

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

CLOVER INSURANCE COMPANY,	)	
	)	
Plaintiff,	)	
	)	
v.	)	Case No. 2:25-cv-142
	)	
U.S. DEPARTMENT OF HEALTH AND	)	
HUMAN SERVICES, ET AL.,	)	
	)	
Defendants.	)	

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

Having ignored in its opening brief significant flaws in its arguments—*e.g.*, that “governing” is not a synonym for “influencing,” Doc. 51 at 17-19, that “based on” does not mean “consisting exclusively of,” *id.* at 27-30, and that CMS did in fact follow its regulations in modifying three challenged measures, *id.* at 44-49—Clover largely responds that Defendants’ arguments do not matter. Its attempts to evade dictionary definitions, binding precedent, and the evidence before this Court are unavailing. It should not be surprising that CMS has followed the law for more than a decade in its administration of the Medicare Advantage Star Ratings, through which it distributes billions of dollars annually to plans that achieve high performance on quality metrics that matter to Medicare beneficiaries. Clover does not deny that its challenge reflects an effort to raise its score this year—nor can it deny that the system was virtually identical last year, when Clover scored 4.0 stars and highlighted its performance on measures that it now insists are illegal.

This Court should grant summary judgment to Defendants. Clover cannot demonstrate that CMS's administration of the Star Ratings violates the Medicare statute or is arbitrary and capricious.

## ARGUMENT

### **I. The Medicare rulemaking provision (42 U.S.C. § 1395hh(a)(2)) does not apply to Medicare Advantage Star Ratings because the Star Ratings do not “govern” payment for services, scope of benefits, or eligibility.**

Defendants showed in their opening brief that the word “govern,” as used in the Medicare statute’s rulemaking provision (42 U.S.C. § 1395hh(a)(2)), means “to prevail or have decisive influence; control” (Merriam Webster) or “to control a point in issue” (Black’s Law Dictionary). Doc. 51 at 18. The Star Ratings measure specifications do not “govern” the matters listed in § 1395hh(a)(2) because a plan’s Star Rating does not control the payment for services, the scope of benefits, or eligibility. Clover’s claims *all* arise from its misapprehension that the word “govern” means something more akin to “influence.” This is unsupported by the plain meaning of the term. Clover engages only perfunctorily with Defendants’ argument, Doc. 57 at 42-43, and its arguments are unpersuasive. And because it insists that the word “govern” means something other than its ordinary meaning, its specific contentions about “payment for services,” “scope of benefits,” and eligibility cannot stand.

#### **A. Clover’s efforts to avoid the plain meaning of the term “govern” are unavailing.**

Clover argues (citing snippets of the Webster’s definition) that the word “govern” “has a broader range of meanings,” yet it ignores that most of the other applicable Webster’s definitions refer (as does Black’s) to “control” in a substantive

sense.<sup>1</sup> Doc. 57 at 43 n.27. This Court’s role in interpreting a statute is to identify “the single, best meaning.” *Loper Bright Enters. v. Raimondo*, 603 U.S. 369, 400 (2024). Clover’s position appears to be that “the single, best meaning” of “governing” as used in the rulemaking statute should be derived from one of Webster’s dozen definitions—specifically, one saying that govern means “to control legal procedure for.” Doc. 57 at 42-43 n.27. Aside from the fact that this phrase also connotes “control,” Clover’s preferred definition makes no sense in the statutory context. Section 1395hh(a)(2) itself controls legal procedure: specifically, it requires that the Secretary act “by regulation” (*i.e.*, follow a specified procedure) when establishing or changing “a substantive legal standard governing the scope of benefits, the payment for services, or the eligibility of individuals, entities, or organizations to furnish or receive services or benefits under” Medicare.<sup>2</sup> And § 1395hh(a)(2) speaks of a “substantive legal standard governing,” which Clover would have this Court read to mean “a substantive legal standard [controlling legal procedure for]” three listed items. This introduces a completely unnecessary surplusage. If Congress wanted to describe something that controls procedure, it could have said “procedural standard.”<sup>3</sup>

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<sup>1</sup> *Govern*, Merriam Webster (2025), <https://tinyurl.com/5xb5pwwp> (definitions of transitive form including “to exercise continuous sovereign authority over,” “to determine rules for and handle administration of,” “to control, direct, or strongly influence the actions and conduct of,” “to exert a *determining or* guiding influence in or over” (emphasis added; Clover notably omits the italicized “determining or” in reproducing this portion of the definition), “to serve as a precedent or deciding principle for.”). Clover’s argument that the *Humana* court quoted definitions of the intransitive form of the verb does not support its argument because most of the definitions of the transitive form also connote “control” and Clover’s preferred definition does not make sense in the statutory context.

<sup>2</sup> In this brief, Defendants use the phrase “eligibility” as shorthand for the longer “eligibility of individuals, entities, or organizations to furnish or receive services or benefits under this subchapter.”

<sup>3</sup> Clover’s proffered “procedural” definition of govern makes no sense even within its own brief. It has argued repeatedly that a “substantive legal standard” must mean something that controls a

The statute makes perfect sense if the word “governing” is replaced by its synonym “controlling”—when the Secretary alters or establishes a substantive legal standard controlling payment for services, scope of benefits, or eligibility for services, he must act by regulation. Standards that do not “control” these things do not need to be promulgated by regulation, even if they might “influence” or “affect” them. This is what the *Humana* court correctly held. *Humana Inc. v. U.S. Dep’t of Health & Hum. Servs.*, 806 F. Supp. 3d 642, 648 (N.D. Tex. 2025).<sup>4</sup>

Clover’s other argument about the word “governing”—that it can refer to a standard guiding the exercise of discretion, *see* Doc. 57 at 42—does not help its case. There is no evidence that Congress used “governing” in § 1395hh(a)(2) to describe a constraint on the agency’s hypothetical “discretion.”<sup>5</sup> There is no evidence that standards governing, *e.g.*, “payment for services” are meant to guide CMS’s discretion. *See, e.g., Azar v. Allina Health Servs.*, 587 U.S. 566, 572 (2019) (announcement of Medicare fractions governs “payment for services”). Clover’s arguments, and the cases it cites, are unmoored from the statutory context here. The “single, best meaning” of the phrase “a substantive legal standard governing” something is that standard is controlling something. Clover’s approach contorts the

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substantive result—for example, “whether plans receive payment increases for their services.” Doc. 57 at 41. It is unclear how this statement fits with Clover’s insistence that “govern” means merely “to control legal procedure for.”

<sup>4</sup> The Plaintiffs in *Humana* argued, much as Clover does here, that the “payment for services” includes payments from CMS to MAOs. *See* Reply Brief for Plaintiff, *Humana v. HHS*, No. 4:25-cv-779-O, ECF No. 36, at 21-22. Clover’s claim that the briefing in *Humana* did not raise certain issues is notably unsupported by any citation. *See* Doc. 57 at 39.

<sup>5</sup> Clover says that the word “governing . . . encompasses non-binding policies that leave broad discretion.” Doc. 57 at 42. It offers no evidence that Congress intended that meaning here; the phrase “substantive legal standard governing” hardly implies this use.

statutory text to achieve its preferred outcome.

**B. The Star Ratings measure specifications do not govern “payment for services,” “scope of benefits,” or eligibility.**

Applying the “single, best reading” of the word “governing,” this Court should conclude that the Star Ratings measure specifications do not control payment for services, scope of benefits, or eligibility.

**1. The Star Ratings do not govern payment for services.**

Clover takes the position that as an insurer, it is a “provider of services” and that the payments from the government to it are “payments for services.” This is wrong. Under the Medicare statute, “payments for services” are payments to the providers (*e.g.*, doctors, hospitals, skilled nursing facilities) who *perform* services, and the Medicare statute defines various types of “service” at 42 U.S.C. § 1395x. *See* Doc. 51 at 20. None of these definitions suggests that insurance is a service. In the Medicare Advantage context, payments for services go *from* the Medicare Advantage Organizations (“MAOs”) to providers. The government’s payments to MAOs are not “payments for services,” as Medicare uses that term, and the Star Ratings do not govern payments that MAOs make to providers (which *are* payments for services). MAOs provide *insurance coverage*, which includes paying providers for services—but insurance itself is not a Medicare service. *See, e.g.*, 42 U.S.C. §§ 1395d, 1395k; *see also* 42 U.S.C. § 1395w-22(a)(1)(A) (plans “shall provide . . . benefits under the original medicare fee-for-service program option.”).<sup>6</sup>

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<sup>6</sup> Although Clover claims that “services expressly include both core (Parts A and B) and supplemental (Part C) benefits,” “benefits” is not a synonym for services under Medicare. *See, e.g.* 42 U.S.C. § 1395d

Clover suggests that Part C creates a new category of Medicare services beyond those described in Parts A and B, but this is incorrect. Part C establishes a new way that Medicare enrollees can obtain insurance coverage through MAOs that contract with CMS. 42 U.S.C. § 1395w-22(a)(1)(B); *see also* 42 C.F.R. § 422.101(a) (MAOs' obligation to “[p]rovide coverage of, by furnishing, arranging for, or making payment for, all services that are covered by Part A and B”). These MAOs are not “providers of services” since that, too, is a defined term in the Medicare statute. *See* 42 U.S.C. § 1395x(u); *see also Humana*, 806 F. Supp. 3d at 648. Because insurance coverage is not a service, MAOs are not service providers under the Medicare statute.

Clover's cited authorities do not show that insurance is a type of “service” or that Medicare Advantage Organizations provide “services.” 42 U.S.C. § 1395w-21(a)(2), *see* Doc. 57 at 43, describes the “types of plans of health insurance” available under Medicare Advantage. Section 1395w-21(i), *see* Doc. 57 at 37, 39, further clarifies that when an individual enrolls in a Medicare Advantage plan, Medicare will not make payments to providers on the individual's behalf (just as the government would for patients enrolled in Original Medicare). Instead, it is the MAO's obligation to make those payments. And 42 U.S.C. § 1395w-24(a)(6)(A)(i) describes the information that MAOs must submit as part of their bid and describes “the provision

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(“benefits . . . consist of entitlement to have payment made on [a beneficiary's] behalf . . . for” specified services); § 1395k(a) (similar). Clover's argument that § 1395x defines “dozens of sub-types of services . . . but never defines services as a whole,” Doc. 57 at 39 (internal quotations omitted), asks this Court to reach the absurd conclusion that Congress's definition of specific types of services somehow can be read to include “insurance” as a service, despite Clover proffering *no* evidence that Congress included insurance as a service in the Medicare statute or that Congress would have intended that result.

of all items and services under the plan” without specifying who is doing the providing. Under Medicare Advantage, as Clover recognizes, “CMS contracts with private plans to provide *Original Medicare benefits* and *other benefits*.” Doc. 34 at 12 (emphasis added). In short, MAOs stand in the government’s shoes, providing the insurance coverage that would otherwise be provided by Medicare (*i.e.*, payments to providers for items and services), plus other “benefits.”<sup>7</sup>

Because MAOs do not provide “services” as the Medicare statute uses that term, and because the benefits that they provide to enrollees are not “services,” the Medicare Advantage Star Ratings do not “govern” the “payment for services.” Medicare Advantage plans must pay for the services provided to their enrollees regardless of their Quality Bonus Payment status. A five-star plan has the same obligation to pay for services as a three-star. And a MAO’s “payment for services” (*i.e.*, how much it pays *providers* who provide services to its enrollees) does not depend on its Star Rating; the number reflects negotiated rates or Medicare fee for service rates.

At bottom, Clover asks this Court to hold that providing health insurance to Medicare beneficiaries is a service, a proposition that has no support in the Medicare

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<sup>7</sup> Clover offers a host of authorities purporting to show that benefits, including supplemental benefits, are services. *See* Doc. 57 at 37-38. These authorities do not mean what Clover says they mean. 42 C.F.R. § 400.202, for example, supports the government’s position: “services means *medical care* services or items,” (emphasis added) including a list of things that does not include insurance. Elsewhere, Clover omits language describing that supplemental benefits are paid for “in the form of premiums or cost sharing,” 42 C.F.R. § 422.100(c)(2)(i)(A), (B), showing that “supplemental benefits” carries its ordinary Medicare meaning of the entitlement to have payment made for services. The regulations Clover cites also say that “benefits may include reductions in cost sharing for benefits under the original Medicare fee for service program.” 42 C.F.R. § 422.2. Clover offers no explanation for how “premiums” or “reductions in cost sharing” are “services” under the Medicare statute. As the *Humana* court correctly held, “payments for services refers to the amount Medicare must pay providers for furnishing covered services.” 806 F. Supp. 3d at 648. If insurance were deemed a “service” under the Medicare statute, it would lead to the odd result that the government acts as a “provider of services” when it provides Medicare benefits to enrollees in the Original Medicare program.

statute. If Congress meant for insurance to be a species of “service,” it would have said so. It did not, and “payment for services” does not include payments from the government to MAOs that provide insurance coverage to Medicare beneficiaries.<sup>8</sup>

## **2. The Star Ratings do not govern eligibility.**

Star Ratings likewise do not “govern” an MAO’s eligibility to furnish benefits because CMS retains discretion as to whether to terminate a plan that has persistently low Star Ratings. Clover’s main response is to insist that “govern” means something other than its standard legal definition, a point already addressed above.

Clover also responds that Congress “obviously” could not have intended CMS’s termination regulations to be discretionary. Doc. 57 at 41. Once again, the basis for Clover’s claim of obviousness is unclear. There are a host of regulations describing non-discretionary eligibility requirements to participate in Medicare, which do “govern . . . eligibility” and were promulgated “by regulation” consistent with 42 U.S.C. § 1395hh(a)(2). *See, e.g., Biden v. Missouri*, 595 U.S. 87, 90 (2022) (“[T]he Secretary has established long lists of detailed conditions with which facilities must comply to be eligible to receive Medicare and Medicaid funds.”) (citing 42 C.F.R. pt. 482; 42 C.F.R. pt. 483; 42 C.F.R. §§ 416.25-416.54). That there are also discretionary regulations that do not “govern[] . . . eligibility” does not somehow undermine the statutory text. “Govern” means what it says.

Finally, Clover makes the unsupported assertion that a “statement of policy”

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<sup>8</sup> Clover largely abandons its original argument that the Medical Loss Ratio (“MLR”) statute somehow shows that Star Ratings govern the payment for services. It accuses Defendants of “miss[ing] the point,” then reiterates its argument that supplemental benefits are services. This argument is wrong for the reasons described above, and the MLR has nothing to do with the issue. *See* Doc. 57 at 38 n.22.

is “inherently discretionary.” Doc. 57 at 42. This is wrong. Some statements of policy, to be sure, describe how an agency will exercise its discretion. *See* Doc. 57 at 42. Other statements of policy bind the agency. This is most obvious from *Allina* itself, which involved “a ‘statement of policy’” that “let the public know the agency’s current adjudicatory approach to a critical question involved in calculating payment for thousands of hospitals nationwide.” *Allina*, 587 U.S. at 572.<sup>9</sup> There was no doubt in *Allina* that the agency’s “announcement of the 2012 Medicare fractions governed payment for services.” *Id.* (cleaned up).<sup>10</sup>

If statements of policy are inherently discretionary, as Clover claims, then they could not “govern[].” *See* 42 U.S.C. § 1395hh(a)(2). But this cannot be right, because Congress said that a “statement of policy . . . governing . . . eligibility” must be promulgated by regulation. *Id.* The Medicare Advantage Star Ratings, which are incorporated into a regulation permitting, but not requiring, CMS to terminate low-performing plans, do not “govern[] . . . eligibility” and thus do not need to be promulgated “by regulation.”

### **3. The Star Ratings do not govern the scope of benefits.**

Defendants showed that the Star Ratings do not govern the scope of benefits

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<sup>9</sup> Clover quotes snippets from different portions of the *Allina* opinion to argue that “a statement of policy” is not a “binding rule.” Doc. 57 at 42. But the full context of that quotation undermines their argument: “if a so-called policy statement is in purpose or likely effect a binding rule of substantive law, it will be taken for what it is.” *Allina*, 587 U.S. at 575 (quotation marks omitted). In other words, some statements of policy are binding rules—the question is about “contents,” not “label.” *Id.*

<sup>10</sup> To be sure, outside the Medicare context a “statement of policy” can be superseded or modified by a different statement enunciating a different policy. But the whole point of *Allina* is that the Secretary cannot change substantive legal standards governing, as relevant here, “payment for services” unless he acts “by regulation.”

in their opening brief. Doc. 51 at 22-24. Clover’s only response is to quibble with Defendants’ assertion that plans can offer whatever supplemental benefits they want, claiming only that plans may not offer benefits that they cannot pay for. But Quality Bonus Payments are hardly the only possible source of revenue for plans; they may charge premiums to beneficiaries to cover the increased cost of supplemental benefits they chose to provide. *See* 42 C.F.R. § 422.2 (“Mandatory supplemental benefits . . . are paid for in the form of premiums and cost sharing, or by an application of the beneficiary rebate rule”; “Optional supplemental benefits . . . paid for in full . . . in the form of premiums or cost-sharing”). So the question is not about the “scope of benefits” because if Clover remains at liberty to offer any supplemental benefit that the Secretary approves. Its 3.5 Star Rating simply means that the government will pay less to subsidize them. If Clover instead chooses to scale back its supplemental benefit offerings rather than charge higher premiums, that is not because the Star Ratings “govern[] . . . the scope of benefits” but because it has made a financial decision about what to offer. Because “govern[]” has its ordinary legal meaning, the “scope of benefits” that Clover offers is governed not by its Star Rating but by its own decisions.

**C. Clover offers no basis to distinguish between the measures it challenges and the measures it does not.**

In their opening brief, Defendants showed that Clover challenged only those measures on which it performed poorly. Clover does not deny this, saying that “[i]njury-specific litigation is not gamesmanship.” Doc. 57 at 5. But the point is not only that Clover has engaged in gamesmanship—it is also about the scope of any remedy. Clover fails to dispute Defendants’ statement that “[i]f the Court does adopt

Clover’s argument, its remand should include the basis for distinguishing between the measures that Clover fails to supply.” Doc. 51 at 26. Clover has once again failed to supply any principled basis for distinguishing among the measures it challenges and those it does not. If this Court agrees with Clover that CMS has violated the Medicare statute’s rulemaking provision, it should remand to the agency for further proceedings consistent with its opinion. Clover offers no basis for distinguishing between the measures it would like to keep and those it would like to eliminate, and there is thus no reason to limit any remand to the measures identified by Clover.

## **II. CMS did not violate congressional directives in its selection of Star Ratings measure specifications.**

Clover’s second brief perpetuates the same two errors it made in its original motion. First, it insists that “based on,” as used in the statute at issue, must convey exclusivity. Second, it would have this Court treat various authorities authorizing CMS to collect and disseminate data to Medicare beneficiaries as virtual nullities. Either of these errors, standing alone, undermines Clover’s argument.

### **A. “Based on” does not mean “consisting exclusively of.”**

Clover devotes substantial space (Doc. 57 at 6-16) trying to explain Eleventh Circuit precedent that “[n]othing about the plain and ordinary meaning of the phrase ‘based on’ connotes exclusivity,’ and ‘nothing about it implies the list that follows is exhaustive.” *Advance Trust & Life Escrow Services v. Protective Life Ins. Co.*, 93 F.4th 1315, 1326 (11th Cir. 2024) (quoting *Slam Dunk v. Conn. Gen. Life Ins. Co.*, 853 F. App’x 451, 455 (11th Cir. 2021)). “[B]ased on’ does not mean ‘exclusively on’ or ‘solely on.’” *Id.* at 1333. The court concluded that “based on” means that what follows is

exclusive relied on the contract law canon that ambiguous contractual terms should be construed against the drafter or have involved denials of motions (*e.g.*, motions to dismiss or for summary judgment) where judicial finding of any ambiguity results in denial of the motion. *See id.* at 1332-33 (citing cases). These factors do not apply here, where the court’s role is to determine a statute’s best meaning.

Clover does not identify any court holding that “based on,” in ordinary usage, unambiguously means that what follows the phrase is exclusive. A statute has “a single, best meaning,” *Loper Bright*, 603 U.S. at 400, and “nothing about the plain and ordinary meaning of the phrase ‘based on’ connotes exclusivity,” *Advance Trust*, 93 F.4th at 1326. Clover thus bears the heavy burden to show that Congress used “based on” to mean something other than its “plain and ordinary meaning.” Its arguments cannot carry the required heavy load.

Most of Clover’s counterarguments have nothing to do with determining whether the phrase “based on,” as used in 42 U.S.C. § 1395ww-23(o)(4)(A), actually means “based exclusively on” or “based only on.” While courts might have used “based on” in an “exclusive sense” outside the statutory interpretation context, the cases Clover cites can be readily distinguished. *See* Doc. 57 at 9.<sup>11</sup>

Similarly, while Clover points to a number of uses of “based on” in the Medicare

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<sup>11</sup> Clover is incorrect to say that “based on” without further modifiers conveys exclusivity in the example it cites. *See* Doc. 57 at 9. This Court in *Streeter v. Dep’t of Public Safety*, for example, used the phrase “based on one circumstance *alone*” to convey exclusivity. 689 F. Supp. 3d 1312, 1328 (S.D. Ga. 2023) (Wood, J.) (cleaned up, emphasis added). And in *Georgia v. Wheeler*, this Court used the phrase “based on *specific* distance limitations” to convey exclusivity. 418 F. Supp. 3d 1336, 1373 (S.D. Ga. 2019) (Wood, J.) (emphasis added). Clover’s citations do not show that the *statutory* phrase “based on” normally connotes exclusivity, a position that is in any event foreclosed by binding precedent. Indeed, these cases indicate that Congress’s use of “based on” without modifiers in § 1395w-22(e) conveys the phrase’s ordinary, nonexclusive meaning.

statute, none conveys exclusivity. *Id.* at 10. For example, Clover cites the use of “based on” in the section title “emergency condition based on prudent layperson.” *Id.*; see 42 U.S.C. § 1395w-22(d)(3)(B). But that section heading summarizes the text below; the term “emergency condition” is based on the prudent layperson standard, which the statute further defines. See A. Scalia & B. Garner, *Reading Law: The Interpretation of Legal Texts* 222 (2012) (statutory titles “may be resorted to for the purpose of ascertaining legislative intent and of relieving the ambiguity”). Congress did not say that “emergency condition” is “based on” three nonexclusive factors, it said it is “based on” the prudent layperson standard, which the statutory text elucidates. Clover’s other examples suffer from similar defects. Doc. 57 at 10, see 42 U.S.C. §§ 1395w-24(b)(1)(C)(iii), (v) (“based on the system” clause does not establish an exclusive formula); 1395w-23(k)(2)(B)(ii) (section title describing what numerator is “based on,” but the inputs to the formula reflect “Secretary’s estimate”); 1395w-23(o)(3)(B) (describing capitation rate “based on” specified amount; because the capitation rate includes factors other than the specified amount, this is not an exclusive use of “based on”); 1395w-23(n)(2)(C) (“ranking based upon the level of the amount *specified* exclusivity). None of Clover’s citations to the Medicare statute uses “based on” to convey exclusivity.

Nor does Congress’s use of “based primarily on” in 42 U.S.C. § 1395w-23(o)(4)(D)(ii) regarding plan consolidations help Clover. Doc. 57 at 11. In fact, it supports the Secretary’s position. “Primarily” is a modifier meaning “for the most part.” <https://www.merriam-webster.com/dictionary/primarily>. In context, it means

that the adjustment applies when the quality rating is *mostly* based on a period prior to a contract's closing. *See id.* "Primarily" thus serves to require more than "based on" would require standing alone, just as "exclusively" or "solely" would. The word "primarily" does not show that the default meaning of "based on" implies exclusivity.

Clover next describes the addition of "entirely" and "only" to convey exclusivity as exceptional phrases that Congress employs only when it "had to use" them in a specific context. *See Doc. 57* at 10. But this does not show that "based on" ordinarily conveys exclusivity; if it did, Congress would not have "had to use" extra words to say the same thing. The point is that when Congress conveys exclusivity in a statute containing the phrase "based on," it adds a signaling adverb. Elsewhere, Clover's proposed default rule about the meaning of "based on" would make no sense. For example, standards "based on input from stakeholders" must mean that the input is a part of formulating the standards, but not the exclusive ingredient. 42 U.S.C. § 1395w-28(f)(8)(D)(i)(I). And an MAO's obligation not to "deny, limit, or condition the coverage or provision of benefits . . . based on any health status-related factor" cannot mean that if the MAO also considers *other* factors in addition to the prohibited ones, it has not violated the statute. 42 U.S.C. § 1395w-22(b)(1).

Clover insists that Defendant's reading of the statute "would effectively nullify § 1395w-22(e) as a constraint on the Star Ratings that increase plans' payments." *Doc. 57* at 3. This is untrue. CMS is not free to abandon the HEDIS, HOS, or CAHPS systems without submitting a report to Congress. But Congress's use of the phrase "based on" indicates that it did not mean to require that the Star Ratings consist

exclusively of data gathered under those systems. There can be little doubt that the Part C Star Ratings system Clover challenges is “based on” HEDIS, HOS, and CAHPS data: the vast majority of measures draw directly from these sources.

**B. Congress specifically preserved CMS’s authority to collect data under 42 U.S.C. § 1395w-21(d)(4)(D) when it enacted 42 U.S.C. § 1395w-22(e).**

Clover commits another, independent error. It misreads the clause at 42 U.S.C. § 1395w-22(e)(3)(B)(iii), which says: “Nothing in the subsection shall be construed as restricting the ability of the Secretary to carry out the duties under [42 U.S.C. § 1395w-21(d)(4)(D)].” Clover does not allege that the Part C measures it challenges under this argument are not authorized by § 1395w-21(d)(4)(D).<sup>12</sup> Instead, Clover’s claim is that the Secretary cannot use *any* information gathered under that broad authority to calculate Quality Bonus Payments.<sup>13</sup>

But 42 U.S.C. § 1395w-23(o)(4)(A) contains no such restriction: “The quality rating for a plan shall be determined according to a 5-star rating system (based on the data collected under [42 U.S.C. §] 1395w-22(e)).”<sup>14</sup> The “data collected,” are, “*subject to subparagraph (B)*, as part of the quality improvement program . . . data

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<sup>12</sup> Similarly, although Clover argues that the Secretary cannot use some Part D measures—specifically, those on which Clover performed poorly—to set Quality Bonus Payments, it appears to have no objection in principle to the inclusion of data gathered under the Secretary’s Part D authority as part of the Medicare Advantage Star Ratings. *See* Doc. 51 at 34-35.

<sup>13</sup> This does not imply that CMS could base the Part C Star Ratings exclusively on its administrative data. “Based on” means that the quality improvement plan data must be an element of the Star Ratings. And there is no doubt that CAHPS, HEDIS, and HOS data underlie a significant majority of the Part C Star Ratings measures. All but five of the Part C measures applicable to Clover (excluding the improvement measure) derive from HEDIS, HOS, or CAHPS. Doc. 51 at 29.

<sup>14</sup> Clover says that the use of “the data” instead of “data” implies that Congress intended to limit its application. Doc. 57 at 12. But the cases on which it relies involve the use of the article “the” with a “singular noun.” *See, e.g., Evanto v. Fed. Nat’l Mortg. Ass’n*, 814 F.3d 1295, 1298 (11th Cir. 2016). “Data” is a plural noun. <https://www.merriam-webster.com/dictionary/data>.

that permits the measurement of health outcomes and other indices of quality.” *Id.* § 1395w-22(e)(3)(A)(i) (emphasis added). Subparagraph (B) says that the Secretary “shall not collect . . . data on quality, outcomes, and beneficiary satisfaction to facilitate consumer choice and program administration other than the *types of data* that were collected by the Secretary as of November 1, 2003.” 42 U.S.C. § 1395w-22(e)(3)(B)(i) (emphasis added). So only when the Secretary is collecting “as part of [a plan’s] quality improvement program . . . data on quality, outcomes, and beneficiary satisfaction to facilitate consumer choice and program administration,” is he limited by the “types of data” provision under subparagraph (B).

But subparagraph (B) also makes clear that “[n]othing *in the subsection* shall be construed as restricting the ability of the Secretary to carry out duties under section 1395w-21(d)(4)(D). 42 U.S.C. § 1395w-22(e)(3)(B)(iii) (emphasis added). Section 1395w-21(d)(4)(D), in turn, is part of the provision requiring the Secretary to “provide for activities under this subsection to broadly disseminate information to medicare beneficiaries.” *Id.* at (d)(1). Section 1395w-21(d)(4)(D) provides that duty “shall include” information on “plan quality and performance indicators” such as disenrollment rates, health outcomes, enrollee satisfaction, and compliance with plan requirements of this part (as determined by the Secretary)” *id.* at (d)(4)(D). CMS “initially acted upon [its] authority” under § 1395w-21(d) as the basis for developing and publicly posting the 5-star ratings system. 83 Fed. Reg. at 16520. Congress presumably knew about the then-extant Star Ratings when it instructed CMS to begin issuing Quality Bonus Payments according to plans’ ratings. Had Congress

intended to require CMS to abandon its original statutory authority for promulgating the Star Ratings, it presumably would not have done so via a parenthetical cross-reference using the term “based on.” Yet that is what Clover argues Congress did.

Clover’s interpretation of the statute (Doc. 57 at 15) is unfaithful to the statutory structure. The data limitations Clover describes simply do not apply except to a narrow subset of collections: data collected “under subparagraph (A)” (i.e., as part of plans’ quality improvement programs) “on quality, outcomes, and beneficiary satisfaction to facilitate consumer choice and program administration.” 42 U.S.C. § 1395w-22(e)(3)(B)(i). And Congress emphasized this narrow reach via § 1395w-22(e)(3)(B)(iii), saying that “nothing in the subsection shall be construed as restricting the ability of the Secretary to carry out the duties under Section 1395w-21(d)(4)(D).” Clover, however, is asking this Court to restrict the ability of the Secretary to provide for the activities necessary to provide enrollees the information described in § 1395w-21(d)(4)(D). As Defendants have already shown, “[i]t cannot be the case that the ‘best reading’ of a statute . . . disregards an adjacent provision.” Doc. 51 at 31. Clover’s interpretation does; Defendants’ does not.

### **C. CMS did not violate the “types of data” restriction.**

As shown above, the “types of data” restriction in 42 U.S.C. § 1395w-22(e)(3)(B)(i) does not apply to data collected outside Part C quality improvement programs. CMS thus does not violate the statute by including administrative and Part D data in the Star Ratings. *See* Doc. 51 at 35-39.<sup>15</sup> Clover itself agrees that at

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<sup>15</sup> Notably, Clover does not respond at all to Defendants’ arguments regarding the agency’s initial

least *some* Part D data—the measures on which it scored 4 or 5 stars—should be included in the Star Ratings.

In response to Defendants’ arguments that “Clover never provides a clear answer” as to what “types of data” means, Doc. 51 at 38, Clover offers a new argument: “CMS changes the ‘types of data’ when it changes criteria for evaluating plan performance,” Doc. 57 at 18.<sup>16</sup> Even if this Court accepts Clover’s belated attempt to define “types of data” for purposes of its claim, CMS has not violated the statute. Clover insists that CMS cannot consider data regarding falls or care coordination because it did not ask specifically about those things in 2003. *Id.* at 19-20. But Clover acknowledges that its new “criteria for evaluating plan performance” is different from a requirement that CMS not change the questions. The care coordination and fall risk measures are consistent with the quality and performance data CMS gathered in 2003. In 2003, the CAHPS survey asked how familiar beneficiaries’ personal doctors were with care from other providers and about beneficiaries’ ability to obtain prescription medicines; the current care coordination

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interpretation of the statute via notice-and-comment rulemaking, even though under *Loper Bright* a statute’s best reading may be informed by “interpretations issues contemporaneously with the statute at issue, and which have remained consistent over time.” Doc. 51 at 38 (quoting *Loper Bright*, 603 U.S. at 394). In a 2004 Federal Register preamble, CMS explained that the “types of data” provision permitted it to “add, delete, or modify” measures within the systems, noting that any changes to those data systems were subject to stakeholder review. *See id.* at 38-39 (citing 69 Fed. Reg. at 46866).

<sup>16</sup> Clover also withdraws three claims related to measures C05, C22, and C25, Doc. 57 at 18, asserting that it discovered those claims were invalid only after reviewing the CAHPS 2003. Doc. 57 at 18. But the invalidity of these claims should have been apparent to Clover from the materials it provided as part of its own MSJ. *See* Doc. 51 at 42-44 (measure C25 drawing from question that changed only slightly between 1998 and 2003 CAHPS survey; measure C05 drawing from questions from 2003 HOS survey, which Clover itself provided; measure C22 drawing from CAHPS questions that were identical in 1998 and 2003). Clover’s withdrawal of three of its claims highlights the cursory nature of its original arguments about “types of data.”

questions reflect the same “types of data” in soliciting information about primary care providers’ specific knowledge about, e.g., test results. *See* Doc. 51 at 20. And Clover does not deny that questions about lower extremity health and difficulty walking are correlated with fall risk; the “types of data” limitation does not restrict the agency from seeking similar information via different questions. Clover failed to show otherwise in its opening brief, and its attempts to fix the mistake do not carry the day. *See* Doc. 51 at 41.

**III. CMS did not violate its regulatory notice and comment obligations (42 C.F.R. § 422.164) with respect to any measure.**

Clover accused CMS of violating its own regulations in promulgating three Star Ratings measures. Doc. 34 at 45. In its opening brief, Defendants showed that Clover had simply ignored the relevant actions that CMS took, which were consistent with its obligations under the regulations. Doc. 51 at 45-49. Clover responds, in essence, that what CMS did was not good enough. Doc. 57 at 22. These objections fail; Clover misreads the regulation to impose obligations on CMS that do not exist.

Clover mischaracterizes the document that it had previously ignored. CMS’s discussion of possible changes to the C04 and C05 Patient-Reported Outcomes measures, Improving or Maintaining Physical and Mental Health, appeared in a portion of the annual notice captioned “Potential New Measure Concepts.”<sup>17</sup> The agency solicited “suggestions for future measure development related to PROs.” *Id.*

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<sup>17</sup> *See* <https://www.cms.gov/medicare/health-plans/medicareadvtspecratestats/downloads/advance2020part2.pdf>. Clover does not acknowledge this, but “Patient Reported Outcome” or “PRO” measures are the C04 and C05 measures. *See* [Annual notice at 140] (“CMS assesses two global PRO measures—improving or maintaining physical health and improving or maintaining mental health.”).

at 140. The regulation requires no more in the annual notice. CMS need not preview the precise content of its proposed new measures; it need only “solicit feedback on whether to make substantive measure updates.” 42 C.F.R. § 422.164(d)(2).

Nor is there anything untoward about how CMS ultimately finalized the measures. For one thing, CMS’s solicitation of “suggestions for future measure development related to PROs” subsumes both possible new measures and updates to existing measures, consistent with 42 C.F.R. § 422.164(c)(2). For another, CMS’s treatment of the substantive updates to the Patient-Reported Outcomes measures was required by its regulations because it agreed with commenters that the update to the C04 and C05 measures was “substantive.” *See* 86 Fed. Reg. at 5919. When the agency makes a substantive change under the regulation, it must move the measures to the display page for two years—the same as if the measure were a “new measure.” *See* 42 C.F.R. §§ 422.164(d)(2) (“CMS will place the updated measure on the display page for at least 2 years prior to using the updated measure . . . as specified in paragraph (c) of this section”); 422.166(e)(2) (“Rules for new and substantively updated measures.”). CMS explained all this in the Federal Register. *See* 86 Fed. Reg. at 5919, 5921. Clover’s allegation that government counsel is engaging in post-hoc rationalization is baseless. *Cf.* Doc. 57 at 23.

Likewise, Clover insists that CMS is wrong to say that its change to the C23 measure was non-substantive. CMS explained why the proposed change was non-substantive: “it would not change the population covered by this measure, the two existing questions that would continue to be included in the measure, and the intent

of the measure that focuses on getting care as soon as needed.”<sup>18</sup> Had Clover disagreed, it could have raised the arguments it raises here in a comment letter; as it acknowledges, it did not. Other commenters who did participate in the process overwhelmingly supported the change.<sup>19</sup>

Clover responds that this court should disregard its failure to participate in the notice-and-comment process. Clover argues that CMS “failed to solicit comment through formal rulemaking,” Doc. 57 at 25 n.14, but CMS explicitly solicited comment through the Advance Notice process *as required by regulation*. See 42 C.F.R. § 422.164.<sup>20</sup> Clover’s failure to comment was not due to lack of opportunity. Clover then cites an out-of-circuit concurrence for the proposition that it can challenge the application of a rule even though it chose not to comment. Doc. 57 at 25 n.14. But even that concurrence notes that “a party is barred from making facial claims that were not raised in the rulemaking process,” and “courts do not hear claims that the agency has had no opportunity to respond to or perhaps, to adapt to or adopt.” *Koretzoff v. Vilsack*, 707 F.3d 394, 400 (D.C. Cir. 2013) (Williams, J., concurring). “The price for a ticket to facial review is to raise objections in the rulemaking.” *Id.* at 401.<sup>21</sup> The

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<sup>18</sup> <https://www.cms.gov/files/document/2024-advance-notice-pdf.pdf> at 121.

<sup>19</sup> <https://www.cms.gov/files/document/2024-announcement-pdf.pdf> at 178.

<sup>20</sup> See also <https://www.cms.gov/files/document/2024-advance-notice-pdf.pdf> at 121 (“We are interested in stakeholder feedback on removing this question from the Getting Appointments and Care Quickly measure”).

<sup>21</sup> Clover raises a facial challenge to measure C23, arguing that it cannot be applied to it in any circumstance because of an alleged procedural defect in its adoption. Clover would not be barred by its non-participation in the regulatory process from raising an as-applied or arbitrary-and-capricious challenge, but it cannot refuse to participate in the notice-and-comment process then come to court alleging that an alleged procedural defect (about which it could have commented) means that the measure cannot be applied to it.

majority opinion is even clearer: The agency in that case “expressly stated” the basis for his rule, and “absent a comment arguing otherwise, [it] had no further obligation.” *Koretoff*, 707 F.3d at 398.<sup>22</sup>

**IV. This Court does not need to consider Clover’s remaining claims, which are meritless in any event.**

Defendants showed in their opening brief that Clover’s 2026 Star Rating would not change if measures C32, C33, D01, D08, D09, and D10 were removed. Clover argues otherwise, but its calculations ignore the Part D Improvement Measure (D04). If Measures D01 and D08-D10 were removed, Clover’s score on the Part D Improvement Measure would decrease to three stars. *See* Ex. 1, Supp. Goldstein Dec. As a result of that decrease, Clover’s overall Star Rating would remain at 3.5 Stars even if these six measures were removed. Thus, regardless of whether the six measures are removed, Clover would not be eligible for the reward factor. *See id.*

Clover then argues that if this Court agrees with it on *other* arguments, its Star Rating might change. Doc. 57 at 26. Defendants did not claim otherwise. Clover also attempts to assert a new form of injury, saying that it is publicly impugned by the publication of low Star Ratings. Clover has not previously claimed injury on this basis. It claims injury from alleged financial harms arising from increased payments to plans that receive four stars. Clover cannot assert a new theory of injury at this

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<sup>22</sup> *Koretoff* involved an argument that the agency lacked statutory authority to promulgate a rule, and the D.C. Circuit stated in dicta that the affected entities could raise “their *statutory* arguments if and when the Secretary applies the rule.” *Koretoff*, 394 F.3d at 399 (emphasis added). Clover’s arguments have nothing to do with statutory authority; it is challenging an alleged procedural error because it performed poorly on Measure C23. The same measure was in effect during the previous year’s Star Ratings, and Clover had no procedural objection then because it received an overall rating of four stars.

stage of the litigation. Even if it could, there is no waiver of sovereign immunity for claims sounding in defamation. 42 U.S.C. § 2680(h); *Alvarez v. United States*, 862 F.3d 1297, 1302 (11th Cir. 2017). This Court should reject Clover’s remaining claims.

**A. CMS Supervises the Independent Review Entity.**

Clover’s attempt to find a constitutional violation remains puzzling. It does not dispute that it submitted disputes related to both C31 and C32 to CMS during the plan preview period, and CMS assessed those disputes and responded to Clover. *See* AR 133 (removing, *inter alia*, the result of case number 1- 4595402316 from the “reviewing appeals decisions” measure). Clover now argues there are hypothetical *other* IRE decisions that *Clover did not ask CMS to review during the plan preview period* that CMS apparently should have reviewed *sua sponte* to avoid a constitutional violation. *See* Doc. 57 at 35 (“Clover *did not* challenge the *merits* of the IRE decisions.”) (emphasis added). Clover claims it could not have raised those hypothetical issues with CMS, but the portions of the Administrative Record it cites do not say that. As *Alignment* and the record in this case show, a plan can request exclusion of any matter from the calculation of the Star Ratings. *Alignment Healthcare, Inc. v. U.S. Dep’t of Health & Hum. Servs.*, No. 25-cv-74, 2025 WL 1635371, at \*4 (D.D.C. June 9, 2025) (challenge to an adverse determination regarding care coordination); AR 100, 133 (challenge related to whether Clover submitted records to IRE). If Clover believed any of Maximus’s decisions were irrational or wrong, it could have raised that claim to CMS. Had CMS refused to review them—something Clover can only speculate about—it could have then

challenged CMS's action in Court. But Clover cannot simply decline to bring an alleged error by a contractor to CMS's attention and then insist in Court that CMS is improperly supervising its contractor.

**B. Clover's arbitrary and capricious claims fail.**

**1. The adherence measures are not arbitrary and capricious.**

Clover agrees that Star Ratings measures do not need to be perfect. Doc. 57 at 28. Its dispute, then, is about policy. At least for 2026, when Clover performed poorly relative to its peers on medication adherence, it believes that CMS should have chosen not to have the measures at all. In 2025, when Clover performed well, it had a different view. Doc. 51 at 1. Clover does not dispute that courts applying the arbitrary and capricious standard do not take sides in policy disputes. *See id.* at 55.

Clover's main complaint is that a patient whose physician discontinues a medication will be deemed non-adherent during the year of the discontinuation if the patient was on the medication for at least 91 days (and two fills) and does not meet the 80% threshold. Plans are unable to obtain standardized data with sufficient controls on patients who discontinue medication as instructed by a physician consistent with their patient privacy and data integrity obligations.<sup>23</sup> Clover had no objection to the Medication Adherence measures when it performed well on them.

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<sup>23</sup> Clover mischaracterizes the record in claiming that CMS is "choosing to proceed despite a known defect." Doc. 57 at 28. CMS explained in 2012 that it had "serious concerns about how to ensure beneficiary privacy protections and data validation," and it "had not yet been able to determine that [it was] authorized to accept" the data that would be necessary to do what Clover requests. AR 144. Clover also mischaracterizes the Federal Register provision it cites. The word "unclear" does not appear at all on the page Clover cites (83 Fed. Reg. at 16533), but on 16553, CMS explains that it was "unclear how sponsors could implement sufficient internal controls" to ensure data quality but also explained that Clover's preferred approach would add to physicians' reporting burdens. 83 Fed. Reg. 16533. These explanations were reasonable.

CMS has consistently explained the limitations of its medication adherence metrics and has reasonably decided to retain them because they provide useful information to Medicare beneficiaries. *See* 83 Fed. Reg. at 16553. This policy choice was reasonable in light of existing limitations and not arbitrary and capricious.

Confusingly, Clover also accuses Defendants of ignoring the record in this case. No one disputes that Clover raised concerns with the medication adherence measure during the plan year. CMS's response was consistent and correct: it "cannot make an ad hoc methodology change to account for medication discontinuation or to add additional exclusions after the measurement year for the three Medication Adherence measures." AR 52. CMS has a process for changing measure specifications. *Id.* (citing 42 C.F.R. §§ 422.164(d)(2) & 423.184(d)(2)). CMS could not grant "one-off, post-hoc exceptions or adjustments," AR 52, because the measures must be uniformly applied. Clover's request was for special treatment—it wanted CMS to apply a different rule for it (*i.e.*, exclude patients with physician-ordered discontinuations) but not to other plans, who would be scored on the medication adherence measures as published and described in advance. It would have been arbitrary and capricious for CMS to adopt Clover's preferred course; it is not arbitrary and capricious to uniformly apply rules announced in advance to all affected parties. The cases Clover cites are not to the contrary because the "relevant factors" for the agency to consider were described in advance (via the Technical Notes) and do not include physician discontinuation. CMS reviewed the evidence and determined, correctly, that it would be inappropriate to make a mid-year change to the measure specification.

**2. The call center measures are not arbitrary and capricious.**

Clover accuses Defendants of “miss[ing] the point” in its defense of the call center measures, suggesting that because test callers place calls, the measure is not a reliable test of “beneficiary experience.” Doc. 57 at 32. It does not explain how its failure during the measurement year, *i.e.*, presenting callers with an automated message informing them that the call center was closed during business hours on a weekday, failed to reflect a beneficiary’s experience. Beneficiaries calling Clover during the period in question received the same automated message that CMS test callers did. *See* AR 64. Instead, Clover says that the problems are “alleged” and suggests that Clover’s failure may not have occurred. *Id.* at 32-33. This conflicts with the record. AR 64 (acknowledging the error). Clover would prefer that CMS adopt a different policy. But the arbitrary and capricious standard requires more. CMS is well within its authority to measure a key aspect of beneficiary experience—call center performance—via test calls.

**CONCLUSION**

This Court should deny Clover’s Motion and grant Defendants’ Motion.

Respectfully submitted,

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

CLOVER INSURANCE COMPANY,

*Plaintiff,*

v.

U.S. DEPARTMENT OF HEALTH AND  
HUMAN SERVICES, *et al.*,

*Defendants.*

Case No. 2:25-cv-142

**SUPPLEMENTAL DECLARATION OF ELIZABETH GOLDSTEIN**

I, Elizabeth Goldstein, declare as follows:

1. I am employed by the Department of Health and Human Services (HHS) in the Center for Medicare (CM) at the Centers for Medicare & Medicaid Services (CMS), located at 7500 Security Boulevard, Baltimore, MD 21244. I am the Director of the Division of Consumer Assessment and Plan Performance, Medicare Drug Benefit and C & D Data Group. I have held this position since October 2000, and I have been employed by CMS since 1993. In my role as the Director of the Division of Consumer Assessment and Plan Performance, I manage a team of professional staff with a variety of advanced degrees in fields including public policy, health economics, and statistics. My team is responsible for overseeing the Medicare Advantage Star Ratings system, including the development and updating of measures, the administration of surveys, and the annual calculation of Part C and D Star Ratings. Statements made in this declaration are based on my personal knowledge, information contained in agency files, and information furnished to me in the course of my official duties. I received my Ph.D. in health economics and public policy from the University of Wisconsin – Madison. I have over 30 years

of experience in survey research, quality measurement, and public policy. I specifically have expertise in federal health policy, value-based purchasing programs, design and implementation of national, large-scale patient experience of care surveys in a variety of settings, development of quality measurement programs in multiple health settings, including Medicare Advantage, and evaluation of large-scale health programs.

2. In my role as Director of the Division of Consumer Assessment and Plan Performance, I have access to data underlying the Parts C and D Star Ratings, including each contract's measure-by-measure raw scores for the 2026 Star Ratings. I can use these data to calculate a hypothetical revised Star Rating to reflect hypothetical changes to the data inputs.

3. I understand that in response to my previous declaration in this case, Clover has asserted that CMS miscalculated its hypothetical 2026 Star Rating for contract H5141 with measures C32, C33, D01, D08, D09, and D10 removed.

4. Clover suggests that it might be entitled to the reward factor under some circumstances. The reward factor is an additional adjustment for contracts that have consistently high performance. Clover's contract did not receive the reward factor for 2026, and it would not receive it with measures C32, C33, D01, D08, D09, and D10 removed. This is because Clover's mean measure score falls below the 65<sup>th</sup> percentile threshold necessary for a contract to receive the reward factor, whether or not the six measures listed above are included.

5. In addition, Clover did not discuss the Part D improvement measure score. Removing D01, D08, D09, and D10 would decrease Clover's Part D improvement measure rating from four stars to three stars. Because of that decrease, its Star Rating would remain 3.5 stars with the six above measures removed.

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