. In this environment, robust, adaptable compliance programs are critical to navigating ongoing uncertainty and enforcement risk.

Legislative Focus is Sharpening

Against this enforcement backdrop, Congress has shown bipartisan interest in alleged MA program misconduct—in particular with respect to risk adjustment.[17] As recently as March 30, 2026, a bipartisan group of U.S. senators applauded CMS's efforts "to truly address the persistent issue of risk score gaming and to curb abuses in coding intensity" [18] by supporting Senate Bill 1105 (more commonly known as the NO UPCODE Act).[19] Citing data assessed by MedPAC in 2025[20] and OIG reports,[21] the senators highlighted MAO conduct like that which has been the subject of FCA settlements (e.g., MAOs' one-way risk adjustment reviews to add but not delete diagnoses), as well as the $40 billion in estimated overpayments that the MA program has made based on such alleged conduct.

In addition to their praise for CMS, the senators also urged continued congressional focus on the MA program by directing HHS to "exclude diagnoses collected from [health risk assessments] and all chart reviews,"[22] "modify the risk adjustment methodology to incorporate two years of diagnostic data rather than one year of data, in order to capture conditions that are not consistently reported year-to-year, such as underreported chronic conditions," and "adjust payments based on the true coding pattern differences between MA and [FFS] Medicare."[23]

Whereas the senators' recommendations represent one potential approach to modifying the MA program to address what they view as the ongoing risks, their goals appear to align with others in Congress who have focused on FWA in the MA program. Indeed, only months before the senators issued their letter to CMS, the United States Senate Committee on the Judiciary, chaired by Sen. Chuck Grassley (R-IA), issued its Majority Staff Report relating to one MAO's risk adjustment practices. That report specifically highlighted the committee's concerns relating to risk adjustment coding intensity not being clinically appropriate—specifically calling out that "MAOs with more resources are able to capture more diagnosis codes" and have been able to "gam[e]" the system.[24] With the proliferation of AI, the report also highlighted the potential misuse of AI tools for potentially inappropriate risk adjustment conduct (discussed in greater detail below).[25]

Stakeholders should take note that, just as DOJ resolutions under the FCA relating to the MA program continue to accelerate, so has Congress aggressively sharpened its focus by investigating participants in the MA program for their alleged misconduct and by proposing legislation aimed at radically changing the MA program's payment structure.

Turbulence is Shaking Up CMS’s RADV Audits

While MAOs have faced a rapidly evolving enforcement and regulatory landscape, CMS has defended its 2023 RADV final rule in federal court and simultaneously implemented a sweeping expansion of its audit program. The litigation over the RADV rule is presently before the U.S. Court of Appeals for the Fifth Circuit and raises fundamental questions about the scope of CMS’s authority to recover alleged overpayments and the procedural limits governing federal agency rulemaking. At the same time, CMS has moved forward with an aggressive, large-scale audit strategy that dramatically increases the volume, speed, and sophistication of RADV audits, signaling a broader enforcement posture focused on identifying and recovering alleged improper payments in the MA program. This combination of unresolved legal challenges and accelerating regulatory action has created significant operational, financial, and compliance uncertainty for MAOs, particularly as CMS continues to reshape both retrospective audit mechanisms, prospective utilization controls, and seeks to curb fraudulent risk adjustment conduct by limiting the scope of appropriate payment.

Key Ongoing RADV Litigation

On March 21, 2026, CMS filed its brief with the Fifth Circuit, marking the latest development in ongoing litigation over its 2023 final rule governing RADV audits in the MA program.[26] The litigation traces back to CMS’s 2018 proposed rule, which sought to formalize its RADV audit methodology.[27] In that rule, CMS proposed eliminating the FFS Adjuster, which was historically used to account for differences between MA and FFS Medicare data, on the basis of (i) a study suggesting that the use of unaudited FFS data did not materially affect payments, and (ii) concerns regarding potential inequities between audited and unaudited MA plans.[28]

Four years later, CMS published the RADV final rule, introducing two consequential changes.[29] First, the final rule authorized extrapolation, permitting CMS to apply error rates derived from a sample of records across an entire MA contract, thereby materially increasing potential recoupment exposure.[30] Second, the final rule eliminated the FFS Adjuster with retroactive effect to payment year 2018.[31] Notably, CMS did not rely on the rationales articulated in the 2018 proposed rule. Instead, CMS adopted a new rationale, taking the position that (i) "actuarial equivalence" requirements do not apply in the audit context and (ii) the FFS Adjuster is duplicative of a different, statutorily required "coding intensity" adjustment.[32]

An MAO challenged the final rule under the APA and, in September 2025, the U.S. District Court for the Northern District of Texas granted summary judgment in the MAO's favor, vacating the rule and remanding it to CMS for further consideration.[33] The court held that CMS had violated the APA because the final rule was not a "logical outgrowth" of that which had been proposed.[34] Specifically, the court found that CMS had impermissibly shifted rationales underlying its decision to eliminate the FFS Adjuster without providing adequate public notice or opportunity for comment as required under the APA. In its appeal to the Fifth Circuit, CMS seeks reversal of the court's decision and argues that its rulemaking complied with applicable procedural requirements.[35]

The litigation over the 2023 final rule governing RADV audits bears thematic and legal parallels to UnitedHealthcare Insurance Co. v. Becerra, an earlier challenge to CMS's 2014 Overpayment Rule.[36] Both lines of litigation arose from CMS's efforts to deploy increasingly aggressive regulatory tools to recoup payments to MAOs that the agency contends are unsupported by medical record documentation. Moreover, both cases implicate the procedural adequacy of CMS's rulemaking under the APA—a concern that carries heightened significant in a post-Loper Bright landscape where federal agencies can no longer rely on Chevron deference to insulate their statutory interpretations from independent judicial scrutiny.[37] Taken together, these two cases reflect an evolving and unresolved tension between CMS's asserted authority to recalibrate its audit and recovery mechanisms to address FWA in the MA program, federal FCA enforcement authority, and the constraints that courts have historically imposed through the procedural safeguards of notice-and-comment rulemaking.

For MAOs, the appeal of the court's ruling concerning the 2023 final rule governing RADV audits prolongs uncertainty regarding not only the elimination of the FFS Adjuster, but also the legality of extrapolation and the potential retroactive financial exposure associated with RADV audits. With respect to extrapolation in particular, the court's order vacating the final rule has curtailed CMS' authority to apply extrapolation in RADV audits for payment year 2018 and beyond. While CMS has initiated payment year 2018 audits in 2024 under the now-vacated final rule methodology, early this year CMS issued a memorandum confirming that it will comply with the court's order while it remains in effect.[38] Notwithstanding these developments, CMS has continued to advance a markedly accelerated and expanded RADV audit strategy.

CMS's Aggressive Audit Strategy

Over the past year, CMS has implemented a new "aggressive strategy" to increase the scope, speed, and intensity of RADV audits, signaling a shift from a limited, retrospective audit program to a comprehensive enforcement framework.[39] Historically, CMS audited a relatively small volume of MA contracts based on risk indicators—but a backlog developed. Under the new approach, CMS intends to audit all eligible MA contracts for each payment year, significantly expanding its annual audit volume from about 60 MA contracts to 550. This approach represents a more than 900% increase in audit activity and signals CMS's view that potential overpayment risk is systemic, rather than isolated.

To address its longstanding backlog, CMS is accelerating audit timelines. On January 27, 2026, CMS announced its intent to proceed with audits for payment years 2020 through 2024 commencing in February 2026, with new audit cycles expected approximately every three months.[40] In March 2026, CMS released its "RADV Audit Schedule," under which audits of payment year 2020 began in March 2026 and proceed for each successive payment year every few months thereafter, concluding with audits of payment year 2025 beginning in April 2027.[41] This compressed timeline means MAOs may face multiple, concurrent audits across several payment years, significantly increasing operational and compliance obligations, as well as their exposure to potential repayments.

These developments reflect CMS's broader enforcement priorities as it positions RADV audits as a primary mechanism to identify potentially unsupported diagnoses and to recover related overpayments. The expanded RADV audit strategy aligns with the current administration's increased focus on combatting healthcare FWA and on ensuring that the MA program pays for only appropriate and supported care. Consistent with this approach, and to further curb the potential for fraudulent risk adjustment conduct, on April 6, 2026, CMS announced its "Calendar Year 2027 MA Capitation Rates and Part C and Part D Payment Policies."[42] In that announcement, CMS finalized that which it had proposed in its Calendar Year 2027 Advance Note on January 26, 2026, relating to its perspective on risk adjustment diagnosis coding.[43] Specifically, CMS confirmed that only diagnoses linked to a face-to-face visit with a qualified healthcare provider are eligible for RAF score consideration—excluding unlinked chart review records and audio-only encounters. This effort to exclude "scraping" operations from reimbursement appears to be related, in part, to OIG's recommendation based on findings reported as early as 2019 about the potential risks relating to unlinked chart review records and their potential contribution to the estimated nearly $3 billion in overpayments to MAOs in 2017 alone.[44]

CMS also launched the Wasteful and Inappropriate Service Reduction (WISeR) Model on January 1, 2026. WISeR introduces prior authorization and pre-payment medical review requirements in FFS Medicare using a combination of AI tools, machine learning, and human clinical review.[45] In particular, through the WISeR model, CMS is attempting to decrease low-value services "shown to have little to no clinical, evidence-based benefit" by implementing a more efficient review of medical necessity for healthcare items and services "earlier in the claims process to reduce inappropriate utilization, lower spending in [FFS] Medicare, expedite decision making, and ease provider administrative burden."[46] Initially implemented in six states over a six-year trial period and focused on select sites of service, items, and services, WISeR represents a parallel effort to address potentially improper payments, prospectively. For MAOs, the hand-in-glove effect of CMS's prospective review approach through WISeR and its retrospective RADV audit expansion signals a sustained and coordinated increase in regulatory scrutiny of payment integrity across the entire MA program.[47]

Even as key aspects of the RADV framework remain subject to judicial review, CMS's enforcement posture suggests that heightened audit activity and associated financial, operational, and compliance risks will persist. And, as set forth in its recently issued Work Plan, OIG plans to continue auditing MAOs for supportability of diagnosis codes submitted to CMS and making recommendations to CMS based on the results of such audits.[48] MA program participants subject to CMS and OIG audits can proactively integrate data mining and other review processes into their compliance program using OIG's Work Plan and CMS's audit methodology as guidance.

Broker Compensation Reforms Face Judicial Headwinds

Alongside the focus on risk adjustment, recent litigation has challenged CMS's authority to curtail financially motivated MA broker practices that can run contrary to beneficiaries' interests, creating an altered, and still unsettled, regulatory landscape for brokers, agents, and TPMOs. Americans for Beneficiary Choice v. HHS and Council for Medicare Choice v. HHS[49] provide both near-term relief and longer-term uncertainty regarding the scope of CMS's authority over compensation structures and marketing practices.

In April 2024, CMS implemented a final rule expanding the definition of "compensation" to include administrative payments and marketing support fees, imposing a fixed fee cap on such payments and prohibiting certain incentive-based contractual arrangements between MA plans and brokers.[50] These reforms were designed to address concerns about patient steering, inflated payments, and marketing practices that could misalign broker incentives with MA beneficiary interests. In particular, CMS aimed to eliminate volume-based bonuses, administrative fees, or "overrides" paid for services other than enrollment, and other financial arrangements that had been viewed as particularly likely to incentivize brokers to direct beneficiaries toward MA plans generating higher broker payments rather than those best suited to their needs.[51]

However, in August 2025, the court vacated key portions of the rule, holding that CMS had exceeded its statutory authority and had acted in a manner that was arbitrary and capricious under the APA.[52] The court concluded that, although CMS has authority to regulate direct commissions paid to agents and brokers, it may not extend that authority to broader administrative payments or effectively engage in rate-setting for private contractual arrangements.

For brokers, agents, and TPMOs, the court's decision appears to restore, at least temporarily, flexibility in compensation structures. However, while payments for administrative services, marketing support, and lead generation are no longer subject to the CMS-imposed caps, they are still subject to scrutiny under the AKS.[53] In particular, the court's decision preserves MAOs' ability to structure contracts with brokers and agents that include incentive-based arrangements (including volume-based bonuses), subject to existing healthcare FWA laws.

But, at least in the interim, the court's ruling leaves open a window of potential heightened regulatory risk. First, CMS retains authority over core commission structures and marketing practices. And the court upheld certain consumer protection provisions, including restrictions on the sharing of MA beneficiary data without consent.[54] Second, the court's decision does not foreclose future rulemaking. Although broker compensation is not addressed in the recently released 2027 MA final rule,[55] in its 2027 MA proposed rule, CMS noted that it is "considering ways to modernize [its] approach to marketing oversight and agent/broker regulation in the Medicare program" and requested information relating to "regulatory changes that will assist the agency in taking appropriate action against TPMOs, including agents and brokers who fail to adhere to our requirements"[56] And third, the policy concerns underlying the rule—including patient steering, marketing misconduct, and rising MA beneficiary complaints, while subject to continued scrutiny under the AKS—remain unresolved and continue to draw scrutiny from Congress and advocacy groups.

Specifically, legislators and advocacy groups recently have highlighted a need for strengthened consumer protections and continued oversight of MA marketing and enrollment practices. A Senate Finance Committee inquiry determined that MA beneficiary complaints about MA marketing more than doubled in a single year and documented allegedly widespread use of aggressive and misleading tactics by agents and brokers, including conduct that could steer patients into MA plans that do not meet their needs.[57] Further congressional inquiry has emphasized that a complex network of TPMOs and financial incentives could mislead MA beneficiaries and encourage enrollment decisions that are driven by factors other than suitability.[58] Advocacy groups, including the Center for Medicare Advocacy, have echoed these concerns, calling for greater oversight of "marketing middlemen"[59] while also warning that the court's decision emphasizes a need for comprehensive reforms.[60] At the same time, and while the MA program continues to grow, OIG has identified certain marketing practices as an ongoing enforcement priority based on MA beneficiary complaints submitted to CMS—a risk factor consistent with the aforementioned OIG Special Fraud Alert.[61]

Where compensation arrangements could influence enrollment decisions, brokers, agents, and TPMOs can expect continued regulatory scrutiny. In light of the court's decision in Americans for Beneficiary Choice and Council for Medicare Choice, stakeholders are left with carefully balancing ongoing government enforcement priorities with their ability to creatively operationalize compensation structures that best fit MA beneficiary needs.

MAOs are Scaling Back Amid Mounting Regulatory and Financial Pressures

Given the increased regulatory scrutiny and litigation, it may be unsurprising that certain MAOs are downsizing or exiting certain markets altogether. However, these decisions appear to be driven by different factors.

In particular, several of the largest MAOs recently announced their plans to exit certain markets—both in terms of geography and product—based on recent federal legislative funding cuts, non-renewal of ACA plans, lower MA payment rates, and increased utilization.[62] For example, Molina Healthcare Inc. announced plans to stop offering MA plans with prescription drug coverage for 2027 for the aforementioned reasons, as well as increased medical costs and underperformance across its program platforms.[63] And the MAO is doing so notwithstanding the fact that it generates $1 billion in annual premium revenue from such MA plans.

For similar reasons, two of the largest MAOs have also indicated their intent to pull back on their MA plan offerings this year.[64] Specifically, UnitedHealthcare and Humana announced they are no longer offering MA plans in more than 400 counties, collectively, across the country.[65] Three other large MAOs are also following suit: Elevance Health announced it is leaving 181 counties,[66] CVS Health (a.k.a. Aetna) announced it is leaving 160, and Centene announced it is leaving 104.[67] Overall, there has been a nearly 10% decrease in available MA plans across the country since last year.[68] But that decrease, at least according to one source, is not surprising given that a steady decrease in available MA plans has been trending since 2023.[69]

Additionally, certain health systems and other types of providers have announced their intent to drop MA plans in 2026.[70] Whatever the reason—which, at least according to one source, appears to be business- or financial-related—at the end of the day, MA beneficiaries are most affected.[71] Perhaps in the long run, though, MA beneficiaries need not worry about these MAO and provider exits because CMS's Center for Medicare & Medicaid Innovation has established a goal for 100% of traditional Medicare beneficiaries (and most Medicaid enrollees) to be in an accountable care relationship by 2030—meaning that MA beneficiaries could experience some of the same or similar benefits of a managed care construct while enrolled in FFS Medicare.[72] And currently, there is no shortage of accountable care programs in which Medicare beneficiaries may participate.[73] Still, the stressors are evident and, at least according to MAOs, the federal government has played a significant role in affecting those MAOs' ability to provide affordable, accessible plans to MA beneficiaries.

The Proliferation and Use of AI is Caught in Regulatory Crosscurrents

The current regulatory landscape also reflects a growing tension concerning the role of AI in the MA program. While CMS is actively exploring and encouraging AI as a program integrity tool, Congress and private litigants are simultaneously scrutinizing MAO use of AI in coverage and payment determinations. Indeed, the current administration is acutely aware of the potential risks of a non-unified AI use policy and has issued an executive order stating that all state AI laws inconsistent with the "minimally burdensome national policy framework for AI"— which has yet to be created—are preempted by federal law.[74]

AI Use by MAOs

MAOs are increasingly embedding AI across a range of operational workflows. Interest in and scrutiny of the use of AI by MAOs tends to focus on prior authorization, utilization management, and claims adjudication processes.[75] CMS guidance about MAO AI use in these contexts is clear: it is subject to longstanding Medicare requirements. MAOs may deploy algorithms to facilitate review, however, they may not use AI to alter coverage criteria or as a substitute for individualized medical necessity determinations.[76] Indeed, determinations must be based on the MA beneficiary's specific clinical circumstances, and adverse decisions must be reviewed by a qualified clinician.[77]

Legal risk increases as AI tools move along the continuum from administrative support to decision-making, which has historically and currently remains within the purview of providers pursuant to their state licensure. Tools that assist with documentation are less controversial, while tools that facilitate coverage decisions are now the focus of both regulatory attention and litigation.

MAOs have been exploring more expansive applications of AI beyond these traditional functions. For example, AI tools are being deployed to support MA enrollment. MAOs are leveraging AI-driven tools to match beneficiaries with plans based on their health profiles, utilization history, and stated preferences.[78] As AI capabilities expand, legislators and regulators are struggling to balance AI's value against the need for careful oversight and scrutiny in the MA context.

Congressional Scrutiny and Litigation

Congressional attention has focused on whether AI-enabled tools—while permitted under CMS guidance to facilitate reviews—are contributing to inappropriate denials of care. Senate investigations, in particular, have examined whether large MAOs deployed predictive algorithms in ways that increased denial rates for certain categories of patients, particularly those requiring post-acute services.[79] Most recently, Sen. Richard Blumenthal (D-CT), chair of the U.S. Senate Permanent Subcommittee on Investigations, submitted inquiries to many MAOs seeking detailed information about how AI tools are designed, validated, and integrated into coverage determinations, as well as what safeguards exist to ensure clinical appropriateness.[80]

In parallel, private litigation continues to test the boundaries of permissible AI use. In two ongoing class actions, for example, plaintiffs allege that MAOs used AI models to systematically deny post-acute care.[81] These cases challenge whether the MAOs' use of AI models replaces required clinical judgments and applies criteria inconsistent with Medicare coverage rules. Against this backdrop, though, CMS is simultaneously moving to expand its own use of AI.

CMS has a CRUSH on AI

Through the Comprehensive Regulations to Uncover Suspicious Healthcare (CRUSH) initiative, CMS has expressly identified AI as a potential tool for improving MA coding oversight and detecting healthcare FWA.[82] The CRUSH Request for Information (RFI) seeks input on how AI can be used in areas such as medical record review, diagnosis validation, and payment integrity.[83] Specifically, the RFI solicits stakeholder feedback on available AI solutions that can accurately and efficiently abstract diagnoses from medical record documentation.[84] CMS has framed these efforts as part of a broader shift from a retrospective "pay and chase" enforcement model to a proactive "detect and deploy" strategy, in which AI tools are used to flag suspicious claims and coding anomalies before payments are issued.[85] The RFI also asks how AI can be leveraged to identify both overpayments and underpayments in MA risk adjustment coding, as well as to support compliance oversight and audit processes across federal healthcare programs.[86]

This aligns with broader federal agency efforts to leverage advanced analytics in enforcement. CMS already relies on predictive modeling to identify anomalous billing patterns,[87] and the DOJ's Health Care Fraud Data Fusion Center integrates, by design, AI and data analytics across federal agencies to detect and prevent fraud schemes.[88] In short, regulators are actively investing in AI as a core enforcement capability—an investment that is expected to continue and increase.

The Emerging Tension

For MAOs, the key issue is not whether AI can be used, but whether its use aligns with the MA program's requirements. On one hand, CMS is signaling that AI can be a valuable tool for identifying fraud and improving program integrity. Through CRUSH and related initiatives, CMS is effectively encouraging more sophisticated use of analytics, including in the MA context. On the other hand, the same tools are being challenged when used by MAOs in ways that appear to constrain access to care or deviate from individualized medical necessity standards. Ultimately, the technologies CMS is advancing through the CRUSH initiative may increase enforcement risk for MAOs if deployed without sufficient clinical and regulatory safeguards. Thus, a central compliance question is whether an AI model is not only accurate in the aggregate, but also whether each individual determination can withstand scrutiny under applicable Medicare regulations and applicable guidance.

Final Thoughts: There is Certainty in the Uncertain

The MA program has entered a period of sustained and multifaceted scrutiny, characterized by coordinated federal agency enforcement activity, heightened congressional oversight, and evolving regulatory priorities. Regulators are employing more aggressive oversight mechanisms, including expanded RADV audits and emerging AI-enabled tools, while federal courts continue to delineate the boundary of CMS's authority and the procedural constraints governing its rulemaking processes. At the same time, market participants face mounting operational and financial pressures arising from the convergence of these regulatory developments, ongoing litigation, and broader dynamics in the MA program. In light of these developments and despite palpable uncertainty, MAOs, downstream providers, and related stakeholders can position themselves for success by ensuring that their adoption of emerging technologies—particularly AI tools—is accompanied by robust compliance infrastructure that is sufficient to satisfy both existing regulatory requirements and the evolving—yet still unsettled—standards under active development in this area.

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[1] 31 U.S.C. §§ 3729–3733.

[2] 5 U.S.C. §§ 551–559.

[3] Balanced Budget Act of 1997, Pub. L. No. 105-33, § 4001, 111 Stat. 251, 275 (codified as amended at 42 U.S.C. §§ 1395w-21–1395w-28).

[4] For example, see Press Release, U.S. Dep't of Justice, *Sutter Health and Affiliates to Pay $90 Million to Settle False Claims Act Allegations of Mischarging the Medicare Advantage Program* (Aug. 30, 2021), https://www.justice.gov/archives/opa/pr/sutter-health-and-affiliates-pay-90-million-settle-false-claims-act-allegations-mischarging; Press Release, U.S. Dep't of Justice, *The Cigna Group to Pay $172 Million to Resolve False Claims Act Allegations* (Sept. 30, 2023), https://www.justice.gov/archives/opa/pr/cigna-group-pay-172-million-resolve-false-claims-act-allegations.

[5] *See Press Release, U.S. Dep't of Justice, Aetna Agrees to Pay $117.7 Million to Resolve False Claims Act Allegations (Mar. 11, 2026), https://www.justice.gov/opa/pr/aetna-agrees-pay-1177-million-resolve-false-claims-act-allegations; Press Release, U.S. Dep't of Justice, Kaiser Permanente Affiliates Pay $556 Million to Resolve False Claims Act Allegations (Jan. 14, 2026), https://www.justice.gov/opa/pr/kaiser-permanente-affiliates-pay-556m-resolve-false-claims-act-allegations; Supra n. 4; Press Release, U.S. Dep't of Justice, Martin's Point Health Care Inc. to Pay $22,485,000 to Resolve False Claims Act Allegations (July 31, 2023), https://www.justice.gov/archives/opa/pr/martins-point-health-care-inc-pay-22485000-resolve-false-claims-act-allegations; Press Release, U.S. Dep't of Justice, Medicare Advantage Provider to Pay $6.3 Million to Settle False Claims Act Allegations (Nov. 16, 2020), https://www.justice.gov/archives/opa/pr/medicare-advantage-provider-pay-63-million-settle-false-claims-act-allegations; Press Release, U.S. Dep't of Justice, Medicare Advantage Organization and Former Chief Operating Officer to Pay $32.5 Million to Settle False Claims Act Allegations (May 30, 2017), https://www.justice.gov/archives/opa/pr/medicare-advantage-organization-and-former-chief-operating-officer-pay-325-million-settle; Press Release, U.S. Att'y's Off., Cent. Dist. of Cal., Long Beach-Based Health Plan Pays Nearly $320 Million to Settle Allegations that it Received Overpayments for Medi-Cal Patients (Aug. 23, 2012), https://www.justice.gov/archive/usao/cac/Pressroom/2012/112.html; Press Release, U.S. Dep't of Justice, Florida-Based Medicare Advantage Plan Owners & Primary Care Provider Agree to Pay $22.6 Million to Settle Claims of Falsifying Diagnoses* (Nov. 24, 2010), https://www.justice.gov/archives/opa/pr/florida-based-medicare-advantage-plan-owners-primary-care-provider-agree-pay-226-million.

[6] Press Release, U.S. Dep't of Justice, *Medicare Advantage Provider Seoul Medical Group and Related Parties Pay Over $62 Million to Settle False Claims Act Allegations* (Apr. 29, 2025), https://www.justice.gov/opa/pr/medicare-advantage-provider-seoul-medical-group-and-related-parties-pay-over-62m-settle; Press Release, U.S. Dep't of Justice, *Medicare Advantage Provider Independent Health to Pay Up to $98 Million to Settle False Claims Act Suit* (Dec. 20, 2024), https://www.justice.gov/archives/opa/pr/medicare-advantage-provider-independent-health-pay-98m-settle-false-claims-act-suit; *Supra* n. 4; Press Release, U.S. Dep't of Justice, *Medicare Advantage Provider and Physician to Pay $5 Million to Settle False Claims Act Allegations* (Aug. 8, 2019), https://www.justice.gov/archives/opa/pr/medicare-advantage-provider-and-physician-pay-5-million-settle-false-claims-act-allegations. One of Beaver Medical's physicians also agreed to resolve his alleged liability; Press Release, U.S. Dep't of Justice, *Medicare Advantage Provider to Pay $270 Million to Settle False Claims Act Liabilities* (Oct. 1, 2018), https://www.justice.gov/archives/opa/pr/medicare-advantage-provider-pay-270-million-settle-false-claims-act-liabilities.

[7] Press Release, U.S. Dep't of Justice, *Former Executive at Medicare Advantage Organization Charged for Multimillion-Dollar Medicare Fraud Scheme* (Oct. 26, 2023), https://www.justice.gov/archives/opa/pr/former-executive-medicare-advantage-organization-charged-multimillion-dollar-medicare-fraud.

[8] U.S. Dep't of Justice, Crim. Div., *HealthSun Health Plans, Inc.* (Oct. 25, 2023), https://www.justice.gov/criminal/case/healthsun-health-plans-inc.

[9] 42 U.S.C. § 1320a-7b(b).

[10] Press Release, U.S. Att'y's Off., Dist. of P.R., *MCS Advantage Agrees to Pay $4.2 Million to Resolve Allegations that It Violated the False Claims Act and Anti-Kickback Statute* (July 1, 2022), https://www.justice.gov/usao-pr/pr/mcs-advantage-agrees-pay-42-million-dollars-resolve-allegations-it-violated-false-claims.

[11] Press Release, U.S. Att'y's Off., Dist. of P.R., *MMM Holdings, LLC Agrees to Pay $15.2 Million to Resolve Allegations that it Violated the False Claims Act and Anti-Kickback Statute* (Dec. 23, 2024), https://www.justice.gov/usao-pr/pr/mmm-holdings-llc-agrees-pay-152-million-dollars-resolve-allegations-it-violated-false.

[12] Press Release, U.S. Dep't of Justice, *Oak Street Health Agrees to Pay $60 Million to Resolve Alleged False Claims Act Liability for Paying Kickbacks to Insurance Agents in Medicare Advantage Patient Recruitment Scheme* (Sept. 18, 2024), https://www.justice.gov/archives/opa/pr/oak-street-health-agrees-pay-60m-resolve-alleged-false-claims-act-liability-paying-kickbacks.

[13] Including but not limited to the FCA, Civil Monetary Penalties Law (42 U.S.C. § 1320a-7a), Physician Self-Referral Law (Stark Law - 42 U.S.C. § 1395nn), AKS, and Exclusions Statute (42 U.S.C. § 1320a-7).

[14] Press Release, U.S. Dep't of Justice, *DOJ-HHS False Claims Act Working Group* (July 2, 2025), https://www.justice.gov/opa/pr/doj-hhs-false-claims-act-working-group.

[15] U.S. Dep't of Health & Hum. Servs., Off. of Inspector Gen., *Medicare Advantage Industry Segment-Specific Compliance Program Guidance* (Feb. 2026), https://oig.hhs.gov/documents/compliance/11464/ma-icpg.pdf.

[16] U.S. Dep't of Health & Hum. Servs., Off. of Inspector Gen., *Special Fraud Alert: Suspect Payments in Marketing Arrangements Related to Medicare Advantage and Providers* (Dec. 11, 2024), https://oig.hhs.gov/documents/special-fraud-alerts/10092/Special%20Fraud%20Alert:%20Suspect%20Payments%20in%20Marketing%2

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[17] In addition to risk adjustment, bipartisan efforts relating to other areas of concern for Congress are also taking shape. For example, as recently as April 27, 2026, Senators Roger Marshall and Shelon Whitehouse introduced the Medicare Advantage Improvement Act of 2026 "designed to reform" the MA program by, in part, expediting prior authorization approval turnaround time, limiting retroactive denials post-authorization, requiring MAOs to publicly report prior authorization data in the interest of transparency for patients, preventing MAOs from applying stricter medical necessity standards than FFS Medicare, and strengthening network adequacy requirements for post-acute care hospitals. *See* Medicare Advantage Improvement Act of 2026, H.R. 8375, 119th Cong. (2026). And, in addition to the Senate legislation and reports described in this article, the House of Representatives also continues to focus on the MA program. On July 22, 2025, the Joint Health and Oversight Subcommittee held a hearing on the MA program to examine, among other aspects of its operations, program integrity concerns. *See* Joint Health & Oversight Subcomm. Hearing on Medicare Advantage: Past Lessons, Present Insights, Future Opportunities, H. Comm. on Ways & Means (July 22, 2025). Earlier this year, the Energy and Commerce Subcommittee on Oversight and Investigations launched an investigation into fraud in the Medicare and Medicaid programs, including the MA program. *See* Chairmen Guthrie & Joyce Announce Oversight & Investigations Hearing on Ongoing Investigation into Medicare & Medicaid Programs Nationwide, H. Comm. on Energy & Com. (Mar. 10, 2026), https://energycommerce.house.gov/posts/ chairmen-guthrie-and-joyce-announce-oversight-and-investigations-hearing-on-ongoing-investigation-into-medicare-and-medicaid-programs-nationwide.

[18] Jeffrey A. Merkley, Bill Cassidy, M.D., Tina Smith, and Roger Marshall, M.D., Letter to Admin. Mehmet Oz, M.D. (Mar. 30, 2026) (https://aboutbgov.com/blh8).

[19] No UPCODE Act, S. 1105, 119th Cong. (2025); *see also* H.R. 3467, 119th Cong. (2025).

[20] Medicare Payment Advisory Comm'n, *Report to the Congress: Medicare Payment Policy* ch. 11, *The Medicare Advantage Program: Status Report* (Mar. 2025), https://www.medpac.gov/document/chapter-11-the-medicare-advantage-program-status-report-march-2025-report/.

[21] *See U.S. Dep't of Health & Hum. Servs., Off. of Inspector Gen., Billions in Estimated Medicare Advantage Payments from Chart Reviews Raise Concerns (OEI-03-17-00470, Dec. 10, 2019), https://oig.hhs.gov/documents/evaluation/2792/OEI-03-17-00470-Complete%20Report.pdf; see also U.S. Dep't of Health & Hum. Servs., Off. of Inspector Gen., Medicare Advantage: Questionable Use of Health Risk Assessments Continues To Drive Up Payments to Plans by Billions* (OEI-03-23-00380, Oct. 21, 2024), https://oig.hhs.gov/reports/all/2024/medicare-advantage-questionable-use-of-health-risk-assessments-continues-to-drive-up-payments-to-plans-by-billions/.

[22] *S*upra n. 20.

[23] *Citing Medicare Payment Advisory Comm'n, The Medicare Advantage Program: Status Report* (Jan. 16, 2026), https://www.medpac.gov/wp-content/uploads/2026/01/Tab-N-MA_Status-Jan-2026.pdf.

[24] S. Comm. on the Judiciary, *How UnitedHealth Group Puts the Risk in Medicare Advantage Risk Adjustment* (Majority Staff Report Jan. 12, 2026), https://www.grassley.senate.gov/imo/media/doc/uhg_report_-_final.pdf.

[25] *Id*. at 39.

[26] Brief for Appellants, *Humana Inc. v. Becerra*, *rev'd sub nom. Humana Inc. v. Kennedy*, No. 25-11293 (5th Cir. Mar. 21, 2026).

[27] 83 Fed. Reg. 54,982 (Nov. 1, 2018).

[28] *Id.* at 55,040-55,041.

[29] 88 Fed. Reg. 6,643 (Feb. 1, 2023).

[30] *Id*. at 6,665.

[31] *Id*. at 6,643.

[32] *Id.* at 6,656-6,660.

[33] Order, *Humana Inc. v. Becerra*, No. 4:23-cv-909 (N.D. Tex. Sept. 25, 2025), ECF No. 76.

[34] *Id*. at 7.

[35] *Supra n. 26 at 20-21. CMS contends that the Court applied the "logical outgrowth" doctrine too rigidly and further asserts that Medicare rulemaking affecting the MA program is governed by the Medicare statute (42 U.S.C. § 1395hh), rather than the APA. CMS posits that the "logical outgrowth" doctrine should apply only to the substance of its regulations—not to its underlying rationale. CMS maintains that its proposed rule "adequately framed" the relevant considerations and gave sufficient notice for the final rule such that stakeholders should have anticipated the federal agency's final approach. See supra n. 26 at 29. CMS also warns that the Court's reasoning would unduly constrain federal agency rulemaking by requiring iterative notice-and-comment cycles until any final rule mirrors the proposed rule in both substance and rationale. See Id. at 37. Although CMS argued at the district court that any APA notice-and-comment violation was harmless because its interpretation reflected the "best reading of the statute" under Loper Bright*, the district court rejected that contention—citing the absence of supporting federal precedent—and CMS does not renew the argument on appeal.

[36] *UnitedHealthcare Insurance Co. v. Becerra, No. 18-5326 (D.C. Cir. 2021), cert. denied, 142 S. Ct. 2850 (2022). When proposed, the 60-day overpayment rule heightened the FCA "recklessness" standard for MAOs. However, when that standard was struck down, CMS issued its final rule, clarifying that the same FCA standard applies. See* 87 Fed. Reg. 79,452; 88 Fed. Reg. 22,120; 89 Fed. Reg. 97,710.

[37] *Loper Bright Enters. v. Raimondo*, 144 S. Ct. 2244 (2024).

[38] Ctrs. For Medicare & Medicaid Servs., *Update on the Status of Medicare Advantage Risk Adjustment Data Validation Audits* (Jan. 27, 2026), https://www.ahcancal.org/Reimbursement/Documents/MA/Update%20on%20Status%20of

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[39] Press Release, Ctrs. for Medicare & Medicaid Servs., CMS Rolls Out Aggressive Strategy to Enhance and Accelerate Medicare Advantage Audits (May 21, 2025), https://www.cms.gov/newsroom/press-releases/cms-rolls-out-aggressive-strategy-enhance-accelerate-medicare-advantage-audits.

[40] *Supra* n. 38.

[41] Ctrs. for Medicare & Medicaid Servs., *Medicare Advantage Risk Adjustment Data Validation (RADV) Audit Schedule* (Mar. 4, 2026), https://www.cms.gov/files/document/radv-audit-schedule.pdf.

[42] Ctrs. for Medicare & Medicaid Servs., Announcement of Calendar Year (CY) 2027 Medicare Advantage (MA) Capitation Rates and Part C and Part D Payment Policies (Apr. 6, 2026), https://www.cms.gov/files/document/2027-announcement.pdf.

[43] Ctrs. for Medicare & Medicaid Servs., Dep't of Health & Hum. Servs., *2027 Medicare Advantage and Part D Advance Notice* (Jan. 26, 2026), https://www.cms.gov/newsroom/fact-sheets/2027-medicare-advantage-part-d-advance-notice.

[44] *See, e.g.*, U.S. Dep't of Health & Hum. Servs., Off. of Inspector Gen., Billions in Estimated Medicare Advantage Payments from Chart Reviews Raise Concerns (Dec. 10, 2019), https://oig.hhs.gov/reports/all/2019/billions-in-estimated-medicare-advantage-payments-from-chart-reviews-raise-concerns//.

[45] Wasteful & Inappropriate Serv. Reduction (WISeR) Model, Ctrs. for Medicare & Medicaid Servs., https://www.cms.gov/priorities/innovation/innovation-models/wiser (last visited Apr. 4, 2026).

[46] *Id*.

[47] A bill was introduced to ban the WISeR model. *See* Ban AI Denials in Medicare Act, H.R. 6361, 119th Cong. (2025). H.R. 6361 would prohibit HHS from implementing the WISeR model and amend the Social Security Act to bar CMS's Center for Medicare & Medicaid Innovation from testing any Medicare models that use prior authorization, particularly AI-driven approaches, for Part A and B services. The bill was introduced on December 2, 2025, and remains in committee with no further floor action to date.

[48] U.S. Dep't of Health & Hum. Servs., Off. of Inspector Gen., Audit of Diagnosis Codes That MA Organizations Submitted to CMS for Use in the Medicare Part C Risk-Adjustment Program, Work Plan Project No. OAS-25-02-025 (Aug. 15, 2025), https://oig.hhs.gov/reports/work-plan/browse-work-plan-projects/audit-of-diagnosis-codes-that-ma-organizations-submitted-to-cms-for-use-in-the-medicare-part-c-risk-adjustment-program/. OIG has published its audits of a number of MAOs including, Humana Health Benefits of Louisiana, Gateway Health Plan, Inc., and Priority Health. *See* U.S. Dep't of Health & Hum. Servs., Off. of Inspector Gen., Medicare Advantage Compliance Audit of Specific Diagnosis Codes That Humana Health Benefit of Louisiana (Contract H1951) Submitted to CMS, Report No. A-06-21-02001 (Dec. 8, 2025), https://oig.hhs.gov/reports/all/2025/medicare-advantage-compliance-audit-of-specific-diagnosis-codes-humana-health-benefit-of-louisiana-contract-h1951-submitted-to-cms/ ; U.S. Dep't of Health & Hum. Servs., Off. of Inspector Gen., Medicare Advantage Compliance Audit of Specific Diagnosis Codes That Gateway Health Plan, Inc. (Contract H5932) Submitted to CMS, Report No. A-03-22-00004 (Mar. 12, 2026), https://oig.hhs.gov/reports/all/2026/medicare-advantage-compliance-audit-of-specific-diagnosis-codes-that-gateway-health-plan-inc-contract-h5932-submitted-to-cms/; U.S. Dep't of Health & Hum. Servs., Off. of Inspector Gen., Medicare Advantage Compliance Audit of Specific Diagnosis Codes That Priority Health (Contract H2320) Submitted to CMS, Report No. A-07-22-01208 (Mar. 31, 2026), https://oig.hhs.gov/reports/all/2026/medicare-advantage-compliance-audit-of-specific-diagnosis-codes-that-priority-health-contract-h2320-submitted-to-cms/.

[49] *Americans for Beneficiary Choice v. U.S. Dep't of Health & Human Servs.*, Nos. 4:24-cv-00439-O, 4:24-cv-00446-O, slip op. (N.D. Tex. Aug. 18, 2025).

[50] 89 Fed. Reg. 30,488 (Apr. 23, 2024).

[51] *Id*. at 30,621–30,627.

[52] *Supra* n. 49 at 19.

[53] U.S. Dep't. of Health & Hum. Servs., Off. of Inspector Gen., *Special Fraud Alert: Suspect Payments in Marketing Arrangements Related to Medicare Advantage and Providers* at 4 (Dec. 11, 2024), https://oig.hhs.gov/compliance/alerts/.

[54] *Id*. at 20-21.

[55] 91 Fed. Reg. 17,384 (Apr. 6, 2026).

[56] 90 Fed. Reg. 54,894 at 54,897 (Nov. 28, 2025).

[57] S. Comm. on Fin., *Deceptive Marketing Practices Flourish in the Medicare Advantage Program* (Nov. 2022), https://www.finance.senate.gov/imo/media/doc/Deceptive%20Marketing%20Practices%20.

[58] S. Comm. on Fin., *Pushing Medicare Advantage on Seniors: Unraveling the Complex Network of Marketing Middlemen* (Mar. 2025), https://www.finance.senate.gov/imo/media/doc/pushing_medicare_advantage_on_seniounraveling_the_complex_network_of_marketing_middlemen_-_32425docx.pdf.

[59] Ctr. for Medicare Advoc., *Senate Finance Committee Holds Hearing on Medicare Advantage Marketing Misconduct* (Oct. 19, 2023), https://medicareadvocacy.org/senate-finance-committee-holds-hearing-on-medicare-advantage-marketing-misconduct/.

[60] Ctr. for Medicare Advoc., *Court Strikes Down Key Medicare Marketing Regulations* (Aug. 28, 2025), https://medicareadvocacy.org/court-strikes-down-key-medicare-marketing-regulations/.

[61] U.S. Dep't of Health & Hum. Servs., Off. of Inspector Gen., *Misleading Marketing Practices in Medicare Advantage* (July 15, 2025), https://oig.hhs.gov/reports/work-plan/browse-work-plan-projects/misleading-marketing-practices-in-medicare-advantage/.

[62] Ike Swetlitz, Molina Healthcare Faces Pressure in Medicare Advantage Earnings, Mod. Healthcare (Feb. 5, 2026), https://www.modernhealthcare.com/insurance/mh-molina-medicare-advantage-earnings/.

[63] *Id*.

[64] *See Sriparna Roy, CVS Health to Offer 2026 Medicare Prescription Drug Plans in 43 States, REUTERS (Oct. 1, 2025), https://www.reuters.com/legal/litigation/cvs-health-offer-2026-medicare-prescription-drug-plans-43-states-2025-10-01/; see also* Amina Niasse, UnitedHealth to Exit Medicare Advantage Plans in 16 U.S. Counties, REUTERS (Oct. 1, 2025), https://www.reuters.com/legal/litigation/unitedhealth-exit-medicare-advantage-plans-16-us-counties-2025-10-01/.

[65] Meredith Freed et al., *Medicare Advantage 2026 Spotlight: A First Look at Plan Offerings*, KFF (Dec. 9, 2025), https://www.kff.org/medicare/medicare-advantage-2026-spotlight-a-first-look-at-plan-offerings/.

[66] We note that CMS also recently issued a notice of imposition of intermediate sanctions upon Elevance for its alleged failure to comply with federal data submission requirements. *See* Ctrs. for Medicare & Medicaid Servs., Dep't of Health & Hum. Servs., *Notice of Imposition of Intermediate Sanctions Against Elevance Health, Inc.* (Feb. 27, 2026), https://www.cms.gov/files/document/elevancehealthsanction02272026.pdf. The effect is that Elevance's MA plans will be prohibited from enrolling any new members until Elevance comes into compliance with CMS's requirements.

[67] *See supra n. 65; see also* Rebecca Pifer Parduhn, UnitedHealthcare, Humana, Aetna Scale Back Medicare Advantage Plans for 2026, HEALTHCARE DIVE (Oct. 2, 2025), https://www.healthcaredive.com/news/medicare-advantage-plans-2026-unitedhealthcare-humana-aetna/801761/.

[68] *Supra* n. 65.

[69] *See id*.

[70] For example, MultiCare, Mayo Clinic, Providence Clinical Network, New York City's Mount Sinai, and UNC Health. *See* Soo Kim, List of Health Systems Dropping Medicare Advantage Plans in January, NEWSWEEK (Dec. 31, 2025), https://www.newsweek.com/list-of-health-systems-dropping-medicare-advantage-plans-in-january-11291771.

[71] *Id*.

[72] Ctrs. for Medicare & Medicaid Servs., CMS Moves Closer to Accountable Care Goals with 2025 ACO Initiatives (Jan. 15, 2025), https://www.cms.gov/newsroom/fact-sheets/cms-moves-closer-accountable-care-goals-2025-aco-initiatives.

[73] Ctrs. for Medicare & Medicaid Servs., Dep't of Health & Hum. Servs., *Innovation Models*, https://www.cms.gov/priorities/innovation/models (last visited Apr. 16, 2026).

[74] Exec. Order No. 14,365, Ensuring a National Policy Framework for Artificial Intelligence, 90 Fed. Reg. 58,499 (Dec. 16, 2025), https://www.whitehouse.gov/presidential-actions/2025/12/eliminating-state-law-obstruction-of-national-artificial-intelligence-policy//.

[75] Carmel Shachar, Amy Killelea & Sara Gerke, AI and Health Insurance Prior Authorization: Regulators Need to Step Up Oversight, HEALTH AFFAIRS FOREFRONT (July 8, 2024), https://www.healthaffairs.org/content/forefront/ai-and-health-insurance-prior-authorization-regulators-need-step-up-oversight.

[76] Ctrs. for Medicare & Medicaid Servs., Frequently Asked Questions Related to Coverage Criteria and Utilization Management Requirements in CMS Final Rule (CMS-4201-F) (Feb. 6, 2024) https://www.aha.org/system/files/media/file/2024/02/faqs-related-to-coverage-criteria-and-utilization-management-requirements-in-cms-final-rule-cms-4201-f.pdf.

[77] 42 C.F.R. §§ 422.101(c)(1)(i)(C), 422.566(d).

[78] For example, in 2024 Humana made a minority investment in Healthpilot, an AI-enabled platform that supports beneficiaries in the Medicare enrollment process. *See* Paige Minemyer, *Humana Makes Investment in AI-Powered Medicare Enrollment Platform Healthpilot*, Fierce Healthcare (July 18, 2024), https://www.fiercehealthcare.com/payers/humana-makes-investment-ai-powered-medicare-enrollment-platform-healthpilot.

[79] Permanent Subcomm. on Investigations, S. Comm. on Homeland Sec. & Gov't Aff., How Medicare Advantage Insurers Have Denied Coverage and Increased Costs for Patients (Majority Staff Report Oct. 17, 2024), https://www.hsgac.senate.gov/wp-content/uploads/2024.10.17-PSI-Majority-Staff-Report-on-Medicare-Advantage.pdf.

[80] Casey Ross, Top Democrat Demands Medicare Insurers Disclose Uses of AI in Care, STAT (Oct. 9, 2025), https://www.statnews.com/2025/10/09/blumenthal-letter-on-medicare-insurers-using-ai-unitedhealth-humana-cvs-aetna/.

[81] *Estate of Gene B. Lokken v. UnitedHealth Grp., Inc., No. 0:23-cv-03514 (D. Minn. filed Nov. 14, 2023); Barrows v. Humana, Inc.*, No. 3:23-cv-00654 (W\.D. Ky. filed Dec. 12, 2023).

[82] Ctrs. for Medicare & Medicaid Servs., Dep't of Health & Hum. Servs., Crushing Fraud Chili Cook-Off Competition White Paper (Dec. 2025), https://www.cms.gov/files/document/crushing-fraud-chili-cook-white-paper.pdf.

[83] Request for Information (RFI) Related to Comprehensive Regulations To Uncover Suspicious Healthcare (CRUSH), 91 Fed. Reg. 9,803 (Feb. 27, 2026).

[84] *Id*. at 9,806.

[85] Press Release, Ctrs. for Medicare & Medicaid Servs., *Trump Administration Prioritizes Affordability by Announcing Major Crackdown on Health Care Fraud* (Feb. 25, 2026), https://www.cms.gov/newsroom/press-releases/trump-administration-prioritizes-affordability-announcing-major-crackdown-health-care-fraud.

[86] 91 Fed. Reg. at 9,806.

[87] Ctrs. for Medicare & Medicaid Servs., Dep't of Health & Hum. Servs., *Center for Program Integrity: New Strategic Direction and Key Antifraud Activities* (Nov. 3, 2011), https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/MedicaidIntegrityProgram/Downloads/CPI_initiatives.pdf.

[88] Press Release, U.S. Dep't of Justice, *National Health Care Fraud Takedown Results in 324 Defendants Charged in Connection with Over $14.6 Billion in Alleged Fraud* (June 30, 2025), https://www.justice.gov/opa/pr/national-health-care-fraud-takedown-results-324-defendants-charged-connection-over-146.

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