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-CRC

PLAINTIFF'S MOTION FOR SUMMARY JUDGMENT

Plaintiff HMO Louisiana, Inc. ("HMOLA"), respectfully moves this Court for summary judgment under Federal Rule of Civil Procedure 56. As set forth more fully in its accompanying brief in support of its motion, HMOLA is entitled to summary judgment because Defendants unlawfully calculated HMOLA's 2025 Star Rating in a manner that was arbitrary and capricious and contrary to law. HMOLA further respectfully requests oral argument regarding its Motion for Summary Judgment.

Dated: February 14, 2025

By:_____

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CERTIFICATE OF SERVICE

I hereby certify that on February 14, 2025, I electronically filed the foregoing document and the accompanying exhibits with the Clerk of the Court using the CM/ECF system, which will send notification of this filing to the attorneys of record and all registered participants.

/s/ Paul Werner
Paul Werner

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INTRODUCTION

This is yet another case in which CMS miscalculated a Medicare Advantage Plan's ("MA Plan's") Star Ratings, costing it hundreds of millions of dollars, damaging its goodwill and reputation in the marketplace, and undermining its ability to provide beneficiaries with access to additional quality services. In doing so, CMS irrationally applied its own regulations, and the Court should now order the agency to recalculate HMO Louisiana, Inc.'s ("HMOLA's"), Star Ratings in accordance with its regulations.

HMOLA is a MA Plan serving thousands of beneficiaries in Louisiana. To improve its services and maximize its offerings to its members, HMOLA's parent company, Louisiana Health Service & Indemnity Company d/b/a Blue Cross and Blue Shield of Louisiana ("BCBSLA"), consolidated two of its Medicare Advantage contracts in 2024 – H5576 and H6453, with H6453, HMOLA's contract, to survive the consolidation. HMOLA expected its plan rating, or "Star Ratings," to positively reflect the consolidation and encourage beneficiaries to select HMOLA's surviving plan. Star Ratings are intended to provide current and prospective beneficiaries with a "a true reflection of the plan's quality." As such, beneficiaries use Star Ratings – which are widely available online and in print resources – to make informed decisions about which plan to choose. Star Ratings also impact the amount of funds CMS pays each MA Plan, which are used to provide additional benefits and services to enhance member care.

In calculating Star Ratings, CMS is bound by its regulations, including the Technical Notes that are incorporated by reference into the regulations. The Technical Notes direct CMS's collection of various data, including data related to a supplemental Special Needs Plan ("SNP") (CMS Measure C05). SNPs are designed for beneficiaries with chronic diseases, concurrently on Medicaid, or living in an institution such as a nursing home, and are not offered by all MA Plans. CMS's Measure C05 recognizes this reality and directs the agency to calculate C05 only

for plans with at least 30 eligible beneficiaries. Thus, for MA Plans that do not offer a SNP, like HMOLA's H6453 contract, CMS must exclude C05 as a "no score" from the Star Ratings calculation.

In calculating HMOLA's consolidated Star Ratings, however, CMS ignored this instruction and the regulation's policy. Instead, the agency combined HMOLA's "no score" for Measure C05 with the 3.0 Stars associated with the SNP of the consumed H5573 contract, which, in effect, reduced HMOLA's Star Ratings from 4.0 to 3.5 stars. This reduction is a direct result of CMS violating its own Technical Notes – failing to exclude Measure C05 from consideration – and flouting their animating purpose to provide beneficiaries "a true reflection of the plan's quality."

CMS's unlawful actions have caused HMOLA substantial, abiding, and irreparable harms. CMS's mistaken Star Ratings will cause HMOLA to lose millions in quality bonus payments used to provide supplemental services and cost-sharing opportunities to its more than 34,000 Medicare beneficiaries. And CMS's lower Star Ratings, which falsely indicate to Medicare Advantage participants that the quality of HMOLA's plan is lower than it truly is, has also impaired HMOLA's goodwill, reputation, and competitive and market positions.

Because CMS has refused to correct HMOLA's mistaken Star Ratings, it therefore has sought this Court's assistance in requiring CMS to comply with its regulations and properly recalculate HMOLA's Star Ratings.

STATEMENT OF FACTS

A. CMS Uses Its Star Ratings Program To Indicate The Quality Of Medicare Advantage Programs And Award Them Additional Funds.

Administered by CMS, the Medicare program 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*. As an alternative to traditional, government-managed Medicare, enrollees may elect to receive benefits under Part C of Medicare, commonly known as the "Medicare Advantage" program. *See* 42 U.S.C. § 1395w-21. Under Part C, CMS contracts with private insurance payors, MA Plans, to provide and arrange for Medicare-covered benefits for beneficiaries who enroll in their benefit plans. *See* 42 C.F.R. § 422.4; 42 U.S.C. § 1395w-23. In addition to arranging and paying Medicare-covered benefits, 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. *See* 42 U.S.C. § 1395w-22(a)(3).

To evaluate the performance of MA Plans and provide beneficiaries with information for comparing plans in the marketplace, CMS issues "Star Ratings" to MA Plans. *See generally* 42 C.F.R. § 422.160. The Star Ratings are intended to be "a true reflection of [the] plan['s] quality" and therefore must be based on data that is "complete, accurate, reliable, and valid." 83 Fed. Reg. 16,440, 16,520–21 (Apr. 16, 2018). To that end, CMS is statutorily required to measure "health outcomes and other indices of quality" that are used to develop the Star Ratings pursuant to methodologies set forth in its regulations. 42 U.S.C. § 1395w-22(e)(3)(A)(i). CMS therefore created the Star Ratings program to study and survey MA Plans for quality, compliance, and other metrics to develop numerical ratings for each MA Plan. *See* 83 Fed. Reg. at 16,520.

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. §§ 422.166(b)(2)(ii). CMS prominently displays Star Ratings for available MA Plans in its online and print resources so that Medicare beneficiaries can compare health plans based on quality when choosing to enroll in a MA Plan. *See, e.g.*, 42 C.F.R. § 422.166(h). Through the online Medicare Plan Finder tool, CMS in fact prominently

displays MA Plans in highest to lowest Star Ratings order to prospective members, with the express purpose of guiding beneficiaries to higher-rated plans.[1]

The Star Ratings also impact the bonuses CMS pays to each MA Plan. MA Plans 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. CMS allocates quality bonuses to MA Plans based on their Star Ratings and awards additional funds to MA Plans rated at or above 4.0 stars. *See* 42 U.S.C. § 1395w–23. 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. *See* Declaration of Benjamin Vicidomina ("Vicidomina Decl.") ¶ 16.

Any changes to how Star Ratings are calculated can have serious and dramatic impacts on MA Plans. When Star Ratings fluctuate because of changes in criteria and methodology, MA Plans may be disqualified from receiving quality bonus payments or removed from the Medicare Advantage program altogether, resulting in devastating financial and coverage consequences for MA Plans and beneficiaries. *See* 42 C.F.R. §§ 422.160(b)(2) & 422.510(a)(1)(iv). Thus, the Star Ratings serve as strong incentives for plans to provide quality care and comprehensive benefits to their members, and allow plans to compete in the marketplace, receive higher compensation, and even remain eligible to continue to participate in the Medicare Advantage program.

[1] *See* CMS Medicare Plan Finder, *available at* https://www.medicare.gov/plan-compare/#/?year=2025&lang=en (last visited Feb. 14, 2025).

B. CMS Calculates Star Ratings Based On A Set Methodology.

CMS promulgated regulations that establish the specific methodology used to calculate annual Star Ratings for MA Plans. *See* 42 C.F.R. §§ 422.162(b) & 422.166. The Star Ratings are calculated based on the data reported for the full year prior to collection.[2] In developing and applying each MA Plan's Star Ratings, CMS must treat each MA Plan "fairly and equally." 83 Fed. Reg. at 16,521. Thus, CMS must consider criteria that are "under the control of the health or drug plan" and 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." *Id.*

CMS also publishes Technical Notes to explain the measure included in the "methodology for creating the Part C & D Star Ratings." AR 9; 42 C.F.R. § 422.164(a). The Technical Notes set forth how CMS calculates the relevant "measures" that are "used for a particular Star Rating." 42 C.F.R. § 422.164(a); *see* AR 11–12 & 38–113. CMS has incorporated its Technical Notes into its operative regulations. 42 C.F.R. § 422.164(a).

CMS calculates Star Ratings based on numerous performance measures and data designed to assess member satisfaction and receipt of care. *See* AR 1–214. Among other measures, CMS assesses an applicable plan's offering of Special Needs Plan ("SNP") Care Management, known as Measure C05. *See* AR 45–47. SNPs are designed for beneficiaries suffering from chronic diseases and conditions as well as those who also receive Medicaid coverage or live in an institution, such as a nursing home. *Id.* However, for CMS to consider a

[2] For example, the 2025 Star Ratings are calculated in late 2024 using data primarily from measurement year 2023. AR 21.

plan's Measure C05 data as part of its Star Ratings, the plan "must have 30 or more enrollees." AR 46.

If a Plan does not offer a SNP, or has a SNP with fewer than 30 enrollees, CMS will treat Measure C05 for that plan as a "no score," formally designated as "no data available." AR 46 & 127. To ensure the absence of a score does not skew the ratings, CMS will thus not issue a rating for Measure C05 and "exclude" consideration of that measure as a "no score." AR 127. CMS also excludes from its calculation "[c]ontracts and [Plan Benefits Packagaes or "PBPs"] with an effective termination date on or before . . . June 15, 2024." AR 45–46.

MA Plans may consolidate their contracts by "combin[ing] multiple contracts into a single contract for the start of the subsequent contract year." 42 C.F.R. § 422.162(a). When contracts are consolidated, CMS develops the Star Ratings for the surviving contract by using a weighted average of the measures of the consumed contract and surviving contract. *See* 42 C.F.R. § 422.162(b)(3)(iv); AR 122. That weighted average methodology applies for the two years after consolidation. *See* 42 C.F.R. § 422.162(b)(3)(iv); AR 122. When either the surviving or consumed contract has a measure that receives a "no score," the measure is properly treated as a "no score" for both contracts. *See* 42 C.F.R. § 422.162(b)(3); AR 45–47.

C. CMS Improperly Calculated HMOLA's 2025 Star Ratings In Violation Of Its Own Regulations.

Based on its high-quality care and services, HMOLA has historically received high Star Ratings, which are critical to its operations and member care. HMOLA received Star Ratings of 4.5 out of 5 in 2023 and 2024 and expected similar ratings for its 2025 Star Ratings. Vicidomina Decl. ¶¶ 14 & 25.

On January 1, 2024, HMOLA's parent company, BCBSLA, consolidated two of its contracts – H5576 and H6453. AR 216. Following that contract consolidation, HMOLA's

contract H6453 survived. *Id.* In September 2024, CMS notified HMOLA of its plan preview for their 2025 Star Ratings. Vicidomina Decl. ¶ 26. HMOLA's 2025 Star Ratings dropped precipitously to 3.5 Stars – instead of its expected 4.0 Stars. Vicidomina Decl. ¶ 27. HMOLA contacted CMS for an explanation of the sudden and surprising drop in its Star Ratings. *See* AR 315–16 & 317–20. In its response, the agency explained it considered data from HMOLA's subsumed contract H5576 in the calculation of Measure C05 for HMOLA's surviving contract H6453. AR 315–16.

In 2023 – the measuring period for 2025 Star Ratings – HMOLA's consumed contract, H5576, offered a SNP for 2023 and received a 3.0 Star Ratings for Measure C05. AR 215. But for the same 2023 period, HMOLA's surviving contract, H6453, did not offer a SNP. *Id.* Thus, under CMS's regulation, CMS should have treated Measure C05 as a "no score," excluding it from consideration in the calculation of HMOLA's Star Ratings. AR 45–46. Instead, CMS calculated HMOLA's Measure C05 by combining the surviving contract's "no score" with the consumed contract's 3.0 Star Ratings for C05, which generated a lower overall Star Ratings for HMOLA. *See* AR 315–316. By considering the measure for both contracts instead of excluding the measure altogether, CMS therefore issued a Star Ratings for *services not actually offered by the surviving H6453 contract*. Had CMS properly applied its regulations, consistent with their intended purpose and policy, and treated Measure C05 as a no score, HMOLA's Part C Star Ratings would properly have been 4.0 Stars.

D. CMS's Unlawful Conduct Has Caused – And Will Continue To Cause – HMOLA Substantial And Irreparable Harm.

CMS's fundamentally flawed 2025 Star Ratings for HMOLA has caused, and will continue to cause, it to suffer substantial and irreparable harms. Its mistakenly low Star Ratings have harmed HMOLA's competitive position, reputation, and goodwill, and undermined its

ability to compete against other plans. Vicidomina Decl. ¶¶ 31–40. Additionally, because 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. Vicidomina Decl. ¶ 35. And by reducing HMOLA's 2025 Star Ratings, CMS has rendered HMOLA ineligible for quality bonus payments worth approximately $23 million in 2026, thereby impacting its operations and ability to provide enhanced benefits and lower premiums to beneficiaries. Vicidomina Decl. ¶¶ 32–33.

Because CMS has informally refused to recalculate HMOLA's Star Ratings, HMOLA seeks judicial relief. It requests the Court to require CMS to vacate the agency's unlawful 2025 Star Ratings, enjoin CMS from relying on the unlawful 2025 Star Ratings in connection with any other agency action, and require CMS to recalculate HMOLA's 2025 Star Ratings in accordance with the text, purpose, and policy of its regulations.

STANDARD

HMOLA's motion is governed by familiar standards. An agency action violates the Administrative Procedure Act ("APA") if it is "arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with law." 5 U.S.C. § 706(2)(A) & (C); *see also* 5 U.S.C. § 702. Thus, Courts set aside an agency action that "disregard[s] rules that are still on the books," "irrationally departs from an agency's governing policy," or "frustrate[s] the policy that Congress sought to implement." *Beaty v. Food & Drug Admin.*, 853 F. Supp. 2d 30, 41 (D.D.C. 2012) (quoting *FEC v. Democratic Senatorial Campaign Comm.*, 454 U.S. 27, 32 (1981)); *Motor Vehicle Mfrs. Ass'n of U.S., Inc. v. State Farm Mut. Auto. Ins. Co.*, 463 U.S. 29, 43 (1983).

In reviewing a motion for summary judgment in an APA case, the Court may not merely "rubberstamp" administrative decisions, especially where they are "inconsistent with a statutory

mandate" or "frustrate the congressional policy underlying a statute." *Bureau of Alcohol, Tobacco and Firearms v. Fed. Lab. Rels. Auth.*, 464 U.S. 89, 97 (1983) (quoting *NLRB v. Brown*, 380 U.S. 278, 291–92 (1965)). Instead, arbitrary and capricious review "has a serious bite," and irrational actions are properly set aside. *UnitedHealthcare Benefits of Tex., Inc. v. Ctrs. for Medicare & Medicaid Servs.*, No. 6:24-cv-00357, 2024 WL 4870771, at *3 (E.D. Tex. Nov. 22, 2024).

ARGUMENT

I. CMS Irrationally And Erroneously Calculated HMOLA's 2025 Star Ratings.

CMS's reliance on Measure C05 to calculate HMOLA's 2025 Star Ratings is arbitrary and capricious because it violates the clear language of its own regulations. Under the APA, an agency action that violates its own regulations is a quintessential example of arbitrary and capricious decision making. *See Scott & White Health Plan v. Becerra*, No. 22-cv-3202 (CRC), 2023 WL 6121904, at *10 (D.D.C. Sept. 19, 2023) (setting aside agency action as contrary to law because the agency acted "contrary to [the operative regulation's] plain language") (citation omitted); *Exportal Ltda v. United States*, 902 F.2d 45, 46 (D.C. Cir. 1990) (reversing agency action "flatly inconsistent with the plain terms" of its regulations).

Here, CMS plainly violated its own regulations. To provide plans with notice regarding its Measure C05 calculations, CMS publishes its Technical Notes, which are incorporated into its regulations. 42 C.F.R. § 422.164(a); *UnitedHealthcare*, 2024 WL 4870771, at *3-4 (holding CMS action arbitrary and capricious where it deviates from its Technical Notes); *see* AR 1–214. Those regulations require CMS to exclude from its calculation "[c]ontracts and PBPs with an effective termination date on or before . . . June 15, 2024" and contracts with fewer than "30 enrollees." AR 45–46. HMOLA's subsumed contract effectively terminated at its merger on January 1, 2024. AR 216 & 226. And its surviving contract did not offer a SNP at all. AR 224.

As a result, CMS should not have included the data for the subsumed contract related to Measure C05 in HMOLA's Star Ratings calculation.

Nor should the agency have issued Star Ratings for a plan that did not actually provide the services supposedly reflected in the ratings. But rather than follow its own regulations, CMS combined Measure C05 data for HMOLA's surviving and consumed contracts and issued HMOLA an overall 3.0 Star Ratings for Measure C05. AR 316; *supra* at Section C. That departure from the plain language of the regulation is a textbook example of arbitrary and capricious agency action. *Nat'l Env't Dev. Assn.'s Clean Air Project v. EPA*, 752 F.3d 999, 1009 (D.C. Cir. 2014) (stating an agency is not free to "violate its regulations while they remain in effect"); *Scan Health Plan*, 2024 WL 2815789, at *5 (holding that CMS must abide "the plain text" of its regulations); *Elevance Health, Inc. v. Becerra*, 736 F. Supp. 3d 1, 13 (D.D.C. 2024) (same).

CMS's consideration of Measure C05 is also arbitrary and capricious because it is "inconsistent with the statutory mandate," *FEC*, 454 U.S. at 32, to provide beneficiaries with a "true reflection of plan quality and enrollee experience," 83 Fed. Reg. at 16,521. The Star Ratings are intended to provide "information about plan quality and performance indicators" to "beneficiaries to help them make informed plan choices." *Id.* at 16,520; *see* 42 U.S.C. § 1395w-21. Accordingly, CMS must issue Star Ratings that "treat contracts fairly and equally" while "minimizing unintended consequences." 83 Fed. Reg. at 16,521. Thus, Star Ratings are designed to be "true reflection[s] of plan quality and enrollee experience" and targeted on "measures under the control of the" MA Plan. *Id.*; *see* AR 9.

But here, CMS "frustrate[d] the policy that Congress sought to implement" by issuing Star Ratings that do not accurately reflect HMOLA's plan. *See Beaty*, 853 F. Supp. 2d at 41

(quoting *FEC*, 454 U.S. at 32). By issuing 2025 Star Ratings that relied on ratings for plans 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. at 16,521; *supra* at Section C. Nor does HMOLA have "control" over the quality of a non-existent SNP plan. 83 Fed. Reg. at 16,521. As a result of this flawed approach, the Star Ratings for the consolidated plan does not "fairly" capture its true quality of services and care for beneficiaries for the year. *Id.* Rather, it misleads beneficiaries about the plan's true quality and prevents them from making informed decisions about which plan to choose. *Supra* at Section D.

II. The Court Should Require CMS To Recalculate HMOLA's Star Ratings And Publish Its Errors.

HMOLA is entitled to injunctive relief. *Nw. Immigrant Rights Project v. U.S. Citizenship & Immigration Servs.*, 496 F. Supp. 3d 31, 45 (D.D.C. 2020). Injunctive relief is particularly appropriate where HMOLA has suffered an "irreparable injury" resulting from a plainly unlawful agency action that violates the public interest. *Id.*; *see Scan Health Plan*, No. 1:23-CV-03910 (CJN), 2024 WL 2815789, at *7 (granting injunctive relief); *see also* 5 U.S.C. § 706. By erroneously calculating HMOLA's 2025 Star Ratings and issuing a flawed 3.5 stars, CMS has rendered HMOLA ineligible to receive quality bonus payments for 2026, amounting to approximately $23 million. Vicidomina Decl. ¶¶ 32–33. In so doing, CMS has also impaired HMOLA's ability to provide existing, much less enhanced, services to its beneficiaries. Vicidomina Decl. ¶ 33. HMOLA cannot now provide as robust supplemental benefits or as low co-payments or other cost-sharing, which would have further reduced the cost of covered services for beneficiaries. Vicidomina Decl. ¶ 33.

Additionally, HMOLA has suffered ongoing harm to its competitive position, reputation and goodwill, which is also irreparable and warrants injunctive relief. *See, e.g., Bell Helicopter*

Textron, Inc. v. Airbus Helicopters, 78 F. Supp. 3d 253, 274–75 (D.D.C. 2015) (finding "risk of future reputational harm, lost sales, and lost customers" irreparable). Since November 2024, CMS has widely publicized HMOLA's flawed 3.5-star Star Ratings. Vicidomina Decl. ¶ 30. As a result, HMOLA's plan appears less attractive to beneficiaries. Vicidomina Decl. ¶¶ 35–36.

If CMS does not correct HMOLA's 2025 Star Ratings, these harms will only worsen as beneficiaries continue to erroneously believe HMOLA offers an inferior plan – with a low-performing SNP that HMOLA *did not even offer*. Vicidomina Decl. ¶¶ 29 & 35. Absent relief, beneficiaries will also switch to competitors' plans, because the loss of approximately $23 million in funding will require HMOLA to significantly cut supplemental benefits, increase member cost-sharing, and reduce reimbursements to providers. Vicidomina Decl. ¶¶ 33 & 36; *see League of Women Voters v. Newby*, 838 F. 3d 1, 9 (D.C. Cir. 2016) (finding irreparable harm when agency action "ma[de] it more difficult for [organizations] to accomplish their primary mission"). HMOLA has expended, and will continue to expend, significant time and resources only to partially remediate these harms. Vicidomina Decl. ¶ 40.

In addition to the harms associated with CMS's unlawful actions, "[CMS's] sovereign immunity" makes HMOLA's injuries "irreparable *per se*." *See, e.g.*, *Nalco Co. v. EPA*, 786 F. Supp. 2d 177, 188 (D.D.C. 2011); *O'Donnell Constr. Co. v. District of Columbia*, 963 F.2d 420, 428 (D.C. Cir. 1992) (finding such a bar "weighs heavily in favor of granting the injunction"). Because of CMS's sovereign immunity, HMOLA will be unable to recover monetary damages from the government, much less recover for the reputational, competitive, and operational harms identified above. *See, e.g.*, *Nat'l Min. Ass'n v. U.S. Army Corps of Eng'rs.*, 145 F.3d 1399, 1408–09 (D.C. Cir. 1998) (finding no adequate remedy at law given no suggestion government

had "waived its sovereign immunity"). Therefore, HMOLA cannot be compensated by the government for its losses caused by the erroneous Star Ratings. *Nalco*, 786 F. Supp. 2d at 188.

HMOLA clearly satisfies the remaining elements for injunctive relief as well. *Nw. Immigrant Rights Project*, 496 F. Supp. 3d at 45. As explained above, HMOLA is likely to succeed on the merits of its APA and declaratory judgment claims because CMS calculated HMOLA's Star Ratings in violation of the plain language and purpose of its own regulations. *Supra* at Section I. The balance of equities and public interest also support injunctive relief. *Nw. Immigrant Rights Project*, 496 F. Supp. 3d at 81. Issuing an injunction will harm no one, including the Defendants, who would only be required to recalculate a Star Ratings in accordance with their own regulations. But, absent injunctive relief, HMOLA will continue to suffer irreparable harm to its competitive position, reputation, and goodwill in the market and its beneficiaries and potential beneficiaries will see a diminution in their benefits and increases in cost-sharing. Vicidomina Decl. ¶¶ 31–33. And there is, of course, "no public interest in the perpetuation of unlawful agency action." *League of Women Voters*, 838 F.3d at 12. Rather, the public has a strong interest in "having governmental agencies abide by the federal laws that govern their existence and operations." *Id*. (citations omitted). Absent an injunction, Defendants will continue to violate their own regulations. The public interest does not support that result.

CONCLUSION

For the foregoing reasons, this Court should:

- Grant HMOLA summary judgment;
- Vacate CMS's determination of HMOLA's 3.5-star Star Ratings;
- Order CMS to redetermine HMOLA's 2025 Star Ratings related to Measure C05 in accordance with the test, purpose, and policy of its regulations; and
- Order Defendants to take remedial action to ensure HMOLA does not continue to be competitively harmed by CMS's actions, including:

- Issue a public statement of its error and the correction of HMOLA's 2025 Star Ratings, to be posted on the CMS website;

- Engage in specific outreach to HMOLA's enrollees those who disenrolled with an effective date of November 21, 2024, through to the release of CMS's correction notice; and

- 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, awarding HMOLA the appropriate quality bonus payments for its recalculated 2025 Star Ratings.

Dated: February 14, 2025

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CERTIFICATE OF SERVICE

I hereby certify that on February 14, 2025, I electronically filed the foregoing document and the accompanying exhibits with the Clerk of the Court using the CM/ECF system, which will send notification of this filing to the attorneys of record and all registered participants.

/s/ 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-CRC

DECLARATION OF BENJAMIN VICIDOMINA IN SUPPORT OF PLAINTIFF'S MOTION FOR SUMMARY JUDGMENT

I, Benjamin Vicidomina, declare as follows:

1. I submit this declaration in support of Plaintiff HMO Louisiana, Inc.'s ("HMOLA's"), Motion for Summary Judgment.

2. I am over the age of 18 years, and this Declaration is based upon my personal knowledge and review of relevant documents.

3. I am fully familiar with the facts and circumstances set forth herein. If called as a witness, I could and would testify competently thereto.

Background

4. I am the informatics and diagnosis coding-accuracy leader of HMOLA. I have held this position since August 16, 2018.

5. I have worked in the healthcare industry for over 15 years and have extensive experience with commercial and Medicare Advantage health plans.

6. In my role as Vice President, Analytics and Quality Improvement of HMOLA, I am responsible for providing reporting, information, statistical models, and econometric data used to drive operational decisions. I am also responsible for diagnosis coding-accuracy operations as it pertains to Qualified Health Plan and Medicare Advantage-related lines-of-business.

7. I am also familiar with the Centers for Medicare and Medicaid Services ("CMS"), Medicare Part C and D programs, CMS's Star Ratings (including the calculation thereof), and CMS's Quality Bonus Payment program.

8. Additionally, I am familiar with the impact of HMOLA's Star Ratings on its business operations and members.

HMOLA

9. HMOLA is a not-for-profit organization that offers Medicare Advantage plans ("MA Plans") for people aged 65 and older or otherwise eligible for Medicare.

10. HMOLA offers MA Plans, currently serving approximately 34,000 members in Louisiana.

11. HMOLA derives revenue from the Medicare Advantage program.

12. For HMOLA to remain viable and fulfill its mission, HMOLA must have beneficiaries select HMOLA's Medicare Advantage plan, rather than other competing plans, by providing high-quality care, a superior member experience, and leading supplemental benefits, all while minimizing premiums and cost-sharing to members.

HMOLA's Star Ratings

13. 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.

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

15. As a result of its excellent overall Star Ratings, HMOLA has in recent years qualified for roughly $20 million to $22 million per year in quality bonus payments.

16. HMOLA has, in turn, used those payments to reduce beneficiary cost sharing, eliminate Part D premiums, and fund supplemental benefits not included in traditional Medicare, such as dental, vision, hearing aids, medical transportation, and over-the-counter drug coverage allowances.

17. Star Ratings represent a clear signal to beneficiaries of the quality of HMOLA's services.

18. And a Star Ratings of 4.0 stars or higher provides HMOLA additional payments that allow HMOLA to offer additional services as part of its plan and lower premiums and cost sharing.

19. As such, HMOLA's Star Ratings is critical to HMOLA's ability to maintain its existing operations and compete in the marketplace for members.

CMS Improperly Reduces HMOLA's 2025 Star Ratings

20. HMOLA's parent company, Louisiana Health Service & Indemnity Company d/b/a Blue Cross and Blue Shield of Louisiana ("BCBSLA") offered five different MA Plans.

21. On January 1, 2024, BCBSLA consolidated contracts H5576 and H6453.

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

23. In 2023 – the measuring period for 2025 Star Ratings – HMOLA's H5576 contract offered a Special Needs Plan ("SNP") for 2023 and received a 3 Star Ratings for Measure C05.

24. For the same 2023 period, HMOLA's surviving contract, H6453, did not offer an SNP.

25. In advance of the release of 2025 Star Ratings, HMOLA expected an overall Star Ratings of 4.0 stars in light of its recent consolidation of two contracts, which was designed to improve the quality of its offerings.

26. In September 2024, CMS informed HMOLA of CMS's determination of HMOLA's overall Star Ratings.

27. CMS determined a 2025 Star Ratings of 3.5 stars for HMOLA – a significant drop from the 4.0 stars it expected.

28. Shortly after CMS notified HMOLA that its overall Star Ratings had fallen from 4.0 stars to 3.5 stars, HMOLA assessed that 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.

29. Contract H6453 did not offer an SNP for the 2023 measuring period.

CMS's 2025 Star Ratings Has Irreparably Harmed HMOLA

30. CMS made public the 2025 Star Ratings, including HMOLA's erroneous 3.5-star Star Ratings, on or about November 21, 2024.

31. CMS's reduction of HMOLA's 2025 Star Ratings from 4.0 stars to 3.5 stars has resulted in grave consequences to HMOLA's finances and has seriously harmed HMOLA's reputation and competitive position in the marketplace.

32. HMOLA estimates that if it had received a 2025 Star Ratings of 4.0 stars, HMOLA would be eligible for approximately $23 million of quality bonus payments for the 2026 plan year, based on its current membership.

33. The loss of approximately $23 million in quality bonus payments will mean that HMOLA must significantly cut supplemental benefits, increase member cost sharing, and reduce reimbursements to healthcare providers, causing them a significant hardship.

34. CMS's assignment of 3.5 stars to HMOLA has also already caused serious harm to HMOLA's competitive position, reputation, and goodwill.

35. As a result of CMS's flawed determination and publication of the 3.5-star Star Ratings, prospective members who are shopping for a MA Plan may, based on its Star Ratings, mistakenly conclude HMOLA's offerings are inferior or lower in quality compared to the offerings of other plans

36. It also makes existing members more likely to disenroll from HMOLA to switch to another plan with a Star Ratings of 4.0 stars or higher.

37. Once HMOLA's members switch to other MA Plans, it is very difficult for HMOLA to reattract those members.

38. Once a member has expended the time and effort to change from HMOLA to a higher-rated plan, it is unlikely they will again expend the same effort to switch back to HMOLA in the future, even if HMOLA were to later revert to a Star Ratings of 4.0 Stars.

39. As a result, even if HMOLA were to later return to a 4.0 Star Ratings, it is highly unlikely that HMOLA's former members will expend the time and undertake the burden of transitioning back to HMOLA.

40. HMOLA has – and will continue to – expend significant time and resources only to partially remediate these harms.

I declare under penalty of perjury that the foregoing is true and correct to the best of my knowledge and belief.

Executed on the 14th day of February, 2025.

Benjamin Vicidomina
Vice President, Analytics and Quality Improvement
HMO Louisiana, Inc.

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-CRC

[PROPOSED] ORDER GRANTING PLAINTIFF'S MOTION FOR SUMMARY JUDGMENT

UPON CONSIDERATION of Plaintiff HMO Louisiana, Inc.'s ("HMOLA's "), Motion for Summary Judgment, and the parties' submissions on this motion, it is **HEREBY ORDERED** that:

1. Plaintiff's Motion For Summary Judgment is **GRANTED**;
2. HMOLA's 3.5-star 2025 Star Ratings related to Measure C05 is **SET ASIDE** and **VACATED**;
3. Defendants are **ORDERED** to recalculate HMOLA's 2025 Star Ratings consistent with the Court's Memorandum Opinion On Plaintiff's Motion For Summary Judgment, namely:
    a. Defendants shall exclude Measure C05 from Defendants' determination of HMOLA's Star Ratings; and
4. Defendants are **ORDERED** to take remedial action to ensure HMOLA does not continue to be competitively harmed by:

a. Issuing a public statement of its error and the correction of HMOLA's 2025 Star Ratings, to be posted on the CMS website;

b. Engaging in specific outreach to HMOLA's enrollees those who disenrolled with an effective date of November 21, 2024, through to the release of CMS's correction notice; and

c. Taking 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, awarding HMOLA the appropriate quality bonus payments for its recalculated 2025 Star Ratings; and

5. This matter is **REMANDED** to CMS for further proceedings consistent with the Court's Opinion.

IT IS SO ORDERED.

ENTERED this the _____ day of _____, 2025.

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