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., Secretary of Health and Human Services, et al., *Defendants*.	Civil Action No. 25-0693 (TNM)

DEFENDANTS' MOTION FOR SUMMARY JUDGMENT

Pursuant to Federal Rule of Civil Procedure 56(a), Defendants Robert F. Kennedy, in his official capacity as Secretary of the Department of Health and Human Services, and Stephanie Carlton, in her official capacity as Acting Administrator of the Centers for Medicare and Medicaid Services, by and through undersigned counsel, respectfully moves for summary judgment. A memorandum of points and authorities and proposed order are attached.

Dated: May 30, 2025

Respectfully submitted,

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Plaintiffs,

v.

ROBERT F. KENNEDY, JR., Secretary of Health and Human Services, et al.,

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DEFENDANTS' OPPOSITION TO PLAINTIFFS' MOTION FOR SUMMARY JUDGMENT AND DEFENDANTS' CROSS MOTION FOR SUMMARY JUDGMENT

INTRODUCTION

The Centers for Medicare & Medicaid Services ("CMS") calculates Medicare Advantage Star Ratings on a one- through five-star scale in half-star increments, which allows Medicare beneficiaries to comparison shop among hundreds of private health insurance plans. That Star Ratings system is also the basis for Medicare payment to Medicare Advantage Organizations like Blue Cross and Blue Shield of Massachusetts ("BCBSMA"). This lawsuit is BCBSMA's effort to nudge their scores over the line into the next half-star category to increase their Medicare payment. As part of this pursuit, BCBSMA asks this Court to endorse rule changes to the calculation of Medicare Advantage Star Ratings that BCBSMA has not before and would never advance as neutral, policy principles before it knew its overall scores. BCBSMA's dubious, post hoc efforts do not satisfy its legal burden to establish that case-mix adjusting and CMS's methodology for calculating the national average are arbitrary and capricious or contrary to law.

First, BCBSMA contends that case-mix adjusting survey data—that is, adjusting contracts' survey results for age, education, health status, and income to account for the fact that some contracts serve populations that are disproportionately likely to give positive or negative responses—is not supported by CMS's regulations. To the contrary, the applicable regulations amply authorize case-mix adjustment. Case-mix adjusting is not a policy to which BCBSMA objected or would have objected before BCBSMA knew its overall contract scores.

Second, BCBSMA contends that when CMS calculates the "national average" used in certain survey measures, CMS is required to average contract-level scores without regard to how many enrollees are in each contract. Some measure-level Star Ratings that factor into the overall Star Rating a contract receives are based on whether that contract's average survey measure score is statistically significantly lower or higher than the "national average" survey measure score. In

calculating this national average, BCBSMA contends that CMS is required to calculate the country's contract-level average. The regulations do not require, and CMS does not calculate, the average of the scores this way. The number of people covered by each contract varies significantly from contract to contract. As a result, CMS calculates a true national average that captures the average beneficiary experience—not the contract's experience—by weighting the contract scores according to enrollment and using those scores to calculate the national average. CMS's method is reasonable and entirely consistent with the regulation.

Every year, it is a near certainty that some contracts, like BCBSMA's, will receive scores that just miss the cut-off for a higher star increment. If this Court grants BCBSMA the relief it seeks, it opens its doors to annual, legally and statistically dubious arguments of Medicare Advantage Organizations seeking to nudge their scores up into the next half-star category. The Court should reject these efforts at the outset.

BACKGROUND

I. Statutory and Regulatory Background

Title XVIII of the Social Security Act, 42 U.S.C. § 1395 *et seq*. ("Medicare statute"), establishes the Medicare program, a federally funded and administered health insurance program for eligible elderly and disabled persons and certain individuals with end stage renal disease. *See* 42 U.S.C. § 1395c. The Secretary administers the Medicare program through CMS, a component agency of the United States Department of Health and Human Services.

The Medicare program is divided into four major components. Part A, the hospital insurance benefit program, provides health insurance coverage for certain inpatient hospital care, post-hospital care in a skilled facility, post-hospital home care services, and other related services. *See id.* §§ 1395c, 1395d. Part B, the supplemental medical insurance benefit program, generally

pays for a percentage of certain medical and other health services, including physician services, supplemental to the benefits provided by Part A. *See id.* §§ 1395j, 1395k, 1395l. Under Part C, the Medicare Advantage program, a Medicare beneficiary can elect to receive his or her Medicare benefits through a public or private healthcare plan. *See id.* § 1395w-21 *et seq*. Finally, Part D is the voluntary prescription drug benefit program. *See id.* § 1395w-101 *et seq.*

Under Part C's Medicare Advantage program, the federal government pays insurers to provide the coverage that participating beneficiaries would otherwise receive through Parts A and B (sometimes known, collectively, as "traditional" Medicare). *Id.* § 1395w-22(a). These insurers, known as Medicare Advantage Organizations, contract to provide coverage in a particular geographic area. Beneficiaries can then choose among the plans available where they reside. *Id.* § 1395w-21(b). Medicare Advantage Organizations receive a predetermined sum for providing coverage to each beneficiary, based in part on the demographic and health characteristics of that beneficiary. *Id.* § 1395w-23(a)(1)(A), (C).

To calculate payments to Medicare Advantage Organizations, CMS first determines its "benchmark," based on the per-capita cost of covering Medicare beneficiaries under Parts A and B in the relevant geographic area. *Id.* § 1395w-23(n); 42 C.F.R. § 422.258. Each Medicare Advantage Organization then submits a "bid," telling CMS what payment the Medicare Advantage Organization will accept to cover a beneficiary with an average risk profile in that area. 42 C.F.R. § 422.254. If the insurer's bid is less than the benchmark, the bid becomes its "base payment"—the amount it is paid for covering a beneficiary of average risk—and the insurer receives a portion of the difference between its bid and the benchmark as a "rebate" that the Medicare Advantage Organization can use to fund supplemental benefits for beneficiaries or reduce plan premiums. 42 U.S.C. § 1395w-24(b)(1)(C); 42 C.F.R. § 422.260. If the Medicare Advantage Organization's bid

is greater than the benchmark, then the benchmark becomes its base payment, and the insurer must charge beneficiaries a premium to make up the difference. *See* 42 U.S.C. §§ 1395w-23(a)(1)(B)(ii), 1395w-24(b)(2)(A).

Star Ratings are a means by which CMS measures the quality of Medicare Advantage plans on a scale of one to five "stars" in half-star increments based on Medicare Advantage data collected by CMS. 42 U.S.C. § 1395w-23(o)(4)(A); *see also* § 1395w-22(e)(3). Star Ratings reflect the experiences of beneficiaries in these plans and assist beneficiaries in finding the best plans for their needs. Advance Notice of Methodological Changes for 2026 for Medicare Advantage Capitation Rates & Part C & Part D Payment Policies, at 109 (Jan. 10, 2025), *available at* https://perma.cc/KWB8-VLWK.

CMS has released Star Ratings for Medicare Advantage contracts since 2008. Contract Year 2019 Policy & Technical Changes to the Medicare Advantage Program, 83 Fed. Reg. 16,440, 16,520 (Apr. 16, 2018). In 2018, CMS adopted a regulatory framework for Star Ratings and since then has used rulemaking to adopt methodology changes and add new measures. *Id.*; *see also* 42 C.F.R. §§ 422.164(c), (d), 423.184(c), (d). The 2018 final rule describes the Star Ratings system's purpose: it "is designed to provide information to the beneficiary that is a true reflection of the plan's quality and encompasses multiple dimensions of high-quality care." 83 Fed. Reg. at 16,520.

Overall Star Ratings are assigned to each individual contract held by a Medicare Advantage Organization, with one star being the lowest rating and five stars being the highest. *See* 42 U.S.C. §§ 1395w-23(o)(4)(A), 1395w-24(b)(1)(C)(v); 42 C.F.R. §§ 422.162(b); 422.166(h)(1)(ii), 423.182(b), 423.186(h)(1)(ii). Star Ratings affect payments to Medicare Advantage Organizations in two main ways. First, Medicare Advantage plans that earn a rating of four stars or higher qualify for Medicare Advantage Quality Bonus Payments in the form of an increased benchmark for the

contract year following the ratings year (*e.g.*, the 2025 Star Ratings can increase the Medicare Advantage bidding benchmarks for contract year 2026). 42 U.S.C. § 1395w-23(o)(1) (increasing, for qualifying plans, the applicable percentage that calculates the benchmark); § 1395w-23(o)(3)(A)(i) (a qualifying plan is one that earns a rating of four stars or higher). This in turn can allow a Medicare Advantage plan to increase its bid, receive higher rebates, or lower premiums. *See id.* § 1395w-24(b)(1)(C); 42 C.F.R. § 422.260.

Second, Star Ratings affect the level of rebate received by plans that bid below their benchmarks for the contract year following the ratings year (e.g., the 2025 Star Ratings are used to set plans' rebate percentages for contract year 2026). Plans that earn a rating of four-and-a-half stars or higher get a rebate of seventy percent of the difference between their bid and the benchmark, while plans that earn three-and-a-half or four stars get a rebate of sixty-five percent of that difference, and plans that earn less than three-and-a-half stars are eligible for a rebate of fifty percent of that difference. 42 U.S.C. § 1395w-24(b)(1)(C)(v) (listing the "final applicable rebate percentage[s]" by rating); 42 C.F.R. §§ 422.166(a)(2)(ii), 423.186(a)(2)(ii) (same).

CMS publishes the Star Ratings each October for the upcoming year at the contract level, with each plan offered under that contract assigned the contract's rating. *See* 42 C.F.R. §§ 422.162(b), 422.166, 423.182(b), 423.186. CMS published the 2025 Star Ratings, for example, in October 2024. CMS, Fact Sheet – 2025 Medicare Advantage and Part D Star Ratings (Oct. 10, 2024) ("Fact Sheet"), *available at* https://perma.cc/8TLH-G7ZL. The 2025 Star Ratings are calculated based mostly on 2023 measurement year data. Administrative Record ("A.R.") 28-105 (indicating "data time frame" for each quality measure is primarily 2023). The 2024 Star Ratings are calculated on mostly 2022 measurement year data. Tech Guidance, 34-111 (indicating "data time frame" for each quality measure is primarily 2022).

A. Measure-Level Star Ratings Calculation Methodology

To calculate overall Star Ratings, CMS scores Medicare Advantage contracts on approximately 30 to 40 unique quality measures, depending on whether the plan is Medicare Advantage-only or also includes Part D coverage. A.R. 13 ("Technical Guidance"). These measures relate to five broad categories—outcomes, intermediate outcomes, patient experience, access, and process, *see id.* at 9—and CMS uses a variety of data including administrative and medical record review data collected as part of the Healthcare Effectiveness Data and Information Set ("Healthcare Effectiveness Data" or "HEDIS") and survey-based data from the Health Outcomes Survey and from the Consumer Assessment of Healthcare Providers and Systems ("CAHPS"). 83 Fed. Reg. at 16,520, 16,525. The 2025 Star Ratings are calculated in late 2024 using data primarily from measurement year 2023. A.R. 21. These measure-level scores are also expressed in "stars" but are awarded in whole-star increments, not half stars like the overall Star Ratings. 42 C.F.R. §§ 422.166(a)(4), 423.186(a)(4).

CMS regulations have incorporated the Technical Notes. *See* 42 C.F.R. §§ 422.164(a), 423.184(c) ("CMS lists the measures used for a particular Star Rating each year in the Technical Notes or similar guidance document with publication of the Star Ratings."). Regulations require CMS to, in advance of a measurement period, announce potential new measures and solicit feedback. *Id.* §§ 422.164(c)(2), 423.184(c)(2). Subsequently, CMS must propose and finalize new measures through rulemaking. *Id.* §§ 422.164(c)(2), 423.184(c)(2). "New measures added to the Part C Star Ratings program will be on the display page on *www.cms.gov* for a minimum of 2 years prior to becoming a Star Ratings measure." *Id.* §§ 422.164(c)(3); 423.184(c)(3) (same for Part D). If CMS finds reliability or validity issues with the measure specification, it will remain on display longer than two years. *Id.* §§ 422.164(c)(4), 423.184(c)(4).

B. CAHPS Measures

Since 1998, CMS has conducted the Medicare Advantage CAHPS surveys annually with a sample of Medicare beneficiaries, currently enrolled in a Medicare Advantage contract for six months or longer, and who live in the United States. CMS, *Medicare CAHPS Fact Sheet* 1 (Mar. 2024), https://perma.cc/4E8A-C8VT. CAHPS refers to a comprehensive and evolving family of surveys that ask consumers and patients to evaluate the interpersonal aspects of health care for which consumers and patients are the best or only source of information. *See* 42 C.F.R. § 422.162(a). For 2025, nine of the forty unique quality measures used CAHPS data as their primary data source. A.R. 125. For example, the quality measure, "Ease of Getting Prescriptions Filled When Using the Plan" is one of the nine measures that relies on CAHPS data. A.R. 96. Medicare Advantage enrollees were asked some formulation of the question, "In the last six months, how often was it easy to use your prescription drug plan to get the medicines your doctor prescribed?" A.R. 96. The score for this measure uses the mean of the distribution of responses converted to a scale from zero to 100, and the score is the percentage of the best possible score each contract earned. A.R. 96.

1. Case-Mix Adjustment

CMS's regulations authorize CMS to apply a case-mix adjustment to CAHPS quality measures. The regulations explain what the term means: "Case-mix adjustment means an adjustment to the measure score made prior to the score being converted into a Star Rating to take into account certain enrollee characteristics that are not under the control of the plan." 42 C.F.R. § 422.162(a). The regulation continues, "[f]or example age, education, chronic medical conditions, and functional health status that may be related to the enrollee's survey responses." *Id.* Most, but not all of CAHPS measures are case-mix adjusted. *See* A.R. 36-113. The regulations

explicitly contemplate that at least some quality measures will be case-mix adjusted. Section 422.166(f)(2)(ii) requires that "[i]n determining the [categorical adjustment index] values, a measure will be excluded from adjustment if the measure" "is already case-mix adjusted for socioeconomic status." 42 C.F.R. §§ 422.166(f)(2)(ii)(A), 423.186(f)(2)(ii). And the 2018 final rule expects that CAHPS measures could be case-mix adjusted: "CAHPS measure specification, including case-mix adjustment, is described in the Technical Notes." 83 Fed. Reg. at 16,537.

Consistent with regulations, the 2025 technical guidance explains that CAHPS measures are case-mix adjusted to "take into account the mix of enrollees." A.R. 114. The case-mix variables include age, education, general health status, and various measures of income. A.R. 114-15. As an example, contracts with higher proportions of beneficiaries in the 75-79 age range will be adjusted downward on this measure to compensate for the positive response tendency of their respondents. A.R. 114. CAHPS measure case-mix adjustments are calculated each year with current data and may be positive or negative. CMS makes case-mix adjustment data available online. *See* CMS, Medicare Advantage and Prescription Drug Plan CAHPS Survey: Scoring and Star Ratings (Nov. 7, 2024) https://ma-pdpcahps.org/en/scoring-and-star-ratings; A.R. 809, 824.

2. CAHPS Measure Star Ratings Calculation Based on the National Average

Regulations describe the method for calculating the raw CAHPS survey data into measure-level stars, known as "relative distribution and significance testing." 42 C.F.R. §§ 422.166(a)(3), 423.186(a)(3). This method is based in part on the national average of scores, and "combines evaluating the relative percentile distribution with significance testing and accounts for the reliability of scores produced from survey data." *Id.* §§ 422.166(a)(3), 423.186(a)(3). Under this method, "[N]o measure Star Rating is produced if the reliability of a CAHPS measure is less than 0.60." *Id.* §§ 422.166(a)(3), 423.186(a)(3).

To calculate CAHPS measure scores pursuant to the above-described specifications, CMS must calculate the national average. For example, to obtain five stars, a contract's CAHPS measure score needs to be ranked at least at the eightieth percentile and be statistically significantly higher than the national average CAHPS measure score, as well as either not have low reliability or be more than one standard error above the eightieth percentile. 42 C.F.R. §§ 422.166(a)(3)(v), 423.186(a)(3)(v); A.R. 18. To obtain one star, a contract's CAHPS measure score needs to be ranked below the fifteenth percentile and be statistically significantly lower than the national average CAHPS measure score, as well as either not have low reliability or be more than one standard error below the fifteenth percentile. 42 C.F.R. §§ 422.166(a)(3)(i), 423.186(a)(3)(i).

To calculate the national average for each CAHPS measures, CMS weights the contract scores by the survey-eligible contract enrollment assessed at the time of sample design, and then averages them. Given that the number of enrollees covered by each MAO contract varies significantly contract to contract, CMS calculates the national average to account for the number of enrollees in each contract to create a fair comparison of these customer-level satisfaction or patient experience of care scores. CMS, *Summary of Analyses for Reporting, MA & PDP CAHPS* 2 (Aug. 2024) https://perma.cc/E626-FQ2N; A.R. 9.

C. Overall Star Ratings Calculation Methodology

CMS calculates summary and overall ratings[1] using forty unique quality measures. The overall rating for a contract is calculated using the average of the Part C and Part D measure Star

[1] This brief uses the phrase "overall ratings" to refer to both summary and overall ratings. Technically, they are different ratings. The Part C and Part D summary ratings are calculated by taking a weighted average of the measure stars for Parts C and D, respectively. A.R. 20. For Medicare Advantage Prescription Drug plans to receive an overall rating, the contract must have stars assigned to both the Part C and Part D summary ratings. Plans that do not only receive a summary rating.

Ratings. 42 C.F.R. §§ 422.166(d)(1), 423.186(d)(1); A.R. 20. The average is weighted based on measure type because not all measures are equally important. CMS assigns the highest weight to the improvement measures,[2] followed by patient experience, complaints and access measures, then outcome and intermediate outcome measures, and finally process measures. *See* 42 C.F.R. § 422.166(e); A.R. 20. New measures are assigned the same weight as process measures for the first year in the Star Ratings. 42 C.F.R. §§ 422.166(e)(1)(v), 423.166(e)(2).

Two adjustments are made to the results of the summary and overall calculations described above: reward factor and categorical adjustment index. *Id.* §§ 422.166(f)(1), 422.166(f)(2), 423.186(f)(1), (f)(2); A.R. 21-23. First, to reward consistently high performance, CMS uses both the mean and the variance of the measure stars to differentiate contracts for overall ratings. If a contract has both high and stable relative performance, a reward factor is added to the contract's ratings. The Reward Factor is 0.0, 0.1, 0.2, 0.3, or 0.4 added to the weighted average star rating. A.R. 21, 23. Second, the overall ratings include the categorical adjustment index, which is added to or subtracted from a contract's summary and overall ratings. 42 C.F.R. § 422.166(f)(2); A.R. 21, 23-30. The categorical adjustment index adjusts for the average within-contract disparity in performance associated with the percentage of beneficiaries who receive a low-income subsidy, are dual eligible (meaning eligible for both Medicare and Medicaid), or have a disability status. 42 C.F.R. § 422.166(f)(2); A.R. 23-24. Some measures are included in the categorical adjustment index adjustment, and some are not. Section 422.166(f)(2)(ii)(A) requires that "[i]n determining

[2] Both the Part C and Part D improvement measures are based on a comparison of a contract's current and prior year measure scores. A.R. 13. The ultimate improvement measure score is a complicated combination of the net improvement for process measures, for outcome and intermediate outcome measures, and access measures divided by all of the eligible measures in each of those measure categories. A.R. 134-35.

the categorical adjustment index values, a measure will be excluded from adjustment if the measure" "is already case-mix adjusted for socioeconomic status."

Following this process, CMS calculated the Star Rating for BCBSMA's H2230 and H2261 to each be 3.5 Stars.

II. Procedural History

Plaintiffs BCBSMA Health and its direct subsidiary, HMO Blue (together "BCBSMA"), filed a complaint claiming that CMS improperly case-mix adjusted CAHPS measures and compared its measure scores to a weighted national average. Compl., ECF No. 1. In its motion for summary judgment, BCBSMA contends that two contracts, H2230 and H2261 were harmed by CMS's allegedly improper Star Ratings calculation. Pls.' Mem. in Support of Mot. Summ. J. ("Pls.' Br.") at 1-2, ECF No. 15. BCBSMA argues that its preferred calculation methodology—requiring CMS not to case-mix adjust CAHPS measures—would have resulted in an overall half-star increase for contracts H2230 and H2261. *Id.* at 18-19. BCBSMA also contends that if CMS compared its measure to the national contract average instead of the national average CAHPS measure score, a single measure score would increase from two to three stars such that the overall Star Rating for contract H2261 would increase from three-and-a-half to four stars. *Id.* at 23.

STANDARD OF REVIEW

In this action under the Medicare statute, judicial review is governed by the standards of the Administrative Procedure Act ("APA"), 5 U.S.C. § 706, and decided on an administrative record. *Se. Ala. Med. Ctr. v. Sebelius*, 572 F.3d 912, 916-17 (D.C. Cir. 2009). Accordingly, "'the district court does not perform its normal role' but instead 'sits as an appellate tribunal'" resolving legal questions. *County of Los Angeles v. Shalala*, 192 F.3d 1005, 1011 (D.C. Cir. 1999) (quoting *PPG Indus., Inc. v. United States*, 52 F.3d 363, 365 (D.C. Cir. 1995)). Although the parties move

for summary judgment, the "standard set forth in Rule 56(c) . . . does not apply." *Gentiva Healthcare Corp. v. Sebelius*, 857 F. Supp. 2d 1, 6 (D.D.C. 2012), *aff'd*, 723 F.3d 292 (D.C. Cir. 2013). Rather, 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." *Id*.

The APA provides for courts to "hold unlawful and set aside agency action, findings, and conclusions" if they are "arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with law," 5 U.S.C. § 706(2)(A), or "in excess of statutory jurisdiction, authority, or limitations, or short of statutory right," *id.* § 706(2)(C). Under the APA's "arbitrary or capricious" standard, the Court "must consider whether the [agency's] decision was based on a consideration of the relevant factors and whether there has been a clear error of judgment." *Marsh v. Or. Nat. Res. Council*, 490 U.S. 360, 378 (1989). An agency is required to "examine the relevant data and articulate a satisfactory explanation for its action including a rational connection between the facts found and the choice made." *Motor Vehicle Mfrs. Ass'n of U.S., Inc. v. State Farm Mut. Auto. Ins. Co.*, 463 U.S. 29, 43 (1983) (internal quotation marks omitted). Even a decision that is not fully explained may be upheld "if the agency's path may reasonably be discerned." *Bowman Transp., Inc. v. Ark.-Best Freight Sys., Inc.*, 419 U.S. 281, 286 (1974).

The "arbitrary or capricious" standard is "narrow . . . as courts defer to the agency's expertise." *Ctr. for Food Safety v. Salazar*, 898 F. Supp. 2d 130, 138 (D.D.C. 2012) (quoting *Motor Vehicle*, 463 U.S. at 43). The Court "is not to substitute its judgment for that of the agency." *Id*. In Medicare cases, the "'tremendous complexity of the Medicare statute" "adds to the deference which is due to the Secretary's decision.'" *Dist. Hosp. Partners, L.P. v. Burwell*, 786 F.3d 46, 60 (D.C. Cir. 2015) (quoting *Methodist Hosp. of Sacramento v. Shalala*, 38 F.3d 1225,

1229 (D.C. Cir. 1994)). The question is not whether the agency's policy is the "best" or only solution, but whether it is a "reasonable solution." *See Petal Gas Storage, L.L.C., v. FERC*, 496 F.3d 695, 703 (D.C. Cir. 2007).

ARGUMENT

I. CMS Acted Reasonably and in Accordance with Law by Applying a Case-Mix Adjustment to Certain CAHPS Measures.

CMS regulations authorize case-mix adjustment. The regulation provides that a case-mix adjustment is "an adjustment to the measure score made prior to the score being converted into a Star Rating to take into account certain enrollee characteristics." 42 C.F.R. § 422.162(a). As part of the 2018 rulemaking, CMS reproposed and finalized all of its existing case-mix adjusted measures, including the CAHPS measures that were case-mix adjusted and on which BCBSMA was evaluated for the 2025 Star Ratings year. Additionally, the categorical adjustment index and health equity index provisions show that the Secretary's regulations authorize case-mix adjusting CAHPS Star Rating measures. Case-mix adjusting is not a policy to which BCBSMA objected or would have objected before BCBSMA knew its overall contract scores.

A. Regulations Authorize Case-Mix Adjustments.

CMS case-mix adjusted the CAHPS measures BCBSMA challenges here in accordance with the Secretary's regulations. The regulations state that case-mix adjustments "to the measure score [are] made prior to the score being converted into a Star Rating to take into account certain enrollee characteristics that are not under the control of a plan." 42 C.F.R. § 422.162(a).[3] Additionally, they confirm that some CAHPS measure scores are "*already* case-mix adjusted." 42

[3] For ease of reference, this brief omits reference to the parallel citations in 42 C.F.R. § 423.182 *et seq*. Section 422.162 *et seq.* applies to Medicare Advantage plans only, and section 423.182 *et seq*. applies to Part D Prescription Drug plans only.

C.F.R. § 422.166(f)(2) (emphasis added). Finally, the regulations refer to "[m]easures that *are* case-mix adjusted in the Star Ratings." § 422.166(f)(3) (emphasis added). Despite these explicit regulatory authorizations, BCBSMA maintains that the Secretary's regulations do not "provide for, or even mention, this case-mix adjustment to calculate [CAHPS-based] measure scores." Pls.' Br. at 5-14. This is wrong. BCBSMA's proposed reading of these regulations is implausible, for the regulations plainly authorize case-mix adjusting of CAHPS measures.

Section 422.162, entitled Medicare Advantage Quality Rating System, authorizes CMS to case-mix adjust certain measures. It states:

> Case-mix adjustment means an adjustment to the measure score made prior to the score being converted into a Star Rating to take into account certain enrollee characteristics that are not under the control of the plan. For example age, education, chronic medical conditions, and functional health status that may be related to the enrollee's survey response.

42 C.F.R. § 422.162(a); *see also id.* §§ 422.162(a), 422.164, 422.166 (providing definitions applicable to calculating Star Ratings, including definitions that instruct how to add, update, remove, and calculate measures). In interpreting an agency's regulation, this Court's analysis should begin and end with the text. *Kisor v. Wilkie*, 588 U.S. 558, 575 (2019) ("A court must carefully consider the text.") (cleaned up). The regulation provides that a case-mix adjustment is "an adjustment to the measure score *made prior* to the score being converted into a Star Rating to take into account certain enrollee characteristics." 42 C.F.R. § 422.162(a) (emphasis added). The regulation unambiguously permits case-mix adjustments to be "made." "Made"—the past participle of "make"—means "to perform an action." *See Make*, Cambridge University Press & Assessment, https://dictionary.cambridge.org/ (last visited May 30, 2025). Here, that action was a case-mix adjustment. The Secretary's use of the past participle of "make" serves to codify in regulations the existing practice of case-mix adjusting CAHPS measures, which began with the

initiation of CAHPS in 1998. CMS, *MA & PDP CAHPS Variables Used as Case-Mix Adjustors 1998-2024* (July 30, 2024) https://perma.cc/W8WS-4T5U. And, as discussed further, the regulation's use of the phrase "made prior" means that the Secretary intended case-mix adjustments to occur before the process set forth in § 422.166, which sets out the methodology for calculating CAHPS measure Star Ratings, and not, as BCBSMA contends, how CAHPS-based measure scores are calculated.

CMS properly specified in its guidance, as required by the Secretary's regulations, that some CAHPS measures will be case-mix adjusted. As the regulations provide, CMS lists the measures used for each particular Star Rating year "in the Technical Notes or similar guidance document with publication of the Star Ratings." 42 C.F.R. § 422.164(a). When CMS adds new case-mix adjusted measures through rulemaking, it specifies that "more specific identification of a measure's . . . case-mix adjustment" will be provided in the Medicare Part C & D Star Ratings Technical Notes as required by section 422.164(a). *See* Medicare Program; Changes to the Medicare Advantage and the Medicare Prescription Drug Benefit Program for Contract Year 2024, 89 Fed. Reg. 30,448, 30,636-37 (Apr. 23, 2024) (specifying measures applicable to the 2027 Star Ratings); *see also* Medicare Program; Contract Year 2024 Policy and Technical Changes, 88 Fed. Reg. 22,120, 22,270-71 (Apr. 12, 2023) (same for 2026 Star Ratings); 83 Fed. Reg. at 16,537 ("[R]esponses are also case-mix adjusted to account for certain respondent characteristics not under the control of the health or drug plan such as age, education, dual eligible status and other variables."). Following this regulatory process, CMS implemented the case-mix adjustments to the CAHPS measures that BCBSMA challenges.

CMS rulemakings expressly authorize case-mix adjusting for the CAHPS measures on which BCBSMA was evaluated for the 2025 Star Rating year. As part of the 2018 rulemaking,

CMS reproposed and finalized all of its existing case-mix adjusted measures, including eight CAHPS measures that were case-mix adjusted and on which BCBSMA was evaluated for the 2025 Star Ratings year: Getting Needed Care; Getting Appointments and Care Quickly; Customer Service; Rating of Health Care Quality; Rating of Health Plan; Care Coordination; Rating of Drug Plan; and Getting Needed Prescription Drugs. 83 Fed. Reg. at 16,549; A.R. 70, 71, 72, 74, 75-76, 76-77, 87, 88. In that final rule, CMS explained that CAHPS measures are case-mix adjusted: "For CAHPS measures, contracts are first classified into base groups by comparisons to percentile cut points defined by the current-year distribution of *case-mix adjusted* contract means." 83 Fed. Reg. at 16,568 (emphasis added). In response to a comment in the 2018 final rule requesting more insight into the relationship between case-mix adjusting and CAHPS measures, CMS indicated that it "provides a detailed explanation of the CAHPS methodology including case-mix adjustment in the annual Star Ratings Technical Notes, in CAHPS plan reports provided to each contract each year, and on the MA and PDP CAHPS web page (*https://www.mapdpcahps.org*)." 83 Fed. Reg. at 16,555. CMS stated further that, "CMS also provides survey vendors all of the necessary data to perform case-mix adjustment validation." *Id.* In short, given this regulatory scheme, the eight CAHPS measures at issue were appropriately case-mix adjusted.

B. The Categorical Adjustment Index and Health Equity Index Regulatory Provisions Provide Support for the Notion that the Regulations Authorize Case-Mix Adjustments.

Contrary to BCBSMA's contention, the categorical adjustment index and health equity index provisions show that the Secretary's regulations authorize case-mix adjusting CAHPS Star Rating measures. The categorical adjustment index regulation states that individual measure scores that are "already case-mix adjusted" are excluded from the categorical adjustment index. 42 C.F.R. § 422.166(f)(2)(ii)(A) ("In determining the categorical adjustment index values, a

measure will be excluded from adjustment if the measure . . . is already case-mix adjusted for socioeconomic status."). The health equity index regulation lays out how to account for "[m]easures that are case-mix adjusted in the Star Ratings" in calculating the health equity index. *Id.* § 422.166(f)(3)(i)(A).

BCBSMA points to the regulations pertaining to the categorical adjustment index and the health equity index containing the words "case-mix adjusted" to claim that "[t]he definition applies to case-mix adjustments in other areas of the Star Ratings regulations." Pls.' Br. at 13-14 (citing to sections 422.166(f)(2) and 422.166(f)(3)). But there is no support for BCBSMA's position that these regulations undermine CMS's authority to case-mix adjust CAHPS measures. Those cited regulations do not authorize case-mix adjustments per se; they simply describe how to account for measures that have *already* been case-mix adjusted as the categorical adjustment index and health equity index calculations occur *after* the calculation of scores for individual measures, such as CAHPS measures. *See* 42 C.F.R. § 422.166(f) (entitled "Completing the Part C summary and overall ratings calculations"). BCBSMA states that "CMS's express authorization of a case-mix adjustment in the calculation of the categorical adjustment index 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." Pls.' Br. at 14. While BCBSMA quotes the pertinent categorical adjustment index language from section 422.166(f)(2)(ii) pertaining to measures that are "already case-mix adjusted," Pls.' Br. at 14, BCBSMA never explains to what measures it thinks this subsection is referring.

Indeed, the rule implementing the categorical adjustment index makes clear that CAHPS measures specifically are excluded from the categorical adjustment index calculation because they are already case-mix adjusted for socioeconomic status. 83 Fed. Reg. at 16,581. It states that

"[m]easures would be excluded as candidates for adjustment if the measures are already case-mix adjusted for [socioeconomic status] (for example, CAHPS and HOS outcome measures)." *Id.* The applicable categorical adjustment index rule thus assumes that CAHPS measures *are* case-mix adjusted—far from showing that CAHPS measures cannot be case-mix adjusted. BCBSMA does not engage with the fact that the case-mix adjusted measures referred to in these provisions are the CAHPS measures they contend the regulations prohibit CMS from case-mix adjusting.

C. BCBSMA's Arguments that the Secretary's Regulations Do Not Permit Case-Mix Adjustments are Premised on a Misunderstanding of the Regulations and Rulemaking Preamble.

BCBSMA contends that "an agency may not rely on the text of a preamble to a proposed rulemaking as purported legal authorization for its actions." Pls. Br. at 16. But CMS does not rely on text of a preamble alone—the Secretary's preamble language "inform[s] the interpretation of a regulation." *Texas v. HHS*, Civ. A. No. 24-348, 2025 WL 818155, at *9 (E.D. Tex. Mar. 13, 2025) (quoting *Peabody Twentymile Mining, LLC v. Sec'y of Lab.*, 931 F.3d 992, 998 (10th Cir. 2019)). The extensive discussion of CMS's application of case-mix adjustments in preamble text informs the interpretation of CMS's regulations as permitting case-mix adjusting of CAHPS measures. BCBSMA's position is that because subsection 422.166(a)(3) does not explicitly reference case-mix adjustments, there is a conflict between the preamble and the regulation text. This supposed regulatory silence does not create the preamble-regulation conflict that was at issue in *Elevance Health, Inc.* and *Scan Health Plan*, as BCBSMA contends.

Unlike in *Elevance Health, Inc. v. Becerra*, 736 F. Supp. 3d 1, 23-24 (D.D.C. 2024), and *Scan Health Plan v. HHS*, Civ. A. No. 23-3910 (CJN), 2024 WL 2815789, at *6–7 (D.D.C. June 3, 2024), where the courts found that the preamble and regulations text were in conflict, here, the preamble of the 2018 rule accords with the reasonable reading of the regulatory text as authorizing

case-mix adjustments. In those cases, for the 2024 Star Ratings, the courts concluded that the regulatory text required application of a guardrail to *actual* cut points, and preamble text required application of a guardrail to *hypothetical* cut points, creating a true conflict. *See Scan Health Plan*, 2024 WL 2815789, at *6; *Elevance Health, Inc.*, 736 F. Supp. 3d at 23–24. There is no similar conflict here. Nothing in subsection 422.166(a)(3) forecloses CMS from case-mix adjusting CAHPS measure scores. In fact, subsection 422.166(a)(3) makes no mention of case-mix adjustments because it relates to calculating Star Ratings *after* the CAHPS-measure scores are already calculated. And as established *supra*, other regulatory provisions authorize case-mix adjustment; the definition of case-mix adjustment at subsection 422.162(a) and the categorical adjustment index and health equity index provisions at subsection 422.166(f). The Secretary explained in preamble text in the 2018 Final Rule that CAHPS measures are case-mix adjusted: "For CAHPS measures, contracts are first classified into base groups by comparisons to percentile cut points defined by the current-year distribution of *case-mix adjusted* contract means." 83 Fed. Reg. at 16,568 (emphasis added). As part of this rulemaking, CMS responded to comments related to case-mix adjustments. *Id.* at 16,527, 16,555.

In each of the other cases that BCBSMA cites for the proposition that preamble text does not create law, the courts concluded that the regulatory text conflicted with the preamble. *See Tex. Child.'s Hosp. v. Burwell*, 76 F. Supp. 3d 224, 237 (D.D.C. 2014) ("To the extent that this definition is contradicted by the Rule's Preamble, the definition controls."); *AT&T Corp. v. FCC*, 970 F.3d 344, 351, 449 (D.C. Cir. 2020) (explaining that when "there is a discrepancy between the preamble and the Code, it is the codified provisions that control"); *Ctr. for Biological Diversity v. EPA*, Civ. A. No. 22-486 (BAH), 2023 WL 5035782, at *11 (D.D.C. Aug. 8, 2023) ("the preamble in clear contradiction with the plain text of the regulation"); *St. Francis Med. Ctr. v. Azar*, 894

F.3d 290, 297 (D.C. Cir. 2018) (declining to "evaluate . . . mixed signals from the preamble" in light of the regulation's clarity); *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).

BCBSMA's argument that the Secretary's regulations do not permit CMS to case-mix adjust CAHPS-based measures scores is predicated on a basic misunderstanding of the applicable regulations. BCBSMA misapprehends 42 C.F.R. § 422.166(a)(3), which sets out the methodology for calculating CAHPS measure Star Ratings. BCBSMA contends that because section 422.166(a)(3) does not mention case-mix adjusting, CMS is not empowered to case-mix adjust CAHPS measures. Pls.' Br. at 12-13. BCBSMA states that 42 C.F.R. § 422.166(a) "explicitly outline[s] the methodology that Defendants must use to calculate CAHPS-based measure scores." *Id*. at 12. This is wrong. Section 422.166(a), entitled "Measure Star Ratings," does not "explicitly outline the methodology that Defendants must use to calculate CAHPS-based measure scores," *id.*—it concerns how measure *Star Ratings* are calculated. This is not an insignificant nuance. Section 422.166(a) sets out the steps for converting measure scores into measure Star Ratings. It does not provide any specifications for calculation of measure scores.

BCBSMA states that "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." *Id.* at 15-16. But BCBSMA missed the mark here too. CMS uses relative distribution and significance testing to calculate *measure Star Ratings* but CMS case-mix adjusts measure scores. *See* 42 C.F.R. § 422.166(a)(3). BCBSMA is conflating numerical measure scores with measure Star Ratings. As BCBSMA correctly explains, section 422.166(a)(3) dictates the methodology for determining whether a measure receives 1, 2,

3, 4, or 5 stars. Pls.' Resp. Br. at 5. The case-m adjustment is part of the calculation of the numeric measure scores for CAHPS measures. *See* 42 C.F.R. § 422.162 ("Case-mix adjustment means an adjustment to the measure score *made prior to the score being converted into a Star Rating* . . ." (emphasis added)). Section 422.166(a)(3) explains how to convert CAHPS measure scores into measure Star Ratings. That regulatory provision does not explain how measure scores should be calculated. It would be improper (and make no sense) for the Secretary to authorize case-mix adjusting in the portion of its regulations pertaining to calculation of measure Star Ratings.

BCBSMA's argument based on references to case-mix adjustments in unrelated statutes is likewise unavailing. CMS's use of case-mix adjustments in Star Ratings differs substantially from the uses BCBSMA cites from other statutes, which do not relate to Medicare Advantage—let alone the Star Ratings—or the iterative process established by CMS's regulations to develop quality measures. *See* Pls.' Br. at 20. For example, 42 U.S.C. § 1395rr(b)(12) states that "[t]he Secretary shall establish a basic case-mix adjusted prospective payment system for dialysis services." Such an across-the-board requirement to use case mix in the End Stage Renal Disease Program does not apply to Star Ratings measures, most of which are not case-mix adjusted. While 42 U.S.C. § 1395fff(b)(3)(B)(iv) permits the Secretary to make some "case-mix changes" in payments under the prospective payment system for home health services, that statutory provision only allows such changes in extremely limited circumstances. *See* § 1395fff(b)(3)(B)(iv). By design, such case-mix prescriptions do not exist under the Star Ratings regulatory scheme devised for flexible measure creation and design, nor do any of these statutes bear on the Star Ratings system in any way.

CMS has been case-mix adjusting CAHPS measures since the initiation of CAHPS in 1998. CMS, *MA & PDP CAHPS Variables Used as Case-Mix Adjustors 1998-2024* (July 30, 2024)

https://ma-pdpcahps.org/globalassets/ma-pdp/scoring-and-star-ratings/2024/case-mix-variables.pdf [https://perma.cc/W8WS-4T5U]. And to CMS's knowledge, no Medicare Advantage Organization has suggested that case-mix adjustments are not authorized by CMS's regulations. Tellingly, BCBSMA does not challenge case-mix adjusting—that is, taking into account differences in the characteristics of enrollees across contracts that may potentially impact survey responses—as unreasonable. CMS explained that certain populations, for example, beneficiaries who are in the 75–79 age range, may tend to respond more positively or negatively to certain survey questions. A.R. 114. Without applying a case-mix adjustment, contracts that serve enrollees who are more likely to give positive responses would be advantaged and contracts that serve enrollees who are more likely to give fewer positive responses would be disadvantaged. BCBSMA fails to explain why that outcome is preferable. Case-mix adjusting is not a policy to which BCBSMA has objected to previously or would have objected before BCBSMA knew its overall contract scores.

This Court should reject BCBSMA's contention that the Secretary's regulations do not permit CMS to case-mix adjusting measures scores. Case-mix adjusting CAHPS measures is amply supported by CMS's rules and regulations.

II. CMS Acted Reasonably and in Accordance with Law When It Calculated the National Average for CAHPS Measure Scores.

When calculating overall Star Ratings, CMS evaluates contracts against the national average CAHPS measure score in accordance with its regulations. CMS's regulations provide that the Star Rating a contract receives on a given CAHPS measure is in part based on whether that contract's "average CAHPS measure score is statistically significantly lower than the national average CAHPS measure score" or "statistically significantly higher than the national average CAHPS measure score." 42 C.F.R. § 422.166(a)(3)(i)-(v). BCBSMA contends that CMS

guidance requires contracts to be compared to a "weighted national average," which BCBSMA contends is at odds with CMS's regulations. Pls.' Br. at 19-24. This is wrong. CMS's guidance requires CMS to assign measure stars based in part on the "statistical significance of the difference of the contract mean from the national mean," not the national *contract* mean. A.R. 161. The CAHPS survey is a survey of enrollees in Medicare Advantage contracts and, as such, the national average CAHPS measure score is the average across enrollees in Medicare Advantage contracts, not the average contract score. BCBSMA's arguments are premised on a fundamental misunderstanding about the requirements of section 422.166(a)(3), which only requires CMS to compare a contract's CAHPS measure score to the "national average." This is just what CMS did.

To calculate the national average of CAHPS measure scores, CMS takes the contract-level scores for each CAHPS measure, weights those scores by beneficiary enrollment, and then averages those scores. CMS, *Summary of Analyses for Reporting, MA & PDP CAHPS* 2 (Aug. 2024) https://perma.cc/E626-FQ2N. CAHPS scores are based on "surveys that ask [Medicare beneficiaries with Medicare Advantage Plans] to evaluate the interpersonal aspects of health care" where "consumers and patients are the best or only source of information," 42 C.F.R. § 422.162(a) (definition of CAHPS). Given that the number of consumers covered by each Medicare Advantage organization contract varies significantly contract to contract, CMS calculates the national average to account for the number of enrollees in each contract to create a fair comparison of these customer-level satisfaction scores. Weighting the contract to account for differences in enrollment when calculating the national average of CAHPS measure scores is reasonable and entirely consistent with what the regulation requires from the data available to CMS. This is because again, the CAHPS survey is a survey of enrollees in Medicare Advantage contracts. Consequently, the national average CAHPS measure score is the average across enrollees in Medicare Advantage

contracts, not the average contract score.

BCBSMA appears to contend that CMS must use the national *contract*-level average as the national average, which would increase overall Star Ratings for contract H2261. Pls.' Br. at 23. BCBSMA errs in misconstruing CMS's regulation. BCBSMA's reading of the regulation effectively adds in the word "contract" such that it would say: "statistically significantly higher [or lower] than the national average CAHPS measure *contract* score." *See* Pls.' Br. at 22. But the word "contract" appears nowhere in the regulation. 42 C.F.R. § 422.166(a)(3)(i)-(v). BCBSMA offers no explanation as to why the regulations unambiguously compel its interpretation of "national average" as the contract-level average except that doing so might push one of its contracts over the line into the next half-star category. The regulation directs CMS to only calculate a "national average CAHPS measure score," which CMS did. BCBSMA's assertion that CMS must calculate a national average of contract-level scores is just wrong.

Using the national average of all CAHPS measure contract scores without accounting for the individual enrollment in those contracts—as BCBSMA seeks to do here, *see* Pls.' Br. at 22—would make little sense. If CMS were to take the national average of CAHPS scores at the contract level, contracts with 2,000 enrollees would influence the national average as much as contracts with 500,000 enrollees. In this kind of average, scores in very large contracts would be underweighted and scores in very small contracts would be overweighted. An apt analogy would be if, in response to a request to compute a national average, you summed the average for each state, added those averages together, and divided by 50. Citizens in lower-population states like Wyoming would have larger per capita representation than citizens in, for instance, California. If CAHPS measure scores were calculated this way, it would not capture the true national average of CAHPS measure scores as the regulation intended. Instead, to reflect the average beneficiary

experience as it is required to do, CMS finds the weights contract-level scores for each CAHPS measure to reach the national average.

BCBSMA's definitions of "average" are helpful in establishing that BCBSMA is requesting that CMS use a contract-level average. Plaintiffs state, "Cambridge Dictionary defines 'average' as 'the result you get by adding two or more amounts together and dividing by the total number of amounts.'" Pls.' Br. at 20-21 (citing Cambridge Dictionary). BCBSMA contends that the numerator, the "two or more amounts" added together, should be the sum of the contract scores for a given measure. It thinks that the denominator, the "total number of amounts," should be the total number of contracts. Pls.' Br. at 21 ("the national average without any weighting is the simple average of all contract values . . . where each contract is weighted equally"). Adding up all of the contracts' measure scores and dividing by the total number of contracts yields a *per-contract* average measure score. Conversely, CMS's approach is to find the national average CAHPS measure score, consistent with the regulation. To calculate the national average of CAHPS measure scores, CMS takes the contract-level scores for each CAHPS measure, weights those scores by beneficiary enrollment, and then averages those scores. CMS, *Summary of Analyses for Reporting, MA & PDP CAHPS* 2 (Aug. 2024). For CMS's national average, the numerator is effectively the sum of the scores for all enrollees across the nation. The denominator is the total number of enrollees in the nation. This approach yields a national average, consistent with the regulation.

BCBSMA cites to a series of regulations that use the phrase "weighted mean" and "weighted average" to demonstrate that CMS "know[s] how to specifically require the use of a weighted average in regulatory text." Pls.' Br. at 23. In these other examples, it is necessary to state that CMS is calculating a weighted mean because CMS has elected to prioritize certain

factors. For instance, section 422.166(c)(1) & (d)(1), requiring the use of the "weighted mean" for calculating Part C and Part D summary star ratings, specify that improvement measures are to receive the highest weight. Not so here. The Secretary's instruction to calculate the "national average CAHPS measure score" is more circumscribed. In the case of CAHPS, CMS's goal is to calculate the national average CAHPS measure score. CAHPS is a survey of Medicare Advantage enrollees, meaning that the population of interest is Medicare Advantage enrollees. The national average CAHPS measure score is therefore the average of the Medicare Advantage enrollees nested in contracts. To reflect the average beneficiary experience, CMS reasonably accounts for enrollment when it finds the national average CAHPS measure score.

A "weighted average" is simply a type of average. If the steps CMS takes to account for beneficiaries from their contracts to determine an average qualifies as weighting by beneficiary enrollment as BCBSMA suggests, BCBSMA's national average contract score theory fares no better. By advocating that CMS use the national average of contract scores, BCBSMA is arguing that CMS should calculate the national average by weighting by contract, "where each contract is weighted equally." Pls.' Br. at 21; Pls.' Abernathy Decl. 11. This is simply a different type of weighting—one that BCBSMA would prefer but is not unambiguously compelled by the regulations. The Court should reject BCBSMA's efforts to have the Court substitute its judgment for CMS's and require CMS to calculate a national average contract score. Instead, the Court should uphold CMS's calculation of "the national average CAHPS measure score" because it was not contrary to law or arbitrary and capricious.

CONCLUSION

For the reasons explained above, CMS's actions were not arbitrary, capricious, and contrary to law, in violation of the APA. Therefore, the Court should grant Defendants' cross-

motion for summary judgment and deny Plaintiffs' motion for summary judgment. A proposed order is enclosed.

Dated: May 30, 2025

Respectfully submitted,

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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., Secretary of Health and Human Services, et al., *Defendants*.	Civil Action No. 25-0693 (TNM)

[PROPOSED] ORDER

UPON CONSIDERATION of Plaintiffs' Motion for Summary Judgment, Defendants' Motion for Summary Judgment, the parties' submissions, and the entire record herein, it is hereby

ORDERED that Plaintiffs' Motion is DENIED. It is further

ORDERED that Defendants' Motion is GRANTED. It is further

ORDERED that summary judgment is entered in Defendants' favor as to all claims in the Complaint. It is further

ORDERED that this matter is TERMINATED. This is a final, appealable Order.

Date: _____ _____

United States District Judge