IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

HMO LOUISIANA, INC., *Plaintiff,* v. DEPARTMENT OF HEALTH AND HUMAN SERVICES, et al., *Defendants.*	)	Case No. 24-2931

PLAINTIFF'S MOTION FOR LEAVE TO FILE AN AMENDED COMPLAINT

Plaintiff HMO Louisiana, Inc. ("HMOLA"), hereby moves for leave to file an amended complaint pursuant to Federal Rule of Civil Procedure 15 and Local Rule 15.1 for the reasons set forth in the accompanying memorandum.[1]

[1] Pursuant to Local Civil Rule 7(m), Plaintiff emailed Defendants' counsel, Jared Littman, to obtain consent to this motion on November 21, 2024. Defendants do not oppose this motion.

Dated: December 6, 2024

By: _____

Paul Werner (D.C. Bar #482637)
Imad Matini (D.C. Bar # 1552312)
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imatini@sheppardmullin.com

Counsel for Plaintiff

CERTIFICATE OF SERVICE

I hereby certify that on December 6, 2024, I electronically filed the foregoing document and the accompanying exhibits with the Clerk of the Court using the CM/ECF system, which will send notification of this filing to the attorneys of record and all registered participants.

/s/ Paul Werner
Paul Werner

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

HMO LOUISIANA, INC., *Plaintiff,* v. DEPARTMENT OF HEALTH AND HUMAN SERVICES, et al., *Defendants.*	)	Case No. 24-2931

PLAINTIFF'S MEMORANDUM IN SUPPORT OF ITS MOTION FOR LEAVE TO FILE AN AMENDED COMPLAINT

Pursuant to Rule 15(a) of the Federal Rules of Civil Procedure, Plaintiff HMO Louisiana, Inc. ("HMOLA"), hereby moves for leave to file an Amended Complaint and states as follows in support of its motion:

1. On October 17, 2024, HMOLA filed a Complaint for declaratory and injunctive relief against Defendants, alleging claims for violations of the Administrative Procedure Act ("APA") based on Defendants' unlawful determination of HMOLA's 2025 Star Ratings (ECF No. 1).

2. HMOLA also filed a Temporary Restraining Order against Defendants seeking to enjoin Defendants from (a) announcing, publishing, or distributing HMOLA's erroneous 2025 Star Ratings; (b) preventing Defendants from relying on HMOLA's 2025 Star Ratings in connection with any further agency action, including but not limited to quality bonus payment determinations; and (c) requiring Defendants to announce, publish, and distribute HMOLA's 2025 Star Ratings until they correctly recalculated HMOLA's 2025 Star Rating. (ECF No. 3).

3. On October 28, 2024, the parties filed a Joint Motion to Temporarily Stay Proceedings, staying all deadlines for fifteen days to allow the parties to explore an informal resolution. (ECF No. 8).

4. On November 15, 2024, CMS reran HMOLA's Star Ratings, resulting in a predicted increase in Measure D11 as alleged by HMOLA. *See* Exhibit ("Ex.") 1 to Ex. B.

5. However, because CMS refused to properly apply Measure C05, the parties have been unable informally to resolve their dispute.

6. Plaintiff now seeks to amend its Complaint based on CMS's continued unlawful actions that violate the APA. *See* Redline Version of Proposed Amended Complaint, Ex. A.

7. Rule 15 of the Federal Rules of Civil Procedures directs courts to "freely give leave where justice so requires." Fed. R. Civ. P. 15(a)(2); *see Forman v. Davis*, 371 U.S. 178, 182 (1962).

8. Accordingly, leave to amend should be granted unless there is "undue delay, bad faith or dilatory motive on the part of the movant," "undue prejudice to the opposing party," or "futility of amendment." *Atchinson v. District of Columbia*, 73 F.3d 418, 425 (D.C. Cir. 1996) (citing *Foman*, 371 U.S. 182). Here, these factors weigh in favor of granting Plaintiff's motion.

9. *First*, amending Plaintiff's Complaint will not prejudice Defendants. This case is in its infancy. Defendants have not filed any responsive pleading, there is no case management order, and no discovery has happened.

10. Additionally, Plaintiff seeks to amend its Complaint only to conform (and streamline) its allegations to the parties' present dispute following settlement efforts.

11. Because Defendants have already been "made fully aware of the events giving rise to the action, an allowance of the amendment could not in any way prejudice preparation of

[Defendants'] case," and Plaintiff therefore should be granted leave to amend. *Davis*, 615 F.2d at 613.

12. *Second*, Plaintiff's amendments to the Complaint are not futile. A proposed amendment is only futile when it "would not survive a motion to dismiss," which is not the case here. *In re Interbank Funding Corp. Sec. Litig.*, 629 F.3d 213, 218 (D.C. Cir. 2010).

13. Plaintiff alleges viable relief under the APA. Because Plaintiff's proposed Amended Complaint is not "obviously" frivolous or facially deficient, leave to amend should be granted. *Id.*

14. *Third*, there is no hint of any bad faith here. Plaintiff worked diligently to resolve this dispute informally, and now seeks to narrow the dispute following those efforts. *Sherrod v. McHugh*, 249 F. Supp. 3d 85, 87 (D.D.C. 2017).

15. Plaintiff also requests this amendment well in advance of any substantive proceedings or trial of this action, as the Court has not yet entered a scheduling order. As such, the Court should grant Plaintiff leave to amend on this basis as well. *See id.*

16. On November 22, 2024, Plaintiff filed a joint status report, including a request to file a motion for leave to amend its complaint by December 6, 2024. *See* ECF No. 9. On November 26, 2024, the Court granted Plaintiff's request.

17. Defendants do not object to the requested relief. *See* ECF No. 9.

18. Plaintiff's proposed Amended Complaint is attached as Exhibit B to this Memorandum. It is electronically signed and ready for filing.

WHEREFORE, the undersigned request that the Court grant Plaintiff's Fed. R. Civ. P. 15(a) motion for leave to file the attached Amended Complaint.

Dated: December 6, 2024

By: _____

Paul Werner (D.C. Bar #482637)
Imad Matini (D.C. Bar # 1552312)
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imatini@sheppardmullin.com

Counsel for Plaintiff

CERTIFICATE OF SERVICE

I hereby certify that on December 6, 2024, I electronically filed the foregoing document and the accompanying exhibits with the Clerk of the Court using the CM/ECF system, which will send notification of this filing to the attorneys of record and all registered participants.

/s/ Paul Werner
Paul Werner

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

HMO LOUISIANA, INC., *Plaintiff,* v. DEPARTMENT OF HEALTH AND HUMAN SERVICES, et al., *Defendants.*	Case No. 24-2931

[PROPOSED] ORDER GRANTING PLAINTIFF'S MOTION FOR LEAVE TO FILE AN AMENDED COMPLAINT

Before the Court is Plaintiff's Fed. R. Civ. P. 15(a) Motion for Leave to File an Amended Complaint. The Court, having read Plaintiff's Motion and supporting memorandum, as well as the Amended Complaint, hereby declares that it is:

ORDERED that the Plaintiff's Fed. R. Civ. P. 15(a) Motion for Leave to File an Amended Complaint is GRANTED; it is further

ORDERED that the filing date of Plaintiff's Amended Complaint shall be deemed filed as of December 6, 2024, the filing date of Plaintiff's Fed. R. Civ. P. 15(a) Motion for Leave to File an Amended Complaint.

ENTERED this the _____ day of _____, 2024.

_____
Honorable Christopher R. Cooper
U.S. District Court Judge

Exhibit A

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

HMO LOUISIANA, INC.,

Plaintiff,

v.

DEPARTMENT OF HEALTH AND HUMAN SERVICES, et al.,

Defendants.

Case No. 24-2931

AMENDED COMPLAINT FOR DECLARATORY AND INJUNCTIVE RELIEF

Plaintiff HMO Louisiana, Inc. ("HMOLA"), submits the following Amended Complaint for declaratory and injunctive relief against Defendants Department of Health and Human Services ("HHS"), the Centers for Medicare & Medicaid Services ("CMS"), Xavier Becerra, in his official capacity as Secretary of HHS, and Chiquita Brooks-LaSure, in her official capacity as Administrator of CMS (collectively, "Defendants" or "CMS"), and alleges as follows:

INTRODUCTION

1. This is yet another case in which CMS miscalculated a Medicare Advantage Plan's Star Ratings, causing serious and irreparable harms to the plan and its members that will persist if left uncorrected.

2. HMOLA is one of the nation's largest Medicare Advantage health plans ("MA Plans"), currently serving approximately 30,000 members in Louisiana.

3. In 2024, HMOLA's parent company, Louisiana Health Service & Indemnity Company d/b/a Blue Cross and Blue Shield of Louisiana ("BCBSLA"), consolidated two of its contracts, H6453 and H5576, with HMOLA's H6453 contract surviving.

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Baton Rouge, LA 70809)¶
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Hubert H. Humphrey Building)¶
200 Independence Avenue, S.W.)¶
Washington, D.C. 20201;) ¶
) ¶
CENTERS FOR MEDICARE &)¶
MEDICAID SERVICES)¶
7500 Security Boulevard) ¶
Baltimore, MD 21244;)¶
)¶
XAVIER BECERRA, in his official)¶
capacity as Secretary of the United States)¶
Department of Health and Human Services)¶
Hubert H. Humphrey Building)¶
200 Independence Avenue, S.W.,)¶
Washington, D.C., 20201; and)

Deleted: CHIQUITA BROOKS-LASURE, in her)¶
official capacity as Administrator,)¶
Centers for Medicare & Medicaid Services)¶
7500 Security Boulevard)¶
Baltimore, MD 21244,)¶
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Deleted: <#>CMS's actions, and its refusal to address them administratively and in compliance with its own regulations, are a disturbing, if textbook, example of rigid and unreasonable agency decision-making that should be set aside under the Administrative Procedure Act ("APA").¶

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4. MA Plans, like HMOLA, receive annual Star Ratings from CMS for their contracts based on "health and drug plan quality and performance measures" that are used by Medicare beneficiaries to shop for plans.

5. HMOLA's contract H6453 did not offer a Special Needs Plan ("SNP"), which is one of the measures CMS evaluates in developing Star Ratings.

6. Thus, according to its own regulations, CMS should have excluded consideration of Measure C05 in developing HMOLA's Star Ratings so they were not artificially impacted by a measure pertaining to a non-existent offering.

7. But CMS did just the opposite. It considered Measure C05, which caused HMOLA's 2025 Part C Star Ratings to precipitously plunge, from 4 to 3.5 Stars, and caused its overall 2025 Star Ratings also to drop from 4 to 3.5 Stars.

8. CMS publicly disclosed HMOLA's unlawfully calculated Star Ratings on its website, which has resulted in irreparable harm to HMOLA's reputation, goodwill, and competitive position, as well as impaired its ability to attract beneficiaries.

9. When HMOLA confronted the agency about its failure to exclude the C05 measure, CMS refused to recognize it regulations and guidance required it to treat C05 as a "no score."

10. CMS's refusal to apply the plain text of its regulations is an arbitrary and capricious agency action in violation of the APA.

11. Accordingly, HMOLA brings this action to obtain relief for the unlawful actions CMS has engaged in to calculate HMOLA's 2025 Star Ratings, which have caused immediate and irreparable harms to its reputation, market and competitive position, and more importantly,

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Deleted: <#>CMS calculates the Star Ratings based on a clear and unambiguous methodology that includes the consideration of all relevant data for a given contract. That methodology and related requirements are set forth in specific regulations that CMS promulgated and must abide by.¶
Among other requirements, CMS has regulations that address how to calculate Star Ratings for MA Plans when they consolidate multiple MA contracts under a single surviving H contract.¶
Fluctuations in an MA Plan's Star Ratings can occur in the short term following contract consolidation. Thus, during the first two years following consolidation, Star Ratings for the surviving contract are based on both the surviving and consolidated contracts' data. ¶
CMS further implements an analytical adjustment, referred to as the Categorical Adjustment Index ("CAI"), to a contract's Star Ratings to mitigate disparities within contract performance. ¶
On January 1, 2024, HMOLA's parent company, Louisiana Health Service & Indemnity Company d/b/a Blue Cross and Blue Shield of Louisiana ("BCBSLA"), consolidated contracts belonging to HMOLA (contract H6453) and another subsidiary (contract H5576), with HMOLA's H6453 contract surviving. ¶
Consistent with its regulations, CMS should have based its Star Ratings for HMOLA's contract on data from both H5576 and H6453.¶
But in calculating the 2025 Star Ratings for HMOLA, CMS applied an entirely different and new methodology that was not subject to any formal notice and comment rulemaking, …

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undermined HMOLA's effort to keep approximately 30,000 Medicare beneficiaries healthy and independent.

PARTIES

12. HMOLA is a Louisiana business corporation, with its principal place of business in Baton Rouge, Louisiana, and is a wholly-owned subsidiary of BCBSLA, which is a non-profit, mutual insurance company.

13. Defendant HHS is the department of the federal government ultimately responsible for the federal Medicare and Medicaid programs.

14. HHS has delegated its authority to administer the Medicare and Medicaid programs to Centers for Medicare and Medicaid Services. *See* 66 Fed. Reg. 35437.

15. Defendant CMS is a federal agency within HHS with the primary oversight responsibility for the Medicare program and the federal portion of the Medicaid program. It was created by the Reorganization Act of March 9, 1977. *See* 66 Fed. Reg. 35437.

16. Defendant Xavier Becerra is named in his official capacity as the Secretary of HHS. *See* 42 C.F.R. § 405.1136(d)(1).

17. Defendant Chiquita Brooks-LaSure is named in her official capacity as Administrator of the Centers for Medicare and Medicaid Services. The Administrator is responsible for the administration of the Medicare program, including the Star Ratings. *Id.*

JURISDICTION & VENUE

18. This Court has jurisdiction over this case pursuant to 28 U.S.C. § 1331 because this action arises under the APA, 5 U.S.C. §§ 701 *et seq.*, and 42 U.S.C. §§ 1395 *et seq.*

Deleted: <#>CMS's 2025 Star Ratings for HMOLA should be vacated, and this matter should be remanded to the agency to adjust HMOLA's 2025 Star Ratings based on a proper application of its regulation and use of complete data. ¶
To prevent HMOLA from suffering irreparable harm from CMS's unlawful conduct, and in light of the public release of the 2025 Star Ratings, the Court should expedite the resolution of this matter on the merits, restrain CMS from disseminating or relying on its improper Star Ratings for HMOLA, and require CMS to announce, publish, and distribute HMOLA's 2024 Star Ratings until it correctly recalculates HMOLA's 2025 Star Rating.¶

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19. Venue is proper in this Court under 28 U.S.C. § 1391(e) because this is an action against officers and agencies of the United States and a substantial part of the events giving rise to HMOLA's claims occurred in this District.

20. The Complaint is timely under 28 U.S.C. § 2401(a).

REGULATORY AND FACTUAL BACKGROUND

The Medicare Program And Star Ratings

21. The Medicare program, authorized under Title XVIII of the Social Security Act ("SSA"), is a federal program that provides health insurance benefits for Americans aged 65 years and older and certain disabled persons. *See* 42 U.S.C. §§ 1395 *et seq.*

22. The Centers for Medicare and Medicaid Services is the federal agency responsible for administering the Medicare program.

23. Individuals enrolled in Medicare may elect to receive their benefits under Part C of the Medicare program, commonly referred to as the "Medicare Advantage" program, as an alternative to original Medicare.

24. Under Part C, CMS contracts with private insurance payors, commonly known as Medicare Advantage Plans ("MA Plans"), to provide and arrange for Medicare-covered benefits for Medicare beneficiaries who enroll in their benefit plan. *See* 42 C.F.R. § 422.4.

25. Besides arranging and paying the Medicare-covered benefits of Medicare beneficiaries, MA Plans typically provide supplemental benefits as well as lower co-payments and other cost sharing, which further reduce the cost of covered services for beneficiaries.

26. The Medicare Advantage program is intended to shift the financial risk of providing health care to beneficiaries from the federal government to the privately run MA Plans in exchange for a per-member, per-month payment.

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27. MA Plans that are better at keeping their members healthy, by effectively managing their care and providing important related services, receive higher Star Ratings, and overall, perform better in the marketplace. *See generally* 42 C.F.R. § 422.160.

28. By providing additional benefits beyond those covered by Medicare, MA Plans compete with original Medicare and with one another to convince beneficiaries to select their plan.

29. In an effort to encourage MA Plans to offer high quality plans and to assist Medicare beneficiaries in selecting a plan, CMS studies and surveys MA Plans for quality, compliance, and other metrics to develop numerical ratings for each MA Plan ("Star Ratings").

30. The Star Ratings are based on a five-star scale, with 1 star being the lowest rating and 5 stars being the highest. *See* 42 C.F.R. § 422.162(b); 42 C.F.R. § 422.166(h)(1)(ii).

31. The Star Ratings are designed to be "a true reflection of the plan's quality" and must be based on data that is "complete, accurate, reliable, and valid." 83 Fed. Reg. 16440, 16521 (Apr. 16, 2018).

32. Star Ratings information is widely available to Medicare beneficiaries to consider when choosing to enroll in an MA Plan. These measures are particularly important, as they allow beneficiaries to compare health plans based on quality.

33. CMS prominently displays Star Ratings on available MA Plans in its online and print resources as required under the SSA. *See* 42 U.S.C. § 1395w–21.

34. Indeed, through the online Medicare Plan Finder tool, CMS displays MA Plans in highest to lowest Star Ratings order to prospective members, with the express purpose of guiding beneficiaries to higher-rated plans first.

35. The Star Ratings also impact the amount of funds CMS will pay to each MA Plan.

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Deleted: <#>CMS also introduced the Categorical Adjustment Index ("CAI") to address the average within-contract disparity in performance among beneficiaries who receive a low-income subsidy, are dual eligible, and/ or have a disability.[2]¶
CMS then adjusts a plan's Star Ratings upwards or downwards based on the percentage of these beneficiaries. ¶

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36. Under Section 1853(o) of the SSA, CMS allocates quality bonuses to MA Plans based on their Star Ratings and awards additional funds to MA Plans rated at or above 4 stars. *See* 42 U.S.C. § 1395w–23.

37. MA Plans use these bonuses, which are often in the tens, if not hundreds of millions, of dollars, to provide additional benefits and services to further improve care to their members.

38. Conversely, MA Plans that consistently receive Star Ratings below 3 stars may be terminated from the Medicare Advantage program altogether. *See* 42 C.F.R. § 422.162(b); 42 C.F.R. § 422.166(h)(1)(ii).

39. Thus, the Star Ratings have tremendous value to MA Plans and are strong incentives for these plans to provide quality care and comprehensive benefits to their members, allow them to compete in the marketplace, receive higher compensation, and even remain eligible to continue to participate in the Medicare Advantage program.

Calculation Of Star Ratings

40. To calculate Star Ratings, CMS must use clear and unambiguous calculations established in its regulations. *See* 42 C.F.R. § 422.162(b); 42 C.F.R. § 422.166(h)(1)(ii).

41. Star Ratings for MA Plans are based on a calculation of numerous performance measures designed to assess member satisfaction and receipt of care, including but not limited to preventative health services, management of long-term conditions, member experiences with the health plan, member complaints, and customer service.[1]

[1] *See* Medicare 2025 Part C & D Star Ratings Technical Notes at 30–105, CENTERS FOR MEDICARE AND MEDICAID SERVICES, https://www.cms.gov/files/document/2025-star-ratings-technical-notes.pdf (hereinafter "2025 Technical Notes").

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42. MA Plans (including HMOLA) use Star Ratings to target areas of improvement and investment to ensure they are maximizing their services for beneficiaries, and in turn, earn higher Star Ratings.

43. Any changes to the Star Ratings calculations can have serious, and sometimes catastrophic, impacts on MA Plans.

44. When Star Ratings fall because of changes in criteria and calculation methodology, MA Plans may be disqualified from receiving quality bonus payments and can even be removed from the Medicare Advantage program altogether, resulting in devastating financial and coverage consequences for MA Plans and beneficiaries.

45. Given their significance, in developing and applying each MA Plan's Star Ratings, CMS must treat each MA Plan "fairly and equally," judging them only on matters that are "under the control of the health or drug plan," in a system that will "minimize unintended consequences" adopted through a "process of developing [a ratings methodology that] is transparent and allows for multi- stakeholder input." 83 Fed. Reg. 16440, 16521.

46. To meet those obligations, CMS calculates Star Ratings based on a rigid methodology set forth in its own regulations that focuses on "health and drug plan quality and performance measures." 42 C.F.R. §§ 422.164 & 422.166; 2025 Technical Notes at 3–5 & 30–105.

47. CMS also issues annual "Technical Notes" that provide further explanation and direction on its Star Ratings methodology, generally, and how to calculate the relevant "measures" that are "used for a particular Star Rating," specifically. 42 C.F.R. § 422.164(a); *see* 2025 Technical Notes at 3 & 30–105.

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48. CMS issues its Technical Notes to "provide quality and performance information" to MA beneficiaries to "assist them in choosing their health and drug services" and "describes the methodology for creating the Part C & D Star Ratings" for each plan. 2025 Technical Notes, at 1.

49. CMS's regulations further specifically incorporate and include its Technical Notes. 42 C.F.R. § 422.164(a).

50. To ensure equal and transparent treatment of all plans, CMS cannot adopt or use a metric different from that articulated in its regulations and Technical Notes. *Id.*; *see e.g.*, *UnitedHealthcare Benefits of Texas, Inc. v. Centers for Medicare & Medicaid Servs.*, No. 6:24-cv-00357, ECF No. 28, at 8–9 (E.D. Tex. Nov. 22, 2024) (remanding an agency action that was "contrary to the agency's" Call Center Technical Notes).

51. Among other measures used to develop Star Ratings, CMS assesses each plan's offering of Special Needs Plan Care Management ("SNP"), which is identified by CMS as C05. *See* 2025 Technical Notes at 37–38.

52. SNPs are designed for specific types of beneficiaries, such as those with chronic disease and conditions and who live in an institution, such as a nursing home. *Id.*

53. For CMS to consider a plan's C05 measure as part of its Star Ratings, the plan "must have 30 or more enrollees." 2025 Technical Notes at 38.

54. But if a Plan does not offer an SNP, or has an SNP with fewer than 30 enrollees, CMS will treat Measure C05 for that plan as a "no score." *Id.* at 119.

55. Accordingly, to ensure the absence of a score does not skew the ratings, CMS will not issue a rating for Measure C05 and "exclude" consideration of that measure in developing the plan's overall Star Ratings. *Id.*

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CMS's Regulations For Consolidated Contracts

56. For MA Plans, they may consolidate contracts, meaning "combines multiple contracts into a single contract for the start of the subsequent contract year." 42 C.F.R. § 422.162(a).

57. HMOLA's parent company, Louisiana Health Service & Indemnity Company d/b/a Blue Cross and Blue Shield of Louisiana ("BCBSLA"), consolidated contracts belonging to HMOLA (contract H6453) and another subsidiary (contract H5576), with HMOLA's H6453 contract surviving.

58. Generally, when contracts are consolidated, CMS develops the Star Ratings for the surviving contract for the two years after consolidation using an enrollment-weighted average of the measures of the consumed contract and surviving contract. *See* 42 CFR § 422.162(b)(3)(ii); 2025 Technical Notes, Attachment B, at 114.

59. But when either the surviving or consumed contract has a measure that receives a "no score," then the measure is properly treated as a "no score" for both contracts. *Id.*

60. Otherwise, the Star Ratings for a plan facing consolidation would be incorrectly weighted because it would have only one – as opposed to two – measure for averaging.

61. Moreover, by considering the measure for both contracts instead of excluding them, CMS would issue a Star Rating for services not actually offered by one of the two contracts.

62. Thus, the result of such a flawed approach would be a Star Ratings for the consolidating plan that does not "fairly" capture its true quality of services and care for beneficiaries for the year. 83 Fed. Reg. 16440, 16521. Such flawed Star Ratings would of course mislead Medicare beneficiaries about the plan's true quality.

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Deleted: <#>Non-CAHPS measures derive data from sources other than CAHPS surveys. *See* Medicare 2025 Part C & D Star Ratings Technical Notes, at 5. Non-CAHPS measures consist of data from, among other sources, the Healthcare Effectiveness Data and Information Set[4]and CMS's Part C and D reporting requirements. *Id.* ¶
Each CAHPS and non-CAHPs measure is given a numeric score. *Id.* at 3. ¶
The agency then determines the "cut point" for each measure – that is, the range of scores that correspond with particular Star Ratings. Together, the CAHPS and non-CAHPS measure scores and cut points are combined to develop each MA Plan's Star Ratings. ¶
CMS Adopts The Categorical Adjustment Index As Part Of The Star Ratings Methodology ¶

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CMS Adopted An Unlawful Interpretation Of Its Regulations And Guidance

63. Based on its high-quality care and services, HMOLA has historically received top-tier Star Ratings that are critical to its operations and ability to serve its members.

64. HMOLA received Star Ratings of 4.5 out of 5 in 2023 and 2024.

65. On January 1, 2024, BCBSLA, the parent corporation of HMOLA, consolidated contracts H5576 and H6453.

66. Following that contract consolidation, HMOLA's contract H6453 survived.

67. In 2023 – the measuring period for 2025 Star Ratings – HMOLA's H5576 contract offered an SNP for 2023 and received a 3 Star Rating for Measure C05.

68. But for the same 2023 period, HMOLA's surviving contract, H6453, did not offer an SNP.

69. Thus, under CMS's own regulation, CMS should have treated Measure C05 as a "no score," thereby excluding it from consideration in the development of HMOLA's Star Ratings. 2025 Technical Notes, at 38.

70. In September 2024, CMS notified HMOLA of its plan preview for their 2025 Star Ratings.

71. HMOLA's 2025 Star Ratings dropped precipitously to 3.5 Stars – instead of its expected 4.0 Stars.

72. HMOLA contacted CMS for an explanation of the sudden and surprising drop in its Star Ratings.

See Exhibit ("Ex.") 1, CMS Correspondence on Nov. 15, 2024.

Deleted: <#>Specifically, the CAI factor adjusts a contract's Star Ratings upwards or downwards to adjust for the average within-contract disparity in performance for Low Income Subsidy/Dual Eligible ("LIS/DE") beneficiaries and disabled beneficiaries. *See* Medicare 2025 Part C & D Star Ratings Technical Notes at 15–17.¶
The CAI value or factor depends on the contract's percentage of beneficiaries with LIS/DE and the contract's percentage of beneficiaries with disabled status. *Id.*¶
The CAI factor is then applied to the contract's Star Ratings. 42 C.F.R. § 422.166(f)(2). ¶
In 2024, CMS promulgated a regulation to establish a new methodology for the calculation of CAI factors for contracts that have recently consolidated. *See* 89 Fed. Reg. 30448; 42 C.F.R. § 422.166(f)(2).¶
When consolidation involves "two or more contracts for health or drug services of the same plan type under the same parent organization, the enrollment data . . . are combined *across the surviving and consumed contracts* in the consolidation." 42 C.F.R.
§ 422.166(f)(2)(B)(1) (emphasis added).¶
Thus, under the new regulation, CMS must use the enrollment data of the surviving and consumed contracts to determine the consolidated contract's final adjustment category, which is then used to finalize the consolidated contract's Star Ratings. ¶
If CMS's resulting calculation results in a positive number, then it will increase the Star Ratings for the consolidated contract. Medicare 2025 Part C & D Star Ratings Technical Notes at 16–17.¶
CMS had to apply its revised CAI methodology immediately, meaning that the methodology would be ...

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73. In its response, the agency explained it considered data from both H5576 and H6453 in the calculation of Measure C05, even though contract H6453 did not offer an SNP for the 2023 period.

74. CMS requires that C05 be treated as a "no score" for HMOLA given it did not provide an SNP under contract H6453 during the measuring period. *See* 42 C.F.R. § 422.162; 2025 Technical Notes at 37–38.

75. Nevertheless, CMS calculated HMOLA's C05 measure by combining the surviving contract's "no score" with the consumed contract's 3.0 Star Ratings for C05, resulting in lower overall Star Ratings for HMOLA. *See* Ex. 1.

76. HMOLA's 2025 Star Ratings significantly dropped as a result of CMS's unlawful actions.

77. Had CMS reasonably and properly applied its regulations and guidance, and excluded Measure C05 given HMOLA did not offer an SNP for the measuring year, HMOLA's Part C Star Ratings would have been 4 Stars, rather than 3.5 Stars.

78. 2025 Star Ratings for HMOLA's surviving contract is meant to provide beneficiaries with "a true reflection of the plan's quality," and in doing so, help them make informed decisions about which plan to choose. 83 Fed. Reg. 16440, 16521 (Apr. 16, 2018).

79. But CMS's arbitrary and unlawful calculation of HMOLA's 2025 Star Ratings does just the opposite. It misleads beneficiaries about the plan's true quality and prevents them from making informed decisions about which plan to choose.

80. By issuing 2025 Star Ratings that relied on ratings for programs HMOLA did not *even offer* during the measuring period, the agency issued Star Ratings that do not represent a "true reflection" of HMOLA's services and care. 83 Fed. Reg. 16440, 16521 (Apr. 16, 2018).

Deleted: <#>That is to say, in computing HMOLA's 2025 Star Ratings and CAI adjustment factor, CMS only used enrollment data for one of the MA contracts, contract H6453, instead of using enrollment data for both MA contracts, including contract H5576.¶

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81. It also frustrates the very purpose of CMS's consolidation regulations, which is meant to ensure the Star Ratings of the surviving contract are properly measured post-consolidation to reflect the surviving plan's true quality. 42 C.F.R. § 422.162(f)(3).

82. When confronted about its flawed and unlawful approach, CMS mistakenly insisted that its regulations directed the combination of the data from the consumed and surviving contracts – regardless of the measure. *See* Ex. 1; 42 C.F.R. § 422.162(b)(2).

83. Despite HMOLA's informal efforts to have CMS correct its Star Ratings, the agency has refused to reconsider its flawed and unlawful approach.

Defendants' Unlawful Conduct Has Caused HMOLA To Suffer Irreparable Harms

84. CMS's unlawful conduct has caused and continues to cause HMOLA to suffer severe and irreparable harms.

85. Defendants have improperly refused to calculate C05 using solely the surviving contract's "no score."

86. As a result, Defendants have issued a fundamentally flawed Part C Star Ratings for HMOLA of 3.5 Stars.

87. The impact of that significant drop in HMOLA's Star Ratings is serious and substantial.

88. The reduced Star Ratings have undermined HMOLA's competitive position, reputation, and goodwill, and impacted its ability to compete against other plans, including those that may have benefited from Defendants' flawed and unlawful methodology.

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HMOLA alerted CMS to its flawed methodology, explaining the regulation requires CMS to use enrollment data from the surviving and consumed contracts in the consolidation. *See* Ex. 2, Notification of Calculation Errors on Sept. 12, 2024; 42 CFR § 422.166(f)(2)(i)(B)(1).¶
HMOLA also advised CMS that this flawed approach undermines the purpose and policy of the regulation to obtain a complete representation of plan performance when calculating Star Ratings. *See* Ex. 2.¶
Calculating the CAI factor for a newly consumed contract with only data from the surviving contract is inconsistent with the plain and express language of the regulation, which calls for use of enrollment data from both the surviving *and consumed* contract. *See* 42 C.F.R. §§ 422.166(f)(2) & 422.166(f)(2)(i)(B)(1). ¶

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89. Additionally, as a result of CMS's flawed rating methodology and reliance on improper data, beneficiaries may, based on its Star Ratings, mistakenly conclude HMOLA's offerings are inferior or lower in quality compared to the offerings of other plans.

90. And by reducing HMOLA's 2025 Star Ratings, CMS has rendered HMOLA ineligible for quality bonus payments in 2026, thereby impacting its operations and ability to provide enhanced benefits and lower premiums to beneficiaries.

91. HMOLA now turns to this Court to redress these grave harms by requiring Defendants to comply with federal law, vacating the flawed 2025 Star Ratings assigned to HMOLA, and enjoining them from disclosing and relying on that unlawful rating in connection with any other agency decision.

COUNT I
(Violation Of 5 U.S.C. § 706(2)(A) – Against All Defendants)
(Consideration of H5576 Data For Measure C05)

92. HMOLA realleges the allegations set forth in Paragraphs 1 through 91 of this Complaint as if fully set forth herein.

93. CMS's consideration of H5576's C05 data to calculate HMOLA's Part C 2025 Star Ratings is a final agency action made reviewable by 5 U.S.C. § 706(2) and 42 C.F.R. § 422.162(b)(3)(ii).

94. HMOLA is adversely affected and aggrieved by CMS's calculation of the C05 Measure for HMOLA's newly-consolidated contract – without an SNP – with the C05 Measure from its consumed contract.

95. The consideration of C05 data from H5576 to calculate HMOLA's 2025 Star Ratings is arbitrary, capricious, and otherwise not in accordance with the law in violation of 5 U.S.C. § 706(2)(A).

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Left with no other option,

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Deleted: (Use Of Surviving Contract Enrollment Data)¶
HMOLA realleges the allegations set forth in Paragraphs 1 through 117 of this Complaint as if fully set forth herein.¶
Defendants' decision to use solely the surviving contract enrollment data to calculate HMOLA's CAI factor and apply such to HMOLA's 2025 Star Ratings is a final agency action made reviewable by 5 U.S.C. § 706(2) and 42 C.F.R. § 422.166(f)(2). ¶
HMOLA is adversely affected and aggrieved by Defendants' action. ¶
Defendants' decision not to use both surviving and consumed contract enrollment data to calculate CAI factors is arbitrary and capricious and contrary to law.¶
Defendants failed to engage in reasoned decision-making; to reasonably (or at all) explain their departure from CMS's own regulation; or to provide an adequate and reasonable explanation for their decision. ¶
Defendants' action flies in the face of the plain and unambiguous text of their own regulation and undermines the policy and purpose of that regulation to alleviate disparities between MA plans in the same MA contract, which in turn harms MA beneficiaries. ¶
Defendants acted unreasonably and contrary to law by deploying a methodology that is inconsistent with the approach mandated by their regulation, and was never disclosed to regulated parties – let alone adopted pursuant to any proper rulemaking proceedings.¶ ...

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96. Defendants failed to engage in a reasoned decision-making; to consider important aspects of the problem they believed they faced; to consider the impact that the incomplete data would have on HMOLA's Star Ratings; to provide an adequate explanation for their decision to consider incomplete data to determine HMOLA's Star Ratings; and considered the consumed contract data even though contrary evidence demonstrated it should never have been considered as is.

97. HMOLA has suffered and will continue to suffer irreparable harm as a result of Defendants' violations of 5 U.S.C. § 706(2)(A).

98. HMOLA is entitled to injunctive and declaratory relief to remedy Defendants' unlawful conduct, as well as all other relief as set forth in its Prayer for Relief. *See* 5 U.S.C. § 705.

COUNT II
Declaratory Judgment

99. HMOLA realleges and incorporates Paragraphs 1 through 91 as if fully set forth herein.

100. CMS's calculation of the 2025 Star Ratings is a final agency action made reviewable by 5 U.S.C. § 706(2).

101. HMOLA is adversely affected and aggrieved by the calculation of its Star Ratings.

102. An actual controversy has arisen and exists between HMOLA and Defendants regarding Defendants' calculation of HMOLA's 2025 Star Ratings using the consumed contract data.

103. HMOLA requests a declaration from this Court under 28 U.S.C. § 2201 that Defendants' calculation is arbitrary and capricious.

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HMOLA is entitled to injunctive and declaratory relief to remedy Defendants' unlawful conduct, as well as all other relief as set forth in its Prayer for Relief. *See* 5 U.S.C. § 705. ¶
COUNT III¶
(Violation Of 5 U.S.C. § 706(2)(A) – Against All Defendants)¶
(Failure To Consider H5576 Data For Measure C05)¶
HMOLA realleges the allegations set forth in Paragraphs 1 through 117 of this Complaint as if fully set forth herein.¶
CMS's failure to consider C05 data from H5576 to calculate HMOLA's Part D 2025 Star Ratings is a final agency action made reviewable by 5 U.S.C. § 706(2) and 42 C.F.R. § 422.162(b)(3)(ii). ¶
HMOLA is adversely affected and aggrieved by the use of this incomplete data measure. ¶
Defendants' decision to not consider H5576's data relating to Measure C05 is arbitrary and capricious and contrary to law.¶

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PRAYER FOR RELIEF

WHEREFORE, Plaintiff HMOLA prays that this Court vacate HMOLA's 2025 Star Ratings and remand this matter to the agency for further consideration. Additionally, HMOLA requests the Court to:

1. Adopt an expedited schedule to resolve the merits of this Complaint;

2. Declare that:

   - Defendants' consideration of the consumed contract's data to calculate Measure C05 and HMOLA's 2025 Star Ratings is arbitrary, capricious, and contrary to law in violation of 5 U.S.C. § 706(2)(A); and

   - Defendants must recalculate HMOLA's 2025 Star Ratings in compliance with CMS's regulations, specifically only using H6453's "no score" for Measure C05.

3. Enjoin Defendants from disclosing and relying on that HMOLA's unlawful 2025 rating in connection with any other agency decision.

4. Require remedial action by Defendants to:

   - Issue a public statement of its error and the correction of HMOLA's 2025 Star Ratings, to be posted both on the CMS website and in one or more newspapers of general circulation in each community or county located in the service area of HMOLA's consolidated contract H6453;

   - Take all actions necessary to ensure that HMOLA is not competitively disadvantaged as a result of CMS's corrective actions to cure its unlawful star ratings calculations, including but not limited to recalculating HMOLA's 2025 Star Ratings; and

5. Award HMOLA its reasonable attorney's fees and costs, as permitted by law; and

6. Grant such other further relief as this Court deems just and proper.

Dated: December 6, 2024

By: _____

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Paul Werner
Imad Matini
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pwerner@sheppardmullin.com
imatini@sheppardmullin.com

Counsel for Plaintiff

Deleted: (D.C. Bar #482637)

Deleted: **DECLARATION**¶
Pursuant to 28 U.S.C. § 1746, I declare under penalty of perjury under the laws of the United States of America that the factual statements contained in the Verified Complaint related to HMOLA are true and correct to the best of my knowledge and belief.¶

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Sheldon Faulk¶
SVP and COO, Government Business ¶
Executed on October 16, 2024¶

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Exhibit B

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

HMO LOUISIANA, INC., *Plaintiff,* v. DEPARTMENT OF HEALTH AND HUMAN SERVICES, et al., *Defendants.*	Case No. 24-2931

AMENDED COMPLAINT FOR DECLARATORY AND INJUNCTIVE RELIEF

Plaintiff HMO Louisiana, Inc. ("HMOLA"), submits the following Amended Complaint for declaratory and injunctive relief against Defendants Department of Health and Human Services ("HHS"), the Centers for Medicare & Medicaid Services ("CMS"), Xavier Becerra, in his official capacity as Secretary of HHS, and Chiquita Brooks-LaSure, in her official capacity as Administrator of CMS (collectively, "Defendants" or "CMS"), and alleges as follows:

INTRODUCTION

1. This is yet another case in which CMS miscalculated a Medicare Advantage Plan's Star Ratings, causing serious and irreparable harms to the plan and its members that will persist if left uncorrected.

2. HMOLA is one of the nation's largest Medicare Advantage health plans ("MA Plans"), currently serving approximately 30,000 members in Louisiana.

3. In 2024, HMOLA's parent company, Louisiana Health Service & Indemnity Company d/b/a Blue Cross and Blue Shield of Louisiana ("BCBSLA"), consolidated two of its contracts, H6453 and H5576, with HMOLA's H6453 contract surviving.

4. MA Plans, like HMOLA, receive annual Star Ratings from CMS for their contracts based on "health and drug plan quality and performance measures" that are used by Medicare beneficiaries to shop for plans.

5. HMOLA's contract H6453 did not offer a Special Needs Plan ("SNP"), which is one of the measures CMS evaluates in developing Star Ratings.

6. Thus, according to its own regulations, CMS should have excluded consideration of Measure C05 in developing HMOLA's Star Ratings so they were not artificially impacted by a measure pertaining to a non-existent offering.

7. But CMS did just the opposite. It considered Measure C05, which caused HMOLA's 2025 Part C Star Ratings to precipitously plunge, from 4 to 3.5 Stars, and caused its overall 2025 Star Ratings also to drop from 4 to 3.5 Stars.

8. CMS publicly disclosed HMOLA's unlawfully calculated Star Ratings on its website, which has resulted in irreparable harm to HMOLA's reputation, goodwill, and competitive position, as well as impaired its ability to attract beneficiaries.

9. When HMOLA confronted the agency about its failure to exclude the C05 measure, CMS refused to recognize it regulations and guidance required it to treat C05 as a "no score."

10. CMS's refusal to apply the plain text of its regulations is an arbitrary and capricious agency action in violation of the APA.

11. Accordingly, HMOLA brings this action to obtain relief for the unlawful actions CMS has engaged in to calculate HMOLA's 2025 Star Ratings, which have caused immediate and irreparable harms to its reputation, market and competitive position, and more importantly,

undermined HMOLA's effort to keep approximately 30,000 Medicare beneficiaries healthy and independent.

PARTIES

12. HMOLA is a Louisiana business corporation, with its principal place of business in Baton Rouge, Louisiana, and is a wholly-owned subsidiary of BCBSLA, which is a non-profit, mutual insurance company.

13. Defendant HHS is the department of the federal government ultimately responsible for the federal Medicare and Medicaid programs.

14. HHS has delegated its authority to administer the Medicare and Medicaid programs to Centers for Medicare and Medicaid Services. *See* 66 Fed. Reg. 35437.

15. Defendant CMS is a federal agency within HHS with the primary oversight responsibility for the Medicare program and the federal portion of the Medicaid program. It was created by the Reorganization Act of March 9, 1977. *See* 66 Fed. Reg. 35437.

16. Defendant Xavier Becerra is named in his official capacity as the Secretary of HHS. *See* 42 C.F.R. § 405.1136(d)(1).

17. Defendant Chiquita Brooks-LaSure is named in her official capacity as Administrator of the Centers for Medicare and Medicaid Services. The Administrator is responsible for the administration of the Medicare program, including the Star Ratings. *Id.*

JURISDICTION & VENUE

18. This Court has jurisdiction over this case pursuant to 28 U.S.C. § 1331 because this action arises under the APA, 5 U.S.C. §§ 701 *et seq.*, and 42 U.S.C. §§ 1395 *et seq.*

19. Venue is proper in this Court under 28 U.S.C. § 1391(e) because this is an action against officers and agencies of the United States and a substantial part of the events giving rise to HMOLA's claims occurred in this District.

20. The Complaint is timely under 28 U.S.C. § 2401(a).

REGULATORY AND FACTUAL BACKGROUND

The Medicare Program And Star Ratings

21. The Medicare program, authorized under Title XVIII of the Social Security Act ("SSA"), is a federal program that provides health insurance benefits for Americans aged 65 years and older and certain disabled persons. *See* 42 U.S.C. §§ 1395 *et seq.*

22. The Centers for Medicare and Medicaid Services is the federal agency responsible for administering the Medicare program.

23. Individuals enrolled in Medicare may elect to receive their benefits under Part C of the Medicare program, commonly referred to as the "Medicare Advantage" program, as an alternative to original Medicare.

24. Under Part C, CMS contracts with private insurance payors, commonly known as Medicare Advantage Plans ("MA Plans"), to provide and arrange for Medicare-covered benefits for Medicare beneficiaries who enroll in their benefit plan. *See* 42 C.F.R. § 422.4.

25. Besides arranging and paying the Medicare-covered benefits of Medicare beneficiaries, MA Plans typically provide supplemental benefits as well as lower co-payments and other cost sharing, which further reduce the cost of covered services for beneficiaries.

26. The Medicare Advantage program is intended to shift the financial risk of providing health care to beneficiaries from the federal government to the privately run MA Plans in exchange for a per-member, per-month payment.

27. MA Plans that are better at keeping their members healthy, by effectively managing their care and providing important related services, receive higher Star Ratings, and overall, perform better in the marketplace. *See generally* 42 C.F.R. § 422.160.

28. By providing additional benefits beyond those covered by Medicare, MA Plans compete with original Medicare and with one another to convince beneficiaries to select their plan.

29. In an effort to encourage MA Plans to offer high quality plans and to assist Medicare beneficiaries in selecting a plan, CMS studies and surveys MA Plans for quality, compliance, and other metrics to develop numerical ratings for each MA Plan ("Star Ratings").

30. The Star Ratings are based on a five-star scale, with 1 star being the lowest rating and 5 stars being the highest. *See* 42 C.F.R. § 422.162(b); 42 C.F.R. § 422.166(h)(1)(ii).

31. The Star Ratings are designed to be "a true reflection of the plan's quality" and must be based on data that is "complete, accurate, reliable, and valid." 83 Fed. Reg. 16440, 16521 (Apr. 16, 2018).

32. Star Ratings information is widely available to Medicare beneficiaries to consider when choosing to enroll in an MA Plan. These measures are particularly important, as they allow beneficiaries to compare health plans based on quality.

33. CMS prominently displays Star Ratings on available MA Plans in its online and print resources as required under the SSA. *See* 42 U.S.C. § 1395w–21.

34. Indeed, through the online Medicare Plan Finder tool, CMS displays MA Plans in highest to lowest Star Ratings order to prospective members, with the express purpose of guiding beneficiaries to higher-rated plans first.

35. The Star Ratings also impact the amount of funds CMS will pay to each MA Plan.

36. Under Section 1853(o) of the SSA, CMS allocates quality bonuses to MA Plans based on their Star Ratings and awards additional funds to MA Plans rated at or above 4 stars. *See* 42 U.S.C. § 1395w–23.

37. MA Plans use these bonuses, which are often in the tens, if not hundreds of millions, of dollars, to provide additional benefits and services to further improve care to their members.

38. Conversely, MA Plans that consistently receive Star Ratings below 3 stars may be terminated from the Medicare Advantage program altogether. *See* 42 C.F.R. § 422.162(b); 42 C.F.R. § 422.166(h)(1)(ii).

39. Thus, the Star Ratings have tremendous value to MA Plans and are strong incentives for these plans to provide quality care and comprehensive benefits to their members, allow them to compete in the marketplace, receive higher compensation, and even remain eligible to continue to participate in the Medicare Advantage program.

Calculation Of Star Ratings

40. To calculate Star Ratings, CMS must use clear and unambiguous calculations established in its regulations. *See* 42 C.F.R. § 422.162(b); 42 C.F.R. § 422.166(h)(1)(ii).

41. Star Ratings for MA Plans are based on a calculation of numerous performance measures designed to assess member satisfaction and receipt of care, including but not limited to preventative health services, management of long-term conditions, member experiences with the health plan, member complaints, and customer service.[1]

[1] *See* Medicare 2025 Part C & D Star Ratings Technical Notes at 30–105, CENTERS FOR MEDICARE AND MEDICAID SERVICES, https://www.cms.gov/files/document/2025-star-ratings-technical-notes.pdf (hereinafter "2025 Technical Notes").

42. MA Plans (including HMOLA) use Star Ratings to target areas of improvement and investment to ensure they are maximizing their services for beneficiaries, and in turn, earn higher Star Ratings.

43. Any changes to the Star Ratings calculations can have serious, and sometimes catastrophic, impacts on MA Plans.

44. When Star Ratings fall because of changes in criteria and calculation methodology, MA Plans may be disqualified from receiving quality bonus payments and can even be removed from the Medicare Advantage program altogether, resulting in devastating financial and coverage consequences for MA Plans and beneficiaries.

45. Given their significance, in developing and applying each MA Plan's Star Ratings, CMS must treat each MA Plan "fairly and equally," judging them only on matters that are "under the control of the health or drug plan," in a system that will "minimize unintended consequences" adopted through a "process of developing [a ratings methodology that] is transparent and allows for multi- stakeholder input." 83 Fed. Reg. 16440, 16521.

46. To meet those obligations, CMS calculates Star Ratings based on a rigid methodology set forth in its own regulations that focuses on "health and drug plan quality and performance measures." 42 C.F.R. §§ 422.164 & 422.166; 2025 Technical Notes at 3–5 & 30–105.

47. CMS also issues annual "Technical Notes" that provide further explanation and direction on its Star Ratings methodology, generally, and how to calculate the relevant "measures" that are "used for a particular Star Rating," specifically. 42 C.F.R. § 422.164(a); *see* 2025 Technical Notes at 3 & 30–105.

48. CMS issues its Technical Notes to "provide quality and performance information" to MA beneficiaries to "assist them in choosing their health and drug services" and "describes the methodology for creating the Part C & D Star Ratings" for each plan. 2025 Technical Notes, at 1.

49. CMS's regulations further specifically incorporate and include its Technical Notes. 42 C.F.R. § 422.164(a).

50. To ensure equal and transparent treatment of all plans, CMS cannot adopt or use a metric different from that articulated in its regulations and Technical Notes. *Id.*; *see e.g.*, *UnitedHealthcare Benefits of Texas, Inc. v. Centers for Medicare & Medicaid Servs.*, No. 6:24-cv-00357, ECF No. 28, at 8–9 (E.D. Tex. Nov. 22, 2024) (remanding an agency action that was "contrary to the agency's" Call Center Technical Notes).

51. Among other measures used to develop Star Ratings, CMS assesses each plan's offering of Special Needs Plan Care Management ("SNP"), which is identified by CMS as C05. *See* 2025 Technical Notes at 37–38.

52. SNPs are designed for specific types of beneficiaries, such as those with chronic disease and conditions and who live in an institution, such as a nursing home. *Id.*

53. For CMS to consider a plan's C05 measure as part of its Star Ratings, the plan "must have 30 or more enrollees." 2025 Technical Notes at 38.

54. But if a Plan does not offer an SNP, or has an SNP with fewer than 30 enrollees, CMS will treat Measure C05 for that plan as a "no score." *Id.* at 119.

55. Accordingly, to ensure the absence of a score does not skew the ratings, CMS will not issue a rating for Measure C05 and "exclude" consideration of that measure in developing the plan's overall Star Ratings. *Id.*

CMS's Regulations For Consolidated Contracts

56. For MA Plans, they may consolidate contracts, meaning "combines multiple contracts into a single contract for the start of the subsequent contract year." 42 C.F.R. § 422.162(a).

57. HMOLA's parent company, Louisiana Health Service & Indemnity Company d/b/a Blue Cross and Blue Shield of Louisiana ("BCBSLA"), consolidated contracts belonging to HMOLA (contract H6453) and another subsidiary (contract H5576), with HMOLA's H6453 contract surviving.

58. Generally, when contracts are consolidated, CMS develops the Star Ratings for the surviving contract for the two years after consolidation using an enrollment-weighted average of the measures of the consumed contract and surviving contract. *See* 42 CFR § 422.162(b)(3)(ii); 2025 Technical Notes, Attachment B, at 114.

59. But when either the surviving or consumed contract has a measure that receives a "no score," then the measure is properly treated as a "no score" for both contracts. *Id.*

60. Otherwise, the Star Ratings for a plan facing consolidation would be incorrectly weighted because it would have only one – as opposed to two – measure for averaging.

61. Moreover, by considering the measure for both contracts instead of excluding them, CMS would issue a Star Rating for services not actually offered by one of the two contracts.

62. Thus, the result of such a flawed approach would be a Star Ratings for the consolidating plan that does not "fairly" capture its true quality of services and care for beneficiaries for the year. 83 Fed. Reg. 16440, 16521. Such flawed Star Ratings would of course mislead Medicare beneficiaries about the plan's true quality.

CMS Adopted An Unlawful Interpretation Of Its Regulations And Guidance

63. Based on its high-quality care and services, HMOLA has historically received top-tier Star Ratings that are critical to its operations and ability to serve its members.

64. HMOLA received Star Ratings of 4.5 out of 5 in 2023 and 2024.

65. On January 1, 2024, BCBSLA, the parent corporation of HMOLA, consolidated contracts H5576 and H6453.

66. Following that contract consolidation, HMOLA's contract H6453 survived.

67. In 2023 – the measuring period for 2025 Star Ratings – HMOLA's H5576 contract offered an SNP for 2023 and received a 3 Star Rating for Measure C05.

68. But for the same 2023 period, HMOLA's surviving contract, H6453, did not offer an SNP.

69. Thus, under CMS's own regulation, CMS should have treated Measure C05 as a "no score," thereby excluding it from consideration in the development of HMOLA's Star Ratings. 2025 Technical Notes, at 38.

70. In September 2024, CMS notified HMOLA of its plan preview for their 2025 Star Ratings.

71. HMOLA's 2025 Star Ratings dropped precipitously to 3.5 Stars – instead of its expected 4.0 Stars.

72. HMOLA contacted CMS for an explanation of the sudden and surprising drop in its Star Ratings. *See* Exhibit ("Ex.") 1, CMS Correspondence on Nov. 15, 2024.

73. In its response, the agency explained it considered data from both H5576 and H6453 in the calculation of Measure C05, even though contract H6453 did not offer an SNP for the 2023 period.

74. CMS requires that C05 be treated as a "no score" for HMOLA given it did not provide an SNP under contract H6453 during the measuring period. *See* 42 C.F.R. § 422.162; 2025 Technical Notes at 37–38.

75. Nevertheless, CMS calculated HMOLA's C05 measure by combining the surviving contract's "no score" with the consumed contract's 3.0 Star Ratings for C05, resulting in lower overall Star Ratings for HMOLA. *See* Ex. 1.

76. HMOLA's 2025 Star Ratings significantly dropped as a result of CMS's unlawful actions.

77. Had CMS reasonably and properly applied its regulations and guidance, and excluded Measure C05 given HMOLA did not offer an SNP for the measuring year, HMOLA's Part C Star Ratings would have been 4 Stars, rather than 3.5 Stars.

78. 2025 Star Ratings for HMOLA's surviving contract is meant to provide beneficiaries with "a true reflection of the plan's quality," and in doing so, help them make informed decisions about which plan to choose. 83 Fed. Reg. 16440, 16521 (Apr. 16, 2018).

79. But CMS's arbitrary and unlawful calculation of HMOLA's 2025 Star Ratings does just the opposite. It misleads beneficiaries about the plan's true quality and prevents them from making informed decisions about which plan to choose.

80. By issuing 2025 Star Ratings that relied on ratings for programs HMOLA did not *even offer* during the measuring period, the agency issued Star Ratings that do not represent a "true reflection" of HMOLA's services and care. 83 Fed. Reg. 16440, 16521 (Apr. 16, 2018).

81. It also frustrates the very purpose of CMS's consolidation regulations, which is meant to ensure the Star Ratings of the surviving contract are properly measured post-consolidation to reflect the surviving plan's true quality. 42 C.F.R. § 422.162(f)(3).

82. When confronted about its flawed and unlawful approach, CMS mistakenly insisted that its regulations directed the combination of the data from the consumed and surviving contracts – regardless of the measure. *See* Ex. 1; 42 C.F.R. § 422.162(b)(2).

83. Despite HMOLA's informal efforts to have CMS correct its Star Ratings, the agency has refused to reconsider its flawed and unlawful approach.

Defendants' Unlawful Conduct
Has Caused HMOLA To Suffer Irreparable Harms

84. CMS's unlawful conduct has caused and continues to cause HMOLA to suffer severe and irreparable harms.

85. Defendants have improperly refused to calculate C05 using solely the surviving contract's "no score."

86. As a result, Defendants have issued a fundamentally flawed Part C Star Ratings for HMOLA of 3.5 Stars.

87. The impact of that significant drop in HMOLA's Star Ratings is serious and substantial.

88. The reduced Star Ratings have undermined HMOLA's competitive position, reputation, and goodwill, and impacted its ability to compete against other plans, including those that may have benefited from Defendants' flawed and unlawful methodology.

89. Additionally, as a result of CMS's flawed rating methodology and reliance on improper data, beneficiaries may, based on its Star Ratings, mistakenly conclude HMOLA's offerings are inferior or lower in quality compared to the offerings of other plans.

90. And by reducing HMOLA's 2025 Star Ratings, CMS has rendered HMOLA ineligible for quality bonus payments in 2026, thereby impacting its operations and ability to provide enhanced benefits and lower premiums to beneficiaries.

91. HMOLA now turns to this Court to redress these grave harms by requiring Defendants to comply with federal law, vacating the flawed 2025 Star Ratings assigned to HMOLA, and enjoining them from disclosing and relying on that unlawful rating in connection with any other agency decision.

COUNT I
(Violation Of 5 U.S.C. § 706(2)(A) – Against All Defendants)
(Consideration of H5576 Data For Measure C05)

92. HMOLA realleges the allegations set forth in Paragraphs 1 through 91 of this Complaint as if fully set forth herein.

93. CMS's consideration of H5576's C05 data to calculate HMOLA's Part C 2025 Star Ratings is a final agency action made reviewable by 5 U.S.C. § 706(2) and 42 C.F.R. § 422.162(b)(3)(ii).

94. HMOLA is adversely affected and aggrieved by CMS's calculation of the C05 Measure for HMOLA's newly-consolidated contract – without an SNP – with the C05 Measure from its consumed contract.

95. The consideration of C05 data from H5576 to calculate HMOLA's 2025 Star Ratings is arbitrary, capricious, and otherwise not in accordance with the law in violation of 5 U.S.C. § 706(2)(A).

96. Defendants failed to engage in a reasoned decision-making; to consider important aspects of the problem they believed they faced; to consider the impact that the incomplete data would have on HMOLA's Star Ratings; to provide an adequate explanation for their decision to consider incomplete data to determine HMOLA's Star Ratings; and considered the consumed contract data even though contrary evidence demonstrated it should never have been considered as is.

97. HMOLA has suffered and will continue to suffer irreparable harm as a result of Defendants' violations of 5 U.S.C. § 706(2)(A).

98. HMOLA is entitled to injunctive and declaratory relief to remedy Defendants' unlawful conduct, as well as all other relief as set forth in its Prayer for Relief. *See* 5 U.S.C. § 705.

COUNT II
Declaratory Judgment

99. HMOLA realleges and incorporates Paragraphs 1 through 91 as if fully set forth herein.

100. CMS's calculation of the 2025 Star Ratings is a final agency action made reviewable by 5 U.S.C. § 706(2).

101. HMOLA is adversely affected and aggrieved by the calculation of its Star Ratings.

102. An actual controversy has arisen and exists between HMOLA and Defendants regarding Defendants' calculation of HMOLA's 2025 Star Ratings using the consumed contract data.

103. HMOLA requests a declaration from this Court under 28 U.S.C. § 2201 that Defendants' calculation is arbitrary and capricious.

PRAYER FOR RELIEF

WHEREFORE, Plaintiff HMOLA prays that this Court vacate HMOLA's 2025 Star Ratings and remand this matter to the agency for further consideration. Additionally, HMOLA requests the Court to:

1. Adopt an expedited schedule to resolve the merits of this Complaint;

2. Declare that:

- Defendants' consideration of the consumed contract's data to calculate Measure C05 and HMOLA's 2025 Star Ratings is arbitrary, capricious, and contrary to law in violation of 5 U.S.C. § 706(2)(A); and

- Defendants must recalculate HMOLA's 2025 Star Ratings in compliance with CMS's regulations, specifically only using H6453's "no score" for Measure C05.

3. Enjoin Defendants from disclosing and relying on that HMOLA's unlawful 2025 rating in connection with any other agency decision.

4. Require remedial action by Defendants to:

   - Issue a public statement of its error and the correction of HMOLA's 2025 Star Ratings, to be posted both on the CMS website and in one or more newspapers of general circulation in each community or county located in the service area of HMOLA's consolidated contract H6453;

   - Take all actions necessary to ensure that HMOLA is not competitively disadvantaged as a result of CMS's corrective actions to cure its unlawful star ratings calculations, including but not limited to recalculating HMOLA's 2025 Star Ratings; and

5. Award HMOLA its reasonable attorney's fees and costs, as permitted by law; and

6. Grant such other further relief as this Court deems just and proper.

Dated: December 6, 2024

By: _____

Paul Werner
Imad Matini
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Tel. 202-747-1900
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Counsel for Plaintiff

Exhibit 1

From: CMS PartC&DStarRatings
To: Miller, Wesley
Cc: Saporito, Mary; Faulk, Sheldon; Patalano, Lou; CMS PartC&DStarRatings
Subject: RE: Plan Preview #2 H6453
Date: Friday, November 15, 2024 12:35:17 PM

Good afternoon,

This is in further response to the notice of calculation errors HMO Louisiana, Inc. ("HMOLA") provided CMS on September 12, 2024, concerning the 2025 Star Ratings for its contract H6453.
In that notice, HMOLA claimed that those Star Ratings contained certain calculation errors arising out of "[t]he consolidation of contracts H5576 (the consumed contract) and H6453 (the surviving contract)," effective January 1, 2024. HMOLA claimed that "to accurately calculate the STAR Rating for contract H6453, CMS must include data from both contract H5576 and H6453 in its calculations" of two performance measures, the SNP Care Management (C05) and the MTM Program Completion Rate (D11) measures. HMOLA claimed that "due to a technical issue with HPMS," it "was unable to submit relevant measurement information data" for each measure, which would have resulted in an increase on the C05 measure from No Star Rating to 96% (5 Stars) and an increase on the D11 measure from 92% (4 Stars) to 95% (5 Stars). HMOLA requested that "CMS recalculate the measure values for contract H6453 using data for measurements D11 and C05 for contract H5576."

At Louisiana Blue's request and after further consideration, CMS agreed to accept H5576's 2023 SNP and MTM data, along with the accompanying Data Validation findings, for calculation of the SNP rate and MTM CMR rate for H6453. CMS received H5576's SNP and MTM data on 10/24/24 and the data validation findings on 10/30/24. The contract's SNP and MTM data passed data validation, and CMS calculated the resulting SNP rate and MTM CMR rate for H6453 per §§ 422.162(b)(3)(iv)(B)(*1*) and 423.182(b)(3)(ii)(B)(*1*).

Below are the updated 2025 Star Ratings for the H6453 contract based on the validated data submitted by HMOLA:

SNP Care Management (C05) Measure. For the data publicly released on Medicare Plan Finder on October 10, 2024, H6453 did not receive a score for the SNP Care Management (C05) measure and did not receive a measure-level Star Rating for C05. After we accepted the data for C05 for the consumed contract (H5576), the score for C05 for H6453 (the surviving contract) was updated to 70% and a 3 star measure rating for H6453. The updated data for SNP Care Management (C05) results in a decrease in the Part C improvement measure rating from 4 to 3 stars since there was a significant decline in the measure score from the prior year, decreasing from 76% to 70%.

MTM Program Completion Rate (D11) Measure. For the data publicly released on Medicare Plan Finder on October 10, 2024, H6453 received a score for the MTM Program Completion

Rate (D11) measure of 92% and 4 stars. After we accepted the data for D11 for the consumed contract (H5576), the score for D11 was updated to 95% and increased to a 5 star measure rating for H6453.

After we accepted the data from H5576, as requested by Louisiana Blue, and updated the scores and measure-level stars for H6453, the overall rating is 3.603658 which rounds to 3.5 stars. The Part C Summary Rating decreases from 4 stars to 3.5 stars with the addition of the SNP Care Management measure and the decrease in the Part C improvement measure star. The Part D Summary Rating increases from 3.5 stars to 4 stars with the increase to the MTM measure star.

CMS plans to proceed with updating the measure scores and stars in HPMS and Medicare Plan Finder soon. If you have questions or wish to discuss, please let us know.

Part C and D Star Ratings Team

From: CMS PartC&DStarRatings <PartCandDStarRatings@cms.hhs.gov>
Sent: Thursday, September 12, 2024 7:41 PM
To: Miller, Wesley <Wesley.Miller@lablue.com>
Cc: Saporito, Mary <Mary.Saporito@lablue.com>; Faulk, Sheldon <Sheldon.Faulk@lablue.com>; Patalano, Lou <Lou.Patalano@lablue.com>; CMS PartC&DStarRatings <PartCandDStarRatings@cms.hhs.gov>
Subject: RE: Plan Preview #2 H6453

Confirming receipt.

From: Miller, Wesley <Wesley.Miller@lablue.com>
Sent: Thursday, September 12, 2024 7:14 PM
To: CMS PartC&DStarRatings <PartCandDStarRatings@cms.hhs.gov>
Cc: Saporito, Mary <Mary.Saporito@lablue.com>; Faulk, Sheldon <Sheldon.Faulk@lablue.com>; Patalano, Lou <Lou.Patalano@lablue.com>
Subject: Plan Preview #2 H6453
Importance: High

Good Afternoon,

Thank you for allowing Plans the opportunity to provide feedback on the Star Rating calculation prior to finalization.

Pursuant to the CMS Memorandum dated September 5, 2024 (“Second Plan Preview of 2025 Part C and D Star Ratings Data”), HMO Louisiana, Inc. (“HMOLA”) is providing notice of three (3) calculation errors identified in the Second Plan Preview STAR Ratings for its contract

H6453. These calculation errors impact HMOLA's contract H6453, which is the surviving contract following a consolidation in 2024, and result from the failure to account for data from the consumed contract (H5576). These errors include:

1) HMOLA was unable to submit relevant measurement information data relating to D11: "MTM Program Completion Rate for CMR," which data would have resulted in an increase of this measure from 92% (4 Stars) to 95% (5 Stars).

2) HMOLA was unable to submit relevant measurement information data relating to C05: "Special Needs Plan (SNP) Care Management," which data would have resulted in an increase of this measure from No Star Rating to 96% (5 Stars).

3) The Categorical Adjustment Index ("CAI") applied to HMOLA's contract (H6453) failed to account for enrollment data across all contracts that had been consolidated into the surviving contract. Had the enrollment data been properly applied, the CAI applied to HMOLA's contract would have changed from -0.033597 to 0.002506.

The current STAR rating for HMOLA's contract (H6453) is 3.74957 (3.5 Stars). If the above errors are corrected, the new adjusted rating for the contract would increase to 3.80839 (4.0 Stars). Notably, the correction of even one (1) of these errors would result in an increase of HMOLA's final STAR Rating from a 3.5 to a 4.0. Therefore, if not corrected, these errors would result in a material financial impact to HMOLA in terms of loss of additional STAR quality bonus payments, which may result in fewer benefits and higher costs for members in future years. **Attached to this correspondence is an Appendix that details the calculation errors and the effect on the overall STAR Rating.**

While we provided you with the additional information in the accompanying Appendix (including the data for measurements D11 and C05) that evidence the calculation errors, we believe the summary below provides all of the information necessary for CMS to understand the errors we have identified and correct them prior to finalization of CY 2025 STAR Ratings data.

History of Contract H6453

Louisiana Health Service & Indemnity Company d/b/a Blue Cross and Blue Shield of Louisiana ("BCBSLA") is the parent company to HMOLA. Prior to 2024, BCBSLA and/or its subsidiaries offered products under the following H-Contracts:

- Vantage Health Plan, Inc. offered a MA HMO-POS product under **H5576** contract
- HMOLA offered a MA HMO product under **H6453** contract
- BCBSLA offered a MA PPO product under **H1248** contract
- Primewell Health Services of Mississippi, Inc. offered a MA HMO-POS product under

H7163 contract

- Primewell Health Services of Arkansas, Inc. offered a MA HMO-POS product under **H2722** contract

Effective January 1, 2024, BCBSLA consolidated contracts H5576 (offered by Vantage Health Plan, Inc.) and H6453 (offered by HMOLA), with HMOLA's contract H6453 as the surviving contract. Contracts H1248 (BCBSLA), H7163 (Primewell Health Services of Mississippi, Inc.), and H2722 (Primewell Health Services of Arkansas, Inc.) remain active and were not affected by the consolidation. HMOLA's contract H6453 is only contract at issue for the purposes of this communication. The consolidation of contracts H5576 (the consumed contract) and H6453 (the surviving contract) directly led to the calculation errors noted above.

Errors # 1 and 2: Failure to Consider Relevant Data for Measures D11 and C05

When contracts are consolidated, the STAR Rating for the surviving contract for the first year after consolidation is determined through the enrollment-weighted average of the measures of both the consumed contract and the surviving contract for all measures except improvement measures. Both the regulation addressing STAR Ratings following contract consolidations as well as current technical instructions for STAR Ratings contain this requirement that data from both contracts be included for the first two years following a contract consolidation. *See* 42 CFR § 422.162(b)(3)(ii); Medicare 2025 Part C & D Star Ratings Technical Notes, Appendix B, p. 115 (Draft) (Sept. 4, 2024) ("Technical Notes"). Thus, to accurately calculate the STAR Rating for contract H6453, CMS must include data from both contract H5576 and H6453 in its calculations. However, only data from HH6453 was considered in the calculation of D11 and C05.

Despite its relevance to the STAR Rating calculation for the surviving contract, HMOLA was unable to submit data for two measures for contract H5576 due to a technical issue with HPMS. Specifically, HMOLA was unable was able to submit measurement information relating to measurements D11 "MTM Program Completion Rate for CMR" and C05 "Special Needs Plan (SNP) Care," both of which are process measures. HMOLA was only able to submit information for these measures for contract H6453. As such, CMS used only partial information for these measures and, in doing so, failed to adhere to its own regulations. Again, had the relevant data been submitted relating to contract H5576, HMOLA's score for D11 would be 95%/5 Stars (as opposed to the calculated 92%/4 Stars), and HMOLA's score for C05 would be 96%/5 Stars (as opposed to the calculated No Star Rating). Both the regulations governing contract consolidation and CMS's Technical Notes require CMS to include all relevant data for the consumed contract when calculating the STAR Rating for the surviving contract. Accordingly, HMOLA requests that CMS recalculate the measure values for contract H6453 using data for measurements D11 and C05 for contract H5576.

Error # 3: Incorrect Calculation of CAI

The consolidation of contracts H5576 and H6453 also led to an incorrect calculation of the CAI for HMOLA contract H6453. The regulation governing application of the CAI states that, for the first two years following a consolidation, CMS determines the CAI using enrollment data from both the surviving and consumed contracts in the consolidation. 42 CFR § 422.166(f)(2)(i)(B)(1). This requirement was added to the regulation in April 2024, and the text of the regulation indicates that it became effective immediately. This is in contrast to the language addressing the calculation of the HEI reward following contract consolidation, which the regulation specifies will go into effect beginning with the 2027 STAR Ratings year. 42 CFR § 422.166(f)(2).[1] In the case of the CAI, there is nothing in the text of the regulation that suggests that the methodology for applying the CAI following a contract consolidation should not go into effect immediately. *See SCAN Health Plan v. Dep't of Health and Human Services*, No. 1:23-cv-03910-CJN, Dkt. No. 33 (D.D.C. June 3, 2024) ("[T]he real dividing point between the portions of a final rule with and without legal force is designation for publication in the Code of Federal Regulations" (citation omitted).).

To comply with the requirements in Section 422.166(f)(2), CMS must include in its CAI calculation the enrollment data from the consumed contract regarding beneficiaries who are dually eligible, receive the low-income subsidy, or have disability status. Using enrollment data from both the surviving and the consolidated contracts to determine the CAI adjustment factor is consistent with how CMS assesses plan performance in other contexts following a contract consolidation. As noted above, the regulations require CMS to combine measure-level data between contracts in the first two years following a consolidation. The purpose of this approach is to obtain a complete representation of plan performance when calculating STAR Ratings. Calculating a weighted average of performance data across contracts appropriately represents consolidated performance.

Prior to the April 2024 amendments, Section 422.166 did not address how to calculate the CAI adjustment factor after a contract consolidation. The Technical Notes are also silent on this issue. In the absence of a specific exception made for the calculation of the CAI adjustment factor, the default rule of weighing data from both the consumed and surviving contracts (as reflected in Section 422.162) should have applied to the current calculation of HMOLA's CAI, in compliance with the specific requirement in Section 422.166(f)(2). Accordingly, HMOLA requests that CMS recalculate the CAI factor for contract H6453 using enrollment data for contract H6453 and contract H5576.[2]

Please contact us if you believe any further information is necessary or if you are unable to validate these errors. We are happy to answer any questions you may have related to any of these issues. Otherwise, we thank you for your review and consideration and look forward to your response.

Thank you,

Wesley Miller, PAHM, Notary Public
Medicare Compliance Officer
Louisiana Blue
o (225) 298-7965

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[1] Similarly, when CMS changed the weights given to certain measures, it amended the regulation to specify that the new weights would go into effect starting with the 2026 STAR Ratings year. 42 CFR § 422.166(e)(1)(iii)-(iv).

[2] In the alternative, CMS has the authority, in the absence of any regulatory requirement to the contrary, to calculate the CAI in this manner following a consolidation. In light of the limited number of consolidations that occur in any given year, this rule could easily be applied to any other similarly situated organizations. For CMS to take the alternative approach for CY 2025 STAR Ratings, after already articulating that this was the "more accurate" approach, would be arbitrary and capricious.