IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF TEXAS
FORT WORTH DIVISION

HUMANA INC., and AMERICANS FOR BENEFICIARY CHOICE, Plaintiffs, v. U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES; CENTERS FOR MEDICARE & MEDICAID SERVICES; ROBERT F. KENNEDY JR., in his official capacity as Secretary of Health and Human Services; and MEHMET CENGIZ OZ, in his official capacity as Administrator of the Centers for Medicare & Medicaid Services, Defendants.	Civil Action No. 4:25-cv-00779-O

DEFENDANTS' REPLY IN SUPPORT OF THEIR CROSS-MOTION FOR SUMMARY JUDGMENT

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I. Introduction

Humana continues to insist that CMS is to blame for its acknowledged failure to attempt callbacks. Its theory is that because CMS would not accept a callback, trying was futile.[1] As Defendants have demonstrated, a necessary (and missing) premise of this argument is a showing that Humana was aware, at the time of the disconnections, that the calls were CMS test calls.[2] And Humana did not make this showing, either during the Agency review process or in this Court. *Id.* at 20-21.

Start with the record below. There is no doubt that Humana repeatedly said it would have attempted a callback but for the no-callback policy. *See* Pls.' Opp'n 8 (citing Administrative Record ("AR") 18, 23, 27, 34, 38, 54, 61, 373, 399). But to call those "straightforward explanations for why Humana did not follow its callback procedure," *id.*, assumes facts not in evidence: that Humana knew at the time the test calls were placed that they were indeed test calls, and failed to attempt callbacks on that basis. All the record shows is that Humana hung up on a caller and did not attempt a callback—a fact pattern that both parties agree should result in a call being marked unsuccessful.[3]

[1] Consolidated Mem. in Opp'n to Defs.' Cross-Mot. for Summ. J. & in Further Supp. of Pls. Mot. for Summ. J. ("Pls.' Opp'n") 8, ECF No. 36.

[2] *See* Defs.' Consolidated Br. in Supp. of Their Cross-Mot. for Summ. J. & Resp. to Pls. Mot. for Summ. J. ("Defs.' Mot.") 20, ECF No 34.

[3] *See* Mem. in Supp. of Mot. for Summ. J. ("Pls. Mot.") 28, ECF No. 17.

If any evidence existed that Humana knew when it received them that the calls were test calls, it could have introduced it during the Plan Preview period or Agency appeal process. It could have offered notes from the customer service representatives ("CSR") who fielded the calls, indicating that they did not attempt callbacks because they had identified the calls as CMS test calls. Or Humana could have introduced evidence of its institutional awareness that the numbers used to place the test calls were associated with prior CMS test calls. It could have offered an affidavit saying it knew at the time that the calls came from CMS. It could have introduced statistics showing what portion of disconnections from its call center resulted in callbacks. It did none of these, nor anything else, to show its contemporaneous awareness. Again, there is no dispute that Humana repeatedly attributed its failure on these calls to CMS's no-callback policy. But this Court's role is to determine whether "the evidence in the administrative record permitted the agency to make the decision it did." *MRC Energy Co. v. U.S. Citizenship & Immigr. Servs.*, No. 3:19-cv-2003-K, 2021 WL 1209188, at * 3 (N.D. Tex. Mar. 31, 2021). Neither the Agency nor this Court is required to accept Humana's unsupported assertions about what it would have done but for a CMS policy, particularly given Humana's failure to link the policy to its own actions.[4]

Recognizing its shortcomings before the Agency, Humana points to a declaration submitted to this Court—the Sanders Declaration. As Defendants have already pointed

[4] Humana never acknowledges that the applicable Agency regulations place the "burden of proof . . . on the MA organization to prove an error was made in the calculation of the QBP status." 42 C.F.R. § 422.260(c)(2)(v). Mere assertion—no matter how many times it is repeated—is not the same as proof.

out, Defs.' Mot. 20, the Sanders Declaration does not connect Humana's failures to the no-callback policy. To the contrary: the declaration avoids saying that Humana knew at the time that the two challenged calls were CMS test calls. Humana does not respond to Defendants' arguments about the declaration's deficiencies; it says that "the declaration of Marla Sanders suffices beyond fair-minded debate." Pls.' Opp'n 8. Humana then tilts at a strawman, saying that the defendants "suggest[ed] that it is improper for Humana to attempt to identify CMS test calls at the outset and apply different protocols to those calls." *Id.* at 9. There is absolutely nothing wrong with Humana attempting to identify CMS test calls; the problem (as Defendants showed) is that neither of the indicators that Humana itself describes as making it "possible to identify CMS test calls" was present for calls D1100955 and D0900533.[5] As far as the administrative record and the declaration are concerned, Humana had not identified the CMS test calls as such at the time that it failed to attempt callbacks. Humana thus violated its own callback policy without any explanation. CMS correctly marked the challenged calls as unsuccessful because Humana hung up on the callers while attempting to put an interpreter on the line.

[5] Humana directs this Court to CMS guidance on how it suggests call centers respond to the scripted question in the test calls without acknowledging—much less refuting—Defendants' opening-brief argument that the test callers were never able to *ask* the "are you the right person to answer questions about . . ." question in the script. Pls.' Opp'n 9; *cf.* Defs.' Mot. 20. In any event, Humana overstates CMS guidance on the topic. A call center may not "insist[] on first knowing the caller's name" before answering the introductory question, and a representative "should refrain from requesting additional identifying information until at a minimum the caller is able to confirm that they have reached the right person." AR 48. That guidance is quite different from an outright prohibition on even asking a caller's name. *See* Pls.' Opp'n 9. The CMS Accuracy & Accessibility study strives "to replicate a beneficiary's actual experience." AR 48.

Humana attributes to CMS—and resists—the argument that a successful post-disconnection callback requires accomplishment, not merely an attempt. *See* Pls.' Opp'n 10. But Humana acknowledged that avoiding an unsuccessful rating requires more than an attempt: A call "should not be scored unsuccessful when the call center *is able* to call back and bring an interpreter on the line in fewer than eight minutes from the initial foreign-language connection." Pls.' Mot. 28 (emphasis added). This is not, as Humana would have it, a "traceability argument." Pls.' Opp'n 10. Defendants do not contest Humana's standing, even as they acknowledge that Article III standing is unwaivable. It does not follow from the mere fact of having Article III standing that Humana may challenge in court any aspect of the Star Ratings calculation metric, no matter how attenuated from the record below. To the contrary: under *Shalala v. Illinois Council on Long Term Care*, Humana may "contest the lawfulness of any regulation or statute *upon which an agency determination depends*." 529 U.S. 1, 23 (2000) (emphasis added).[6] Whether or not this Court considers Humana's belated declaration, it should determine

[6] Plaintiffs offer a flawed analogy to a hypothetical statute prohibiting the distribution of handbills, arguing that a plaintiff does not need to violate the statute to have standing to challenge it. Pls.' Opp'n 7. But that waves away the "effectively coerced" requirement in *MedImmune, Inc. v. Genentech*, *Inc.*, 549 U.S. 118, 129 (2007). There, the Supreme Court held that eliminating the "imminent threat of harm by simply not doing what [the plaintiff] claimed the right to do . . . did not preclude subject-matter jurisdiction *because* the threat-eliminating behavior was effectively coerced." *Id.*(emphasis added). Futility is not the same as effective coercion, and the presence of that coercion (i.e., the threat of harm from enforcement of a law) was key to the Supreme Court's holding. *Id.* Putting that aside, Defendants' argument is that the record does not show that Humana knew at the time it failed to call back that the calls at issue were CMS test calls. Because Humana's claim that the no-callback policy induced its behavior is unsupported by evidence in the administrative record, the cases Humana cites are inapt.

that the Agency's determination did not depend on the no-callback policy.[7] *See* AR 460 (hearing officer determination that "CMS provided evidence, through call logs and notes, that attempts were validly made, yet contacts were not completed as outlined in the Technical Notes").

On the record before this Court, Humana's complaints about the lawfulness of the no-callback policy are a red herring. Humana asserts, without citation, that the statements of its officials in memoranda during the Agency review process are "akin to written testimony in Court" that the Agency "took as true." Pls.' Opp'n 15. This is incorrect. The Hearing Officer made "findings of fact," none of which adopted the arguments of Humana's officials. To the contrary, she noted that "Humana did not provide its own call logs to CMS, thus the CMS call logs *are the only available empirical evidence* associated with these calls." AR 459 (emphasis added). And it bears repeating, again, that the call logs are unambiguous: Humana hung up on the callers while asking

[7] Humana's contention that this argument is a "a post hac [sic] rationalization that the Court may not consider," Pls.' Opp'n 12-15, quotes selectively from the record. In the very sentence after the Agency stated "CMS does not allow callbacks from the plan as all questions should be answered in a single call," AR 36; *accord* Pls.' Opp'n 12, CMS explained that "[t]he attached call log shows that for each of these calls the disconnect source was not CMS." AR 36. CMS thus explained that the reason the calls were marked unsuccessful was because Humana hung up on the caller. More important, the Hearing Officer decision—which is the final agency decision at issue before this Court—explains that "CMS provided evidence, through call logs and notes, that attempts were validly made, yet contacts were not completed as outlined in the Technical Notes." AR 460. Again, CMS marked the calls unsuccessful because they were unsuccessful. *See Motor Vehicle Mfrs. Ass'n v. State Farm Mut. Auto. Ins.*, 463 U.S. 29, 43 (1983) (court should "uphold a decision of less than ideal clarity if the agency's path may reasonably be discerned") (citing). CMS's position in this Court follows the Hearing Officer's holding that the calls were marked unsuccessful because Humana hung up on a caller seeking an interpreter. The no-callback policy did not cause Humana to hang up on a test caller, and Humana cannot—consistent with *Illinois Council*—make any showing that the Agency determination at issue here depended on the no-callback policy. This is not, as Humana would construe it, a misplaced prejudice or harmless-error argument. *See* Pls.' Opp'n 12-14. Rather, it is a straightforward application of the APA substantial evidence standard and *Illinois Council*.

them to hold for a translator. The Court should therefore conclude that substantial evidence supports CMS's disposition of the challenged calls.

II. Summary

Humana now concedes that there is no factual dispute underlying its effort to have this Court revise Defendants' determination that its three challenged calls were unsuccessful. In each instance, a caller requiring a foreign-language translator's assistance dialed Humana's call center and attempted to ask a question. Humana hung up on all three callers. Consistent with its longstanding guidance, promulgated annually under a regulation that Humana does not challenge, CMS marked those calls unsuccessful. Humana sought Agency review of the calls, and a CMS Hearing Officer affirmed the Agency's initial ruling. This result is hardly surprising: Humana itself agrees that "[i]f a call center drops a call and then fails to call back or takes too long calling back, the call of course should be marked unsuccessful." Pls.' Mot. 28. This Court's role in reviewing CMS's disposition of the calls is to determine whether "substantial evidence" supports the Agency's determination that the calls were unsuccessful. Undisputed evidence is far more than substantial, and this Court can and should grant summary judgment to the Defendants on that basis alone.

Humana would have this Court treat a simple Administrative Procedure Act ("APA") record-review case as a complicated one. It says that an Agency policy forbidding callbacks—a policy that is plainly laid out in annual guidance on which the Agency solicits comments from Medicare Advantage Organizations like Humana—was promulgated improperly under the Medicare statute or the APA. There are several

problems with this argument, but the main one goes back to the undisputed facts described above and in Defendants' opening brief. Humana never attempted a callback on either of the two disconnected calls that it insists would have been successful but for the no-callback policy. And despite its belated efforts to blame CMS's no-callback policy for its unsuccessful calls, there is no evidence linking Humana's acknowledged failure to call back to CMS's no-callback policy. Even the evidence Humana withheld from the Agency but presents in this Court cannot demonstrate its contemporaneous awareness that the failed calls were test calls, rendering its decision not to attempt a callback inexplicable even on its own theory.

Humana's challenge to the Agency's disposition of the third call suffers from related defects. Humana would once again have this Court imagine a different administrative record—specifically, one where there was a genuine factual dispute about whether a human being joined the challenged call on Humana's side. The record is clear—a point Humana tacitly admits by saying what it "would have" and "could have" produced during the Agency appeal process. Challenges under the substantial evidence standard are not won via hypotheticals, and this Court should affirm Defendants' disposition of the third challenged call.

As Defendants noted in their opening brief, this Court does not need to reach many of the arguments Humana presents in this case. Substantial evidence supports the Agency's disposition of all three calls, and this Court can and should grant summary judgment to Defendants on that basis.

III. Argument and Authorities

A. The Substantial Evidence Standard Applies to Judicial Review of an Agency Decision Following an Informal Hearing

Humana opens its opposition brief with a purported "point of clarification" about the applicable standard of review. Pls.' Opp'n 4. There is nothing to clarify. Humana's opening brief said nothing about the applicable standard of review, and Defendants have not suggested they are entitled to deference under *Loper Bright Enterprises v. Raimondo*, 603 U.S. 369 (2024), which in any event would not apply to Humana's argument that CMS's no-callback policy violates its own regulation. *Cf.* Pls.' Opp'n 5. The immediate question before this Court is whether CMS, after an informal Agency hearing on the record, erred in scoring three test calls to Humana's call center "unsuccessful," and that question is governed by the substantial evidence standard. *See* 5 U.S.C. § 706(2)(E). A recent decision by another judge in this District involving a different Medicare Advantage Organization's ("MAO") challenge to its Star Ratings held that "Agency decisions are presumptively valid; the plaintiff bears the burden of showing otherwise." *Elevance Health, Inc. v. Kennedy*, No. 4:24-cv-1064-P, 2025 WL 2394087, at *4 (N.D. Tex. Aug. 18, 2025) (cleaned up). "The Court reviews agency actions to ensure they comply with the law and do not blatantly disregard the administrative record." *Id.* Humana's arguments with respect to all three calls at issue ask this Court to make conclusions contrary to the administrative record below. On substantial evidence review, this Court should not do so.

B. Humana Agrees that a Call Identical To the Two Disconnected Calls Should Be Marked Unsuccessful

Humana's opposition brief never addresses its acknowledgement in its opening brief that "[i]f a call center drops a call and then fails to call back or takes too long calling back, the call of course should be scored unsuccessful." Pls.' Mot. 28. That is exactly what happened on calls D1100955 and D0900533. No further analysis is needed with respect to the disconnections: the parties agree that a disconnection caused by the plan, followed by a failure by the plan to attempt a callback, should result in an unsuccessful call.

C. The No-Callback Policy Was Lawfully Promulgated

Humana makes a series of arguments against the procedural lawfulness of the no-callback policy, arguing that CMS was required under the Medicare statute or the APA to conduct notice-and-comment rulemaking. Pls.' Opp'n 15-27. Defendants will address Humana's arguments, but it is worth noting at the outset that Humana does not argue that it was deprived of either notice or the opportunity to comment on CMS's Star Ratings measure specifications, which include the no-callback policy.

Take the issue of notice first. According to Humana, it established a special policy "deviat[ing] from Humana's standard sales script" for CMS calls.[8] Humana's creation of that policy leaves no doubt that the company had full notice of the no-callback policy.

[8] App. in Supp. of Pls. Mot. for Summ. J. ("Pls. App.") 14, ECF No. 19 (Decl. of Marla Sanders ("Sanders Decl.") ¶ 6); *see also id.* (Sanders Decl. ¶ 8).

Given that undisputed evidence in the record, Humana cannot now credibly contend that the no-callback policy caused it any unfair surprise.

As for the opportunity to comment: Humana does not (and cannot) dispute that as part of its 2018 rulemaking establishing the Star Ratings measure specification update process (42 C.F.R. §§ 422.160-166[9]), CMS responded to comments about the call center measure. *See* 83 Fed. Reg. 16,440, 16,551 (Apr. 16, 2018); *accord* Defs.' Mot. 26 n.12. Since that 2018 rulemaking, the measure specifications have been updated annually, and CMS each year provides MAOs notice and an opportunity to comment "through the process described . . . in section 1853(b) of the [Social Security] Act." 42 C.F.R. § 422.164; *see* 42 U.S.C. § 1395w-23(b)(2). Humana contends that CMS's process is insufficient, but there can be no doubt that Humana had notice of the no-callback policy and has had the opportunity to comment on the Star Ratings measure specifications for years.

1. Humana's Argument Misunderstands the Purposes of the Accuracy & Accessibility Study

Humana repeatedly misnames the Accuracy & Accessibility Study, calling it the "Star Ratings Accuracy & Accessibility Study." Pls.' Opp'n 16, 17. In a perhaps related error, it misconstrues CMS's argument—insisting that CMS has described the Accuracy & Accessibility Study as "disconnected" from the minimum standards regulation at 42 C.F.R. § 422.111(h)(1)(iii). Pls.' Opp'n 16. But the Accuracy & Accessibility Study

[9] As in their opening brief, *see* Defs.' Mot. 4 n.2, Defendants frequently cite only to the Part C regulatory provisions when there are substantively identical regulations covering Part D, *see* 42 C.F.R. §§ 423.180-186.

does more than gather data underlying the Star Ratings, and CMS's claim is much narrower: that the minimum standards regulation has nothing to do with Star Ratings. CMS has never denied that the Accuracy & Accessibility Study *also* supports possible compliance actions related to the minimum standards regulation. But there is no compliance action at issue before this Court.

CMS conducts two separate annual call center studies: (1) the Timeliness Study; and (2) the Accuracy & Accessibility Study. *See* AR 64. None of the data gathered in the Timeliness Study contributes to the Star Ratings; rather, some of that data is made available to the public for informational purposes on the CMS website. *See* 42 C.F.R. § 422.162(a) ("Display page"). By contrast, some of the data from the Accuracy & Accessibility Study contributes to Star Ratings—but not all of it does. That is because the Accuracy & Accessibility Study serves other purposes besides gathering data for Star Ratings. AR 65. For example, the Accuracy & Accessibility Study gathers data related to compliance actions and public reporting. AR 65. Specifically, "[t]he Accuracy & Accessibility Study measures Part C and Part D *prospective beneficiary* call center telephone lines to determine (1) the **availability of interpreters** for individuals, (2) teletypewriter **(TTY) functionality**, and (3) the **accuracy of plan information provided by customer service representatives** (CSRs) in all languages." AR 64-65 (italics and bold in original). That third measure—i.e., the accuracy of plan information provided by customer service representatives—is not a component of the Star Ratings; rather, it was a measure that formerly appeared only on CMS's website for informational purposes. *See* 42 C.F.R. § 422.162(a) ("Display page"); AR 253. The fact that CMS

continues to gather data about that third measure—i.e., the accuracy of plan information—via the "Accuracy & Accessibility Study"—is proof positive that the purpose of the study is not limited to gathering Star Ratings data. Instead, the data gleaned from the Accuracy & Accessibility Study may be "reflected in compliance actions, public reporting, *or* star ratings." AR 65 (italics added, bold omitted). In sum, gathering data for Star Ratings is *one* purpose of the Accuracy & Accessibility Study, but the study serves other purposes—to wit, compliance actions and public reporting.

Plaintiffs ignore this context. For example, they contend that "the Accuracy & Accessibility Study is undertaken 'to determine if the services were compliant with 42 C.F.R. §§ 422.111(h)(1)(iii) and 423.128(d)(1)(iii), which require interpreters to be available for 80 percent of incoming calls requiring an interpreter within 8 minutes.'" Pls.' Opp'n 17 (quoting AR 104).[10] But note the nested quotation marks in the previous sentence. Page 104 of the Administrative Record is part of the "Frequently Asked Questions" section of the 2024 Accuracy & Accessibility Study Technical Notes, and the

[10] In a similar vein, Plaintiffs' quote from AR 76 does not show that the minimum standards regulation is related to the Star Ratings. *See* Pls.' Opp'n 17. Indeed, AR 76 does not reference the minimum standards regulation at all; it cites 42 C.F.R. § 422.111(h)(1), of which the minimum standards regulation (at (h)(1)(iii)(B)) is only a part. CMS has long acknowledged that the call center Star Ratings measure specifications are connected to the regulatory requirement that MAOs "provi[de] . . . specific information" via a "toll-free customer service call center." 42 C.F.R. § 422.111(h), (h)(1); *see* CMS, Call Center Monitoring Webinar (Feb. 3, 2016), available at https://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovContra/Downloads/Call-Center-Monitoring-Webinar-.pdf, at 6; *accord* Defs.' Mot. 24. That the Technical Notes mention the broad regulatory requirement *of which the minimum standards regulation is only a part* does not imply that the Star Ratings enforce the minimum standards regulation. So too with Humana's citation to the annual memo, which refers to the broader (h)(1) regulation, not the minimum standards regulation specifically. *See* Pls. Mot. 18 (citing AR 50, 72). The Annual Memo also discusses both the Timeliness Study (which has nothing to do with Star Ratings) and the Accuracy & Accessibility Study (which does, in part). AR 64. It is a thin reed on which to hang an argument for the proposition that CMS's call center monitoring activities are all about gathering Star Ratings data.

"question" preceding the language Humana quotes is "How was compliance determined for the 2024 Accuracy and Accessibility Study?" AR 104. As discussed above, "compliance" is separate from "Star Ratings" for purposes of the study, and the minimum standards regulation is far better understood as a compliance regulation. That CMS uses the minimum standards regulation to determine compliance does not imply that it also uses the minimum standards regulation to calculate Star Ratings. A plan that fails to make interpreters available within eight minutes for 80% of incoming calls requiring an interpreter is noncompliant—that is what the plain text of the regulation says. Defendants have already explained this. In their opening brief, they said "[t]he 80% minimum standard in § 422.111(h)(1)(iii) is incoherent as applied to Star Ratings." Defs.' Mot. 25; *see Sanderson Farms v. Occupational Safety & Health Review Comm.*, 964 F.3d 418, 425 (5th Cir. 2020) ("Interpretations of statutes and regulations that avoid surplusage are favored."). Humana does not respond at all to this argument.

Nor does Humana provide evidence for its bald assertion that the minimum standards regulation "was adopted for the explicit purpose of committing the requirements of the Accuracy & Accessibility Study to the C.F.R." Pls.' Opp'n 18. The 2021 Final Rule preamble that added the minimum standards regulation included an entirely separate section entitled "Adding and Updating Measures (§§ 422.164 & 423.184)." 86 Fed. Reg. 5864, 5918 (Jan. 19, 2021). In that section, CMS discussed its "Proposed Measure Updates," *id.*, and "Proposed Measure Additions," *id.* at 5921. CMS concluded with a table entitled "New and Revised Individual Star Ratings Measures for Performance Periods Beginning on or After January 1, 2022." *Id.* at 5926. About eighty

Federal Register pages later, in a section called "Call Center Requirements," CMS discussed its finalization of the minimum standards rule. *Id.* at 6005. Without mentioning Star Ratings in that portion of the preamble, CMS characterized its minimum standards final rule as "adding greater specificity and clarity to our requirements for MA and Part D plans by delineating more explicit minimum performance standards for MA and Part D customer service call centers." *Id.* If CMS had meant to modify its existing Star Ratings measure specifications, why would it promulgate a rule that never mentions Star Ratings in an entirely separate section of the Federal Register from the section where it explicitly announced modifications to the Star Ratings Measures? Humana has no answer. CMS knows how to modify the Star Ratings measure specifications and how to "add[] specific minimum standards," and it did the latter with § 422.111(h)(1)(iii)(B). There is no basis for this Court to conclude otherwise.

2. The Medicare Statute Does Not Require Notice and Comment For Star Ratings Measure Specifications

Humana characterizes as "just wordplay," Pls.' Opp'n 22, Defendants' argument that Section 1395hh does not apply to Star Ratings measure specifications. Perhaps Humana would like to explain to the Supreme Court why it is engaging in "just wordplay" when it "start[s] where [it] always do[es]: with the text of the statute." *Bartenwerfer v. Buckley*, 598 U.S. 69, 74 (2023) (quoting *Van Buren v. United States*, 593 U.S. 374, 381 (2021)). The text of the statute says notice and comment is required for a "rule, requirement, or other statement of policy . . . that establishes or changes a substantive legal standard *governing* the scope of benefits, the payment for services, or

the eligibility of individuals, entities, or organizations to furnish or receive benefits under" the Medicare statute. 42 U.S.C. § 1395hh(a)(2) (emphasis added). Humana—not Defendants—alleged that the no-callback policy "influences . . . lower-performing MAOs' eligibility to participate" in Medicare programs. Pls.' Mot. 20. Defendants quoted the statute and stated "mere influence is not enough." Defs.' Mot. 28. Tellingly, Humana cited no authority — not even a dictionary or thesaurus—for its contention that "influencing" is a synonym for "governing." Instead, Humana insists that "even CMS acknowledges in the end . . . that the Star Ratings are an 'eligibility criterion.'" Pls.' Opp'n 23 (quoting Defs.' Mot. at 28). Defendants never said that Star Ratings are an eligibility criterion. Quite the opposite. To quote from Defendants' opening brief:

> Nor does the fact that Star Ratings can 'influence[],' Pls. Mot. 20, MAOs' ability to enroll beneficiaries outside of open enrollment and affect plans' ability to participate render every Star Ratings measure an eligibility criterion under § 1395hh.

Defs.' Mot. 28. Defendants denied—and continue to deny—that the Star Ratings are an eligibility criterion. Rather, the "substantive legal standard governing eligibility . . . is found in regulation" at 42 C.F.R. § 422.502(b)(1)(*i*)(D). Plaintiffs' argument to the contrary rests on inventing an argument that CMS never made and arguing that application of statutory text is "just wordplay."

Humana's insistence that the Star Ratings measure specifications govern "payment for services" suffers from a similar defect. *See* Pls.' Opp'n 21. It is true that the "quality Star Ratings system" is "a component of the payment methodology for" Parts C and D Plans. 83 Fed. Reg. at 16,524; *accord* Pls.' Opp'n 21. That does not mean that "the Star

Ratings system governs quality bonus payments," Pls.' Opp'n 21,[11] which is something that CMS has never alleged. Humana contends that the "'monthly rebate' . . . is payable to MA plans for services." Pls.' Opp'n 22 (italics omitted). The statutory text disagrees: "The MA plan shall *provide to the enrollee a monthly rebate*." 42 U.S.C. § 1395w-24(b) (emphasis added). Without citation, Humana says the "regulations refer to the plan's share of the difference between the bid and the benchmark . . . as the 'monthly rebate,' which is payable to MA plans for services." Pls.' Opp'n 22 (italics omitted). Wrong again. The regulations refer to "monthly rebate" the same way the statute does—something "an MA organization must provide to the enrollee." 42 C.F.R. § 422.266(a)(2). A monthly rebate is not the same as a quality bonus payment. Quality bonus payments are—as Defendants have said all along—bonus payments from the government to Medicare Advantage Organizations. They are not payments for services.

Humana cannot show that 42 U.S.C. § 1395hh applies to Star Ratings. Indeed, under Humana's sweeping view of that statutory provision, the specific notice-and-comment provision relevant to Medicare Advantage would be a nullity. The statute — 42 U.S.C. § 1395w-23(b)(2)—requires advance notice and comment of methodological changes, including "risk and other factors to be used in adjusting" capitation rates, but does not require that those changes be made "by regulation." 42 U.S.C. § 1395w-23(b)(2); *accord* 42 U.S.C. § 1395hh(a)(2). Under Humana's view, anything that

[11] Plaintiffs might respond that it is "just wordplay" to point out that being "a component of" something is not the same as "governing" it. Once again, "to govern" is not a synonym for "to be a component of."

qualifies as an "other factor[]" to be used in adjusting Medicare Advantage capitation rates must be promulgated by regulation, leaving very little (or nothing) covered by the annual process under § 1395w-23(b). This Court can avoid an unnecessary conflict between §§ 1395hh and 1395w-23(b) by acknowledging that Quality Bonus Payments are not covered by the Medicare statute's special rulemaking provision.

3. The APA Does Not Require Notice and Comment For Star Ratings Measure Specifications

In its opening brief, Humana asserted that the no-callback policy was a "substantive rule under" a five-part framework that it never applied. *See* Pls.' Mot. 23. In response, Defendants noted Humana's failure to apply the relevant framework, actually applied it, and explained that under Plaintiffs' own standard, the no-callback policy is not a legislative rule. Defs.' Mot. 30-31. Plaintiffs respond, first, that the no-callback policy is an amendment to a rule in the Code of Federal Regulations, an argument addressed above. Second, Plaintiffs contended that there is no "way, practically speaking, to understand the no-callbacks rule as non-binding or interpretive." Pls.' Opp'n 25. But "practically speaking" is not the relevant inquiry here—the *Mock* framework is. *See Mock v. Garland*, 75 F.4th 563, 580 (5th Cir. 2023). And Defendants have already shown that the *Mock* framework does not support Humana's position. Defs.' Mot. 30-31.

Humana also notes that it is not alleging a standalone procedural injury related to the no-callbacks policy. Pls.' Opp'n 26. Defendants appreciate this concession, which is inconsistent with Humana's earlier briefing: "All of this could have been brought to the

agency's attention, if only it had held out the no-callback rule for notice-and-comment rulemaking." Pls.' Mot. 28. Humana's other counter to Defendants' harmless-error argument asserts that "the annual Call Letter process under § 422.164(d)(1) is not an adequate substitute for notice and comment." Pls.' Opp'n 26. This amounts to an argument that § 422.164 is inconsistent with the APA, a claim that does not appear in Humana's complaint. The point of the annual call-letter process is that it provides a notice-and-comment procedure separate from the APA's rulemaking provisions. And because the call-letter process has applied to Star Ratings measure specifications since 2019, Humana has had ample opportunity to comment on the no-callback policy. Defendants do not advocate an "overreaching harmless error doctrine," *United States v. Johnson*, 632 F.3d 912, 931 (5th Cir. 2011), because the argument applies to narrow circumstances, such as Medicare Advantage, where *Congress itself* has established a provision for notice and comment different from the APA's general rulemaking provision.

* * *

Humana's procedural arguments against the no-callback policy fail, principally because it cannot show that the no-callback policy modifies a legislative rule that has nothing to do with the Star Ratings. This Court does not need to reach Humana's procedural claims at all, but if it does, it should reject them.

D. The No-Callback Policy Is Not Substantively Arbitrary and Capricious

"Customer service" is one of the "domains" that Star Ratings capture and quantify. *See* AR 195, 198, 200. Call center performance is part of that domain measure. *Id.*

Defendants have explained that the no-callback policy "captures a plan's ability to provide a service that is important to Medicare beneficiaries." Defs.' Mot. 34. They have shown that Humana's arguments against the policy do not account for people who use a private telephone number. *Id.* Under the deferential arbitrary and capricious standard, this alone is enough—and Humana does not respond to those arguments. *See generally* Pls.' Mot. 27-28.

Humana's only rejoinder is to say that it is arbitrary to "double-count call disconnections as a general factor *in the Star Ratings.*" Pls. Mot. 28 (emphasis added). But the Timeliness Study, unlike the Accuracy & Accessibility Study, does not contribute any data to the Star Ratings. Humana's argument thus operates from a faulty premise. But even if it did not, the arbitrary and capricious standard does not prohibit an agency from using multiple data sources to track call disconnections, particularly given Humana's concession that no single call disconnection is double counted by the data. *See Kennecot Greens Creek Min. Co. v. Mine Safety & Health Admin.*, 476 F.3d 946, 954 (D.C. Cir. 2007) (the "standard of review under the arbitrary and capricious test is only reasonableness, not perfection"). CMS has explained the reasonableness of its no-callback policy, so Humana's arbitrariness argument should fail.

E. Humana's Arguments About The Silent Call are Unsupported By Record Evidence

Humana's arguments for invalidating its third unsuccessful call suffer from similar shortcomings as its arguments for invalidating the disconnected calls. In its opening brief, Defendants showed that Humana had no evidence supporting its insistence that the

test caller was "mistaken" in believing he or she was on a silent hold. Defs.' Mot. 35. Humana's response is, once again, to blame CMS. Humana asserts that it "would have readily produced" some "additional evidence to confirm [its] written statement" that the CMS caller was wrong about his hold status. Pls.' Opp'n 30. But CMS "did not say that it required additional evidence to confirm Humana's written statement." *Id.* CMS was not required to do so, and it explained repeatedly that the evidence available to it indicated that there was no one from Humana's side on the line. AR 13 ("before the CMS caller could make contact with a CSR the call disconnected"); AR 454 ("they had no reason to believe there was anyone on the other end of the call to hear the request").

Humana cites no authority for the proposition that the APA arbitrary-and-capricious standard requires an agency to ask a regulated party for specific pieces of evidence throughout the administrative process. At the informal hearing level, the "MA organization must prove by a preponderance of the evidence that CMS' calculations of the measure(s) and value(s) in question were incorrect. The burden of proof is on the MA organization to prove an error was made in the calculation of the [Quality Bonus Payment] status." 42 C.F.R. § 422.260(c)(2)(v). Before the Hearing Officer, "CMS maintained that there is no indication that there may have been a live person speaking at any point." AR 459. This position follows from the CMS call logs, which state clearly that the CMS caller believed he was on a silent hold. AR9.[12] Humana chose to attempt a

[12] The data for this call is contained in an Excel spreadsheet with the file name ""03.A Attachment SII_RawCallLog_2024_Full_C0701002." The corresponding columns are H, I, and AY.

refutation of CMS's evidence with nothing more than argument, and the CMS Hearing Officer found that Humana had not carried its burden. AR 460. This conclusion is unassailable on substantial evidence review, which Humana concedes applies to call C0701002.[13]

The rest of Humana's briefing on call C0701002 rests on its unsupported argument that a customer service representative was, in fact, present. *See* Pls.' Opp'n 31 ("once the representative joins the line, the caller *must* engage the representative verbally."). But Humana introduced no evidence that there was ever a representative on the line, and the CMS Hearing Officer reviewed the record, including "the additional information submitted by Humana," AR 459, and found that Humana had not met its burden of proof to show an error. *Id.* at 460. This is "the reasoning 'articulated by the agency itself.'" *Clarke v. Commodity Futures Trading Comm'n*, 74 F.4th 627, 641 (5th Cir. 2023); *see* Pls.' Opp'n 31; *accord* 42 C.F.R. § 422.260(c)(2)(vii) ("If the Administrator does not review and issue a decision within 10 business days, the hearing officer's decision is final and binding."). It is odd for Humana to accuse the Agency of "post hoc rationalizations," Pls.' Opp'n 31, given that the gravamen of its argument with respect to call C0701002 is evidence that "Humana would have readily produced" or "might have simply submitted" but did not, *id.* at 30. Defendants' argument with respect to the silent call is simple: the Agency Hearing Officer reviewed all the evidence, specifically including CMS's

[13] As discussed above, Humana belatedly and incorrectly argues that the substantial evidence standard does not apply to the other two challenged calls, but neither its opening brief nor its reply brief say anything about the standard of review applicable to call C0701002. The substantial evidence standard unquestionably applies to call C0701002.

assertion that "there is no indication that there may have been a live person speaking at any point," AR 459. Then, based on that review of the evidence, the Hearing Officer concluded that Humana had failed to meet its burden. *Id.* Under the substantial evidence standard that the parties agree applies, this Court should uphold the Agency's conclusion.

Contrary to Plaintiffs' theory, *UnitedHealthcare Benefits of Texas v. CMS*, 2024 WL 4870771 (E.D. Tex. Nov. 22, 2024), does not support a different conclusion. Defendants have already explained that *UnitedHealthcare* arose on a different set of facts: the court in that case held that the call "connected" to a customer service representative, based on a call recording provided by UnitedHealthcare to the Agency during the Plan Preview period. Defs.' Mot. 37 (citing *UnitedHealthcare*, 2024 WL 4870771, at *4). Indeed, the Agency acknowledged on the record in *UnitedHealthcare* that the test caller "connected to a CSR." *UnitedHealthcare*, 2024 WL 4870771, at *4. By contrast, Humana agrees that the call at issue here "never connected within the meaning of the guidelines." Pls.' Mot. 31. The question for this Court is thus untethered from the Eastern District of Texas's holding in *UnitedHealthcare*.

Humana argues that "the eight-minute clock never began." Pls.' Opp'n 32. If that is the case, it further shows that *UnitedHealthcare* is inapt and does not support Humana's preferred result. There is no doubt that the test caller dialed the correct number and reached Humana's Interactive Voice Recording system. It is further undisputed that Humana terminated the call. If the eight-minute clock never began, then the CMS guidance Defendants have already cited in their opening brief applies and supports the scoring of the call as unsuccessful: "A call is classified as unsuccessful for

any of the following reasons . . . [s]urvey could not continue, Call Center disconnected call (including hanging up)." AR 81; *accord* Defs.' Mot. 36.

Humana also mises the mark when it contends that CMS designs its call-center study to not resemble real-world calls. Pls.' Opp'n 29. Defendants have already shown that Humana's stray example of how test calls do not mirror real-world calls is overstated; a call will not be marked unsuccessful if a CSR asks a CMS test caller for his or her name. *Supra* n.5; *see* AR 48 (Accuracy & Accessibility study designed "to replicate a beneficiary's actual experience"). It is thus quite relevant that, as Humana now concedes, no ordinary beneficiary would consider the experience on the silent call "successful."

The question for this Court as it assesses the silent call is simple: when the Agency scores a call unsuccessful based on record evidence showing that a health plan was unable to put a live person on the line as required by Agency guidance, should a court applying the deferential "substantial evidence" standard reverse that conclusion? To pose the question is to answer it. For the reasons described above and in Defendants' opening brief, the Agency's disposition of call C0107002 was supported by substantial record evidence and should not be disturbed.

IV. Conclusion

In each CMS test call at issue before this Court, Humana treated the caller in a way that no ordinary beneficiary would deem "successful." None of the test callers was able to pose a question before Humana hung up. It is hardly surprising that CMS scored all three calls "unsuccessful." For the reasons described above and in their opening brief,

Defendants respectfully request that this Court deny Plaintiffs' summary-judgment motion and grant summary judgment to Defendants on all counts, pursuant to Federal Rule of Civil Procedure 56.

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Certificate of Service

On August 19, 2025, I electronically submitted the foregoing document with the clerk of court for the U.S. District Court, Northern District of Texas, using the electronic case filing system of the court. I hereby certify that I have served all parties electronically or by another manner authorized by Federal Rule of Civil Procedure 5(b)(2).

/s/ Andrea Hyatt
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