

**IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF GEORGIA
BRUNSWICK DIVISION**

CLOVER INSURANCE COMPANY,

Plaintiff,

v.

DEPARTMENT OF HEALTH AND HUMAN SERVICES; CENTERS FOR MEDICARE & MEDICAID SERVICES; ROBERT F. KENNEDY, JR., in his official capacity as Secretary of the United States Department of Health and Human Services; MEHMET OZ, in his official capacity as Administrator, Centers for Medicare & Medicaid Services,

Defendants.

Civil Action No. 2:25-cv-142

**PLAINTIFF'S OPPOSITION TO DEFENDANTS'
MOTION FOR SUMMARY JUDGMENT AND
REPLY IN SUPPORT OF
PLAINTIFF'S MOTION FOR EXPEDITED SUMMARY JUDGMENT**

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INTRODUCTION

The Centers for Medicare & Medicaid Services (“CMS”) unlawfully determined Clover Insurance Company’s (“Clover”) 2026 Star Rating on seven grounds. Unable to defend its actions on the merits, CMS resorts instead to irrelevant and baseless speculation about Clover’s motives. The Court should grant Clover’s motion for summary judgment and deny CMS’s motion.

First, starting with Clover’s claim that CMS violated 42 U.S.C. § 1395w-23(o)(4)(A), CMS determined Clover’s 2026 *overall* Star Rating based on data that were not collected as part of Clover’s quality improvement program under § 1395w-22(e). *CMS does not dispute this dispositive point.* Correction of this error alone is sufficient to provide an overall 4-Star Rating.

CMS’s response would effectively nullify § 1395w-22(e) as a constraint on the Star Ratings that increase plans’ payments. Congress placed statutory guardrails on the quality rating used to determine *payments* to plans. But CMS reads those guardrails out of the statute. CMS argues that the restriction that the quality rating must be based on the data collected under § 1395w-22(e) does not constrain CMS’s use of Part D data at all, and that even with respect to Part C data, CMS may freely incorporate data outside § 1395w-22(e). Under CMS’s reading, Congress’s restriction on the data to underlie the payment-linked system imposes no meaningful limits.

CMS’s attempt to evade Congress’s guardrails fails because it ignores the distinction between determining payments and publishing information. Congress dictated that the Star Ratings used to determine plans’ payments are governed solely by § 1395w-23(o)(4)(A), which requires the system be “based on the data collected under section 1395w-22(e).” CMS is correct that it possesses separate, broader authorities to disseminate information about Part C and Part D plans. Clover’s interpretation is the only one that harmonizes all of these provisions without rendering any provision superfluous: CMS may disseminate whatever information it wishes to consumers under those other, broader authorities, but it is explicitly forbidden from using them to

determine the Star Ratings that dictate payments. Congress acted twice—in 2003 and 2010—to enact these targeted restrictions, purposefully ending CMS’s unbounded discretion to morph how plan “quality” and, in turn, billions of dollars in payments, are determined from year to year. CMS’s attempt to resurrect the unchecked discretion that Congress explicitly curtailed must fail.

Second, CMS determined Clover’s Star Rating using “types of data” not collected prior to “November 1, 2003.” This error, likewise, is alone sufficient to award Clover a 4-Star Rating.

Third, CMS violated its own notice-and-comment requirements in promulgating several measures; applied unlawful and arbitrary measures to Clover; and violated the private non-delegation doctrine by outsourcing evaluation of Clover to a private third party. This set of interrelated violations, too, is independently sufficient to raise Clover’s Star Rating to 4 Stars.

Fourth, and perhaps most significantly, CMS also failed to disseminate measures that it applied to reduce Clover’s Star Rating “by regulation,” as required by § 1395hh(a)(2). The measures’ specifications establish legal standards “governing the scope of benefits, the payment for services, or the eligibility of [plans] . . . to furnish . . . services or benefits,” and thus were required to be disseminated “by regulation” with notice and comment. 42 U.S.C. § 1395hh(a)(2). If ever there was any aspect of Medicare that required promulgation “by regulation,” it is these measure specifications. Most Medicare beneficiaries elect Medicare Advantage. And CMS itself admits (at 2) that the Star Ratings system is used to “distribute billions of dollars annually” to plans, which in turn use those funds to “offer supplemental benefits,” and determine whether plans are terminated from the program. 42 C.F.R. § 422.510(a)(4)(xi). Crucially, resolution of this claim alone in Clover’s favor would also raise its overall Star Rating to 4 Stars.

The math of this case is straightforward. Clover needs to prevail on only one of these four independent pathways to restore its 4-Star Rating. To keep Clover’s rating wrongfully depressed,

CMS must defeat all four. Thornton Suppl. Decl. ¶¶ 20-34. CMS’s arguments are all unavailing.

CMS’s violations have harmed Clover and eviscerated Congress’s vision of healthcare quality. CMS has effectively admitted as much: In a Final Rule issued this month, CMS conceded that the Star Ratings measures need reform to “level the playing field” for “smaller, regional” plans like Clover that deliver “improved health outcomes for beneficiaries,” and noted the need to reduce the system’s focus on mere “administrative effort or administrative skill” rather than clinical outcomes. 91 Fed. Reg. 17,384, 17,555-56 (Apr. 6, 2026). Putting action to those words, the Final Rule deletes 11 measures beginning next year—including several measures that Clover challenges here. *Id.* at 17,498. So CMS’s accusation that Clover wants to rewrite the system is backwards: Clover simply seeks to conform its 2026 Star Rating to Congress’s commands, applying the exact same focus on actual clinical outcomes that CMS itself concedes is necessary moving forward.

Finally, CMS accuses Clover of engaging in gamesmanship because Clover challenged only the measures that reduced its overall 2026 Star Rating. CMS tries to have it both ways. CMS cannot simultaneously demand (at 49) that Clover prove a concrete, redressable injury to establish standing to challenge each specific measure, and then attack Clover for targeting only the specific measures that actually injured it. *See, e.g., Elevance Health, Inc. v. Becerra*, 736 F. Supp. 3d 1, 18 (D.D.C. 2024) (rejecting Star Ratings claims for lack of standing where correcting the error would not improve the plan’s Star Rating). Clover targets the flawed measures that *harmed* it, because federal courts do not issue advisory opinions about measures that caused no harm. *See id.* Injury-specific litigation is not gamesmanship; it is Article III of the U.S. Constitution.¹

¹ Separate from this suit, Clover has urged CMS to confine *all* of the Star Ratings to a small set of valid clinical measures, to the extent the system remains in place at all. Clover’s consistent advocacy for a level, clinically focused playing field is the opposite of opportunistic cherry-picking. But because this is an Article III court and not the legislature, Clover seeks only the narrower judicial relief necessary to redress its specific, concrete injuries under the current system.

For all of these reasons and those that follow, Clover respectfully requests that the Court vacate Clover’s 2026 Star Rating and order CMS to recalculate that Rating without reliance on the unlawful measures identified herein by May 29, 2026, prior to the June 1, 2026 bid deadline.

ARGUMENT

I. CMS DETERMINED CLOVER’S 2026 STAR RATING BASED ON DATA THAT CONGRESS FORBADE

A. CMS Determined Clover’s 2026 Star Rating Based On Data *Not* Collected As Part Of Plans’ Quality Improvement Programs

CMS violated Congress’s command that the quality rating for a plan shall be determined according to a 5-star rating system “based on the data collected under section 1395w-22(e) of this title” as part of their quality improvement programs. 42 U.S.C. § 1395w-23(o)(4)(A). As Clover explained, and CMS does not dispute, CMS applied to Clover 10 measures—namely, C32, C33, D01, D05, D06, D08, D09, D10, D11, and D12—that use data *not* collected under § 1395w-22(e). Clover Br. 24-31. That error is dispositive, and alone sufficient to award 4 Stars.

In response, CMS argues (at 32-35) that Congress’s command in § 1395w-23(o)(4)(A)—that the Star Ratings be “based on the data collected under section 1395w-22(e)” —effectively restrains nothing at all. CMS claims the restriction provides no constraint on the agency’s ability to inject Part D prescription drug data into Congress’s statutory payment formula, no matter how broadly. And even for Part C data as to which CMS admits the restriction applies, the agency contends the phrase “based on” is non-exclusive, leaving CMS free to dilute the Star Rating with additional data outside § 1395w-22(e). Under CMS’s reading, a statutory provision enacted specifically to restrict agency discretion somehow provides no real constraint on CMS’s authority.

CMS’s theory fails because it is inconsistent with the statute’s “text, structure, and purpose.” *Org. of Pro. Aviculturists, Inc. v. U.S. Fish & Wildlife Serv.*, 130 F.4th 1307, 1314 (11th Cir. 2025). When Congress provided that CMS shall determine “[t]he quality rating for a plan,”

it gave that “quality rating” a specific statutory function: to determine *payments* to plans. 42 U.S.C. § 1395w-23(o)(4)(A). Whether plans benefit from those enhanced payments is *exclusively* determined by the authority Congress set forth in § 1395w-23(o)(4)(A), and no other. CMS cannot rely on any other authorities to determine the “quality rating” *that sets payments to plans*.

Specifically, under Congress’s first payment formula, a “qualifying plan” that receives quality bonus payments under § 1395w-23(o)(1)(C) is a plan with a “quality rating under paragraph (4) of 4 stars or higher,” *i.e.*, under § 1395w-23(o)(4)(A). *Id.* § 1395w-23(o)(3)(A)(i). Under Congress’s second formula, Congress awards higher-rated plans a greater rebate (additional revenue), with the rebate proportion determined by “quality rating under such system,” *i.e.*, “the system under section 1395w-23(o)(4)(A).” *Id.* § 1395w-24(b)(1)(C)(iii)-(v).

Turning to the plain text of § 1395w-23(o)(4)(A), Congress instructed CMS to determine quality ratings using data collected under § 1395w-22(e), and no other data. Congress *could have* drafted § 1395w-23(o)(4)(A) as CMS suggests, permitting other data: The “quality rating for a plan shall be determined according to a 5-star rating system (based on the data collected under § 1395w-22(e), **and such data as CMS deems appropriate**).”² But Congress chose the opposite construction. *Id.* § 1395w-23(o)(4)(A). This restriction in § 1395w-23(o)(4)(A) “undercut[s] the agency’s claim that [another provision] gives it power to [adopt] other measures.” *Heating, Air Conditioning & Refrigeration Distribs. Int’l v. EPA*, 71 F.4th 59, 67 (D.C. Cir. 2023). That is because when Congress mentions “one thing, like a grant of authority it . . . impl[ies] the preclusion of alternatives.” *Id.*; *see also Savage Servs. Corp. v. United States*, 25 F.4th 925, 936 (11th Cir. 2022) (explaining “*expressio unius*” canon means “omissions [a]re intentional exclusions”).

At bottom, CMS’s mistake is treating § 1395w-23(o)(4)(A) as if it were just a generalized

² Of course, this hypothetical statute resembles the language that Congress *deleted* in 2003 to rein in CMS. 42 U.S.C. § 1395w-22(e) (1997) (granting CMS authority to collect “appropriate” data).

information-dissemination provision. It is not. Structurally and textually, § 1395w-23(o) concerns payment increases, *i.e.*, “applicable percentage quality increases,” and paragraph (o)(4) specifies the “quality determination for application of increase.” 42 U.S.C. § 1395w-23(o)(4); *see also id.* §§ 1395w-24(b)(1)(C), (C)(iii) (similar). So when Star Ratings are used to move money from CMS to plans, Congress required a particular kind of rating—one “based on the data collected under section 1395w-22(e).” *Id.* § 1395w-23(o)(4)(A). CMS cannot evade that limit by pointing to separate provisions that let it *disseminate* broader comparative *information* for other purposes.

That should be the end of the story, but CMS raises a second argument. According to CMS, even if the Star Ratings (or more precisely, under CMS’s view, Star Ratings derived from Part C data) must be “based on the data collected under § 1395w-22(e),” the statute still permits CMS to rely on data *outside* § 1395w-22(e), because “based on” is a flexible term and refers not to the exclusive source of data, but the primary data source. That argument does not work either.

The meaning of “based on” is “context dependent.” *EPA v. Calumet Shreveport Refin., L.L.C.*, 605 U.S. 627, 644 (2025). Here, the context is a statutory restriction on the sources of information CMS may use to determine a payment-linked rating. In that context, “based on” does limiting work: It directs the decisionmaker to the relevant data source, not to that source plus other, different sources the decisionmaker prefers. The former is how the phrase operates in law. For example, a juror must “lay aside his impression or opinion and render a verdict *based on* the evidence presented in court,” *Irvin v. Dowd*, 366 U.S. 717, 723 (1961), *i.e.*, “find the required facts . . . and render a verdict *based on* those facts,” *United States v. Brown*, 996 F.3d 1171, 1187 (11th Cir. 2022) (*en banc*) (Courts “do not bless the use of metrics other than the evidence and the law to determine guilt.”)³ Or, review under the APA is “based on the record,” not agencies’ post-hoc

³ All emphases applied to quotations in this brief have been added.

explanations. *Fla. Power & Light Co. v. Lorion*, 470 U.S. 729, 743 (1985). Or, determining a ranking “based on enrollment” provides “specificity” by “stating precisely . . . which data values are of interest.” *Zuni Pub. Sch. Dist. No. 89 v. Dep’t of Educ.*, 550 U.S. 81, 98 (2007). “Based on” is often used in this exclusive sense. *See Streeter v. Dep’t of Pub. Safety*, 689 F. Supp. 3d 1312, 1328 (S.D. Ga. 2023) (Wood, J.) (using “based on” in this exclusive sense to refer to “only one factor”); *Georgia v. Wheeler*, 418 F. Supp. 3d 1336, 1373 (S.D. Ga. 2019) (Wood, J.) (similar). That is the plain meaning of “based on” in the context of directing a decisionmaker to permissible data: “Based on” means “to use *particular* ideas or *facts* to make a decision [or] do a calculation.” Ex. 2, *Based on*, MacMillan English Dictionary (for Advanced Learners) 99 (1st ed. 2002).

The statutory history also supports Clover’s plain-text interpretation. *See Bourdon v. DHS*, 940 F.3d 537, 543-44 (11th Cir. 2019) (explaining that “statutory history” provides key “context”). When Congress codified the Star Ratings in 2010, Congress was aware that (1) from 1998 to 2003, CMS had asserted unbounded authority to morph its measures of plan “quality” and performance standards annually by relying on “appropriate” data; and (2) Congress had reined in CMS in 2003 by constraining § 1395w-22(e) to remove that discretion. Clover Br. 13-17. All of that is undisputed. Congress also knew that CMS had circumvented these limitations by creating a new sub-regulatory Star Rating system in 2008, reasserting unlimited power to change measures of plan quality, using multiple *information dissemination* authorities. *Id.* Congress acted again in 2010 to curtail that purported unlimited discretion, requiring a quality rating “based on” the data in § 1395w-22(e) and *excluding* the very informational authorities CMS expressly relied on. *Id.*

CMS’s interpretation therefore makes no sense: CMS suggests Congress meant “based on” to straightjacket *some* of the *Part C* Star Ratings using § 1395w-22(e), while leaving CMS *free rein* over everything else. In effect, CMS’s reading renders the statute’s reference to § 1395w-

22(e) a nullity. 42 U.S.C. § 1395w-23(o)(4)(A). Congress wanted direct oversight and reporting before CMS changed its measures, *id.* § 1395w-22(e)(3)(B)(ii); it would make little sense for Congress to have included this restriction if CMS could simply claim that it was relying on other sources of data to achieve the same result without complying with the Act’s procedural safeguards.

And in context, the Act uses “based on” in this exclusive sense throughout. For example, CMS shall calculate increased rebates for Star Ratings “*based on* the system under section 1395w-23(o)(4)(A)” using an exclusive formula. *Id.* § 1395w-24(b)(1)(C)(iii), (v). There are many other examples. *E.g.*, *id.* § 1395w-23(k)(2)(B)(ii) (defining “[n]umerator based on difference between demographic rate and risk rate” as “equal to” defined formula); *id.* § 1395w-23(k)(2)(B)(iii) (similar); *id.* § 1395w-23(o)(3)(B)(i) (defining “qualifying county” as “based on the amount specified in subsection (c)(1)(B)”); *id.* § 1395w-23(n)(2)(C) (requiring ranking “based upon the level of the amount specified in subparagraph (A)(i)”); *id.* § 1395w-23(m)(4)(D) (“based on a methodology specified by the Secretary”); *see also id.* § 1395w-22(d)(3)(B) (defining “emergency medical condition based on prudent layperson” via 3 exclusive factors); *id.* § 1395w-22(g)(2)(B) (similar). CMS does not acknowledge—let alone explain—why “based on” is used throughout the Act in this exclusive sense, then non-exclusively in one provision—one that, again, Congress added to rein in CMS’s asserted unbridled discretion over payments. Instead, CMS identifies 2 provisions (at 29) using “based *entirely* on” and “based *only* on,” but the text shows *why* Congress had to use those exceptional phrases to clarify *which* sense of “based on” it was using.⁴

⁴ Both provisions concern capitation rates, which impact the benchmark that plans bid against. *Id.* § 1395w-23(c)(4)(A), (C). The first provision provides a “[p]ayment adjustment budget neutrality factor,” which seeks to ensure that program costs remain budget neutral. *Id.* § 1395w-23(c)(5). Congress did so by imposing a two-way “cap,” namely, “the aggregate of the payments under this part” (Part C) “shall equal the aggregate payments that *would have been made* under this part if payment were *based entirely* on area-specific capitation rates.” *Id.* § 1395w-23(c)(5). That is, CMS must adjust payments so that they do not differ from what *would hypothetically* result if

By contrast, when Congress wanted an input into the Star Ratings to be “based on” a factor in its *non-exclusive* sense, Congress provided *expressly* for non-exclusivity. Specifically, Congress enacted a specialized provision that CMS must average together two plans’ Star Ratings after the plans’ merger to combine the Star Rating, in circumstances where the “quality rating of the continuing contract is *based primarily on* a measurement period that is prior to the first year in which a closed contract is no longer offered.” *Id.* § 1395w-23(o)(4)(D)(ii). That is, if the Star Rating is *primarily* driven by older data, CMS must average the plans’ ratings. *Id.* CMS could have likewise specified Star Ratings to be “based primarily on” § 1395w-22(e), leaving ample breathing room for CMS to incorporate other data sources. Congress chose not to do so.

Most importantly, when Congress intends “based on” to carry a non-exclusive meaning in the Medicare Act, it expressly provides in the text the very authority to add on “appropriate” data that CMS tries to *impliedly insert* into the statute here. For example, Congress directs CMS to define classes for payments “based on age, disability status, and *such other factors as the Secretary determines to be appropriate.*” *Id.* § 1395mm(a)(1)(B). Congress did not use “based on,” as CMS suggests, to *itself* authorize CMS to use other factors; it said so explicitly. *Id.* Similarly, Congress instructs CMS to determine the “frequency for performing screening mammography, based on age

payment were based *solely* on the “area-specific capitation rates.” *Id.* Congress had to use the phrase “based *entirely* on area-specific capitation rates” because *by definition* the statute *always* determines payments by reference to the “area-specific capitation rates,” and so § 1395w-23(c)(5) must clarify that CMS is to *exclusively* consider those rates and *ignore* the other factors that by statute CMS usually *must* consider. *Id.* Similarly, Congress provided a detailed formula for “index[ing]” costs setting the capitation rate. *Id.* § 1395w-23(c)(4)(C)(iii)-(iv). Medicare mostly benefits seniors, but also benefits other populations (like the disabled). Congress provided a formula of *subtraction*, namely, “the index values shall be computed *based only on* the beneficiary population who are 65 years of age or older and who are not determined to have end stage renal disease,” *id.* § 1395w-23(c)(4)(C)(v), meaning that CMS must only use a population “carved out” from *all* beneficiaries. *Both* provisions command CMS to depart from the statute’s *normal* command to calculate a value, and use “entirely” and “only” to make clear that *modification*.

and *such other factors as the Secretary believes to be pertinent.*” *Id.* § 1395m(c)(2)(B)(i). And CMS must identify individuals “based on such medical conditions, diagnostic standards, and *other criteria as the Secretary specifies.*” *Id.* § 1395rr-1(e)(3)(B). CMS’s interpretation of “based on” as non-exclusive and *implicitly* permitting other appropriate data renders all of the italicized text surplusage. If “based on” itself leaves CMS discretion, the italicized text does no work.

That is not how courts interpret Congress’s grants of agency authority. An agency “has no power to act . . . unless and until Congress authorizes it to do so by statute.” *FEC v. Cruz*, 596 U.S. 289, 301 (2022). Whereas a contract’s *silence* on a given subject connotes a party’s *freedom* to act, *infra* at 13, *statutory* “silence” on authority over a subject *excludes* authority over that *unmentioned* subject, *see Loper Bright Enters. v. Raimondo*, 603 U.S. 369, 383, 411 (2024).

Finally, any lingering doubt is resolved by Congress’s specification that the 5-Star rating system be “based on *the* data collected under § 1395w-22(e).” Rather than using the more open-ended phrase “based on *data* collected under § 1395w-22(e),” Congress used the definite article “the,” which connotes exclusivity by acting “as a function word before a noun to *limit its application* to that specified by a succeeding element in the sentence.” Webster’s Third New Int’l Dictionary 2368-69 (1993); *Roop v. Parker Northwest Paving Co.*, 94 P.3d 885, 904 (Or. Ct. App. 2004) (same). Here, the noun “data” is limited by the modifier to *one* source, “the data *collected under § 1395w-22(e).*” *See Royal Palm Props., LLC v. Pink Palm Props., LLC*, 38 F.4th 1372, 1378 (11th Cir. 2022) (“the” connotes “no more than one”); *Regions Bank v. Legal Outsource PA*, 936 F.3d 1184, 1192 (11th Cir. 2019) (“the” means “single person” not third party); *Evanto v. Fed. Nat’l Mortg. Ass’n*, 814 F.3d 1295, 1298 (11th Cir. 2016) (“one particular” object); *see also Cochise Consultancy, Inc. v. United States ex rel. Hunt*, 587 U.S. 262, 272 (2019) (“only one”).

CMS’s own regulation confirms that “based on” does this limiting work. Section

422.162(c)(1) states that “CMS bases Part C Star Ratings on the type of data specified in section 1852(e) [§ 1395w-22(e)] and on CMS administrative data.” 42 C.F.R. § 422.162(c)(1); see also Clover Br. 26. If “based on” already carried an open-ended permission to rely on whatever other data CMS wished, CMS would have had no reason to append that second category of “CMS administrative data.” The regulation thus reflects CMS’s own understanding that “based on” identifies distinct and exclusive data sources. Tellingly, CMS never addresses this regulation in its brief, because it squarely shows that CMS “bases” its Part C Star Ratings on both the data Congress authorized and also unauthorized administrative data outside of § 1395w-22(e).

The decision in *Advance Trust & Life Escrow Services, LTA v. Protective Life Insurance Company* reinforces this conclusion. 93 F.4th 1315 (11th Cir. 2024). Although CMS relies on that case to argue against exclusivity, the court there emphasized that the meaning of “based on” is dictated by context. *Id.* at 1332-33. The context in *Advance Trust*—a private contract featuring the open-ended phrase “based on our expectations,” devoid of any “mandatory obligation” to act—naturally supported a looser reading. *Id.* at 1322, 1331-33. But the court explicitly acknowledged that in other contexts, “based on” had been construed exclusively. *Id.* at 1333. So CMS’s notion that “based on” is *always* non-exclusive cannot be right. *Id.*; *supra* at 6-12. Moreover, the court explained that, even when used non-exclusively, “based on” connotes “the fundamental part” and the “principal ingredient.” *Advance Trust*, 93 F.4th at 1333; see also *Base*, The American Heritage Dictionary 148 (4th ed. 2000) (“The fundamental principle or underlying concept of a system.”).

Advance Trust thus reinforces Clover’s point: because *this* case involves a restriction on agency authority, defined by the definite article “the,” set within a statutory context that treats “based on” as exclusive, and which dictates billions in federal obligations, the context demands an exclusive reading. *Supra* at 6-12. And, even under *Advance Trust*’s “fundamental part” or

“principal ingredient” definition, “based on” refers to the “gravamen” and “primary explanation for and driver,” which *excludes* any other “significant . . . considerations” that drive an agency’s decision in “significant part.” *Calumet*, 605 U.S. at 644. CMS’s reliance in “significant part” on data beyond § 1395w-22(e) clearly is impermissible. *Id.*; *Oklahoma v. EPA*, 605 U.S. 609, 622 (2025) (“based on” excludes other factors playing “significant part” in decision). CMS’s measures undisputedly rely in “significant part,” and indeed, *mostly* on data outside § 1395w-22(e). *Significant*, Webster’s Third New Int’l Dictionary 2116 (1993) (having “influence or effect”).

For all of these reasons, CMS’s broader authorities to *disseminate information* are beside the point. Under Part C, CMS has authority to “broadly disseminate information” to beneficiaries on their “coverage options,” 42 U.S.C. § 1395w-21(d)(1), including “mailing” a “list” of plans and “benefits” and “quality and performance indicators”—as in CMS’s annual “Medicare & You” guide, *id.* § 1395w-21(d)(4). CMS has parallel Part D authority to carry out “similar . . . activities” to § 1395w-21(d), including disseminating information regarding Part D drug benefits, plan “quality and performance,” and “consumer satisfaction surveys.” *Id.* § 1395w-101(c)(3)(A).⁵ But Congress prohibited CMS from using these authorities to determine a plan’s quality rating under § 1395w-23(o)(4) “for application of increase”—*i.e.*, for payment. *Supra* at 6-13.

That choice was intentional. As explained, when Congress codified the Star Rating system for *payment* purposes in 2010, it legislated against a known backdrop: namely, CMS’s prior attempts to shift plans’ performance standards annually from 1998 to 2003, and then to resurrect that authority through sub-regulatory Star Ratings from 2008 to 2010, *explicitly* anchoring them to the *exact* information dissemination authorities CMS invokes here: §§ 1395w-21(d)(4) and

⁵ CMS also points out (at 32-33) that § 1395w-101(c)(3)(A)(v) allows CMS to disseminate information collected under CMS’s § 1395w-104(d) authority to “conduct consumer satisfaction surveys with respect to . . . prescription drug plans” similar to surveys conducted under Part C.

1395w-101(c)(1). *Supra* at 9-12; 83 Fed. Reg. 16,440, 16520 (Apr. 16, 2018) (citing these authorities). So CMS’s claim (at 30-32) that Congress intended to *implicitly* include those exact authorities within § 1395w-23(o)(4)(A) is textually, structurally, and historically baseless. Because CMS publicly relied on these broader authorities from 2008 to 2010, yet Congress chose to “expressly incorporate” only the restricted data pool of § 1395w-22(e), it is “inescapable that Congress’s decision to exclude [the other provisions] was intentional.” *Johnson v. White*, 989 F.3d 913, 918 (11th Cir. 2021); *see also United States v. Hurtado*, 779 F.2d 1467, 1475 (11th Cir. 1985) (a court “may not import into the statute a provision Congress elected not to include”).

Section 1395w-22(e) reinforces that Congress’s choice was intentional. Section 1395w-22(e)(3)(B)(i) limits permissible data collected as part of plans’ quality improvement programs to “the types of data that were collected . . . as of November 1, 2003”; § 1395w-22(e)(3)(B)(ii) forbids changing those data without a report to Congress; and § 1395w-22(e)(3)(B)(iii) provides that these two restrictions shall not be “construed as *restricting* the ability of the Secretary to carry out the duties under section 1395w-21(d)(4)(D) of this title.” 42 U.S.C. § 1395w-22(e)(3)(B)(i)-(iii). Putting this all together, Congress restricted CMS’s ability to alter data that plans collect in their *quality improvement programs* under § 1395w-22(e), but those *restrictive provisions* do *not* restrict CMS’s *separate* authority to conduct broader *information dissemination* activities under § 1395w-21(d)(4). Thus, when Congress anchored the payment formula to § 1395w-22(e), it knew exactly what it was doing: It invoked a provision that explicitly acknowledges—but deliberately walls off—CMS’s broader dissemination authority under § 1395w-21(d)(4)(D). *Id.*

Clover’s interpretation is the only one that harmonizes the Medicare Act, allowing each provision to operate fully, without rendering any part superfluous. CMS’s reading, by contrast, creates an irreconcilable conflict: By using its “informational” authority to bypass the payment

limitations of § 1395w-22(e), CMS erases Congress’s carefully constructed payment guardrails. CMS’s reading renders Congress’s 2003 and 2010 amendments superfluous, violating the rule that “a statute should be construed so that effect is given to all its provisions, so that no part will be inoperative or superfluous.” *Rubin v. Islamic Republic of Iran*, 583 U.S. 202, 213 (2018).

CMS did not determine Clover’s Star Rating “based on the data collected under section 1395w-22(e),” including the 10 measures that injured Clover. 42 U.S.C. § 1395w-23(o)(4)(A). (More generally, CMS’s system relies in “significant part” (54%) on data outside § 1395w-22(e).⁶) CMS must redetermine Clover’s 2026 Star Rating without the inclusion of those 10 measures.

B. CMS Determined Clover’s 2026 Star Rating Utilizing Measures Based On Types Of Data Not Collected As Of November 1, 2003

CMS committed another, independent error: CMS determined Clover’s 2026 Star Rating based on data that are not the “types of data that were collected by the Secretary [of HHS] as of November 1, 2003” under plans’ quality improvement programs, including in measures C15, C27, C32, C33, D01, D05, D06, D08, D09, D10, D11, D12. *Id.* § 1395w-22(e)(3)(B)(i).

CMS’s primary response is to recycle its argument (at 35-37) that Congress’s restriction in § 1395w-22(e) applies only to CMS’s Star Ratings derived from Part C data, not Star Ratings derived from Part D data, and also permits *other* data *even under* Part C. This move is key, because CMS believes it allows CMS to end-run Congress’s “types of data” restriction in § 1395w-22(e) for any data collected *outside* of that provision. But, as explained, CMS cannot evade the restrictions in §§ 1395w-23(o)(4)(A) and 1395w-22(e) in this manner. *Supra* at 6-15.

Notably, CMS provides *no* other defense for 10 of the measures Clover put at issue in this

⁶ CMS’s preferred calculation of the system (at 29 n.10) excludes measures applicable to “special needs plans,” yielding 78 total weighted points in the Star Rating system. AR166-82; 42 C.F.R. §§ 422.166(e)(1), 423.186(e)(1). Of those, 42 of 78 points (54%) are determined by data outside § 1395w-22(e). AR166-82. (And even *just considering Part C*, 29.4% of *those* Part C Star Ratings (C28 to C33) by weight are derived from data collected outside of § 1395w-22(e). *Id.*)

claim (C32, C33, D01, D05, D06, D08, D09, D10, D11, D12). CMS does not contend those measures use HEDIS, HOS, or CAHPS data collected as part of plans' quality-improvement programs as of November 1, 2003. CMS offers no response, beyond its flawed statutory theory. And resolving *these measures*, standing alone, in Clover's favor, raises its quality rating to 4 Stars.

As to the remaining measures that CMS actually defends, CMS argues (at 36-37) that the "types of data" that it collected prior to "November 1, 2003" are any data that are collected within CMS's "measurement systems" as of 2003, *i.e.*, the HEDIS, HOS, and CAHPS systems. This argument commits the exact same error as CMS's primary one: It nullifies the guardrails Congress placed around plan payments. Under CMS's view, if CMS wished to begin measuring plans based on injuries from firearms in the home or other controversial issues, it could do so, simply by adding those data to these systems. That interpretation transforms a deliberate congressional limitation into a blank check. Instead, the "types of data" collected as of November 1, 2003 under § 1395w-22(e) means data in common with the data collections, *i.e.*, the survey questions, as of 2003.

CMS objects (at 38) that Clover's interpretation leaves unclear the necessary degree of commonality among survey questions in 2003 and 2024-2025. But, as always, the analysis is resolved by the "text, structure, and purpose." *Org. of Pro. Aviculturists*, 130 F.4th at 1314. The "types" of data refers to data with the "common traits or characteristics" of the data CMS collected in 2003. *Type*, The American Heritage Dictionary (4th ed. 2000). And it is undisputed that CMS *only* has authority to collect data on "quality, outcomes, and beneficiary satisfaction" under § 1395w-22(e), meaning the "common traits or characteristics" must be narrower than "quality," "outcomes," or "satisfaction," to avoid rendering the "types of data" restriction surplusage. *See Rubin*, 583 U.S. at 213. CMS makes exactly that mistake: It treats the statute as preserving only the broad system names—HEDIS, HOS, and CAHPS—while allowing CMS to rewrite the actual

performance criteria inside those systems at will. That reading nullifies Congress’s limitation.

The best reading given the text, structure, and purpose is that CMS changes the “types of data” when it changes criteria for evaluating plan performance. Congress neither chose to rely on CMS’s proffered terminology of “systems” (broader), nor required that CMS maintain the exact same “questions” or “data” (narrower): It focused on *types* of data *within* quality, outcomes, and satisfaction. And Congress enacted those limitations in 2003 for a specific purpose: CMS had asserted authority to unilaterally morph its data collections and minimum performance criteria each year however it found “appropriate.” Clover Br. 11-20; *AvMed*, 2021 WL 2209406, at *10. Congress incorporated those exact limitations into the Star Rating system in 2010 to address the same concern, namely, that CMS was changing criteria for plan performance. Clover Br. 11-20.

CMS has now produced with its brief a non-public, extra-record survey (Dkt. 50-1) from 2003, showing that for some measures (C05, C22, C25), CMS *has not altered* plans’ performance criteria, contrary to Clover’s prior arguments—which relied on the administrative record and public records. Clover thus withdraws this “types of data” challenge to C05, C22, and C25. By contrast, the record makes clear two measures (C15 and C27) do violate § 1395w-22(e)(3)(B).⁷

Reducing the Risk of Falling (C15): CMS defines this as the percentage of beneficiaries “who had a fall or had problems with balance or walking in the past 12 months, who were seen by a practitioner in the past 12 months (denominator) and who *received a recommendation for how*

⁷ CMS’s Local Rule 7.1(b) objection fails. Clover identified the challenged measures in its motion, what data those measures were based on, and the complete absence of 2003 data collections remotely resembling those data. Clover Br. 31-36. CMS’s argument (at 41) that it has to “comb through about 60 pages of surveys to rebut vague and novel allegations” is therefore wrong: Clover cited the publicly available 2003 surveys, which confirm that *nothing* even resembling CMS’s 2024-2025 survey questions existed in 2003. Clover Br. 34 n.7 (citing Exs. H, I, and J). Indeed, that deficiency is *why* CMS is now arguing that surveys about foot “sores” are actually about falls, and that surveys about “listening” to patient are actually about coordinating lab results. *Infra* at 19-21. CMS’s positions are baseless, and Clover had no way to anticipate them in its motion.

to prevent falls or treat problems with balance or walking from their current practitioner.” AR209. In turn, the underlying, current HOS survey questions concern whether a person did fall, whether she had “problems with balance or walking,” and the determinative issue: whether a provider has “done anything to help prevent falls or treat problems with balance or walking,” such as suggest a cane, walker, physical therapy, or a vision or hearing test. *Id.*

CMS does not dispute (at 42) that it did not collect data concerning *actual* falls or providers *doing anything* to prevent falls as of November 1, 2003. *See* Dkt. 34-10 (reflecting 2003 HOS survey). Rather, CMS asserts (at 42) that in its 2003 HOS survey, CMS asked questions about health conditions affecting “walking” and “legs” and that such issues are “correlated with fall risk.” But the questions CMS cites from 2003 asked whether a beneficiary suffered limitations with walking “more than a mile” or “one block”; whether she had “difficulty . . . walking”; and whether there were issues in the last “4 weeks” with “numbness or loss of feeling in your feet,” “tingling or burning” in the feet, or “sores or wounds on your feet that did not heal.” Dkt. 34-10 at 4, 8. That is, they concern *health status exclusive of falls*. *Id.* By contrast, the current questions concern providers *taking* action to prevent *falls*, *i.e.*, whether the provider has “done anything to help prevent falls.” AR209. That difference between measuring health status prior to 2003, and specific interventions to prevent falls today, is critical: It is a different performance criterion, not a mere wording update within the same “type[] of data.” 42 U.S.C. § 1395w-22(e)(3)(B)(i). CMS therefore could not adopt that new criterion without first reporting the change to Congress.

Care Coordination (C27): CMS defines this as how well the plan coordinates care among providers. AR227. CMS asserts (at 42) that both 2003 and 2025 CAHPS surveys “solicit information about how familiar a physician was with important information about the patient,” and calls the changes over time mere “changes to the wording.” Simply comparing the 2003 and

2025 survey questions that CMS now relies on in its Star Ratings shows that CMS is incorrect.

2003 Survey Questions	2025 Care Coordination Questions
Does your personal doctor or nurse understand how any health problems you have affect your day-to-day life?	In the last 6 months, when your personal doctor ordered a blood test, x-ray or other test for you, how often did someone from your personal doctor's office <u>follow up to give you those results?</u>
In the last 6 months, how often did doctors or other health providers listen carefully to you?	In the last 6 months, when your personal doctor ordered a blood test, x-ray or other test for you, how often did you <u>get those results as soon as you needed them?</u>
In the last 6 months, how often did doctors or other health providers spend enough time with you?	In the last 6 months, did you get the help you needed from your <u>personal doctor's office to manage your care among these different providers and services?</u>
In the last 6 months, how often did doctors or other health providers explain things in a way you could understand?	In the last 6 months, how often did your personal doctor seem informed and up-to-date about <u>the care you got from specialists?</u>
Does your personal doctor or nurse know the important facts and decisions about your health care?	In the last 6 months, when you talked with your personal doctor during a scheduled appointment, how often did he or she have your medical records or other information about your care?
In the last 6 months, how much of a problem, if any, was it to get the prescription medicine you needed?	In the last 6 months, how often did you and your personal doctor talk about all the prescription medicines you were taking?
Of the times when you needed prescription medicines in the last 6 months, how often were you able to get the medicine?	

Dkt. 50-1 at 11, 15, 17; AR227-28. Under the 2003 questions, plans were evaluated on patients' perceptions of whether their clinicians understood them, listened carefully, explained things clearly, and spent enough time with them. Dkt. 50-1 at 11, 15, 17. Under the current measure, plans are evaluated on whether the doctor's office performed coordination functions, including following up on test results, timely delivering third-party test results, and managing care across providers. AR227-28. Again, that is a different performance criterion, not a mere wording update.

Finally, turning from the 12 measures that Clover scored 3-Stars or less to CMS's system

more generally, CMS *does not* contest Clover’s showing that the *overwhelming majority* (67%) of the Star Rating is determined by data *not* collected as part of plans’ quality improvement programs as of November 1, 2003. Clover Br. 34 n.6.⁸ No wonder. Measures C28 to C33 and D01 to D12 are not collected in the HEDIS, HOS, and CAHPS systems. AR296-304. And while measures C17 to C21 are based on 2024 HEDIS technical specifications, CMS’s 2003 HEDIS surveys did not collect data on these subjects, and CMS has never argued otherwise. Clover Br. 34 n.6.⁹

In sum, CMS did not determine Clover’s 2026 Star Rating based on the “types of data that were collected by the Secretary [of HHS] as of November 1, 2003,” including with respect to at least the 12 measures that harmed Clover’s 2026 Star Rating. *See supra* at 16. CMS should be required to redetermine Clover’s 2026 Star Rating without inclusion of those measures.

II. CMS DETERMINED CLOVER’S 2026 STAR RATING BY APPLYING MEASURES THAT HAD NOT GONE THROUGH NOTICE-AND-COMMENT AS REQUIRED BY CMS’S REGULATIONS

CMS also determined Clover’s 2026 Star Rating by applying three measures (C04, C05, and C23) that had not gone through the two-step notice-and-comment process CMS’s regulations require. Before adding a “new” measure or substantively updating a measure, CMS must first “announce potential new measures and solicit feedback” through the “annual call” process, which

⁸ Today, at least 52 points (67%) of the weighted average Star Rating are determined by data *not* collected as part of plans’ quality improvement programs as of November 1, 2003. AR209, 212-20, 227-39, 240-65 (denoting that measures C15, C17 to C21, C27 to C33, and D01 to D12 are based on data not collected prior to November 1, 2003); *see also* AR286-87 (relevant weights).

⁹ Measure C17 reflects the percentage of “discharges” who had their “medications . . . reconciled” within “30 days after discharge.” AR212. Measure C18 reflects the “percentage of acute inpatient stays . . . that were followed by an unplanned acute readmission for any diagnosis within 30 days.” AR213. Measure C19 reflects the percentage of members with heart disease who “were dispensed at least one high or moderate-intensity statin medication.” AR215. Measure C20 reflects the “average of the rates for” certain “transitions in care.” AR217. Measure C21 reflects the percentage of ER visits “who have multiple high-risk chronic conditions who had a follow-up service within 7 days of the ED visit.” AR219. There is *nothing* in the pre-2003 HEDIS data having anything to do with these performance criteria. Dkts. 34-11, 34-20 at 22-27 (HEDIS data).

CMS carries out by posting a notice of its proposal on its website. 42 C.F.R. § 422.164(c)(2), (d)(2). CMS must “*then subsequently* . . . propose and finalize new measures” or updated measures through Federal Register rulemaking. *Id.* CMS failed to follow this two-step procedure.

Improving or Maintaining Physical Health (C04); Improving or Maintaining Mental Health (C05): CMS did not follow the first step for “new” measures. CMS must “announce potential new measures and solicit feedback” through the annual call process, and only “then subsequently” propose and finalize the measure through rulemaking. *Id.* § 422.164(c)(2). CMS skipped that first step and jumped straight into rulemaking. 85 Fed. Reg. 9,002, 9,045 (Feb. 18, 2020). CMS then removed these measures from the Star Ratings system for years, reintroducing them as “new” measures in the 2026 Star Ratings, all without first undertaking the “annual call” step in its process, *i.e.*, posting on its website for comment as the regulations require. AR158, 286.

CMS’s response does not show otherwise. CMS points (at 45-47) to a set of “annual call” documents obliquely referencing *old* versions of the measures, and discussing the general policy objective of “moving toward more specific [measures]” of *specific* health issues like “depression, substance abuse, fatigue, [and] mobility” rather than higher level measures.¹⁰ Nowhere did CMS mention or propose the actual changes to the measures that rendered them “new,” case-mix adjustment or minimum required denominator,¹¹ which CMS later proposed *solely* through formal rulemaking. 85 Fed. Reg. at 9,045. The “annual call” simply stated CMS was considering doing *something*, unrelated to what it *actually* proposed and did to render the measures “new.” *Id.*

¹⁰ CMS, *Advance Notice of Methodological Changes for Calendar Year (CY) 2020* at 140 (Jan. 30, 2019), <https://tinyurl.com/yjh323b3> (“Advance Notice”); CMS, *Announcement of Calendar Year (CY) 2020 Medicare Adv. Capitation Rates*, 160 (Apr. 1, 2019), <https://tinyurl.com/mthn8js8>.

¹¹ “Case-mix adjustment” is how CMS compares variations in the underlying health characteristics of beneficiaries across plans, which CMS does to “ensure fair and comparable contract-level scores.” 85 Fed. Reg. at 9,045. The “minimum required denominator” is the minimum number of responses necessary for a measure to be counted for any given plan. *See* AR190-91.

CMS's action does not amount to an "announce[ment]" of the "potential new measure[s]" and "solicit[ing] feedback" through the annual call process as its regulation required. 42 C.F.R. § 422.164(c)(2). To "announce" is "[t]o make publicly known" or "to proclaim formally." Black's Law Dictionary (12th ed. 2024); *Republican Party of Minn. v. White*, 536 U.S. 765, 770 (2002) (noting that "announce" means to make clear one's "current position"). CMS never "announced" or "made publicly known" the "potential new measures," including the aspects of C04 and C05 that actually made them new, through the annual call, as required. 42 C.F.R. § 422.164(c)(2).

CMS also ignores its regulation governing "new" measures, 42 C.F.R. § 422.164(c)(2), instead relying (at 46-47) on § 422.164(d)(2) governing substantive updates. But that doesn't help CMS. First, CMS *itself* determined these were "new" measures; indeed, CMS *removed* them from the Star Ratings for two years *as required* for "new" measures. AR158, 286; 86 Fed. Reg. 5,864, 5,919 (Jan. 19, 2021) (removing measures for 2 years as "new"); 42 C.F.R. § 422.164(c)(3) (requiring new measures be listed online for "2 years"). CMS's counsel's *post hoc* rationalization of these "new" measures as substantive updates is irrelevant. *Am. Textile Mfrs. Inst., Inc. v. Donovan*, 452 U.S. 490, 539 (1981) (finding "post hoc rationalizations" irrelevant). Second, even if CMS were right to treat these as substantive updates, it still would lose. Section 422.164(d)(2) likewise requires CMS to "*propose and finalize these measures,*" including soliciting "feedback on *whether to make substantive measure updates* through the [annual call] process." 42 C.F.R. § 422.164(d)(2). Those requirements plainly refer to the *actual* revised measures and updates, not to some other, unrelated changes. *Id.* Otherwise, the notice step would impose no real constraint.

Getting Appointments and Care Quickly (C23): CMS violated its regulations by substantively updating this measure without required rulemaking. 42 C.F.R. § 422.164(d)(2).

CMS argues (at 47-49) that no rulemaking was required because its change was merely a

“non-substantive” update. It was not. CMS eliminated the only question that measured whether patients are seen promptly at their appointments, removing: “In the last 6 months, how often did you see the person you came to see within 15 minutes of your appointment time?” Dkts. 34-13 at 178, 34-14 at 72. That left just two questions about how quickly beneficiaries can get on the calendar/schedule to see a provider,¹² not whether the beneficiary is *quickly seen once they arrive* at an appointment. Compare Dkt. 34-12 at 70 (2024 Tech. Notes) with AR222 (2026 Tech. Notes). CMS’s own regulations define non-substantive updates as narrow, technical adjustments, including updates that (1) “[n]arrow the denominator or population” of the measure, (2) “[d]o not meaningfully impact the numerator or denominator of the measure,” (3) “[u]pdate the clinical codes with no change in the target population or the intent of the measure,” (4) provide “clarifications” (like “additional instructions” or “[c]larifying documentation requirements”), or (5) “[a]dd alternative data sources or expand modes of data collection.” 42 C.F.R. § 422.164(d)(1).

CMS contends (at 48) that its definition of “non-substantive” updates is non-exhaustive because it uses the word “include.” But even if the five categories in CMS’s regulation are read as non-exhaustive examples, they cannot be read so broadly as to swallow up the separate category of substantive updates. Rather, the five categories are “illustrative of . . . the general principle” of a non-substantive update. *Ala. Educ. Ass’n v. State Superintendent of Educ.*, 746 F.3d 1135, 1157 (11th Cir. 2014); see *Stansell v. FARC*, 704 F.3d 910, 915 (11th Cir. 2013). Here, the categories of non-substantive updates change the *process* of measurement (updating codes, clarifying instructions, adding data sources)—not *what is being measured*. 42 C.F.R. § 422.164(d)(1). That coheres with the plain meaning of “substantive” as of “practical importance,” “considerable,” or

¹² These questions are: (1) “In the last 6 months, how often did you get an appointment for a check-up or routine care as soon as you needed?” and (2) “In the last 6 months, when you needed care right away, how often did you get care as soon as you needed?” AR222.

“substantial.” *Substantive*, Merriam-Webster Dictionary (11th ed. 2003).

CMS provides no explanation for how removing the only question that measured whether patients are seen promptly upon arrival at appointments is anything like the narrow, immaterial changes that CMS deemed non-substantive, such as “clarifications,” updating “codes,” “additional instructions,” or “clarifying documentation requirements.” 42 C.F.R. § 422.164(d)(1). It is not. Indeed, this will often be one of the *most important* aspects of an appointment as a “practical” matter: Whether a routine annual checkup occurs September 1 or 30 is plainly less important than whether it takes 2, 3, or more hours to be seen, particularly for frailer beneficiaries and those reliant on others to drive. This update changes how plans and providers expend resources, by *rewarding* overbooking *earlier* appointments, even if it takes hours for the beneficiary to be seen.

All of that is of “practical importance,” “considerable,” and “substantial.” *Supra* at 23-24. And it is far more like the categories CMS specified *are* substantive, because they “substantively change the nature of the measure.” 83 Fed. Reg. at 16,534. For example, a change that “meaningfully impact[s] the numerator” is substantive because it changes what the measure is measuring, here, whether CMS measures quick scheduling or also measures efficiently being seen at the office (the numerator) out of 100 total points (the denominator).¹³ CMS’s change also degraded the measure’s reliability. Dkt. 34-13 at 178-79. That change is clearly substantive.¹⁴

For all these reasons, these 3 measures should be excluded from Clover’s 2026 Star Rating.

¹³ CMS argues it did not change the “numerator.” That is both irrelevant, *supra* at 23-24, and wrong. CMS changed the numerator because it changed what the plan’s score, the numerator, *means*: from a number from 1 to 100 referring to *appointment scheduling and efficiency at the appointment*, to a number from 1 to 100 referring *solely to speed of appointment scheduling*.

¹⁴ CMS argues (at 48) that Clover failed to comment on its 2024 Advance Notice. But CMS is conflating concepts: A party need not comment on a rule to later challenge the *application* of that rule to a party. *Koretov v. Vilsack*, 707 F.3d 394, 399 (D.C. Cir. 2013) (Williams, J., concurring). And that is doubly true given that CMS itself *failed to solicit comment* through formal rulemaking.

III. CMS DETERMINED CLOVER'S 2026 STAR RATING BY APPLYING UNAUTHORIZED, ARBITRARY MEASURES

CMS also applied five measures (C33, D01, D08, D09, D10) to Clover that are entirely disconnected from plan quality and are thus contrary to law and arbitrary and capricious.

Before proceeding to the merits, a word is necessary about CMS's assertion (at 49) that the Court need not address Clover's challenges to these 5 measures (or its private non-delegation challenge to C32) because removing these six measures "would not improve [Clover's] [overall] score" to 4 Stars. CMS is missing 3, independent points. First, it appears that CMS erred in its calculation, and resolving these 6 measures in Clover's favor *would in fact* increase its Star Rating to 4 Stars. Thornton Suppl. Decl. ¶¶ 20-27.¹⁵ Second, even accepting CMS's calculation, if Clover prevails on *some but not all* of the measures above, *supra* at 6-25, prevailing on some or all of these 5 (or 6) measures would raise Clover's overall Star Rating to 4.0 Stars. Thornton Suppl. Decl. ¶¶ 29-30. Third, CMS also publishes Clover's *measure-specific* Star Rating for *each* of these 6 measures, including in its Plan Finder. *Id.* ¶¶ 9-12; Clover Br. 20; Dkt. 34-1 ¶¶ 25, 32, 34; Dkt. 34-5. That publicly impugns Clover's performance on these *specific* measures, and Clover seeks correction on that basis, irrespective of the overall Star Rating. Thornton Suppl. Decl. ¶¶ 9-12.

A. CMS Unlawfully Determined Clover's 2026 Star Rating Using Medication Adherence Measures That Are Disconnected From Clover's Quality

CMS's application of its 3 Medication Adherence measures (D08, D09, and D10) violates the statute and is arbitrary and capricious because it fails to measure adherence to *prescribed* drugs.

On this issue, much is undisputed. First, CMS does not dispute that the relevant measure

¹⁵ As explained in the declaration, Clover's and CMS's calculations appear to differ on certain narrow, technical details. *Id.* Given CMS's failure to produce its model and its exclusive control over certain data used in its modeling, Clover's reconstruction is the best available from the administrative record consistent with CMS's rules. And, in any event, CMS still must defeat Clover's *other* independent bases supporting review of these six measures. *Supra* at 6-21.

of “quality,” medication adherence, refers to patients “who adhere” to a “prescribed” drug therapy, *i.e.*, members “with a prescription” who pick up prescription drugs. AR252-58. Second, CMS does not dispute that, to accurately measure adherence, it would be necessary to track *whether* a prescription *still exists*, *i.e.*, whether a prescription is medically discontinued by a prescriber. CMS Br. 55-58. Third, CMS does not dispute that, because CMS does not collect data about prescription discontinuations, these measures cannot distinguish treatment discontinuation from non-adherence and do, in fact, code discontinuation as non-adherence. *Id.* Finally, CMS does not dispute it coded 733 Clover members non-adherent who had their prescriptions discontinued. Clover Br. 42.

These measures do not measure adherence to *prescribed* drugs because they systematically misclassify physician-directed discontinuation as non-adherence. CMS’s contrary arguments fail.

1. CMS’s Application Of The Medication Adherence Measures Violates The Statute And Is Arbitrary And Capricious

CMS’s application of these measures to Clover was contrary to law and arbitrary and capricious. CMS is only authorized to disseminate a “*quality rating*” for a plan. 42 U.S.C. § 1395w-23(o)(4)(A); *see also id.* § 1395w-22(e)(3)(B)(i) (similar). CMS argues (at 56) that a measure of *actual* adherence to *prescribed* medications could measure a plan’s “quality.” Clover accepts that for purposes of this case. But CMS has never argued—nor could it—that a measure of the number of members taking *un-prescribed* medications measures “quality.” By simply tracking whether pharmacies keep dispensing drugs, regardless of whether the prescription actually remains in place, CMS’s measures violate the statute’s command. Clover Br. 41-48.

CMS’s overarching response (at 56-58) is that CMS has “consistently been forthright” about its data limitations and built the best measures it could from the data it has access to, which does not include treatment discontinuations. But CMS conflates two inquiries. CMS is correct (at 56) that it need not create a “perfect” measure. But CMS must obey the statute’s command to use

a “quality” rating, which CMS has defined for these measures to mean adherence to *prescribed* drugs. AR252-58. CMS’s measures do not measure that, as they have *no way* of identifying when a medication remains “prescribed” or not. CMS’s “forthrightness” in admitting these critical faults underscores *why* CMS violated the statute’s constraints to measure plan “quality.”

So CMS’s explanations (at 56-57) for *why* it chose not to collect the necessary data are irrelevant. Even if CMS’s explanations were reasonable, they show why more data is needed for accurate measures. That is a reason *not to use* the measures, not a reason to use *broken* measures.

Nor does the record support CMS’s newfound, post-hoc explanation (at 58) that collecting discontinuation data was impossible. In 2012, CMS *considered collecting* such data, and said only that the needed controls for data quality and privacy remained “unclear,” and deferred the issue for “future discussions” with plans to “resolve these questions.” AR144-45. In 2018, CMS again acknowledged the data problem remained “unclear” and proceeded without solving it. 83 Fed. Reg. at 16,533. That shows a decision to proceed despite a known defect, not any impossibility.

CMS provided *one* explanation for how its measures might nonetheless address whether a drug is taken *as prescribed*: “In the case of changes in therapy (such as holding or discontinuing medication), we believe that the 80 percent compliance threshold incorporates these circumstances as the ideal compliance expectation is 100 percent.” 83 Fed. Reg. at 16,553. As Clover has explained, that arbitrary “compliance threshold” does nothing to alter the fundamental flaw: Regardless of the arbitrary value CMS selects (50%, 60%, 80%), CMS still *cannot* distinguish non-adherence and discontinuation. Clover Br. 44. Instead of meaningfully disputing that,¹⁶

¹⁶ CMS cites (at 59 n.22) an extra-record study showing 80% is sometimes used to track adherence. But that study supports *Clover*: It shows that scientists, unlike CMS, track whether a drug *actually remains prescribed*, including the date of “last prescription.” And it *rejects* CMS’s 80% “universal threshold” as a “myth,” instead identifying thresholds between 46% and 92% as “adherent.”

CMS’s counsel offers *post hoc* explanations for why CMS’s measures can provide “useful insights” despite critical flaws. *None* of these explanations appear in the record, and all are non-cognizable. *See Am. Textile Mfrs.*, 452 U.S. at 539. CMS counsel speculates (at 58) that because the measures cover chronic conditions, “discontinuations might be expected for a lower proportion of total prescriptions than other medications.” That speculation finds zero support in the record. In reality, physicians discontinue prescriptions for CMS’s specified medications all the time, *as the record shows*. *See, e.g.*, AR2, 12-13, 36-37, 55-56.¹⁷ CMS’s counsel also speculates (at 55) that the measures fully capture prescription changes *within classes* of drugs, but that is wrong too.¹⁸

CMS argues (at 57) that Clover is not “uniquely impacted” by the measures because there is “no evidence that Clover’s beneficiaries are more likely to discontinue medications . . . under a

¹⁷ For example, patients with type 2 diabetes can obtain remission through lifestyle changes, making continued treatment unwarranted and even dangerous (by lowering blood sugar too far). Roy Taylor et al., *Nutritional basis of type 2 diabetes remission*, *BMJ* (July 7, 2021), <https://tinyurl.com/yj8t83fr>. Similarly, patients with hypertension often switch drugs (including away from the RAS antagonists that CMS measures) due to side effects like persistent cough or high potassium, Yiyun Hu et al., *Angiotensin-converting enzyme inhibitor induced cough compared with placebo, and other antihypertensives: A systematic review, and network meta-analysis*, 25 *J. CLINICAL HYPERTENSION* 661(2023), <https://tinyurl.com/3nhxrcz8>, or stop if their condition improves. Finally, it is common for patients to switch away from statins (the cholesterol drugs CMS measures) due to side effects, or due to lifestyle changes. *See* Kenneth R. Feingold, *Cholesterol Lowering Drugs*, EndoText.com (Feb. 12, 2024), <https://tinyurl.com/2v5fkef7>.

¹⁸ For example, focusing on hypertension, there are many distinct drug classes, apart from the RAS antagonists that CMS measures. *See* Utkarsh Ojha et al., *Current and Emerging Classes of Pharmacological Agents for the Management of Hypertension*, 22 *AM. J. CARDIOVASCULAR DRUGS* 271 (2021), <https://tinyurl.com/bde8atv5> (listing 16 classes). In fact, the problem is far worse than just that, because RAS antagonists are a common first-line treatment, while calcium channel blockers, beta blockers, and thiazide diuretics, are common as both first-line *and as second line alternatives*, including in circumstances where an RAS antagonist proves ineffective or inappropriate and is discontinued. *See, e.g.*, Adam P. Bress & James M. Luther, *Approaching Drug Choices and Challenges for the Management of Hypertension*, 82 *HYPERTENSION* 1545 (Aug. 14, 2025), <https://tinyurl.com/y6n5ptdt>. Thus, a patient switching from RAS antagonists to a different blood pressure drug will be coded as *non-adherent* to the RAS antagonist. AR255. The same issue impacts cholesterol drugs: There are many classes besides statins, *supra* n.17, yet CMS’s measures treat switching *away* from statins as discontinuation. AR257.

physician’s direction” than other plans’ beneficiaries. That claim ignores the record evidence that Clover *is* uniquely impacted. Unlike larger, vertically integrated plans that control pharmacies, Clover does not “game” the system through automatic or long-term (90 day) refills of unnecessary, unrecommended drugs, but *encourages* physicians to discontinue unnecessary drugs, as occurred 733 times here. *E.g.*, AR2, 12, 15, 35-41, 46-49. In any event, Clover is harmed because it scored 3 Stars on these 3 measures, which measure *nothing resembling* what Congress authorized.

The measures are also arbitrary. By failing to measure adherence to *prescribed* drugs and instead measuring adherence to *un-prescribed* drugs, CMS relies “on factors which Congress has not intended it to consider.” *Motor Vehicle Mfrs. Ass’n of the U.S. v. State Farm Mut. Auto. Ins. Co.*, 463 U.S. 29, 43 (1983). CMS cannot simply acknowledge a critical flaw that undermines its approach and fail to remediate it. *Skipper v. U.S. Fish & Wildlife Serv.*, 796 F. Supp. 3d 996, 1009-10 (S.D. Ala. 2025) (agency ignored an “important aspect of the problem” where it “threw up its hands” after finding “data limitations”); *Goodson Drug Co. v. Bondi*, No. 25-CV-257, 2025 WL 3405237, at *6-8 (N.D. Ga. Oct. 15, 2025) (similar). Agencies “do not have free rein to use inaccurate data.” *Dist. Hosp. Partners, L.P. v. Burwell*, 786 F.3d 46, 56-57 (D.C. Cir. 2015).

Clover also noted the unexplained inconsistency that beneficiaries who stop filling prescriptions on, for example, September 1 due to physicians’ discontinuation, are coded as *non-adherent* in that year, but *not* in the next, even though nothing has changed about their behavior: they simply stopped picking up their prescription. CMS responds (at 58-59) that it is reasonable not to treat patients as non-adherent in the second year because the patients’ prescriptions were “discontinued” and they do “not have a prescription.” But if that is true, *why was the patient coded non-adherent as of September 1 of the previous year?* CMS cannot explain that inconsistency.

CMS also cannot inexplicably act contrary to its guidance. *See Encino Motorcars, LLC v.*

Navarro, 579 U.S. 211, 221-22 (2016). CMS’s Technical Notes state these measures determine patients “who adhere” to “prescribed” drugs, AR252-58, by taking drugs “as directed,” Dkt. 34-12 at 99. Yet CMS refuses to consider whether the drug *actually remains prescribed*. CMS cannot disregard its own guidance in this way. Nor can it paper over this problem by deleting the phrase “as directed” from its 2026 Star Rating Technical Notes. Clover Br. 48. CMS cannot simply “fix” the problem of an arbitrary measure by deleting the very text that shows that it is arbitrary. *Encino Motorcars*, 579 U.S. at 221-22 (agency must provide “good reasons for the new policy”).

2. CMS’s Refusal To Consider The Record Evidence In This Case Violates The Statute And Is Arbitrary And Capricious

Even if CMS could consider data on prescription dispenses *alone* (excluding data on discontinuations) as *prima facie* evidence of adherence, CMS is wrong in arguing (at 59) that it can *also* ignore the record evidence of 733 members of Clover’s plan that discontinued treatment at physician direction, but that CMS erroneously coded as “non-adherent.” *See* AR36-37; 54-56.

Everyone agrees that evidence of discontinuation is highly relevant to determining *actual* adherence. CMS thus could not refuse to consider evidence that members it coded as non-adherent were actually adherent. CMS must “base its decisions on the entire record” and “may not ignore some evidence before it.” *Purepac Pharm. Co. v. Thompson*, 354 F.3d 877, 885 (D.C. Cir. 2004). Nor may CMS “ignore evidence that undercuts its judgment.” *Genuine Parts Co. v. EPA*, 890 F.3d 304, 312 (D.C. Cir. 2018). CMS accepts (at 56-58) that failing to consider discontinuation data will cause errors. By choosing not to consider primary source data of 733 discontinuations, CMS ignored a “relevant factor” and an “important aspect of the problem.” *Bidi Vapor LLC v. FDA*, 47 F.4th 1191, 1204 (11th Cir. 2022) (finding FDA erred by ignoring record evidence).

Contrary to CMS’s claims (at 59-60), an agency *cannot* simply establish *by guidance* a rigid formula of “adherence” that ignores relevant evidence bearing on an issue. *Purepac*, 354

F.3d at 885; *see also Bidi Vapor*, 47 F.4th at 1203-04 (finding impermissible FDA’s blanket policy not to consider evidence). In *Purepac*, the D.C. Circuit confronted a similar issue, in which FDA chose by policy to limit its review to only a subset of record evidence, and to disregard other record evidence it deemed irrelevant to its analysis. 354 F.3d at 885. The court held that FDA could not limit its review to only preferred sources of evidence, so as to “ignore crucial facts” and “construct a legal fiction.” *Id.* at 884. The Eleventh Circuit reached a similar conclusion in *Bidi Vapor*, finding that FDA’s blanket policy not to consider tobacco products’ individualized marketing plans was impermissible because they were relevant evidence of approvability. 47 F.4th at 1203-04. And a district court recently held that, although CMS may use uniform, nationwide data as *prima facie* evidence for a given formula, it must *also* consider countervailing, party-specific record evidence. *PharmaEssentia USA Corp v. HHS*, 805 F. Supp. 3d 261, 275 (D.D.C. 2025).

Here, CMS had *undisputed* evidence that 733 cases it coded as “non-adherence” were in fact valid treatment discontinuation. CMS cannot simply ignore that evidence, and must consider it in Clover’s Star Rating. *Purepac*, 354 F.3d at 885; *Bidi Vapor*, 47 F.4th at 1204.

B. CMS Unlawfully Determined Clover’s 2026 Star Rating Using Call Center Measures Which Are Disconnected From Clover’s Quality

The problems from CMS’s decision to blow past Congress’s restraints also extend to the Call Center measures (C33 and D01). Clover has already detailed the problems with these measures at length, and incorporates those arguments by reference. Clover Br. 48-50. CMS’s defense of the Call Center measures (at 52-55) misses the point. Interpreter access and TTY availability might matter to some members. The problem is that these measures, C33 and D01, turn on a small number of CMS contractor “test” calls rather than broad, reliable measures of clinical performance, health outcomes, or *beneficiary* experience as Congress allowed, and they are highly susceptible to small operational disruptions. Clover Br. 48-50. CMS points to alleged

business-hour closure problems in Clover’s call center, but even assuming that occurred, one operational problem does not convert these volatile administrative metrics into lawful proxies for the “quality” Congress authorized CMS to use in determining a payment-linked Star Rating. *Id.*

IV. CMS DETERMINED CLOVER’S 2026 STAR RATING BY APPLYING THE REVIEWING APPEAL DECISIONS (C32) MEASURE IN VIOLATION OF THE PRIVATE NON-DELEGATION DOCTRINE

In applying the Reviewing Appeals Decision (C32) measure, CMS violated the private non-delegation doctrine by abdicating its decision-making authority to a wholly private entity—the IRE. *See FCC v. Consumers’ Rsch.* (“*Consumers’ Rsch. II*”), 606 U.S. 656, 690-91 (2025).

This measure “shows how often an independent reviewer”—the IRE—found a given health plan’s decisions to deny coverage (*e.g.*, as medically unnecessary) “reasonable.” AR236. The measure’s formula simply reflects what percent of a plan’s decisions denying coverage were ultimately “upheld” as “reasonable” *by the IRE* on appeal. *Id.* CMS mechanically incorporates the IRE’s decisions into its Star Ratings without any governmental consideration of or control over whether the IRE’s decision was *actually* correct *on its merits*. AR236-37. CMS is *prohibited* from considering whether the IRE’s decision was later overturned by an ALJ, the Medicare Appeals Council, or a federal court: All that counts is the IRE “independent reviewer[’s] judgment.” *Id.*

Whether an agency’s delegation of authority to a private entity is permissible turns on (1) whether the entity merely performs “ministerial” tasks, and (2) whether the agency retains sufficient “authority and surveillance” over the entity. *Consumers’ Rsch. v. FCC* (“*Consumers’ Rsch. I*”), 88 F.4th 917, 925-26 (11th Cir. 2023). CMS does not contend, nor could reasonably contend, that the IRE’s reasonableness and medical-necessity determinations are ministerial.

The only question is whether CMS has retained sufficient “authority and surveillance” over the IRE. *Consumers’ Rsch. I*, 88 F.4th at 926. But C32’s sole function is to reflect the decisions of a private entity *without* government oversight. AR236. CMS *cannot* consider government

oversight in calculating this measure: “The results of appeals that occur beyond Level 2 (i.e., [ALJ] or Medicare Appeals Council appeals) are not included.” AR237. That is impermissible. *See Consumers’ Rsch. II*, 606 U.S. at 695 (concluding that a private party’s recommendations violate the private non-delegation doctrine when they “go into effect without an agency’s say-so”).

To overcome these problems, CMS relies (at 49-50) on its “plan preview” period, a time in August and September when CMS invites plans to identify any technical errors or mistakes in their Star Ratings. 42 C.F.R. §§ 422.166(h)(2), 423.186(h)(2). That argument gets CMS nowhere. CMS limits the plan preview to technical “data issues or errors” and “corrections.”¹⁹ For example, a plan can argue that CMS’s Star Ratings reflected that a case was “overturned” when the IRE actually “upheld” the decision. *See id.*; AR100 (Clover asserting a “black-and-white reporting error”). But a plan has no opportunity to challenge the IRE’s determination of the *merits* of the appeals as “reasonable” or “unreasonable”: for example, that an appeal that was granted for the member (for a medically necessary treatment) should have actually been overturned. *Supra* at 33.

Critically, CMS nowhere argues that plans may overturn the IRE’s decision during the plan preview by showing (1) the IRE was wrong on the *merits*, e.g., that coverage “reasonabl[y]” should have been covered as “medically necessary” rather than denied as unnecessary, or (2) the IRE’s decision was later overturned on further review by CMS or courts. CMS *could not* issue such a decision during a plan preview because its Technical Notes provide the only decision that matters in determining this measure is the IRE’s, not anyone else’s. AR236. So, any “oversight” CMS purports to exercise during the plan preview is no “oversight” at all. *See Nat’l Horsemen’s Benevolent & Protective Ass’n v. Black*, 53 F.4th 869, 884-85 (5th Cir. 2022) (concluding that

¹⁹ CMS, *First Plan Preview 1* (2021), <https://tinyurl.com/yjc3fwj>; CMS, *Announcement of Calendar Year (CY) 2026 Medicare Advantage (MA) Capitation Rates 96* (2025).

“arms-length review hardly subjects the Authority’s rules to ‘independent’ oversight”).

This conclusion is reinforced by CMS’s gesture (at 50) to the record. In 2025, Clover requested review of C32 for a “clerical reporting error,” discrepancies regarding whether medical records were received by the IRE, and discrepancies related to a purported failure to comply with timeframes set forth in CMS guidance. AR100-09. Clover *did not* challenge the *merits* of the IRE’s decisions, *i.e.*, whether the claims *were in fact* medically necessary and *should in fact* be covered under the law. As explained, CMS cannot review any of that.²⁰ And CMS’s citation to *Alignment Healthcare* (at 51) *confirms* CMS cannot review the merits of the IRE’s decision.²¹

V. CMS DETERMINED CLOVER’S 2026 STAR RATING IN VIOLATION OF 42 U.S.C. § 1395hh(a)(2)

On top of all of the foregoing errors, CMS erred in an additional way: It applied 20 measures to lower Clover’s Star Rating from 4 to 3.5 Stars without adopting those measures’ specifications as regulations as required by § 1395hh(a)(2). Clover Br. 53 n.8 (listing measures). Resolution of this claim in Clover’s favor alone would also raise its overall Star Rating to 4 Stars.

If ever there was an aspect of Medicare that required promulgation “by regulation,” it is the Star Rating measures. Section 1395hh(a)(2) provides that “[n]o rule, requirement, or other statement of policy . . . that establishes or changes a substantive legal standard governing the scope

²⁰ CMS argues (at 50-51) that Clover challenged an *entirely different* measure in the plan preview, Plan Makes Timely Decisions About Appeals (C31). That is a different measure that concerns the *speed* with which the plan sends information to the IRE. AR235. It has nothing to do with C32.

²¹ In *Alignment Healthcare, Inc. v. HHS*, the plaintiff asked CMS to correct the IRE’s merits error in adjudicating coordination-of-benefits (which plan has “primary” coverage responsibility), among other issues. No. 25-CV-74, 2025 WL 1635371 (D.D.C. June 9, 2025). CMS refused to consider the merits of whether the coverage denial was “reasonable,” and addressed only the *procedural* issue of whether the plan had *timely* sought IRE review. *Alignment Healthcare*, Dkt. 17-1 at 183. CMS made clear it *cannot* review the merits of IRE’s determination: CMS’s review only ensures “the Star Rating measure *accurately reflects what happened during the appeals process*” with the IRE. *Id.* All of this is why the district court explained that CMS *refused* to engage with the merits of the IRE’s decision. 2025 WL 1635371, at *4 (“CMS did not state that it agreed with [the IRE’s] substantive reasoning, or otherwise express any view on the merits.”).

of benefits, the payment for services, or the eligibility of . . . entities[] or organizations to furnish . . . services or benefits under this subchapter shall take effect unless it is promulgated . . . by regulation.” 42 U.S.C. § 1395hh(a)(2). Congress so-provided because the *APA*’s default notice-and-comment provisions do not apply to Medicare, yet Medicare “touches the lives of nearly all Americans” by altering the healthcare system. *Azar v. Allina Health Servs.*, 587 U.S. 566, 568 (2019). Thus, “even minor changes to the agency’s approach can impact millions of people and billions of dollars in ways that are not always easy for regulators to anticipate.” *Id.* at 582.

Congress provided for codification by regulation for exactly this circumstance. Most Medicare beneficiaries elect Medicare Advantage, and the Star Rating is one of the most important determinants—if not the most important—of how plans are paid, what benefits they offer, and whether program participation is terminated. *E.g., supra* at 4. The measures determine those outcomes, and in turn, dictate how plans must reshape American healthcare. AR149-265.

Unsurprisingly, CMS does not contest much of Clover’s argument, namely, that the measures and their specifications amount to a “rule, requirement, or other statement of policy” that establishes a “substantive legal standard.” 42 U.S.C. § 1395hh(a)(2); Clover Br. 54-56. Instead, CMS argues (at 17-18) that the measures supposedly do not “govern[] the scope of benefits, the payment for services, or the eligibility of individuals, entities, or organizations to furnish . . . services or benefits under this subchapter.” 42 U.S.C. § 1395hh(a)(2). That is incorrect.

A. The Measures Govern Payment For Services

The Star Rating measure specifications “govern[] . . . payment for services.” *Id.* In Medicare Advantage, the relevant “payment for services” is the payment that CMS by statute must make to the plan for furnishing covered items and services under the plan, and Star Ratings directly determine the amount of that payment. CMS’s contrary arguments fail.

Unlike traditional Medicare, in which *providers* provide services and *CMS* pays providers

for *each* service, under Medicare Advantage, *plans* provide services, in exchange for *fixed* monthly payments from CMS, and *plans* generally decide provider reimbursements. The plan's function is to *itself* "provide health care services" via its network. *Id.* § 1395w-21(a)(2)(A)(i) ("Coordinated care plans . . . provide health care services."). All "services" are "provide[d]" by the plan. *Id.*; *id.* § 1395w-24(a)(6)(A)(i) (the plan's annual bid is for "provision of all items and services under the plan"). Subject to limited exceptions not applicable here, *only* the plan, *not* providers, may "receive payments from the Secretary under this subchapter for services furnished." *Id.* § 1395w-21(i)(2). So "payment for services" clearly includes payments *to plans*.

And what are those "services"? Under Medicare Advantage, they are core Medicare Part A and B benefits (hospital and physician/outpatient), *id.* § 1395w-21(a)(1)(A), and supplemental benefits, *id.* § 1395w-22(a)(3). To provide *all* of these services, a plan must submit a "monthly aggregate bid amount for the *provision of all items and services under the plan.*" *Id.* § 1395w-24(a)(6)(A)(i). Those "items and services under the plan" are then immediately divided in the next provision into sub-components: core "benefits under . . . original Medicare," "supplemental health care benefits," and "basic prescription drug coverage." *Id.* § 1395w-24(a)(6)(A)(ii). *All those services are paid in a single payment to the plan.* *Id.* § 1395w-23(a)(1).

So CMS is wrong that "payment for services" only refers to payments *to providers* under *Parts A and B*. Rather, those "services" *expressly* include *both* core (Parts A and B) and supplemental (Part C) benefits. *Id.*; 42 C.F.R. § 400.202 ("services means medical care or services and items, such as medical diagnosis and treatment"); *id.* § 422.100(c)(2)(i)(A)-(B) ("Supplemental benefits consist of . . . services not covered by Medicare"); *id.* § 422.2 ("supplemental benefits" are "services not covered by Medicare"); *id.* §§ 422.504(a)(16), (d)(1)-(2), (e)(1)-(2), (f)(2) (treating *all* benefits as "services"); 91 Fed. Reg. at 17,485 ("supplemental

benefits” are “services”); 88 Fed. Reg. 22,120, 22,186 (Apr. 12, 2023) (similar); *Glob. Rescue Jets, LLC v. Kaiser Found. Health Plan, Inc.*, 30 F.4th 905, 909 (9th Cir. 2022) (similar).

With the understanding that “payment for services” includes payments to plans for *all* of their services, it is clear the Star Rating measures “govern” “payment for services.” As explained, the Star Ratings directly determine the amounts of payments to plans for *all* of their services by raising the benchmark and increasing rebates. *Supra* at 10; *infra* at 38 n.23; *Scan Health Plan v. CMS*, No. 23-3910, 2024 WL 2815789, at *1 (D.D.C. June 3, 2024) (CMS must “offer additional funding to plans with better Star Ratings.”). Indeed, the core function of the § 1395w-23(o) quality rating is to determine the “application of increase,” the *amount* payments increase. *Supra* at 8-10.

CMS’s responsive arguments all miss the point. CMS argues (at 19) that *all* plans are entitled to monthly payments for each beneficiary, and *must* pay providers for treatment, regardless of Star Ratings. True, but the *amount* of the payment from CMS *to the plan* for *its* services is determined by its Star Rating. *Supra* at 37. CMS next argues (at 19-20) that plans are *forbidden* from using quality bonus payments to pay for Part A and B “services,” only for supplemental benefits and premium reductions. But *all* of those categories of benefits, core Part A and B *and* supplemental benefits, are “services.” *Supra* at 37.²² And although it does not matter, CMS’s claim that plans do not use bonus payments to pay for core Part A/B benefits is wrong too.²³

²² CMS argues (at 20) that the medical loss ratio (“MLR”) does not dictate that plans must allocate Star Ratings funds to pay providers higher rates, but those amounts could be used for supplemental benefits. CMS misses the point: As CMS recognizes (at 10, 19-20), plans allocate bonus payments to provide *medical* benefits, including supplemental benefits, *which are services*. And, if a plan fails to meet the MLR for 3 consecutive years, CMS *must* suspend enrollment, and if it fails for 5 years, the statute *mandates* contract termination. 42 U.S.C. § 1395w-27(e)(4)(A)(ii)-(iii), (C).

²³ A plan provides a bid for the amount it requires, per beneficiary, to provide all benefits. 42 U.S.C. §§ 1395w-23(a)(1)(B), 1395w-24(a). CMS sets a benchmark based on how much Part A and B benefits should cost in a given geographical area for *any plan*. *Id.* § 1395w-23(j). A plan with a Star Rating bonus payment earns a higher benchmark and obtains more revenue. *Id.* § 1395w-23(o). If a plan’s bid is at or *above* the benchmark, the plan receives a monthly payment

CMS relies (at 19) on the out-of-circuit, pending-on-appeal *Humana* decision. Humana’s briefs failed to raise the arguments above, and with limited briefing, the court reached the wrong result. The court surmised that “payments for services” must refer to amounts “*Medicare must pay providers* for furnishing covered services.” *Humana Inc. v. HHS*, 806 F. Supp. 3d 642, 648 (N.D. Tex. 2025). Although the court did not explicate its reasoning, it does not follow from the *Medicare Advantage* statute, under which CMS generally *cannot* pay providers for services. 42 U.S.C. § 1395w-21(i)(2). The notion that payments must be for Part A or B “covered services,” too, is erroneous; as explained, Medicare Advantage “services” encompass both core “covered services” *and* supplemental benefits. *Supra* at 36-38. For its definition of “services,” the court relied on “1395w-22(a)(B)(iv)” (presumably intending to refer to § 1395w-22(a)(1)(B)(iv)). 806 F. Supp. 3d at 648. But that provision does not define “services”: Rather, § 1395w-22(a)(1)(A) requires plans to provide Part A and B services, and § 1395w-22(a)(1)(B)(iii)-(iv) define *which* of those services must have *cost-sharing limited*. Indeed, the court’s cited list of “services” in (B)(iv) *excludes most* core Medicare services, including hospital, ER, and physician services. 42 U.S.C. § 1395w-22(a)(1)(B)(iv). Section 1395x similarly defines dozens of *sub-types* of “services,” like “nursing services” and “surgical services,” but *never* defines “services” as a whole.²⁴

Finally, CMS asserts (at 23-24) that, if measure specifications were to “govern[] . . . the

that is equal to the benchmark. *Id.* § 1395w-23(a)(1)(B)(ii). If a plan’s bid is *below* the benchmark, the plan receives a payment that is equivalent to its bid *plus a rebate*. *Id.* §§ 1395w-23(a)(1)(B)(i), (a)(1)(E). The critical point is that a bonus payment increases the monthly payment, *regardless* of whether the plan bids above or below the benchmark, and *regardless* of whether a rebate is generated, by raising the benchmark. *Id.* § 1395w-23(o). That is, the bonus payment increases the “headroom” for the bid, and the plan can use that “headroom” to raise its bid (for Part A/B benefits), and/or receive higher rebates (which fund supplemental benefits). *Id.* Indeed, CMS elsewhere *accepts* (at 10) a plan can “increase its bid” for Part A/B benefits using bonus payments.

²⁴ Here, CMS also proffers §§ 1395d, 1395k, which *Humana* did not rely upon, but those citations are even further afield: They are *Part A and B* provisions that define the right to have payment made for specified *sub-types* of services under *Parts A and B*, unrelated to Part C.

payment for services” under § 1395hh(a)(2), it would create a conflict with § 1395w-23(b). Section 1395w-23(b) provides that CMS “shall determine, and shall announce . . . [t]he annual MA [Medicare Advantage] *capitation rate* for each MA *payment area* for the year.” *Id.* § 1395w-23(b)(1)(B)(i). CMS makes this announcement through its annual call process on its website, but does not engage in rulemaking. *Id.* § 1395w-23(b)(2); *supra* at 21-23 (discussing “annual call”). CMS claims that Clover’s reading of § 1395hh(a)(2) imposes a more burdensome procedure than § 1395w-23(b)(1)-(2), and if both provisions were read to cover the same subject (capitation rates), it would nullify the “annual call” process in § 1395w-23(b)(1)-(2).

CMS misreads the statute, and it is not a close call. CMS is reading (at 23-24) the announcement of “[t]he *annual MA capitation rate* for each MA payment area for the year” as meaning “*the amount the government pays* each Medicare Advantage plan for each enrollee.” That is flatly incorrect. In the simplest terms possible, the “annual MA capitation rate” is a sub-component-of-a-sub-component that informs the *uniform benchmark* in a region that *all* plans bid against (a single number), while the “amount the government pays” is the *final output* of that bidding process, and is *specific to each plan*.²⁵ So the linchpin of CMS’s argument is wrong.

²⁵ The “annual MA capitation rate” or equivalently “annual Medicare+Choice capitation rate” is calculated under § 1395w-23(c)(1) as “the largest of the amounts specified in . . . subparagraph (A), (B), (C), or (D),” and is not itself the amount paid to any plan. Rather, it is an input into the “MA area-specific non-drug monthly *benchmark* amount,” defined under § 1395w-23(j) as “1/12 of the blended benchmark amount determined under subsection (n)(1) for the area for the year.” That blended benchmark in (n)(1), in turn, is the uniform, county-level bidding target against which every plan submits its bid. *Id.* § 1395w-23(n). Specifically, (n)(4) requires that no county’s blended benchmark may exceed the county’s “applicable amount” under subsection (k)(1), which itself is derived from the (c)(1) capitation rate. *Id.* §§ 1395w-23(k)(1)(A)(i), (B). By contrast, the amount the government actually pays a given plan is determined under § 1395w-23(a)(1)(B): If a plan’s bid falls below the benchmark (technically, the “MA area-specific non-drug monthly benchmark amount”), its payment equals the bid plus a rebate; if a plan’s bid is at or above the benchmark, its payment equals the benchmark, and the enrollee pays the excess as a premium. (*Prior to 2006*, the “capitation rate” served a different function, and *was* the payment to the plan.)

With that clarification in mind, there is no conflict. Section 1395w-23(b) requires CMS to announce the annual Medicare Advantage capitation rate for each payment area, which is a numerical value (a dollar amount), not a generalized rule, requirement, or policy that establishes a legal standard under § 1395hh(a)(2). 42 U.S.C. § 1395w-23(b)(1)(B)(i); *see id.* §§ 1395w-23(a)(1)(A)(i), (c)(1)(B). The capitation rate is the statutory formula’s *output*. *Id.* The challenged Star Rating measure specifications, by contrast, are the rules, requirements, and policies that establish substantive legal standards for whether plans receive payment increases for their services. Because those are fundamentally different things, CMS’s claimed conflict is illusory.²⁶

B. The Measures Govern Eligibility To Furnish Services And Benefits

The Star Rating measure specifications also “govern[] . . . the eligibility of . . . entities, or organizations to furnish . . . services or benefits.” *Id.* § 1395hh(a)(2). CMS may terminate plans from the Medicare Advantage program if they fail to achieve a Star Rating of at least 3 Stars over 3 years, 42 C.F.R. § 422.510(a)(4)(xi), or they receive a Part C or Part D Star Rating of 2.5 or less for 2 years, *id.* § 422.502(b)(1)(i)(D). For a plan, that is the corporate death penalty.

CMS offers one response (at 21-22): that termination is discretionary, not mandatory, if the termination criteria are met, and thus the Star Ratings do not “govern” eligibility. CMS is misreading the word “govern.” And the practical consequence of CMS’s reading (at 22) is that, because all (or essentially all) of CMS’s regulations allowing program termination *under Parts A, B, C, or D* are discretionary, *no rules, requirements, or policies* elaborating, interpreting, or defining these enumerated bases for termination actually “govern” eligibility. 42 C.F.R. §§ 422.510(a), 423.509(a), 489.53(a), 424.535. That is obviously not what Congress had in mind.

²⁶ Another problem with CMS’s argument is that it proves far too much. If CMS were correct that the surplusage canon means that nothing relating to plan payments can ever trigger § 1395hh(a)(2)—because Congress provided a separate mechanism for announcing the capitation rate—then § 1395hh(a)(2) would be drained of its force in the Medicare Advantage context.

CMS cannot avoid rulemaking by retaining unilateral “discretion” whether to actually terminate. Section 1395hh(a)(2) requires rulemaking for, *inter alia*, a “statement of policy,” which provides how CMS intends to *exercise its discretion*. *Allina*, 587 U.S. at 572, 575 (a “statement of policy” describes CMS’s current “adjudicatory approach,” and is not a “binding rule”); *Nat’l Mining Ass’n v. Sec’y of Labor*, 589 F.3d 1368, 1371 (11th Cir. 2009) (explaining that a “policy statement” is not “binding” but “leaves the agency free to exercise its discretion”). Because a “statement of policy” is *inherently* discretionary, it makes no sense to construe a “statement of policy” establishing a standard “governing . . . eligibility” as one imposing a *mandatory* duty.

Nor does the term “governing” connote a non-discretionary duty. Here, “governing” clearly refers to a legal standard that “control[s] legal procedure for (an action, practice, process, etc.),” for example, in the phrase “laws that govern the sale of alcohol.” *Govern*, Webster’s Dictionary Online; *see also Govern*, Webster’s New World College Dictionary (4th ed. 1999) (“to be a rule or law for”); *id.* (“influence” or “guide”); *Abbott v. Biden*, 70 F.4th 817, 830-31 & n.9 (5th Cir. 2023) (“govern” as to “regulate,” “influence,” “manage,” “regulate by authority”). For example, Rule 11 governs sanctions, but it does not mandate them. Or, factors like premeditation and cruelty all govern imposition of the death penalty, even if a jury retains ultimate discretion.

The Eleventh Circuit has likewise explained that a legal standard “governing” a subject encompasses non-binding policies that leave broad discretion. *Thamotar v. U.S. Att’y Gen.*, 1 F.4th 958, 974 (11th Cir. 2021). The court explained that in the agency’s *wholly* discretionary asylum decisions, “*discretion* must be exercised according to *governing* regulations *and* agency decisions,” including those providing “a general policy by which its exercise of discretion *will be governed*.” *Id.*; *see also Ga. Dep’t of Hum. Res. v. Nash*, 915 F.2d 1482, 1489 n.19 (11th Cir. 1990) (discussing “standards *governing* the agency’s *exercise of discretion*”); *Sherry Mfg. Co. v.*

Towel King of Fla., Inc., 822 F.2d 1031, 1034 (11th Cir. 1987) (similar).

CMS’s citation (at 21) to *Humana* is thus unpersuasive. That court adopted a distinct definition of “govern” as connoting a degree of *power, i.e.*, “decisive influence.” 806 F. Supp. 3d at 648. *Id.* But the court did not discuss the surrounding text, all of which points to “governing” as providing *standards for a given subject*, not a degree of *power*. *Supra* at 42. Indeed, the court selected a definition of “governing” that, according to its own selected dictionary, *does not apply* to the verb form that Congress enacted here.²⁷ In all events, Star Ratings are a *sufficient* basis to terminate; that is “decisive.” *See Bland v. New York*, 263 F. Supp. 2d 526, 551 (E.D.N.Y. 2003).

C. The Measures Govern The Scope Of Benefits

The measures also “govern[] the scope of benefits.” 42 U.S.C. § 1395hh(a)(2). As CMS notes (at 20), plans with higher Star Ratings use the resultant funds to “provide [beneficiaries] with additional benefits” and lower premiums. *Scan Health Plan*, 2024 WL 2815789, at *1. As detailed at length above, Star Ratings are determinative of payments to plans, and in turn the benefits including under Part C (supplemental benefits) that they offer. *Supra* at 36-41. Indeed, the *overriding* function of Star Ratings is to determine payments and benefits. *Id.*

CMS responds (at 22) that a plan “can offer whatever supplemental benefits it wants, regardless of its Star Rating.” But the Medicare Act does not permit plans to offer unfunded benefits untethered from revenues (payments). By law, a plan’s bid must be prepared on an

²⁷ The court’s cited definition of “govern” applies only to the *intransitive* verb form. *Govern*, Webster’s Dictionary Online, <https://tinyurl.com/5xb5pwwp>. An intransitive verb lacks an object. *Maples v. State*, 968 N.W.3d 446, 451 (Mich. 2021). The *intransitive* “govern” connotes a degree of power, *i.e.*, “decisive influence,” as in “allow reason to govern” or “a contract’s text governs.” *Govern*, Merriam Webster (2025). But as used here, the verb is *transitive*, with an object, *i.e.*, a standard “governing . . . eligibility.” 42 U.S.C. § 1395hh(a)(2). The *transitive* form has a broader range of meanings, including “to control legal procedure for (an action, practice, process, etc.),” such as “laws that govern the *sale of alcohol*,” the object. *Govern*, Merriam Webster (2025). (And even when used *transitively* to connote power, the term connotes a “guiding influence.” *Id.*)

actuarial basis reflecting the plan’s “revenue requirements” to provide benefits, and CMS may accept a bid only if it “reasonably and equitably reflects the revenue requirements . . . of benefits provided under that plan.” 42 U.S.C. §§ 1395w-24(a)(6)(A), (B)(ii); 42 C.F.R. § 422.254(b)(3). Plans must strictly match benefits with the revenues to offer them. *Id.* A standard that dictates whether plans have hundreds of millions of dollars in revenue dictates the scope of benefits. *Id.*

Finally, CMS’s argument (at 22-23) that measures cannot govern the scope of benefits because “Clover presents no evidence that the Secretary’s approval of supplemental benefits must be ‘by regulation’ under Section 1395hh(a)(2)” attacks a position Clover does not take. Clover does not contend that CMS’s annual approval of each particular plan’s supplemental benefits package must itself be issued by regulation, because that is not a “rule, requirement, or statement of policy” that establishes a general “legal standard.” 42 U.S.C. § 1395hh(a)(2).

* * * * *

CMS must promulgate the challenged Star Rating measure specifications by regulation. CMS portrays Clover’s position as extraordinary and unduly restrictive. But it is nothing of the sort. CMS has already codified by regulation *every other material aspect* of the Star Ratings system, *apart from* the measures themselves. *See* 42 C.F.R. §§ 422.160-66, 423.182-86. And since 2019, CMS has engaged in notice and comment on *new* and *updated* measures. *Supra* at 21-25. Clover’s position thus asks only that CMS mildly expand the process it already uses.

CMS’s parade of horrors does not work. For example, CMS argues (at 24) that it would be “unworkable” to publish “case-mix” “coefficients” annually. AR266-76. But, these numerical values are simply *outputs* of CMS’s rules for *how* to calculate such coefficients; the *coefficients* are not rules, requirements, or policies that establish a general “legal standard.” 42 U.S.C. § 1395hh(a)(2). And the Supreme Court has already explained that any burdens, to the extent they

exist, cannot outweigh Congress's command to act "by regulation." *Allina*, 587 U.S. at 581-83. Clover asks only that CMS do that which Congress instructed that CMS must do by regulation.

CONCLUSION

For the foregoing reasons, this Court should grant Clover's motion for summary judgment, deny CMS's motion, set aside CMS's determination of Clover's 3.5-star Star Rating, and order CMS to redetermine Clover's Star Rating as at least 4 Stars.

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CERTIFICATE OF SERVICE

On April 29, 2026, I caused a copy of the foregoing document to be electronically filed with the Clerk of Court using the CM/ECF filing system, which will send notification of such filing to all registered participants.

/s/ James B. Durham
James B. Durham