UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

BLUE CROSS AND BLUE SHIELD OF MASSACHUSETTS, INC., et al. Plaintiffs, v. **ROBERT F. KENNEDY, JR.,** in his official capacity as Secretary of Health and Human Services, U.S. Department of Health and Human Services, et al.	Case No. 1:25-cv-00693 (TNM)

PLAINTIFFS' MOTION FOR SUMMARY JUDGMENT

Pursuant to Rule 56 of the Federal Rules of Civil Procedure and Local Rule 7(h), Plaintiffs Blue Cross and Blue Shield of Massachusetts, Inc. ("BCBSMA") and Blue Cross and Blue Shield of Massachusetts HMO Blue, Inc. ("HMO Blue") (collectively with BCBSMA "Plaintiffs"), respectfully request that this Court enter summary judgment in their favor for the following reasons.

Plaintiffs bring this case under the Administrative Procedure Act, 5 U.S.C. §§ 500 *et. seq.*, challenging the unlawful, arbitrary and capricious methodology used by the Centers for Medicare & Medicaid Services ("CMS") to calculate Plaintiffs' 2025 Medicare Advantage Star Ratings. Star Ratings have a significant financial and operational impact on Medicare Advantage plans. Star ratings directly impact: (1) plan member enrollment; (2) the amount of payment that CMS makes to a plan; and (3) the premiums and benefits that a plan may offer to Medicare beneficiaries. Each year, plans must prepare and submit financial bids to CMS on the first Monday in June. These bids comprise the plans' expected costs for providing Medicare benefits to their members for the

coming year. Because the Star Ratings system influences the revenue a plan expects to receive, knowing the correct Star Rating directly impacts the bids and services that a plan can ultimately afford to provide its members. This Court's decision on Plaintiffs' Motion for Summary Judgment will directly impact Plaintiffs' Star Ratings, thereby affecting Plaintiffs' forthcoming financial bids to CMS.

Plaintiffs respectfully request an oral hearing at the Court's discretion under Local Rule 7(f). As noted above and indicated in the parties' Joint Motion for Expedited Briefing Schedule (Dkt. 9), however, time is of the essence as Plaintiffs' Medicare Advantage bids are due on June 2, 2025 this year. CMS subsequently conducts a "desk review period" until August 2025, during which changes to a plan's benchmark and bids may be made. Given these timing considerations, the parties respectfully requested in the joint motion that the Court render a decision by the end of July 2025 to allow sufficient time for adjustments as needed during the desk review period. Accordingly, if this Court notifies Plaintiffs that oral argument would not be materially helpful, and that holding a hearing may unnecessarily delay the Court's decision, Plaintiffs will withdraw their request for an oral hearing.

For the reasons set forth more fully in the accompanying Memorandum of Law in Support of Plaintiffs' Motion for Summary Judgment, which is incorporated herein by reference, this Court should grant Plaintiffs' Motion for Summary Judgment.

Dated: May 16, 2025

Respectfully submitted,

BLUE CROSS AND BLUE SHIELD OF MASSACHUSETTS, INC. AND BLUE CROSS AND BLUE SHIELD OF MASSACHUSETTS HMO BLUE, INC.

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DISTRICT OF COLUMBIA

BLUE CROSS BLUE SHIELD OF MASSACHUSETTS, INC., et al. Plaintiffs, v. **ROBERT F. KENNEDY, JR.**, in his official capacity as Secretary of Health and Human Services, U.S. Department of Health and Human Services, et al. Defendants.	Case No. 1:25-CV-00693-TNM

DECLARATION OF J. MARK ABERNATHY

I, J. Mark Abernathy, declare the following to be true and correct:

1. I am over twenty-one years of age, of sound mind, and fully competent to make this declaration.

2. I am a Managing Director with Berkeley Research Group ("BRG") and was retained by Reed Smith LLP ("Counsel") on behalf of Blue Cross Blue Shield of Massachusetts ("BCBS MA") and its affiliated entities ("BCBS MA") to provide my opinions on certain aspects of the Centers for Medicare and Medicaid Services' ("CMS") calculation of the 2025 Medicare Advantage Stars Ratings ("Star Ratings").

3. BRG is a global consulting firm that helps leading organizations advance in three key areas: disputes and investigations, corporate finance, and performance improvement and advisory. For more than a decade, BRG has been a trusted advisor to clients on operations, compliance, and strategic issues in the Medicare Advantage ("MA") arena.

4. I am a leading expert in the managed care industry. I am a Certified Public Accountant, Certified in Financial Forensics, a Certified Valuation Analyst, and have held positions in health plans and managed care organizations as CEO, COO, CFO/VP Finance. My work includes financial and operational consulting to managed care regulators and health plans, as well as litigation support and expert testimony in internal investigations, state and federal investigations, and numerous litigation and arbitration matters. I have been appointed by state and federal judges to provide operational and financial oversight of managed care plans, including both Medicaid and Medicare plans. As state appointed Conservator, I have overseen the collection and reporting of survey and statistical data to state and federal agencies for both Medicare and Medicaid programs. I have also had responsibility for oversight of member call centers, member services, claims adjudication, medical management, and grievances and appeals. I have assisted with developing and providing oversight of corrective action plans and reporting to regulators.

5. I have been asked by Counsel to review CMS's methodology for the determination of individual Star Ratings for Consumer Assessment of Healthcare Providers and Systems ("CAHPS") survey measures for the 2025 Star Ratings, especially as it relates to CMS's use of: 1) a case-mix adjustment and 2) a national average weighted by contract enrollment in its test of significant difference from the mean.[1] Counsel also asked me to recalculate the CAHPS measures for the 2025 Star Ratings without use of the case-mix adjustment, as well as to recalculate the CAHPS measures for the 2025 Star Ratings using a comparison to the simple national average of all relevant contracts (instead of a national average weighted by contract enrollment). I have also been asked to opine on any resulting impacts to plaintiffs' (BCBS MA contracts H2230 and H2261) CAHPS measures from changes to either of the above methodologies, as well as any impact to plaintiffs' overall Star Ratings from these changes.

[1] The applicable regulation uses the term "national average." 42 C.F.R. §§ 422.166(a)(3). The terms "average" and "mean" are used interchangeably by CMS and at times throughout my Declaration.

Medicare Star Ratings Program

6. CMS has been publishing Medicare Star Ratings for Medicare Advantage Organizations ("MAOs") since 2008. The purpose of the Star Ratings program is to "measure the quality of health and prescription drug services received by consumers enrolled in MA and Part D prescription drug plans" and "to provide people with Medicare and their caregivers with meaningful information about quality, alongside information about benefits and costs, to assist them in comparing plans and choosing the Medicare coverage option that best fits their health needs."[2] An MAO's annual Star Rating is calculated for each of its contracts with CMS using the weighted average of its Star Ratings across several quality and performance measures (up to 40 for Medicare Advantage Part C and Prescription Drug Part D plans ("MA-PD"), up to 30 for Part C only plans, and up to 12 for Part D only plans).[3]

7. Each individual Star measure is derived from data identified by CMS for that particular measure, including data collected from MAOs, enrollee surveys, CMS contractors, and CMS. For measures that are based on the CAHPS surveys (nine Star Rating measures that are based on CAHPS patient satisfaction survey data, including seven Part C and two Part D measures), CMS uses a methodology that evaluates the relative distribution of all plans' scores with significance testing (comparing each plan's score against a national average weighted by the survey-eligible contract enrollment assessed at the time of sample design) and accounts for the reliability of the scores to translate the scores into measure Star Ratings levels ranging from 1 to 5, with 1 being the worst and 5 being the best.[4]

8. As part of this process, CMS makes case-mix adjustments to each plan's individual CAHPS raw measure scores in various circumstances (except for measure C03: "Annual Flu

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[2] CMS, "2025 Medicare Advantage and Part D Star Ratings," October 10, 2024, available at: https://www.cms.gov/newsroom/fact-sheets/2025-medicare-advantage-and-part-d-star-ratings, accessed April 22, 2025.

[3] A maximum of 30 Part C measures are grouped to calculate a Part C Rating and a maximum of 12 Part D measures are grouped to calculate a Part D Rating. Summary ratings are calculated from the weighted average Star Ratings of the included measures. (CMS, "Medicare Part C & D Star Ratings Technical Notes," Updated October 3, 2024, available at: https://www.cms.gov/files/document/2025-star-ratings-technical-notes.pdf, accessed April 22, 2025.).

[4] CMS, "Medicare Part C & D Star Ratings Technical Notes," Updated October 3, 2024, available at: https://www.cms.gov/files/document/2025-star-ratings-technical-notes.pdf, accessed April 22, 2025.

Vaccine"). According to the Agency for Healthcare Research and Quality, which administers CAHPS, the adjustments are meant, "to account for different patient characteristics within each entity that might affect scores" and, "make[] it more likely that reported differences are due to real differences in performance, rather than differences in the characteristics of enrollees or patients."[5] The Instructions for Analyzing Data from CAHPS Surveys in SAS acknowledges that a user of the CAHPS data may or may not execute the CAHPS analysis using a case-mix adjustment as one can "specify an unlimited number of [case-mix] adjuster variables or choose not to [case-mix] adjust the data."[6]

9. The overall Star Rating assigned to an MAO is critically important to the MAO and the beneficiaries enrolled in its contracts as it has a direct impact upon the total payments that CMS makes to the MAO through additional rebates and quality bonus payments, as well as a direct impact on the premiums and benefits that the MAO is able to offer to enrollees, thereby influencing a Medicare beneficiary's choice to enroll in an MAO plan. MAO contracts that receive at least 4 out of 5 Stars qualify for a quality bonus. Additionally, MAOs that achieve an overall 5-Star Rating are allowed to market to and enroll beneficiaries throughout the year, rather than only during annual Medicare open enrollment periods.[7] For more information on the benefits to MAOs of higher Star Ratings, *see* Appendix A.

CAHPS Survey Measures

10. As noted above, in determining the Star Ratings for the CAHPS measures, CMS makes case-mix adjustments to each plan's individual CAHPS raw measure scores in various circumstances. These case-mix adjusted CAHPS measure scores are then classified into "Base

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[5] AHRQ, "Preparing Data from CAHPS® Surveys for Analysis," Updated May 15, 2017, available at: https://www.ahrq.gov/sites/default/files/wysiwyg/cahps/surveys-guidance/helpful-resources/analysis/preparing-data-for-analysis.pdf, accessed on April 22, 2025.

[6] AHRQ, "Instructions for Analyzing Data from CAHPS® Surveys in SAS: Using the CAHPS Analysis Program Version 5.0," Updated August 2020, available at: https://www.ahrq.gov/sites/default/files/wysiwyg/cahps/surveys-guidance/helpful-resources/analysis/2020-instructions-for-analyzing-data.pdf, accessed on April 22, 2025.

[7] The annual Medicare open enrollment period lasts from October 15th through December 7th each year. Beneficiaries already enrolled in Medicare Advantage also have an open enrollment period from January 1st through March 31st each year. (*See* https://www.medicare.gov/basics/get-started-with-medicare/get-more-coverage/joining-a-plan, accessed April 22, 2025 and https://www.cms.gov/files/document/medicare-communications-marketing-guidelines-2-9-2022.pdf, accessed April 22, 2025.)

Groups" (which are also reported as "Cut Points" by CMS each year[8]). These are "percentile cut points defined by the current-year distribution of case-mix adjusted contract means." See 83 Fed. Reg. at 16568. These percentile cut points are defined as the 15th, 30th, 60th, and 80th percentiles. See 42 C.F.R. §§ 422.166(a)(3), 423.186(a)(3). However, as further covered in the applicable regulations, the Base Groups do not necessarily reflect the final CAHPS Star Rating for each applicable measure for the contract. CMS implements two additional factors to the percentile Base Group before finalizing the CAHPS Star Rating measures. These factors are: 1) an assessment of reliability and 2) a comparison of each plan's average CAHPS measure score to the national average. For purposes of the second additional factor, CMS interprets the national average to be the weighted average (by enrollment) of all contracts ("weighted national average").[9] This application is defined by CMS in the 2025 Technical Notes Table K-9, as presented below.[10]

Table K-9: CAHPS Star Assignment Alternate Representation

Mean Score	Base Group	Signif. below avg., low reliability	Signif. below avg., not low reliability	Not signif. diff. from avg., low reliability	Not signif. diff. from avg., not low reliability	Signif. above avg., low reliability	Signif. above avg., not low reliability
< 15th percentile by > 1 SE	1	1	1	2	2	2	2
< 15th percentile by ≤ 1 SE		2	1	2	2	2	2
≥ 15th to < 30th percentile	2	2	2	3	2	3	2
≥ 30th to < 60th percentile	3	2	2	3	3	4	4
≥ 60th to < 80th percentile	4	3	4	3	4	4	4
≥ 80th percentile by ≤ 1 SE	5	4	4	4	4	4	5
≥ 80th percentile by > 1 SE		4	4	4	4	5	5

Notes: If reliability is very low (<0.60), the contract does not receive a Star Rating. Low reliability scores are defined as those with at least 11 respondents and reliability ≥0.60 but <0.75 and also in the lowest 12% of contracts ordered by reliability. The SE is considered when the measure score is below the 15th percentile (in base group 1), significantly below average, and has low reliability: in this case, 1 star is assigned if and only if the measure score is at least 1 SE below the unrounded base group 1/2 cut point. Similarly, the SE is considered when the measure score is at or above the 80th percentile (in base group 5), significantly above average, and has low reliability: in this case, 5 stars are assigned if and only if the measure score is at least 1 SE above the unrounded base group 4/5 cut point.
For example, a contract in base group 4 that was not significantly different from average and had low reliability would receive 3 final stars.

[8] CMS, "Part C and D Performance Data," Updated December 2, 2024, available at: https://www.cms.gov/medicare/health-drug-plans/part-c-d-performance-data, accessed April 22, 2025
[9] CMS guidance states that the weighted average is used. CAHPS, "Summary of analyses for reporting, MA & PDP CAHPS," Updated August 2024, available at: https://ma-pdpcahps.org/globalassets/ma-pdp/scoring-and-star-ratings/2024/analysis_of_reported_measures.pdf, accessed April 22, 2025 ("the national mean (the weighted mean of all contract scores) for each measure, weight[ed] by the survey-eligible contract enrollment assessed at the time of sample design.").
[10] CMS, "Medicare Part C & D Star Ratings Technical Notes," Updated October 3, 2024, available at: https://www.cms.gov/files/document/2025-star-ratings-technical-notes.pdf, accessed April 22, 2025.

11. Once the ratings of 1 to 5 for all individual Star measures are assigned, including the final CAHPS measures, the measures are weighted by type of measure and then averaged to arrive at an MAO's overall Star Rating for a given contract in the given year.[11]

Opinion 1:

CMS's Use of the Case-Mix Adjustment for CAHPS Measures Resulted in Lower Star Ratings for Several of BCBS MA's CAHPS Measures for Contracts H2230 and H2261, as well as a Lower Overall Star Rating for Contracts H2230 and H2261.

12. I have been asked by Counsel to recalculate the CAHPS measures for the 2025 Star Ratings without use of the case-mix adjustment and opine on any resulting impact to plaintiffs' (BCBS MA contracts H2230 and H2261) CAHPS measures, as well as any impact to plaintiffs' overall Star Ratings.

13. To assess the potential effect of the case-mix adjustment, I used the "Means Tests" files for BCBS MA's contracts (e.g., "H2230_Means_Tests_CAHPS_2024.xlsx") that CMS shares with plans each year and allows plans to see, for each applicable CAHPS measure, the components of its Star Rating per measure reliant on the Base Group classification, statistical test of distance from the weighted national average, and reliability score. A.R. 001181-001185, H2230 Means Tests CAHPS 2024; A.R. 001189-001193, H2261 Means Tests CAHPS 2024. In order to determine whether and how the case-mix adjustment may have impacted BCBS MA's H2230 and H2261 contracts' CAHPS measures, I reassessed where each of the contracts' raw measure scores (i.e., prior to the case-mix adjustment) would have been categorized in terms of a Base Group, and then applied the 2025 Technical Notes Table K-9 translation as required under 42 C.F.R. § 422.186.

14. First, I used the unadjusted raw measure scores reported in CMS's Means Tests files to re-classify each contract's CAHPS measures in the applicable Base Group using the Base

[11] For 2025, CMS assigned the highest weights to improvement measures, the next highest to patient experience/complaints and access measures, then by outcome and intermediate outcome measures, and finally by process measures. (CMS, "Medicare Part C & D Star Ratings Technical Notes," Updated October 3, 2024, available at: https://www.cms.gov/files/document/2025-star-ratings-technical-notes.pdf, accessed April 22, 2025.)

Group cut points also found in the Means Tests file. As an example, for contract H2261, measure C20 ("Getting Appointments and Care Quickly"), the unadjusted score is 83.657070. Due to the reported cut points (80, 82, 84, 86),[12] this unadjusted value would fall into Base Group 4 (e.g., 83.657070 rounds[13] up to 84 – see Table 1 below). CMS had adjusted this value through a negative case-mix adjustment of -0.451197 to 83.205873. Due to the reported cut points, the rounded lower adjusted value falls into Base Group 3 (e.g., 83.205873 rounds down to 83 – see Table 1 below).

Table 1: Measure C20 ("Getting Appointments and Care Quickly")

Base Group	Qualifying Rounded Values
1	< 80
2	80 – 81
3	82 – 83
4	84 – 85
5	>= 86

15. The next step in the analysis to assess the effect of the case-mix adjustment on the final Star Rating was to test whether or not the adjusted score is significantly different from the weighted national average. For example, per CMS's methodology for translating a CAHPS measure Base Group to Star Rating laid out in Table K-9 of the 2025 Technical Notes (provided above), in cases like contract H2261 and measure C20 where the first factor, reliability, is not low, a Base Group 3 value could result in a Star Rating of 2, 3, or 4 depending on if the second factor, the plan's distance from the weighted national average, is significantly lower, not significantly different, or significantly higher than the weighted national average, respectively.

[12] While the reported cut points are calculated using the various plan adjusted scores, the adjustments are meant to maintain a net effect so that, "the national mean of contract means for any rating…is unchanged by case-mix adjustment." (see Quality Assurance Protocols & Technical Specifications Version 15.0 November 2024 – page 80: https://ma-pdpcahps.org/globalassets/ma-pdp/quality-assurance/2025/ma--pdp-cahps-qapts-v15.0_updated.pdf, accessed April 22, 2025). Without the ability to recalculate the percentiles and cut points for the spread of unadjusted values, one must rely on the reported cut points shown below and the assumption that these would not move materially based on unadjusted scores (i.e., the overall population spread would remain consistent despite certain contracts/plans moving up or down).

[13] CMS indicates that, "each base group includes those contracts whose rounded mean score is at or above the lower limit and below the upper limit." (CMS, "Medicare Part C & D Star Ratings Technical Notes," Updated October 3, 2024, available at: https://www.cms.gov/files/document/2025-star-ratings-technical-notes.pdf, accessed April 22, 2025.)

Conversely, in cases where a plan's reliability is not low, a Base Group of 4 will result in a Star Rating of 4 no matter the outcome of the statistical test against the weighted national average.

16. To continue with the current example for contract H2261, one can see that H2261's C20 measure adjusted score has a distance from the weighted national average that is not deemed significantly different in the Means Test file. CMS uses a t-statistic value less than -1.96 to make that determination. The t-statistic value is calculated by dividing the difference between the measure value and the weighted national average by the standard error of estimated difference between the contract's score and weighted national average score (on 0-100 scale) reported in the Means Tests file (e.g., the adjusted score of 83.205873 minus the weighted national average of 83.458083 or -0.252210 divided by the standard error or 0.842425[14] = -0.30, which is between -1.96 and 1.96).

$$\frac{Adjusted\ Measure\ Score - Weighted\ National\ Average}{Standard\ Error}$$

$$\frac{83.205873 - 83.458083}{0.842425} = -0.30$$

17. When using the unadjusted measure score of 83.657070 the difference away from the weighted national average becomes 0.198987 resulting in a t-statistic of 0.24, which is also between -1.96 and 1.96. Under the reported cut points for the Base Groups and the reported standard error for contract H2261, the unadjusted score would not result in a statistical difference from the weighted national average. Therefore, CMS's current methodology utilizing the case-mix adjustment for this particular contract (H2261) and measure (C20), results in a final Star Rating of 3 compared to a final Star Rating of 4 if no adjustments were applied.

[14] CMS currently does not release all underlying CAHPS-related data, thereby preventing plans from auditing, replicating, or validating CMS's calculations. Without such data, plans cannot replicate or validate all elements of the methodology.

$$\frac{Unadjusted\ Measure\ Score - Weighted\ National\ Average}{Standard\ Error}$$

$$\frac{83.657070 - 83.458083}{0.842425} = 0.24$$

Table K-9: CAHPS Star Assignment Alternate Representation

Mean Score	Base Group	Signif. below avg., low reliability	Signif. below avg., not low reliability	Not signif. diff. from avg., low reliability	Not signif. diff. from avg., not low reliability	Signif. above avg., low reliability	Signif. above avg., not low reliability
< 15th percentile by > 1 SE	1	1	1	2	2	2	2
< 15th percentile by ≤ 1 SE		2	1	2	2	2	2
≥ 15th to < 30th percentile	2	2	2	3	2	3	2
≥ 30th to < 60th percentile	3	2	2	3	3	4	4
≥ 60th to < 80th percentile	4	3	4	3	4	4	4
≥ 80th percentile by ≤ 1 SE	5	4	4	4	4	4	5
≥ 80th percentile by > 1 SE		4	4	4	4	5	5

18. From this analysis, I concluded that because CMS compares a plan's case-mix adjusted score to the Base Group cut points prior to assigning a Star Rating, CMS is effectively penalizing a plan (H2261) through a negative case-mix adjustment to reduce the measure score and the Star Rating related to that score. Moreover, upon analyzing the 16 reported and applicable CAHPS measures that were case-mix adjusted, five CAHPS measures experienced a detrimental reduction in Star Rating for those measures due to the case-mix adjustment for H2230 and three CAHPS measures experienced a detrimental reduction in Star Rating for those measures due to the case-mix adjustment for H2261. No measure within these two contracts benefited from a positive case-mix adjustment that resulted in an increased Star Rating per my analysis.

19. Further, replacing H2261's current Star Rating for only measure C20 of 3-Star with a 4-Star results in a change in overall Star Rating from 3.5 to 4 (despite two other CAHPS measures also having this same negative effect). Notably, BCBS MA's H2230 has five CAHPS measures with this same effect. This demonstrates that minor case-mix adjustments in CAHPS measure scores can have significant impacts, causing a measure to achieve a lower Star Rating and, in some cases (including BCBS MA's H2230 and H2261), a lower overall Star Rating. *See* Table 2 below for the results of each of the two BCBS MA contracts. The rows shaded in grey

represent the contracts and CAHPS measure scores that experience a detrimental reduction in Star Ratings for that measure due to the case-mix adjustment.

Table 2: 2025 CAHPS Measure Star Ratings

Contract	CAHPS Measure	Case-Mix Adj.	Low Reliab.	Base Group		Statistical Difference from Weighted National Average		Star Rating	
				Current	Updated w/No Case-Mix Adj.	Current	Updated w/No Case-Mix Adj.	Current	Updated w/No Case-Mix Adj.
H2230	**C19**	**-1.12**	**No**	**3**	**3**	**Lower**	**No**	**2**	**3**
H2230	**C20**	**-0.82**	**No**	**2**	**3**	**Lower**	**No**	**2**	**3**
H2230	**C21**	**-0.42**	**No**	**4**	**5**	**Higher**	**Higher**	**4**	**5**
H2230	**C22**	**-1.38**	**No**	**3**	**3**	**Lower**	**No**	**2**	**3**
H2230	C23	0.10	No	3	3	No	No	3	3
H2230	**C24**	**-0.99**	**No**	**3**	**3**	**Lower**	**No**	**2**	**3**
H2230	D05	0.59	No	2	2	Lower	Lower	2	2
H2230	D06	-0.67	No	2	3	Lower	Lower	2	2
H2261	C19	-0.74	No	3	3	No	No	3	3
H2261	**C20**	**-0.45**	**No**	**3**	**4**	**No**	**No**	**3**	**4**
H2261	C21	-0.25	No	5	5	Higher	Higher	5	5
H2261	**C22**	**-0.84**	**No**	**3**	**3**	**Lower**	**No**	**2**	**3**
H2261	C23	0.02	No	3	3	Lower	Lower	2	2
H2261	**C24**	**-0.54**	**No**	**3**	**4**	**No**	**No**	**3**	**4**
H2261	D05	0.38	No	2	2	Lower	Lower	2	2
H2261	D06	-0.54	No	2	3	Lower	Lower	2	2

20. In total, as demonstrated in Table 3 below, the overall Star Rating for both BCBS MA contracts increase based solely on the removal of the case-mix adjustment. These contracts both cross a threshold of moving up from 3.5 to 4 Stars. This change is material in that it would result in BCBS MA being eligible to receive quality bonus payments and increased rebates from CMS based on 2025 Star Ratings for these contracts, allowing BCBS MA to offer enhanced benefits to its enrollees.

Table 3: 2025 Overall Star Ratings

Contract	Current 2025 Summary Score	Updated 2025 Summary Score (w/No Case-Mix Adjustment)	Current 2025 Star Rating	Updated 2025 Star Rating (w/No Case-Mix Adjustment)
H2230	3.578237	3.880257	**3.5**	**4.0**
H2261	3.713878	3.935090	**3.5**	**4.0**

Opinion 2:

CMS's Use of a Weighted National Average Instead of a Non-Weighted National Average for CAHPS Measures Resulted in Lower Star Ratings for a BCBS MA CAHPS Measure for Contract H2261, as well as a Lower Overall Star Rating for this Contract.

21. I have been asked by Counsel to recalculate the CAHPS measures for the 2025 Star Ratings without use of a national average *weighted* by contract enrollment ("weighted national average"), and instead use the national average of all contracts without weighting, in the CAHPS significance testing methodology and opine on any resulting impact to plaintiff's (BCBS MA contract H2261) CAHPS measures, as well as any impact to plaintiff's overall Star Ratings.

22. Similar to the above analysis, to assess the potential effect of the use of a weighted national average, I used the "Means Tests" files for BCBS MA's contracts to determine whether and how the use of the *weighted* national average may have impacted BCBS MA's H2261 contracts' CAHPS measures. Using CMS's CAHPS methodology, I reassessed where the contract's measure scores (adjusted by the case-mix adjustment) would have been categorized in terms of a Base Group, and then applied the 2025 Technical Notes Table K-9 translation using a national average without weighting (i.e., the simple average of all contract values used to determine the Base Groups where each contract is weighted equally).[15]

23. As an example, for contract H2261, measure C23 ("Rating of Health Plan"), the case-mix adjusted score is 86.118791. Due to the reported cut points (84, 86, 88, 89), this value

[15] A simple or non-weighted national average of all relevant plan values for each measure would be the default average absent a specific instruction to use weighting. Nevertheless, I may refer to the national average as the "non-weighted national average" for clarity when indicated in this report.

falls into Base Group 3 (e.g., 86.118791[16] rounds down to 86). The next step in the analysis is to test whether or not the adjusted measure score is significantly different from the national average. For example, per CMS's methodology for translating a CAHPS measure Base Group to Star Rating laid out in Table K-9 of the 2025 Technical Notes (provided above), in cases like contract H2261 and measure C23 where the first factor, reliability, is not low, a Base Group 3 value could result in a Star Rating of 2, 3, or 4 depending on if the second factor, the plan's distance from the national average, is significantly lower than, not significantly different from, or significantly higher than the national average, respectively.

24. To continue with the current example, H2261's C23 measure case-mix adjusted score has a distance from the weighted national average that is deemed significantly lower in the Means Test file. CMS uses a t-statistic value less than -1.96 to make that determination. The t-statistic value is calculated by dividing the difference between the measure value and the national average by the standard error of estimated difference between the contract's score and national average score (on 0-100 scale) reported in the Means Tests file (e.g., the adjusted score of 86.118791 minus the weighted national average of 87.932216, or -1.813425 divided by the standard error, or 0.446739 = -4.06, which is less than -1.96).

$$\frac{Adjusted\ Measure\ Score - Weighted\ National\ Average}{Standard\ Error}$$

$$\frac{86.118791 - 87.932216}{0.446739} = -4.06$$

25. Notably, when using the non-weighted national average of all plans' C23 measure scores of 86.657529[17], the difference away from the national average falls to -0.538738, resulting in a t-statistic of -1.21, which is greater than -1.96. Therefore, under the reported cut points for

[16] CMS, "Medicare Part C & D Star Ratings Technical Notes," Updated October 3, 2024, available at: https://www.cms.gov/files/document/2025-star-ratings-technical-notes.pdf, accessed April 22, 2025.

[17] The simple or non-weighted national average was calculated by taking the average across all available plan measure score values for a given CAHPS measure (assigning each plan equal value in the calculation). *See* A.R. 1197 (2025_Sample_Data.xlsx).

the Base Groups and the reported standard error for contract H2261, the case-mix adjusted score using a non-weighted national average would not result in a statistical difference from the national average. CMS's current methodology utilizing the weighted national average for this particular contract (H2261) and measure (C23), results in a final Star Rating of 2, compared to a final Star Rating of 3 if a non-weighted national average is used.

$$\frac{Adjusted\ Measure\ Score - Non\text{-}Weighted\ National\ Average}{Standard\ Error}$$

$$\frac{86.118791 - 86.657529}{0.446739} = -1.21$$

Table K-9: CAHPS Star Assignment Alternate Representation

Mean Score	Base Group	Signif. below avg., low reliability	Signif. below avg., not low reliability	Not signif. diff. from avg., low reliability	Not signif. diff. from avg., not low reliability	Signif. above avg., low reliability	Signif. above avg., not low reliability
< 15th percentile by > 1 SE	1	1	1	2	2	2	2
< 15th percentile by ≤ 1 SE		2	1	2	2	2	2
≥ 15th to < 30th percentile	2	2	2	3	2	3	2
≥ 30th to < 60th percentile	3	2	2	3	3	4	4
≥ 60th to < 80th percentile	4	3	4	3	4	4	4
≥ 80th percentile by ≤ 1 SE	5	4	4	4	4	4	5
≥ 80th percentile by > 1 SE		4	4	4	4	5	5

26. From this analysis, I concluded that CMS is placing more value (or a higher weight) on the measure scores of certain plans resulting in a shift of the national average upward from what it would be if a non-weighted average was used. Therefore, because CMS compares a plan's case-mix adjusted score to a weighted national average and adjusts a plan's measure Star Rating from the Base Group if the adjusted score for the measure does or does not exceed a certain statistical distance away from the weighted national average, CMS is making it more difficult for plans to achieve higher Star Ratings, as demonstrated above in the Table K-9 assignments.[18] For

[18] In other words, because CMS is using a weighted national average, when comparing plan CAHPS measure scores, larger plans with more enrollees have a greater influence on the national average than smaller plans with less enrollees. By using a weighted national average, CMS's comparison looks at scores affected by membership and not pure contract-level scores. Ultimately, members select plans for how well the plan scores and not the size of its membership.

the BCBS MA contract that was evaluated against the weighted national average, one CAHPS measure experienced a detrimental reduction in Star Rating for that measure due to the use of a weighted national average. No measure within this contract benefited from an increased Star Rating from CMS's use of a weighted national average when compared with the Star Rating resulting from the use of a non-weighted national average.

27. Further, when replacing H2261's current Star Rating for measure C23 of 2-Star with a 3-Star, H2261's overall Star Rating increases from 3.5 to 4. This demonstrates the significance of CMS's decision to use a weighted national average versus a non-weighted national average, causing a measure to achieve a lower Star Rating and, in some cases (including BCBS MA's H2261), a lower overall Star Rating. See Table 4 below for the results of the BCBS MA contract. The row shaded in grey represents the CAHPS measure score that experiences a detrimental reduction in Star Ratings for that measure due to the use of a weighted national average.

Table 4: 2025 CAHPS Measure Star Ratings

Contract	CAHPS Measure	Low Reliab.	Base Group	Statistical Difference from Non-Weighted National Average		Star Rating	
			Current	Current	Updated w/Non-Weighted National Avg	Current	Updated w/Non-Weighted National Avg
H2261	C03	No	5	Higher	Higher	5	5
H2261	C19	No	3	No	No	3	3
H2261	C20	No	3	No	No	3	3
H2261	C21	No	5	Higher	Higher	5	5
H2261	C22	No	3	Lower	Lower	2	2
H2261	**C23**	**No**	**3**	**Lower**	**No**	**2**	**3**
H2261	C24	No	3	No	No	3	3
H2261	D05	No	2	Lower	Lower	2	2
H2261	D06	No	2	Lower	Lower	2	2

28. In total, as demonstrated in Table 5 below, the overall Star Rating for a BCBS MA contract increased based solely on the use of a non-weighted national average when determining whether any CAHPS measures had a significant difference from the national average. This

contract, H2261, crossed a threshold of moving up from 3.5 to 4 Stars. This change is material in that it would result in BCBS MA being eligible to receive quality bonus payments and increased rebates from CMS based on 2025 Star Ratings for this contract, allowing BCBS MA to offer enhanced benefits to its enrollees.

Table 5: 2025 Overall Star Ratings

Contract	Current 2025 Summary Score	Updated 2025 Summary Score (w/Non-Weighted National Avg)	Current 2025 Star Rating	Updated 2025 Star Rating (w/Non-Weighted National Avg)
H2261	3.713878	3.854282	**3.5**	**4.0**

Appendix A:

Medicare Star Ratings Impact Payments to MAOs

29. When an MAO contracts with CMS, it does so through an annual financial bidding process. Each MAO's "bid" is based on its annual expected revenues and costs for the package of services it intends to provide. The bid is in the form of a per member per month dollar amount that represents the cost of providing services to a beneficiary with average health. The MAO also submits to CMS a detailed package on the benefits included and beneficiary cost sharing amounts for Part C services, as well as actuarial support and certification for the bid calculation. An MAO must prepare this information annually for every contract that it operates. The package of benefits must include at least all services that beneficiaries are entitled to receive under traditional (Part A and Part B) Medicare except hospice.[19]

30. During the bidding process, CMS also calculates a per member per month "benchmark" for each county in which MAOs operate. CMS calculates county-level benchmarks by determining the average spending in traditional Medicare adjusted for geography and

[19] *See* MedPac, "Medicare Advantage Program Payment System," Revised October 2023, available at: https://www.medpac.gov/wp-content/uploads/2022/10/MedPAC_Payment_Basics_23_MA_FINAL_SEC.pdf, accessed April 22, 2025.

demographics. These benchmarks act as targets against which MAOs bid to provide Part A and Part B coverage to beneficiaries. The per member per month "base rate" that CMS ultimately pays to an MAO is the lower of the MAO's bid or the CMS-set county level benchmark.[20]

31. If an MAO's bid is lower than the benchmark, the MAO receives a rebate from CMS equal to a percentage of the difference between the benchmark and the bid. A portion of these rebates are returned to plan enrollees in the form of supplemental benefits or lower premiums. If an MAO's bid is higher than the benchmark, the enrollees in that MAO pay a premium equal to the difference between the MAO's bid rate and the benchmark.[21]

32. To encourage MAOs to compete for enrollees based on quality, the Affordable Care Act established a Quality Bonus Program that increases CMS's payments to MAOs based on the number of Stars it earns under the Medicare Star Ratings program. MAO contracts that receive at least 4 out of 5 Stars qualify for a quality bonus. Quality bonuses are based upon the county-level benchmarks set by CMS during the annual Medicare Advantage bidding process. For most MAOs in bonus status, the benchmark is increased by up to five percentage points. For MAO's in "double bonus" counties, the benchmarks are increased by up to 10 percentage points.[22]

33. For MAOs with bids below the benchmark, the rebates they receive from CMS are also impacted positively by increases to the benchmarks for MAOs that receive at least 3.5 Stars.[23] These rebates are used by MAOs to enhance benefits or lower premiums for enrollees, which helps MAOs to attract and retain enrollees to remain competitive in their respective markets.

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[20] *Ibid.*

[21] *Ibid.*

[22] "Double bonus counties" are defined as urban counties with low traditional Medicare spending and historically high Medicare Advantage enrollment. Additionally, benchmarks are capped and cannot be higher than they would have been prior to the Affordable Care Act, which can result in MAOs that are eligible under the quality bonus program receiving a smaller percentage increase to their benchmark or possibly no increase at all. (Biniek, Jeannie Fugelsten, Freed, Meredith, Damico, Anthony, and Neuman, Tricia, "Medicare Advantage Quality Bonus Payments Will Total at Least $11.8 Billion in 2024," *Kaiser Family Foundation*, September 11, 2024, available at: https://www.kff.org/medicare/issue-brief/medicare-advantage-quality-bonus-payments-will-total-at-least-11-8-billion-in-2024/, accessed April 22, 2025.)

[23] All plans that bid below the benchmark receive a percentage of the difference between the bid and benchmark as a rebate, ranging from 50% to 70% of the difference between the bid and the benchmark. The amount of the rebate paid to the plan is determined by the plan's Star Rating. Plans with < 3.5 Stars get a 50% rebate, plans with 3.5 to 4 Stars get 65%, and plans with 4.5+ Stars get 70%. (CMS, "Advance Notice of Methodological Changes for Calendar Year (CY) 2025 for Medicare Advantage (MA) Capitation Rates and Part C and Part D Payment Policies," January 31, 2024, available at: https://www.cms.gov/files/document/2025-advance-notice.pdf, accessed April 22, 2025.).

Medicare Star Ratings Influence Enrollment in MAOs

34. As noted above, one of CMS's stated goals of the Star Ratings program is "to provide people with Medicare and their caregivers with meaningful information about quality, alongside information about benefits and costs, to assist them in comparing plans and choosing the Medicare coverage option that best fits their health needs." To help facilitate a beneficiary's plan selection, CMS maintains a "plan compare" online tool on its Medicare.gov website that Medicare beneficiaries can use to help search for Medicare plans. The plan compare tool includes the Star Rating for each plan, which could influence a beneficiary's selection of one MAO over another MAO with similar benefits and cost sharing.[24]

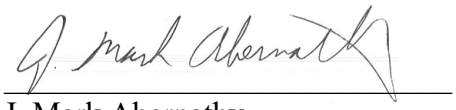
35. CMS also allows MAOs that receive a 5-Star Rating the opportunity to enroll beneficiaries throughout the year, rather than only during annual Medicare open enrollment periods. This creates a marketing advantage for 5-Star plans.

36. The influence that the Star Ratings program has on Medicare Advantage enrollment is supported by recent enrollment figures. In 2024, 72% of Medicare Advantage Enrollees were in MAOs that received a Star Rating of 4 or above and qualified for a quality bonus.[25] Further, a systematic literature review conducted in 2023 of PubMed MEDLINE, Embase, and Google attempted to identify articles that quantitatively assessed the impact of Medicare Star Ratings on health plan enrollment. The authors concluded, in part, that, "[i]ncreases in Medicare star ratings led to statistically significant increases in health plan enrollment and decreases in health plan disenrollment."[26] In other words, an MAO's overall Star Rating for any given year has a direct impact on its enrollment, which demonstrates that MAOs with higher Star Ratings are at a significant advantage in the market to attract and retain enrollees. This is in

[24] *See* https://www.medicare.gov/plan-compare/#/?year=2025&lang=en, accessed April 22, 2025.
[25] Biniek, Jeannie Fugelsten, Freed, Meredith, Damico, Anthony, and Neuman, Tricia. "Medicare Advantage Quality Bonus Payments Will Total at Least $11.8 Billion in 2024," Kaiser Family Foundation, September 11, 2024, available at: https://www.kff.org/medicare/issue-brief/medicare-advantage-quality-bonus-payments-will-total-at-least-11-8-billion-in-2024/, accessed April 22, 2025.
[26] Borrelli, Eric P et al. "Impact of star ratings on Medicare health plan enrollment: A systematic literature review," Journal of the American Pharmacists Association: JAPhA vol. 63,4 (2023): 989-997.e3, available at: https://doi.org/10.1016/j.japh.2023.03.009, accessed April 22, 2025.

addition to the impact a Star Rating can have on an MAO's revenue and ability to offer competitive benefits and cost sharing options to its enrollees.

Pursuant to 28 U.S.C. § 1746, I declare under penalty of perjury under the laws of the United States of America that the foregoing is true and correct. Executed on May 16, 2025, in Tampa, Florida."

By: 

J. Mark Abernathy
Managing Director
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UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

BLUE CROSS AND BLUE SHIELD OF MASSACHUSETTS, INC., and **BLUE CROSS AND BLUE SHIELD OF MASSACHUSETTS HMO BLUE, INC.** Plaintiffs, v. **ROBERT F. KENNEDY JR.,** in his official capacity as Secretary of Health and Human Services, U.S. Department of Health and Human Services and **MEHMET OZ**, in his official capacity as Administrator, Centers for Medicare and Medicaid Services, Defendants.	Case No. 1:25-cv-693

MEMORANDUM OF LAW IN SUPPORT OF
PLAINTIFFS' MOTION FOR SUMMARY JUDGMENT

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Plaintiffs Blue Cross and Blue Shield of Massachusetts, Inc. ("BCBSMA") and Blue Cross and Blue Shield of Massachusetts HMO Blue, Inc. ("HMO Blue") (collectively with BCBSMA "Plaintiffs"), by and through undersigned counsel, hereby submit this Memorandum of Law in support of their Motion for Summary Judgment.

INTRODUCTION

Medicare Advantage Star Ratings are vital to Medicare Advantage Organizations ("MAOs") and the Medicare Advantage Program, as they drive an MAO's member enrollment and determine whether the MAO will receive millions of dollars in quality bonus and other payments. MAOs reinvest those payments to directly benefit Medicare beneficiaries through improved benefits and reduced premiums. The applicable regulations set forth a straightforward process to calculate Star Ratings for each contract held by an MAO on a 5-Star scale, set in half-star increments, with 1 Star being the lowest and 5 Stars being the highest. Defendants calculate Star Ratings by individually scoring various measures designed to assess the quality of the plan. Each year, Defendants assign each measure a weight and use the measure scores to calculate an overall weighted numerical score that is converted into the plan's overall Star Rating.

The regulations governing the calculation of Star Ratings fully outline the methodology Defendants must follow when calculating measure scores—including measures based on Consumer Assessment of Healthcare Providers and Systems ("CAHPS") survey data—and a plan's overall Star Ratings. Despite the clear regulatory methodology in place, Defendants have created a convoluted process through sub-regulatory guidance to calculate Star Ratings that conflicts with the plain text of the regulations in two significant, harmful ways:

First, Defendants unlawfully applied a case-mix adjustment to Plaintiffs' contracts H2230 and H2261, improperly lowering various measure scores and the contracts' overall Star Ratings. The applicable regulations that detail the methodology for calculating Star Ratings do not

contemplate or permit this case-mix adjust ent. Yet, Defendants chose to apply a case-mix adjustment pursuant to sub-regulatory guidance that conflicts with the plain text of the regulations. Defendants' application of the case-mix adjustment is contrary to law and arbitrary and capricious.

Second, Defendants violated the regulations when calculating CAHPS-based measure scores by comparing Plaintiffs' contract H2261 to the national *weighted* average. Even though the regulations clearly specify that contracts must be compared to the "national average," *see* 42 C.F.R. § 422.166(a)(3)(i)–(v), Defendants use a national weighted average (*i.e.*, a weighted average that accounts for contract enrollment). But a simple average and a weighted average are fundamentally different, and the regulations unambiguously call for a simple average of all contract scores without any weighting. By using the weighted average, Defendants improperly calculated the Star Rating for contract H2261 in a way that is contrary to law and arbitrary and capricious.

Defendants' actions significantly harmed Plaintiffs. Due to Defendants' improper calculation of Plaintiffs' Star Ratings, Plaintiffs expect that they will not receive approximately $35 million in funding through quality bonus and other payments that Plaintiffs would utilize to improve member benefits and reduce member premiums. Accordingly, Plaintiffs respectfully request that the Court grant Plaintiffs' Motion for Summary Judgment.

STATEMENT OF FACTS

I. THE PARTIES

Plaintiffs are BCBSMA, a not-for-profit medical service corporation and independent licensee of the Blue Cross and Blue Shield Association, and its direct subsidiary HMO Blue. *See* Dkt. 1 ("Compl.") ¶ 8. Plaintiffs operate numerous health plans serving residents and businesses in Massachusetts that provide medical and prescription drug coverage to Medicare beneficiaries under Medicare Parts C and D. *Id.* HMO Blue entered into contracts with Defendants to provide coverage to Medicare beneficiaries under Medicare Parts C and/or D. *See id.*

Defendant Robert F. Kennedy Jr. in his official capacity as Secretary of Health and Human Services ("HHS"), is responsible for overseeing the Centers for Medicare and Medicaid Services ("CMS"). *See* Compl. ¶ 10. Defendant Dr. Mehmet Oz, in his official capacity as Administrator of CMS (collectively with Kennedy, the "Defendants") is responsible for the administration of the Medicare health program, including Medicare Parts C and D. *See id.* ¶ 11.[1]

II. PROCEDURAL HISTORY

Plaintiffs filed this action on March 7, 2025 challenging Defendants' unlawful and arbitrary and capricious calculation of Plaintiffs' Star Ratings and accompanying quality bonus payment (QBP) determinations. *See* Dkt. 1. Plaintiffs are properly before the Court as Defendants' informal QBP reconsideration process excludes any challenges to Defendants' methodology such as those raised here. *See* 42 C.F.R. § 422.260(c)(3)(ii) (explaining that administrative review cannot be requested for the methodology for calculating the star ratings, including the calculation of overall star ratings). The administrative review process may be used only to challenge calculation and data inclusion errors. *See* 42 C.F.R. § 422.260(c)(1)–(2) (detailing reconsideration process followed by informal hearing process).[2]

[1] When Plaintiffs filed their Complaint, the Acting Administrator of CMS was Stephanie Carlton. Plaintiffs modified this motion to reflect that Dr. Mehmet Oz now serves as the Administrator of CMS.

[2] Additionally, as noted in the Complaint, Plaintiffs challenged through the administrative process the inclusion of a specific call—identified as D1800221—in the data Defendants used to calculate the D01 call center measure for contracts H2230 and H2261. *See* Compl. ¶ 38. On April 14, 2025, the informal hearing officer upheld the reconsideration official's determination to include the disputed call in the data and did not change the QBP determination for contracts H2230 and H2261. *See generally* A.R. 1194–96. Thus, Plaintiffs fully exhausted the administrative process and the decision is final and binding on the parties as of April 24, 2025. *Id.* The issues in this case are outside of the scope of that administrative process. Therefore, Plaintiffs are appropriately before the Court.

III. MEDICARE ADVANTAGE PROGRAM

The Medicare Program is a federal health insurance program that provides healthcare benefits for people 65 and older and under 65 with certain disabilities or diseases. *See* 42 U.S.C. §§ 1395 *et seq*. While Medicare-eligible individuals may receive medical benefits from the federal government under Medicare Parts A and B, *see* 42 U.S.C. §§ 1395c to 1395i-6 (Part A); 42 U.S.C. §§ 1395j to 1395w-6 (Part B), under the Medicare Advantage Program (Medicare Part C), MAOs offer health plans to Medicare-eligible individuals and provide Medicare benefits to enrollees. *See* Establishment of the Medicare Advantage Program, 70 Fed. Reg. 4588, 4589 (Jan. 28, 2005).

Typically, Defendants pay MAOs per member, per month for providing coverage to their enrollees for traditional Medicare services. To contract with Defendants, Defendants require that MAOs prepare and submit annual financial bids. Along with the bid amount, MAOs must also submit (1) a detailed package to CMS detailing the specific benefits and cost sharing amounts their plans will cover, for both Medicare Advantage medical coverage and Part D prescription drug coverage, 42 U.S.C. § 1395w-24(a)(6)(A); and (2) a detailed financial breakdown of how the plan calculated its bid amount, including the actuarial basis and support for those calculations. *See* 42 U.S.C. § 1395w-24(a)(6)(A)(ii)–(iii). Each year, bids are due by the first Monday in June. This year, bids will be submitted on June 2, 2025. After the bid deadline, CMS will conduct a "desk review period" until August 2025, which will allow for adjustments to bids during this period based on the Court's decision in this case.

IV. MEDICARE ADVANTAGE STAR RATINGS

A. Star Ratings significantly impact member enrollment, Defendants' payments to the MAO, and the premium and benefits the MAO provides.

Defendants publish annual Star Ratings for MAOs by rating each MAO's contract on a scale of 1 to 5 Stars. *See* 42 U.S.C. § 1395w-23(o); *see also* 42 C.F.R. Part 422, Subpart D. An

MAO's Star Rating is critical because it directly impacts: (1) member enrollment; (2) the amount of payment that CMS makes to the MAO; and (3) the premiums and benefits the MAO can offer Medicare beneficiaries. *See* 42 U.S.C. § 1395w–23(a), (o); *see also* Compl. ¶¶ 19–21. In fact, Star Ratings are designed for prospective and existing members to use them to compare Medicare plans and select the plan and coverage that is best for them. *See* CTRS. FOR MEDICARE & MEDICAID SERVS., 2025 MEDICARE ADVANTAGE AND PART D STAR RATINGS, (2024), https://www.cms.gov/newsroom/fact-sheets/2025-medicare-advantage-and-part-d-star-ratings#:~:text=Approximately%2040%25%20of%20MA%2DPDs,or%20more%20stars%20in%202025. To aid with plan selection, Defendants maintain a public tool called the "Medicare Plan Finder," which displays information about available plans, including their measure-specific scores and their overall Star Rating for the upcoming plan year. *See* 42 C.F.R. § 422.166(h).

Star Ratings also impact member benefits. Under the statutory "Quality Bonus Payment" program, MAOs that receive an overall Star Rating of 4 Stars or higher receive higher payments from CMS, which are reinvested into plans to improve healthcare affordability and the quality of member benefits and services. *See* 42 U.S.C. § 1395w-23(a), (o). Therefore, MAOs with higher Star Ratings can offer more competitive pricing and benefits to potential members and ensure that current members retain existing benefits. *Id.*

B. CMS's methodology to calculate Star Ratings detrimentally impacts measure scores and overall Star Ratings.

1. *2025 Star Ratings were calculated using 42 measures based on various data sources.*

Star Ratings are assigned at the contract level based on a 5-Star scale, set in half-star increments, with 1 Star being the lowest rating and 5 Stars being the highest. *See* 42 C.F.R. §§ 422.162(b), 422.166(h) (discussing how ratings are assigned based on each contract's individual

data). CMS calculates Star Ratings by assessing and individually scoring (on a 1 to 5-Star scale, without half star increments) several measures that fall into multiple categories designed to measure the quality of the plan. Defendants assign each measure a certain weight and use measure scores to calculate an overall weighted numerical score (the "Final Summary Score"). Defendants subsequently convert the Final Summary Score into a contract's overall Star Rating (the "Overall Star Rating").

In 2025, Defendants designated a total of 42 measures (30 Part C measures designated as C01 to C30 and 12 Part D measures designated as D01 to D12) categorized as follows: (1) outcomes; (2) intermediate outcomes; (3) patient experience; (4) access to care; and (5) process for maintaining, monitoring or improving beneficiaries' health status. *See* CTR. FOR MEDICARE AND MEDICAID SERVICES, MEDICARE 2025 PART C & D STAR RATINGS TECHNICAL NOTES ("2025 Technical Notes") at 28–105, A.R. 36–113 (listing measures used to determine an MA-PD plan's 2025 Star Rating); *see id*. at 1, A.R. 09 (listing categories).[3] In evaluating how an MAO performed for the 42 measures, Defendants relied on various data sources including: (1) Healthcare Effectiveness Data and Information Set ("HEDIS"); (2) Consumer Assessment of Healthcare Providers and Systems ("CAHPS") survey data for Medicare Advantage and Prescription Drug Plans; (3) CMS administrative data; and (4) data from various third party sources such as independent review entities. *Id.* at 5, A.R. 13.

To calculate an MAO's Overall Star Rating, Defendants calculated a numerical score for each measure based on the data applicable to each measure. *Id.* at 28–105, A.R. 36–113.

[3] "A.R. __" refers to a citation to a page in the Administrative Record served on Plaintiffs on May 9, 2025 (Dkt. 10) and completed by service to Plaintiffs on May 16, 2025. Two additional documents were provided to Plaintiffs on May 16, 2025. *See* A.R. 1194-1197. Plaintiffs understand that Defendants will complete the certified index with these two documents on May 19, 2025.

Defendants converted the numerical score into a measure-specific Star Rating on a five-star scale by determining "cut points" to separate each contract into the whole star increments. 42 C.F.R. §§ 422.166(a)(4), 423.186(a)(4). As relevant to this action, CMS utilizes a detailed methodology (*i.e.*, relative distribution and significance testing) to calculate cut points and assign measure Star Ratings for measures that are based on "CAHPS" data. 42 C.F.R. §§ 422.166(a)(2), (3); 423.186(a)(2), (3); 2025 Technical Notes at 13, A.R. 18. These calculations led to the scores identified in contract score cards for contracts H2230 and H2261. A.R. 1135-36, 1143-44 (H2261 overall score card); 1138-39, 1146-47 (H2230 overall score card).

2. *In calculating CAHPS-based measures, CMS unlawfully applied a "case-mix adjustment" that is contrary to the regulations to negatively adjust scores.*

"CAHPS" refers to the Consumer Assessment of Healthcare Providers & Systems surveys. Defendants conduct CAHPS surveys through CMS vendors to measure beneficiaries' experiences with their health plans. *See, e.g.*, 42 C.F.R. § 422.162(a). Different CAHPS surveys measure different aspects of Medicare beneficiaries' experiences in the healthcare industry, and include hospital surveys, home health surveys, and MAOs. *See Consumer Assessment of Healthcare Providers & Systems (CAHPS)*, CTRS. FOR MEDICARE AND MEDICAID SERVS., https://www.cms.gov/data-research/research/consumer-assessment-healthcare-providers-systems (last modified Nov. 14, 2024) (identifying various CAHPS surveys). Relevant to MAO Star Ratings, Defendants administer the Medicare Advantage and Prescription Drug Plan CAHPS surveys, which are designed to capture the experience of MAO enrollees. *See Medicare Advantage and Prescription Drug Plan CAHPS Survey*, HEALTH SERVS. ADVISORY GRP., https://ma-pdpcahps.org/en (last modified May 1, 2025).

Defendants administer CAHPS surveys of MAO enrollees through government-approved vendors. *See Medicare Advantage Prescription Drug Plan (MA & PDP) CAHPS Survey Approved*

Survey Vendors, HEALTH SERVS. ADVISORY GRP., https://www.ma-pdpcahps.org/en/approved-survey-vendor-list (last modified Nov. 18, 2024). To perform the survey, Defendants sample a group of enrollees for each contract and their designated vendors administer the surveys to selected enrollees using a mixed mode data collection protocol that includes an invitation to complete a web survey, followed up by mail and telephone. *See Medicare Advantage and Prescription Drug Plan CAHPS (MA and PDP CAHPS)*, CTRS. FOR MEDICARE AND MEDICAID SERVS., https://www.cms.gov/data-research/research/consumer-assessment-healthcare-providers-systems/medicare-advantage-and-prescription-drug-plan-cahps (last modified Sept. 10, 2024).

Defendants' vendors ask questions regarding access to needed care and specialists, getting appointments and care quickly, rating of health and/or drug plan, rating of health care quality, and whether the individual received certain vaccines. *Id.* Defendants publish survey results in the publicly-available Medicare & You Handbook and Medicare Plan Finder tool, *see, e.g.*, *Medicare & You*, CMS, https://www.medicare.gov/medicare-and-you (last visited May 14, 2025), so beneficiaries can review the results in assessing and selecting an MAO plan. *Id.*

After the survey responses are assessed for each contract, Defendants apply a "case-mix adjustment" pursuant to Defendants' sub-regulatory guidance. *See* 2025 Technical Notes at 106, A.R. 114. The case-mix adjustment is not contemplated in the regulations governing the calculation of CAHPS-based measure scores, *see* 42 C.F.R. § 422.166(a)(3), but the case-mix adjustment significantly impacts—and may detrimentally impact—a contract's measure scores and Overall Star Rating. Defendants' CAHPS Technical Notes assert, without regulatory support, that "[c]ertain respondent characteristics, such as education, are not under the control of the health plan, but are related to the sampled enrollee's survey responses . . . [and] CMS adjusts for such respondent characteristics when comparing contracts." *See* CTRS. FOR MEDICARE AND MEDICAID

SERVICES, MA & PDP QUALITY ASSURANCE PROTOCOLS & TECHNICAL SPECIFICATIONS ("CAHPS Technical Notes") at 75, A.R. 332. Defendants further state that "individuals with less education and those who report better general and mental health provide more positive ratings and reports of care," and that the "case-mix model used for analyzing MA & PDP CAHPS Survey data includes the following variables (each of which has mutually exclusive categories)": (i) education; (ii) self-reported general health status; (iii) self-reported mental health status; (iv) proxy completion of the survey or other proxy assistance; (v) dual eligibility; (vi) age; and (vii) Asian (Chinese, Korean, Tagalog, and Vietnamese) language survey completion. *Id.* According to this sub-regulatory guidance, Defendants take the raw CAHPS score for each measure and adjust the score up or down based on these demographic factors to re-score the measure. *See* 2025 Technical Notes at 106, A.R. 114. The case-mix adjustments applied to contracts H2230 and H2261 can be found at A.R. 1178-1193.

Defendants do not publicly disclose how the above-outlined factors influence respondents across all contracts, or how Plaintiffs' contracts specifically are influenced by these factors. Following the case-mix adjustment, Defendants implement relative distribution and significance testing methodology to assign measure-specific Star Ratings to each CAHPS-based measure. 2025 Technical Notes at 153, A.R. 161. Specifically, Defendants take the case-mix adjusted scores for each measure and classify them into "base groups" that are based upon "cut points" set at the 15th, 30th, 60th, and 80th percentiles for all contracts in that year. *See* 42 C.F.R. §§ 422.166(a)(3), 423.186(a)(3); *see also* 2025 Technical Notes at 153, A.R. 161.

Finally, Defendants must compare the contract's score to the national average. *See* 42 C.F.R. § 422.166(a)(3)(i)–(v) (when assigning measure Star scores for each CAHPS-based measure, Defendants must determine if the contract's measure score is "statistically significantly

higher [or lower] than the ***national average*** CAHPS measure score.") (emphasis added). These adjustments can be found at A.R. 1181-85 (H2230); 1189-93 (H2261). However, Defendants compared Plaintiffs' contracts to the national *weighted* average for all contracts. *See* 2025 Technical Notes at 153, A.R. 161; *see also* CAHPS Technical Notes at 76, A.R. 333. The regulations do not support using the national *weighted* average, as the plain language requires comparison to the "national average" without mention of weighting for any factors.

STANDARD OF REVIEW

"[W]hen a party seeks review of agency action under the APA . . . , the district judge sits as an appellate tribunal." *Rempfer v. Sharfstein*, 583 F.3d 860, 865 (D.C. Cir. 2009) (quoting *Am. Bioscience, Inc. v. Thompson*, 269 F.3d 1077, 1083 (D.C. Cir. 2001)). "The general standard for summary judgment set forth in Rule 56 of the Federal Rules of Civil Procedure does not apply to a review of agency action." *Ctr. for Biological Diversity v. Regan*, No. 21-119 (RDM), 2024 WL 655368, at *16 (D.D.C. Feb. 15, 2024). Instead, "summary judgment [] serves as the mechanism for deciding, as a matter of law, whether the agency action is supported by the administrative record and otherwise consistent with the APA standard of review." *Sierra Club v. Mainella*, 459 F. Supp. 2d 76, 90 (D.D.C. 2006) (citing *Richard v. INS*, 554 F.2d 1173, 1177 & n.28 (D.C. Cir. 1977)). In other words, "[t]he entire case on review is a question of law." *Marshall Cnty. Health Care Auth. v. Shalala*, 988 F.2d 1221, 1226 (D.C. Cir. 1993).

Under the APA, a court shall hold unlawful and set aside agency action that is "arbitrary, capricious . . . or otherwise not in accordance with law." 5 U.S.C. § 706(2)(A). It is well-settled that an agency's failure to follow its own regulations renders its decision invalid. *Service v. Dulles*, 354 U.S. 363, 382–89 (1957). In addition, if an agency acts contrary to the law, it likewise acts arbitrarily and capriciously. *See Erie Blvd. Hydropower, LP v. FERC*, 878 F.3d 258, 269 (D.C. Cir. 2017) ("[I]f an agency action fails to comply with its regulations, that action may be set aside

as arbitrary and capricious."); *see also Nat'l Envtl. Dev. Ass'ns Clean Air Project v. EPA*, 752 F.3d 999, 1009 (D.C. Cir. 2014) (holding that an "agency is not free to ignore or violate its regulations" and "an agency action may be set aside as arbitrary and capricious if the agency fails to 'comply with its own regulations'") (citation omitted); *Melinta Therapeutics, LLC v. FDA*, No. 22-2190 (RC), 2022 WL 6100188 at *4 (D.D.C. Oct. 7, 2022) ("An agency action is arbitrary and capricious if an agency fails to comply with its own regulations.") (internal quotation marks omitted) (citation omitted).

In assessing whether an agency acted arbitrarily and capriciously, courts in the D.C. Circuit conduct a review that is "searching and careful." *See Getty v. Fed. Sav. & Loan Ins. Corp.*, 805 F.2d. 1050, 1055 (D.C. Cir. 2016) (citation omitted). Courts must ensure that the agency did not fail to consider "an important aspect of the problem" that it seeks to address and reject "an explanation for its decision that runs counter to the evidence before the agency, or is so implausible that it could not be ascribed to a difference in view or the product of agency expertise." *AT&T Servs. v. FCC*, 21 F.4th 841, 845 (D.C. Cir. 2021) (quoting *Motor Vehicle Mfrs. Ass'n v. State Farm Mut. Auto. Ins. Co.*, 463 U.S. 29, 43 (1983)); *see also United Steel, Paper & Forestry, Rubber, Mfg., Energy, Allied Indus. & Serv. Workers Int'l Union v. FHA*, 151 F. Supp. 3d 76, 90 (D.D.C. 2015) (holding that the administrative record did not explain the agency's rationale and there was not "a 'rational connection between the facts found and the choice made") (citation omitted); *Quantum Entm't, Ltd. v. U.S. Dep't of Interior, Bureau of Indian Affairs*, 597 F. Supp. 2d 146, 155 (D.D.C. 2009) (explaining that "a reviewing court must have more than a result; it needs the agency's reasoning for that result"). Put simply, courts must "consider whether the decision was based on a consideration of the relevant factors and whether there has been a clear

error of judgment." *Fred Meyer Stores, Inc. v. NLRB*, 865 F.3d 630, 638 (D.C. Cir. 2017) (citation omitted).

ARGUMENT

I. DEFENDANTS ACTED CONTRARY TO LAW AND ARBITRARILY AND CAPRICIOUSLY IN ITS CALCULATION OF CAHPS MEASURE SCORES.

A. Defendants lack regulatory authority to apply a case-mix adjustment to CAHPS measure scores.

Defendants improperly apply a case-mix adjustment to CAHPS-based measure scores when the applicable regulations do not provide for, or even mention, this case-mix adjustment to calculate these scores. "[I]t is elementary that an agency must adhere to its own rules and regulations." *Reuters Ltd. v. FCC*, 781 F.2d 946, 950 (D.C. Cir. 1986); s*ee also Nat'l Envtl. Dev. Ass'ns Clean Air Project*, 752 F.3d 999, 1009 (holding that an "agency is not free to ignore or violate its regulations" and "an agency action may be set aside as arbitrary and capricious if the agency fails to 'comply with its own regulations'") (citation omitted); *Fuller v. Winter*, 538 F. Supp. 2d 179, 190–91 (D.C.C. 2008) (holding that an agency decision that fails to comply with governing regulations is arbitrary, capricious, and contrary to law as "an agency is required to adhere to its own regulations during its decision-making process"); *Panhandle Eastern Pipe Line Co. v. Fed. Energy Regul. Com.*, 613 F.2d 1120, 1135 (D.C. Cir. 1979) (explaining that just because the agency's regulation as written does not provide the agency a quick way to achieve its desired outcome, does not mean it has authority to ignore it).

The regulations governing the calculation of Star Ratings explicitly outline the methodology that Defendants must use to calculate CAHPS-based measure scores. Under 42 C.F.R. § 422.166, Defendants are required to use relative distribution and significance testing methodology. *See* 42 C.F.R. § 422.166(a)(3). The regulations account for certain challenges associated with the use of survey methodology by providing for adjustments to be made to an

MAO's individual scores in various circumstances. For example, the regulations state that "no measure Star Rating is produced if the reliability of a CAHPS measure is less than .60." *See id.* Likewise, the regulations provide additional overrides on the scoring of a CAHPS measure between 1–5 Stars, including how an MAO's score compares to the national average CAHPS score for that measure and/or whether the score is determined to be reliable. *See id.*

However, the plain text of the regulation outlining this clear methodology does not provide for case-mix adjustments. *See* 42 C.F.R. § 422.166(a)(3). An agency's interpretation may not stand if it is contrary to the regulation's plain language. *Buffalo Crushed Stone, Inc. v. Surface Transp. Bd.*, 194 F.3d 125, 128–29 (D.C. Cir. 1999). Courts only depart from a regulation's plain text where it causes an "absurd result" or where there is clear legislative intent contrary to the plain meaning. *See Elevance Health, Inc. v. Becerra*, 736 F. Supp. 3d 1, 24 (D.D.C. 2024) (only in rare instances where a regulation's plain text causes an "absurd result" will courts depart from the plain text meaning) (internal quotations omitted); *Air Prods. & Chems. v. Quigg*, 709 F. Supp. 1, 3 (D.D.C. 1988) (without clear legislative intent to the contrary, the regulation's plain language controls). Moreover, even where an agency advances strong policy considerations, the plain meaning of a regulation cannot be discarded. *See Zhang v. United States Citizenship & Immigr. Servs.*, 978 F.3d 1314, 1322 (D.C. Cir. 2020).

Indeed, "case-mix adjustment" appears in 42 C.F.R. § 422.162(a), the definitions pertaining to the Medicare Advantage Quality Rating System, where the term is defined. The definition applies to case-mix adjustments in other areas of the Star Ratings regulations, including with respect to determining the "Categorical Adjustment Index" (CAI) (which is a different adjustment to Star Ratings required by 42 C.F.R. § 422.166(f)(2)) and the Health Equity Index (which is a new Stars factor that does not apply until the 2027 Star Ratings per 42 C.F.R. §

422.166(f)(3)). For example, the CAI regulations expressly provide that "measures that remain after the exclusion criteria… ***will be adjusted*** for the determination of the CAI." *See* 42 C.F.R. § 422.166(f)(2)(iii) (emphasis added). And while the CAI regulations assume that certain measures are case-mix adjusted for socioeconomic status, there is simply no independent regulatory authorization for case-mix adjustments in the applicable regulations governing the calculation of Stars for CAHPS measures. *See id.* § 422.166(f)(2)(ii) (providing that a measure will be excluded from the CAI if, among other criteria, the measure "is already case-mix adjusted for socioeconomic status").

CMS's express authorization of a case-mix adjustment in the calculation of CAI and Health Equity Index demonstrates that CMS (like Congress) knows exactly how to authorize case-mix adjustments, but intentionally did not do so for the calculation of CAHPS-based measure scores. *See Sierra Club v. EPA*, 21 F.4th 815, 882 (D.C. Cir. 2021) ("[C]ongress acts intentionally and purposely when it includes particular language in one section of a statute but omits it in another.") (citation omitted); *Va. Dep't of Med. Assistance Servs. v. United States HHS*, 678 F.3d 918, 922 (D.C. Cir. 2012) ("Courts must presume that a legislature says in a statute what it means and means in a statute what it says there.") (internal quotations omitted); *Smith v. Comm'r of Soc. Sec.*, 482 F.3d 873, 876 (6th Cir. 2007) ("When an agency includes a requirement in only one section of a regulation, we presume the exclusion from the remainder of the regulation to be intentional.").

Notably, Congress also authorized case-mix adjustment in certain areas of the Medicare statute. For example, Congress has authorized its use in the context of home health services:

> *Adjustment for case-mix changes*. Insofar as the Secretary determines that the adjustments under paragraph (4)(A)(i) for a previous fiscal year or year (or estimates that such adjustments for a future fiscal year or year) did (or are likely to) result in a change in aggregate payments under this subsection during the fiscal year or year that are a result of changes in the coding or classification of different units of services that *do not reflect real changes in case-mix, the Secretary may adjust*

> *the standard prospective payment amount (or amounts)* under paragraph (3) for subsequent fiscal years or years so as to eliminate the effect of such coding or classification changes.

See Prospective Payment for Home Health Services, 42 U.S.C. § 1395fff(b)(3)(B)(iv) (emphasis added). Congress has also authorized case-mix adjustment in the context of the End Stage Renal Disease Program:

> The *Secretary shall establish a basic case-mix adjusted prospective payment system* for dialysis services furnished by providers of services and renal dialysis facilities in a year to individuals in a facility and to such individuals at home. *The case-mix under such system shall be for a limited number of patient characteristics*.

See End Stage Renal Disease Program 42 U.S.C. § 1395rr(b)(12) (emphasis added). In contrast, the applicable statute authorizing Star Ratings and corresponding quality bonus determinations does not mention case-mix adjusting scores. *See* 42 U.S.C. § 1395w-23(o).

At bottom, the applicable regulations fully set forth a detailed methodology to calculate Star Ratings that does not contemplate a case-mix adjustment of CAHPS measure scores. In departing from these clear regulations, Defendants have acted contrary to law and in a manner that is arbitrary and capricious.

B. Defendants improperly applied a case-mix adjustment pursuant to sub-regulatory guidance.

Despite the clear regulatory methodology outlined in 42 C.F.R. § 422.166(a)(3), which does not provide for the application of case-mix adjustments, Defendants chose to apply case-mix adjustments. Specifically, Defendants' sub-regulatory guidance deviates from regulatory requirements and provides for case-mix adjustments to purportedly "take into account differences in the characteristics of enrollees across contracts that may potentially impact survey responses," like enrollee age and education. *See* 2025 Technical Notes at 153, A.R. 161. In other words, Defendants take the raw CAHPS measure scores for a contract and adjust the score based upon the case-mix from the contract. A.R. 1182-1183 (H2230); 1189-1190 (H2261). But the applicable

regulations do not authorize or provide for case-mix adjustments as part of the relative distribution and significance testing methodology to determine the contract's measure-specific Star Ratings. *See* 42 C.F.R. § 422.166(a)(3).

Defendants' sub-regulatory guidance directly conflicts with applicable regulations and, therefore, is invalid as a matter of law as applied to Plaintiffs' contracts. "It is well-settled that [agency] guidelines cannot trump the language of a regulation when the regulation is clear on its face." *Dialysis Clinic, Inc. v. Leavitt*, 518 F. Supp. 2d 197, 203 (D.D.C. 2007); *ItServe All., Inc. v. Cissna*, 443 F. Supp. 3d 14, 34 (D.D.C. 2020) ("An agency interpretation is substantively invalid when 'it conflicts with the text of the regulation the agency purported to interpret.'"); *Scott & White Health Plan v. Becerra*, 693 F. Supp. 3d 1, 10 (D.D.C. 2023) (setting aside CMS Administrator's decision because it was contrary to the regulation's plain language). This is especially true when agency guidance has significant impacts on the rights of parties. Agency guidance with such binding effects is only appropriately issued through notice-and-comment rulemaking, and an agency may not simply issue major substantive additions to its regulations through sub-regulatory guidance under the guise of agency interpretation. *See Appalachian Power Co. v. EPA*, 208 F.3d 1015, 1023–28 (D.C. Cir. 2000) (holding the agency's guidance had a binding effect and its interpretation carried the force and effect of law, therefore the agency could not skirt notice and comment requirements); *United States Telecom Ass'n v. FCC*, 400 F.3d 29, 35 (D.C. Cir. 2005) (explaining that "'rules that work substantive changes' or 'major substantive legal additions to. . . regulations are subject to the APA's procedures").

In the same vein, in the absence of regulatory text issued through notice-and-comment rulemaking, an agency may not rely on the text of a preamble to a proposed rulemaking as purported legal authorization for its actions. While Defendants mentioned and briefly commented

on the concept of a case-mix adjustment in the preamble to the 2018 final rule that implemented 42 C.F.R. § 422.166, they did not propose the use of case-mix adjustments in the language of the regulation itself. *See* Medicare Quality Rating System, 83 Fed. Reg. 16440, 16555 (April 16, 2018). Unlike a regulation itself, a preamble does not have the force and effect of law. *See Tex. Child.'s Hosp. v. Burwell*, 76 F. Supp. 3d 224, 237 (D.D.C. 2014) ("[A] preamble does not create law; that is what a regulation's text is for."); *Ctr. for Biological Diversity v. United States EPA*, No. 22-486 (BAH), 2023 WL 5035782, at *11 (D.D.C. Aug. 8, 2023) ("[T]he preamble of a regulation is not an operative part of the rule and thus does not overcome the plain and clear meaning of the rule's text."); *St. Francis Med. Ctr. v. Azar*, 894 F.3d 290, 297 (D.C. Cir. 2018) ("Because the regulation itself is clear, we need not evaluate. . . the preamble, which itself lacks the force and effect of law."). Indeed, the "'real dividing point' between the portions of a final rule with and without legal force is designation for 'publication in the Code of Federal Regulations.'" *AT&T Corp. v. FCC*, 449 U.S. App. D.C. 106, 112 (D.C. Cir. 2020) (quoting *Brock v. Cathedral Bluffs Shale Oil Co.*, 796 F.2d 533, 539 (D.C. Cir. 1986)). In other words, a preamble cannot contradict or otherwise be inconsistent with clear regulatory text. *Barrick Goldstrike Mines, Inc. v. Whitman*, 260 F. Supp. 2d 28, 36 (D.D.C. 2003) (holding that the preamble was inconsistent with the plain language of the regulation and thus was invalid); *Milton S. Hershey Med. Ctr. v. Becerra*, Nos. 23-1382; 1384, 2024 WL 3673614, at *8 (D.D.C. Aug. 6, 2024) ("[L]anguage in regulatory preambles is 'not controlling over the language of the regulation itself.'") (quoting *Wyo. Outdoor Council v. U.S. Forest Serv.*, 165 F.3d 43, 53 (D.C. Cir. 1999)).

In two cases in the District of Columbia last year, the courts rejected Defendants' attempts to use preamble language to act in a way inconsistent with their own regulations when calculating Star Ratings. *See Elevance Health, Inc.*, 736 F. Supp. 3d at 23–25 (Moss, J.); *see also Scan Health*

Plan v. HHS, Case No. 23-cv-03910, 2024 WL 2815789, at *6–7 (D.D.C. June 3, 2024) (Nichols, J.). In both cases, this Court rejected Defendants' reliance on the preamble and held that the regulation did not permit the Defendants' actions. *See Elevance Health, Inc.*, 736 F. Supp. 3d at 23–24; *see also Scan Health Plan*, No. 23-cv-03910, 2024 WL 2815789 at *6. Similarly, here, the preamble language and the Defendants' sub-regulatory guidance conflict with the regulatory requirements outlined in 42 C.F.R. § 422.166(a)(3) regarding the calculation of CAHPS-based measure scores. Case-mix adjustments constitute a significant, substantive expansion (or modification) of the regulatory text that Defendants must authorize by statute or regulation. *Appalachian Power Co.*, 208 F.3d at 1024 ("It is well-established that an agency may not escape the notice and comment requirements. . . by labeling a major substantive legal addition to a rule a mere interpretation.").

Defendants' improper application of the case-mix adjustment can have significant, detrimental impacts on a contract's measure scores and Overall Star Rating. Indeed, as set forth in the Declaration of J. Mark Abernathy, even "minor case-mix adjustments in CAHPS measure scores can have significant impacts, causing a measure to achieve a lower Star Rating, and in some cases (including BCBSMA's H2230 and H2261), a lower Overall Star Rating." *See* Ex. A., Declaration of J. Mark Abernathy ("Abernathy Decl.") ¶ 19. Due to Defendants' improper case-mix adjustment, Plaintiffs were harmed as follows:

For contract H2230: a total of five measures experienced a determinantal reduction in measure Star Ratings and would increase by 1 Star by removing the case-mix adjustment. *Id.* ¶ 19, Table 2. Specifically, measure C19 would increase from 2 to 3 Stars; measure C20 would increase from 2 to 3 Stars; measure C21 would increase from 4 to 5 Stars; measure C22 would increase from 2 to 3 Stars; and measure C24 would increase from 2 to 3 Stars. *See id.* Further, for example,

re-calculating contract H2230's Overall Star Rating with an updated measure score for these measures (*i.e.*, without the case-mix adjustment) results in an Overall Star Rating increase from 3.5 Stars to 4 Stars. *See id.* ¶ 20, Table 3.

For contract H2261: a total of three measures experienced a detrimental reduction in measure Star Ratings and would increase by 1 Star by removing the case-mix adjustment. *Id.* Specifically, measure C20 would increase from 3 to 4 Stars; measure C22 would increase from 2 to 3 Stars; and measure C24 would increase from 3 to 4 Stars. *See id.* ¶ 19, Table 2. Similarly, re-calculating contract H2230's Overall Star Rating with an updated measure score for these measures (*i.e.*, without the case-mix adjustment) results in an Overall Star Rating increase from 3.5 Stars to 4 Stars. *See id.* ¶ 20, Table 3.

Here, the applicable regulation simply does not contemplate a case-mix adjustment. Yet, Defendants applied a case-mix adjustment pursuant to sub-regulatory guidance and calculated Plaintiffs' CAHPS-based measure scores in a way that negatively impacted Plaintiffs' measure scores and Overall Star Ratings. Due to Defendants' actions, Plaintiffs have been damaged by at least $35 million. Therefore, Defendants have acted contrary to the law and in an arbitrary and capricious manner.

II. CMS IMPROPERLY CALCULATED CAHPS-BASED MEASURES SCORES USING A NATIONAL WEIGHTED AVERAGE WHEN THE REGULATION REQUIRES THE USE OF THE AVERAGE WITHOUT ANY WEIGHTING.

In addition to the improper application of the case-mix adjustment, Defendants violated the plain text of 42 C.F.R. § 422.166(a) in calculating Plaintiffs' CAHPS-based measure scores by comparing Plaintiffs' measure scores to national *weighted* average scores instead of to national average scores. To determine the Star score for all CAHPS-based measures, 42 C.F.R. § 422.166(a)(3)(i)–(v) requires CMS to, among other things, compare each contract's measure

scores to the "national average." CMS's own sub-regulatory guidance echoes this requirement. *See* 2025 Technical Notes, Table K-8 at 154, A.R. 162.

For example, the plain language of these instructions requires that a contract measure score will be assigned 1 Star if (among other requirements) the contract's "measure score is statistically significantly lower than the *national average* CAHPS measure score." *See* 42 C.F.R. § 422.166(a)(3)(i)(B) (emphasis added); *see also* 2025 Technical Notes, Table K-8 at 154, A.R. 162. On the other end of the scale, Defendants will assign 5 Stars to a contract's measure score if (among other requirements) the contract "measure score is statistically significantly higher than the *national average* CAHPS measure score." 42 C.F.R. § 422.166(a)(3)(v)(B) (emphasis added); *see also* 2025 Technical Notes, Table K-8 at 154, A.R. 162.

Despite these clear regulatory instructions, echoed in Table K-8 of the 2025 Technical Notes, requiring the use of the national average to make the required comparison, Defendants look to the page preceding Table K-8 in the Technical Notes to justify their use of a national *weighted* average instead of a national average as required by the regulation. *See* 2025 Technical Notes at 154, A.R. 162. This contradiction in the guidance is on page 153, in which the 2025 Technical Notes state that "[t]he number of stars assigned is determined by the position of the contract mean score relative to percentile cut offs from the distribution of contract *weighted* mean scores from all contracts." *See* 2025 Technical Notes at 153, A.R. 161 (emphasis added). However, as explained below, Defendants may not substitute their own contrary interpretation for the plain language found in the notice and comment rulemaking.

The regulation at 42 C.F.R. § 422.166(a) does not define the term "national average," and therefore its plain meaning controls. *See NRDC, Inc. v. Raimondo*, No. 23-982, 2024 WL 4056653, at *17 (D.D.C. Sept. 5, 2024) ("[W]hen a term is not defined, the plain meaning controls."). The

plain meaning of national average is a simple average in which all the contracts are assigned an equal weight. *See* Abernathy Decl. ¶¶ 21–22; *Average*, Cambridge University Press & Assessment, DICTIONARY.CAMBRIDGE.ORG, https://dictionary.cambridge.org/dictionary/english/average (last visited May 16, 2025) (defining "average" as "the result you get by adding two or more amounts together and dividing the total by the number of amounts"); *Average*, Merriam-Webster, Inc., MERRIAM-WEBSTER.COM, https://www.merriamwebster.com/dictionary/average (last visited May 16, 2025) (providing that "average" equals an "arithmetic mean," and defining "arithmetic mean"[4] as "a value that is computed by dividing the sum of a set of terms by the number of terms").

Despite Defendants' attempt to use the terms interchangeably, national average and national weighted average are not the same thing. As explained in the Declaration of J. Mark Abernathy, the national *weighted* average takes into account the total enrollment of each contract, while a national average is "the simple average of all contract values . . . where each contract is weighted equally." Abernathy Decl. ¶ 22. The Defendants' use of a weighted average to assign Star Ratings for CAHPS measures is directly contrary to the plain language and meaning of the regulation, therefore Defendants' interpretation is contrary to law, arbitrary and capricious. *See Thomas Jefferson Univ. v. Shalala*, 512 U.S. 504, 512 (1994) (holding a court cannot accept an agency's interpretation that is contrary to "the regulation's plain language or [to] other indications of the [agency's] intent at the time of the regulation's promulgation") (citation omitted); *Scott & White Health Plan*, 693 F. Supp. 3d at 9 (holding that agency's contrary interpretation was contrary to law "[g]iven that the controlling regulation is clear on the matter, the Court finds no reason to

[4] *Arithmetic Mean*, Merriam-Webster, Inc., MERRIAM-WEBSTER.COM, https://www.merriam-webster.com/dictionary/arithmetic%20mean (last visited May 16, 2025).

defer to the agency's contrary interpretation"); *ItServe All., Inc.*, 443 F. Supp. 3d at 34 ("An agency interpretation is substantively invalid when 'it conflict[s] with the text of the regulation the agency purported to interpret.'") (quoting *Perez v. Mortg. Bankers Ass'n*, 575 U.S. 92, 104–05 (2015)).

Moreover, Defendants know how to specifically require the use of a weighted average. Different sections of 42 C.F.R. § 422.166 expressly use "weighted mean" and "weighted average" for use in other calculations. *See, e.g.*, 42 C.F.R. § 422.166(c)(1) & (d)(1) (requiring the use of the "weighted mean" for calculating Part C and Part D summary star ratings); 42 C.F.R. § 422.166(d)(2)(vi)(A) (calculating a Star rating for a new contract using the "weighted average" highest Star rating of the parent organization); 42 C.F.R. § 422.166(f)(1)(i) (requiring the use of the "weighted mean" for calculating the reward factor).

Similarly, Defendants expressly use the term "weighted average" or "weighted mean" repeatedly throughout Title 42, Chapter IV (Centers for Medicare & Medicaid Services, Department of Health and Human Services), demonstrating that Defendants clearly know how to codify the use of a "weighted" average or mean. *See, e.g.*, 42 C.F.R. § 422.258(a)(2) (requiring the use of a "weighted average" of capitation rates for calculating a benchmark amount); 42 C.F.R. § 422.2440(g) (calculating a deductible factor using a "weighted average" deductible of all applicable plans).[5]

Given the repeated use of the terms "weighted average" or "weighted mean" when Defendants intend to perform a *weighted* calculation, the clear interpretation of the term "national average" in 42 C.F.R. § 422.166(a)(3)(i)–(v) is the simple average of all contracts without weighting. In other words, if "national *weighted* average" was intended, then that language would

[5] Using the search terms "weighted average" or "weighted mean" in Title 42, Chapter IV yields 47 results on different regulations.

have been used—but it was not. *See Smith*, 482 F.3d at 876 (finding that "[w]hen an agency includes a requirement in only one section of a regulation, we presume the exclusion from the remainder of the regulation to be intentional"); *see also* Abernathy Decl. ¶ 22, n.15 (explaining that a simple or non-weighted national average is… the default average absent a specific instruction to use weighting).

As set forth in the Declaration of J. Mark Abernathy, Defendants' arbitrary and capricious use of the national weighted average had a material, negative impact on contract H2261. Abernathy Decl. ¶ 27. For example, contract H2261's CAHPS measure C23, (Rating of Health Plan) has a case mix adjusted score of 86.118791, which, pursuant to Defendants' sub-regulatory instructions, rounds down to 86 and falls into base group 3. *See* 2025 Technical Notes at 68, A.R. 76. When compared to the national weighted average, however, measure C23's case-mix adjusted score was statistically significantly lower than the national ***weighted*** average CAHPS measure score and Defendants assigned a measure score of 2. *Id.* ¶¶ 23–25. By contrast, using the simple national average for comparison, measure C23's case-mix adjusted score would not result in a statistically significant difference from the national average and using the national average, Defendants would have assigned C23 a measure score of 3. *Id.* ¶ 25. By replacing the current Star Rating for measure C23 of 2 Stars with 3 Stars, H2261's Overall Star Rating increases from 3.5 to 4 Stars. *Id.* ¶¶ 26–27.

As explained *supra*, this increase is important because a Medicare Advantage plan is entitled to quality bonus payments ("QBPs") from Defendants depending on the "quality rating" of the plan. *See* 42 U.S.C. § 1395w-23(o)(4)(A); *see also* Abernathy Decl. ¶ 9. Specifically, if a plan receives a Star Rating of 4 Stars or higher, its benchmark amount is increased, which in turn increases the difference between the plan's benchmark and its bid, making additional rebates

available. *See* 42 U.S.C. § 1395w-23(o)(1), (3)(A); *see also* Abernathy Decl., Appendix A. Star Ratings also determine the portion of the difference that is returned to the plan as a bid rebate. 42 C.F.R. §§ 422.162(b)(2), 423.182(b)(2). The change calculated by Mr. Abernathy is material in that it would result in contract H2261 being eligible to receive QBPs and increased rebates from Defendants, allowing BCBSMA to offer additional benefits to its members. *See* Abernathy Decl. ¶ 28.

As is evident, this arbitrary and capricious deviation from the regulatory language in the process of calculating the Star ratings had a tremendous impact on Plaintiffs, including causing Plaintiffs to lose quality bonus payments and retained rebates that are estimated to be approximately $35 million and would be used to increase member benefits.

CONCLUSION

For the foregoing reasons, this Court should grant Plaintiffs' motion for summary judgment, set aside Defendants' unlawful actions as "not in accordance with law" and "arbitrary" and "capricious" 5 U.S.C. § 706(2)(A), and order Defendants to recalculate Plaintiffs' 2025 Star Ratings for contracts H2230 and H2261.

Dated: May 16, 2025

Respectfully submitted,

By: /s/ *Lesley C. Reynolds*

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CERTIFICATE OF SERVICE

I hereby certify that on May 16, 2025, I electronically filed the foregoing document and the accompanying exhibits with the Clerk of the Court using the CM/ECF system, which will send notification of this filing to the attorneys of record and all registered participants.

/s/ *Lesley C. Reynolds*
Lesley C. Reynolds

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

BLUE CROSS AND BLUE SHIELD OF MASSACHUSETTS, INC., et al. Plaintiffs, v. **ROBERT F. KENNEDY, JR.,** in his official capacity as Secretary of Health and Human Services, U.S. Department of Health and Human Services, et al.	Case No. 1:25-cv-00693 (TNM)

[PROPOSED] ORDER

UPON CONSIDERATION of Plaintiffs' Motion for Summary Judgment and Memorandum in Support, and for good cause shown and the entire record herein, it is hereby ORDERED that Plaintiffs' Motion for Summary Judgment is GRANTED; and it is further DECLARED that Defendants' actions are contrary to law and arbitrary and capricious in violation of the Administrative Procedure Act, 5 U.S.C. § 706(2)(A) based upon the entire record herein; and it is further ORDERED that Defendants shall recalculate Plaintiffs' 2025 Medicare Advantage and/or Medicare Part D Star Ratings for Plaintiffs' H2230 and H2261 contracts:

(i) without a case-mix adjustment to CAHPS-based measure scores in determining 2025 Star Ratings; and

(ii) by using the national average without any weighting, as required by regulation, instead of using a national weighted average; and

(iii) by updating the Overall Star Rating for contracts H2230 and H2261 to 4 Stars.

IT IS FURTHER ORDERED that Defendants shall redetermine the Quality Bonus Payment eligibility for Plaintiffs' contracts H2230 and H2261, and update all public displays of Plaintiffs' Star Ratings, including the Plan Finder website, after performing the recalculation of the Star Ratings as set forth herein.

SO ORDERED.

_____ _____

Dated:

TREVOR N. MCFADDEN
United States District Judge

Attorneys to be noticed:

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