SCHEDULED FOR ORAL ARGUMENT ON FEBRUARY 12, 2026

United States Court of Appeals for the District of Columbia Circuit

No. 25-5269

HMO LOUISIANA, INC.,

Plaintiff-Appellant,

v.

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

Defendants-Appellees.

On Appeal from the United States District Court for the District of Columbia in No. 1:24-cv-02931-CRC, Christopher Reid Cooper, U.S. District Judge

REPLY BRIEF FOR PLAINTIFF-APPELLANT

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GLOSSARY

APA: Administrative Procedure Act

Br.: Opening Brief for Appellant

Opp.: Brief for Appellees

CMS: Centers for Medicare and Medicaid Services; as used herein, CMS refers collectively to Appellees.

DHS: Department of Homeland Security

HMOLA: HMO Louisiana, Inc.

MA Plan: Medicare Advantage Plan

SNP: Special Needs Plan Care Management; as used herein, SNP refers to the program measured by C05.

SSA: Social Security Act

INTRODUCTION AND SUMMARY OF THE ARGUMENT

HMOLA brought this appeal to address CMS's unlawful calculation of its 2025 Star Ratings. CMS violated its own regulations by including Measure C05 data from HMOLA's terminated contract for services it no longer provided. That not only conflicts with CMS's regulations but the agency's prior application – indeed, the agency went so far as to program its computer systems *to reject* that data at the outset. Nor does it align with CMS's statutory mandate in developing Star Ratings: To provide beneficiaries with useful information about a plan's quality for benefits under their control. Providing beneficiaries with a plan rating based on services the plan does not actually offer flatly contradicts that mandate.

Yet, in the face of its own regulations and statutory directive, the agency included data it is expressly prohibited from including and had previously excluded, resulting in a substantial drop in HMOLA's Star Ratings, a loss of $23 million in bonus payments, and adverse impacts on the scope and breadth of services it can provide its 34,000 beneficiaries. And the only terse justification it gave for doing so – that it did so on "request and after further consideration" – is no reasoned justification at all.

Now in opposition, CMS tries to distance itself from its regulations, statutory mandate, and past application. The agency argues that it must consider whether HMOLA's consolidated contract offered an SNP plan *in 2025*. But it does not point

to any support for that new position in its regulations, Technical Notes, or the SSA. Nor could it. To quote CMS itself, if "a contract was not evaluated on a particular quality measure for a *measurement year*, there would be no score for that measure and it would not factor into the mean for the consolidated contract's measure score." Opp. at 13. That "measurement year" is 2023 – when HMOLA's surviving contract did not offer an SNP plan under Measure C05.

CMS further argues the Court should disregard its Technical Notes. But as the agency has represented to the parties and District Court, and stated in its own regulation, the Technical Notes are *binding*. And the agency's Technical Notes could not be more clear: CMS shall exclude contracts "with an effective termination date on or before . . . June 15, 2024," and contracts with fewer than "30 enrollees." JA194–195. HMOLA's surviving contract did not have an SNP with more than "30 enrollees" and its consumed contract terminated after January 1, 2024. The only reading and application of the regulation and Technical Notes that makes sense is to exclude Measure C05 – just as the agency previously did.

CMS also argues that HMOLA's consumed contract was not terminated, and as such, must be considered. But CMS's regulations (and common sense) make clear HMOLA's consumed contract was terminated – *i.e.*, no longer existed – just as the agency determined from the outset. While CMS further argues its prior application and interpretation of its regulation was "erroneous," it cannot side-step

the APA by proclaiming it made a mistake in correcting a mistake. It is Administrative Law 101 that an agency must provide a reasoned and rational explanation for its departure from existing policy, and CMS has failed to do so here.

The Court should reverse the judgment of the District Court and vacate CMS's calculation of HMOLA's 2025 Star Ratings with directions that the matter be remanded to CMS for further consideration consistent with the Court's opinion and relief sought by HMOLA.

ARGUMENT

I. CMS's Calculation Violates Its Regulations And Statutory Mandate.

CMS's regulations expressly require the agency to exclude from its calculation of Measure C05 any contracts "with an effective termination date on or before . . . June 15, 2024," and contracts with fewer than "30 enrollees." JA194–195. HMOLA's consumed contract "terminat[ed]" on January 1, 2024, when it was consolidated because it "no longer exist[ed]" after that date. 42 C.F.R. § 422.162(a) (defining "[c]onsumed contract" as one "that will no longer exist after a contract year's end as a result of consolidation"); *see also* JA367. And HMOLA's surviving contract did not have an SNP with more than 30 enrollees. JA367.

Further confirming that HMOLA's consumed contract checked those boxes is the agency's own actions: It expressly recognized HMOLA's consumed contract as "terminated" and determined its surviving contract "did not offer [an] SNP," and as

such, excluded data on Measure C05. JA367. It even programmed its own data submission computer system to *reject* submission of that data from HMOLA because it was keyed to that interpretation found in the regulations and Technical Notes. JA143; *Garner v. Jones*, 529 U.S. 244, 256 (2000) (explaining the agency's "actual practices provide important instruction as to how [it] interprets its . . . regulations"); *Purepac Pharm. Co. v. Thompson*, 354 F.3d 877, 884–85 (D.C. Cir. 2004) (holding an agency violates the APA by failing "to justify seeming inconsistencies in its approach"). CMS's refusal to "abide" its own regulations is quintessentially arbitrary and capricious. *Exportal Ltda v. United States*, 902 F.2d 45, 51 (D.C. Cir. 1990); *Loper Bright Enter. v. Raimondo*, 603 U.S. 369, 392 (2024); JA194–195 & JA276.

CMS now makes four arguments to avoid this conclusion – all of which are mistaken and speculates as to an unsupported "parade of horribles" that would result from HMOLA's proper interpretation of the regulations.

First, CMS argues its regulations establish a two-step process "whereby CMS first looks to the measurement years of the consumed and surviving contracts prior to consolidation and then looks to the Star Ratings year for the resulting consolidated contract." Opp. at 23. But CMS's newfound "two-step process" is found nowhere in its regulations or Technical Notes. While CMS cites its general regulation on Star Ratings and consolidation, *see* Opp. at 23–24; 42 C.F.R. §§ 422.162(b)(1) & (b)(3),

neither of these regulations describe a two-step process that looks at whether the consolidated contract has an SNP plan *in 2025*. The 2025 Star Ratings are based on data *from 2023*. JA170 & JA274. CMS cannot rewrite its regulations after the fact to serve its litigation position. *See Am. Textile Mfrs. Inst., Inc. v. Donovan*, 452 U.S. 490, 539 (1981) (holding agency's post hoc rationalizations "cannot serve as a sufficient predicate for agency action").

Instead, this Court must "enforce" the "plain meaning" of CMS's regulations. *King v. Burwell*, 576 U.S. 473, 486 & 496 (2015) And doing that here leads to one result: The exclusion of Measure C05 data from HMOLA's 2025 Star Ratings. JA194–195. The only two step process contained in CMS's regulation requires it to "[s]tart with all contracts that offer at least one SNP plan" during the measurement year, JA276, and "exclude" any contracts "with an effective termination date on or before . . . June 15, 2024," and contracts with fewer than "30 enrollees." *Id.*; *see also* JA194–195. And as CMS concedes on brief, "if a contract was not evaluated on a particular quality measure for a measurement year, *there would be no score for that measure*," and as such, "it would not factor into the mean for the consolidated contract's measure score." Opp. at 13 (emphasis added). HMOLA's consumed and surviving contracts plainly satisfied that exclusion criteria, *supra* at 1–3, and as such, they should not be "evaluated" or "factor[ed] in the mean for the consolidated

contract's measure score." Opp. at 13.[1]

Second, CMS next argues the Technical Notes should "be disregarded" and give way to its regulations. Opp. at 34. CMS is, again, mistaken. At every phase of this litigation (until now), CMS has represented to HMOLA and the Court the Technical Notes are "binding," just like its regulations. JA142; *Gen. Elec. Co. v. EPA*, 290 F.3d 377, 385 (D.C. Cir. 2002). And the agency itself has made that clear in its regulations. 42 C.F.R. § 422.164(a) ("CMS lists the measures used for a particular Star Rating each year in the Technical Notes").

But beyond that admission, the Technical Notes are binding as a matter of law. Agency "guidance and rules," like the Technical Notes, can be binding. *Vitarelli v. Seaton*, 359 U.S. 535, 539 (1959). That is especially so given CMS uses the Technical Notes to further explain its regulations and impose "rights" and "obligations" on MA Plans. *Am. Bus. Ass'n v. U.S.*, 627 F.2d 525, 529 (D.C. Cir. 1980); *see* JA159 & JA162–163 (imposing reporting requirements on MA Plans); JA162–166 (describing data collection process); JA166–170 (dictating the Star

[1] CMS attempts to create confusion by raising other measures that are not properly before the Court. *See* Opp. at 38 n.2. HMOLA's appeal is based on its Amended Complaint and the relief it seeks, which is limited to the consideration of Measure C05 in calculating HMOLA's H6453 consolidated 2025 Star Rating. *See* JA8–22. Because HMOLA does not challenge measures other than C05 in this action, there is no basis to consider the other measures now. *See generally* Br. at 22–25; *Am. Ctr. for Int'l Lab. Solidarity v. Chavez-DeRemer*, 789 F. Supp. 3d 66, 83–84 (D.D.C. 2025) ("plaintiffs are [the] 'masters of the complaint' with the power to bring th[eir] claims as they see fit") (internal citations omitted).

Ratings methodology). And as other courts have held, including those in this Circuit, CMS's failure to abide by its Technical Notes violates the APA. *See SCAN Health Plan v. Dep't of Health & Human Servs.*, No. 1:23-cv-03910, 2024 WL 2815789, at *5 (D.D.C. June 3, 2024) (applying Technical Notes); *Elevance Health v. Becerra*, 736 F. Supp. 3d 1, 15–16 & 19 (D.D.C. 2024) (same).[2] Thus, CMS's Technical Notes are "binding," and it cannot seriously argue otherwise now on appeal. *See Vitarelli*, 359 U.S. at 539.

CMS further argues excluding Measure C05 data here would somehow result in a conflict between the Technical Notes and regulation. Opp. at 32–33. CMS is once again mistaken. While the contract consolidation regulations generally apply a weighted average approach to calculate ratings for consumed and surviving contracts, the Technical Notes provide specific exclusions unique to each measured service, including Measure C05. *Compare* 42 C.F.R. § 422.162(b)(3)(iv)(B)(1), *with* 42 C.F.R. § 422.164(a) *and* JA194–195. The broader consolidation regulation addresses the general processes for consolidation and default application of a weighted average. 42 C.F.R. § 422.162(b)(3). But to determine how each measurement is calculated or "excluded," JA194–195, CMS's regulations require

[2] *See also UnitedHealthcare Benefits of Tex., Inc. v. Ctrs. for Medicare & Medicaid Servs.*, No. 6:24-cv-00357, 2024 WL 4870771, at 7 (E.D. Tex. Nov. 22, 2024) (holding CMS action arbitrary and capricious where it failed to comply with its Technical Notes).

the agency to "list the measures used for a particular Star Rating each year in the Technical Notes," which dictate measure-specific methodologies and exclusions. 42 C.F.R. § 422.164(a); JA194–195. Thus, CMS "specifically dealt with" what measures should be excluded and when in its Technical Notes, and nowhere else. *Bloate v. U.S.*, 559 U.S. 196, 207 (2010); JA194–195. Where, as here, CMS has adopted a "comprehensive scheme" while also "deliberately target[ing] specific problems with specific solutions," the specific terms in the Technical Notes would naturally "govern." *RadLAX Gateway Hotel, LLC v. Amalgamated Bank*, 566 U.S. 639, 645 (2012).

Here, read together and by their "plain" terms, the regulations and Technical Notes properly require the exclusion of HMOLA's C05 data. *King*, 576 U.S. at 486; *supra* at 5. By excluding a contract that has terminated or does not offer a measured service – here, SNPs – CMS properly "exclude[s]" those measures by designating them as "no data available." JA194–195 & JA276. That makes good sense because an MA Plan does not have any "control" over a service that is not offered, and thus data on a non-existent service is not properly included in an MA Plan's Star Ratings. 83 Fed. Reg. 16,440, 16,521 (Apr. 16, 2018). Otherwise, an MA Plan would receive a "zero" for a measured service it does not offer, thus resulting in a lower rating that does not in fact reflect the true "quality" of the plan's provided services – since it reflects a score for a service that it is not actually offered to beneficiaries. *Id.* at

16,521. On the other hand, rating a plan based on the arbitrary inclusion of skewed data about a service the plan does not offer would mislead – rather than help – beneficiaries in "mak[ing] informed plan choices." *Id.* at 16,520; *see generally* 42 U.S.C. § 1395w-21.[3]

Third, CMS further argues consumed contracts cannot be "terminated" if they are consolidated. Opp. at 27–30. But CMS's regulations and actions directly refute that argument. HMOLA's consumed contract terminated following consolidation on January 1, 2024, because it "no longer exist[ed]" after that date. 42 C.F.R. § 422.162(a); *see also* JA367. Thus, CMS initially determined HMOLA's consumed contract was "terminated," even going so far as "key[ing]" its data submission portal to reflect this understanding of the regulations and Technical Notes. JA143. That "practice" and determination are damning. *Commc'ns & Control, Inc. v. F.C.C.*, 374 F.3d 1329, 1335 (D.C. Cir. 2004) (analyzing an agency's prior actions and practice in holding it acted arbitrarily and capriciously). CMS's policy and practice plainly carried out the language of its regulations and Technical Notes; it cannot credibly back away from that on appeal. *SEC v. Chenery*, 318 U.S.

[3] CMS asserts the specific-governs-the-general canon does not apply. Opp. at 32. HMOLA agrees the canon has "no real pertinence," Br. at 29, and HMOLA's interpretation of the regulations and Technical Notes – which the agency had initially adopted from the outset – does not result in any conflict. *Supra* at 7–8; Br. at 29–30. But should the Court determine the canon applies, the District Court erred in its application. Br. at 30–31.

80, 92 (1942); *Summer Hill Nursing Home LLC v. Johnson*, 603 F. Supp. 2d 35, 39 (D.D.C. 2009) (rejecting the Secretary's litigation position because "[n]owhere in the Secretary's decision is that rationale articulated, and the Court cannot accept the lawyer's *post hoc* rationalization"); JA143 & JA367.

In response, CMS summarily dismisses its past determination and application as a mistake. Opp. at 36. It instead points to the location of the termination and consolidation regulations in the Code of Federal Regulations as proof that a contract cannot be considered terminated during the consolidation process. Opp. at 28–29. Not so. Regulations in the same code sections are to be read as a "symmetrical and coherent regulatory scheme, and fit, if possible, all parts into an harmonious whole." *Food & Drug Admin. v. Brown & Williamson Tobacco Corp.*, 529 U.S. 120, 133 (2000) (internal citations omitted). CMS's regulations for the MA Program, including the consolidation and termination regulations, are all located in Part 422 of chapter 42 in the Code of Federal Regulations. *See* 42 C.F.R. pt. 422 (titled "Medicare Advantage Program"). Moreover, while certain regulations address ways in which an MA Plan's contract can be terminated, 42 C.F.R. §§ 422.508–422.512, they do not provide an exhaustive list of all the ways in which a contract could terminate. Those sections just provide certain ways in which CMS or an MA Plan "may . . . terminate a contract" – but say nothing about whether a consumed contract has terminated. 42 C.F.R. § 422.510(a); *see also* 42 C.F.R. §§ 422.508–422.512.

Obviously, HMOLA's consumed contract was terminated, since it "no longer exist[s]." 42 C.F.R. § 422.162(a). And while CMS's Technical Notes (and regulations) do not define "termination," the only "coherent" and commonsense meaning of that term is a contract that has "come or been brought to an end or conclusion" after it is consumed by another surviving contract.[4] That reading and application is entirely consistent with the "regulatory scheme" at issue. *Brown & Williamson Tobacco Corp.*, 529 U.S. at 133.

Even if "termination" and "consumed" are mutually exclusive – they are not – CMS did not assert that position during its plan preview communications. Opp. at 28–29; *see also* JA367 & JA375–376. That argument is nothing more than a *post-hoc* rationalization in support of a calculation methodology that advances its litigation position. *See Am. Textile Mfrs. Inst., Inc.*, 452 U.S. at 539 (holding agency's post hoc rationalizations "cannot serve as a sufficient predicate for agency action").

Fourth, CMS finally argues "HMOLA's proposed methodology would encourage Medicare Advantage plans to artificially inflate their scores by strategically consolidating contracts." Opp. at 31. As a threshold matter, CMS has

[4] OXFORD MOD. DICTIONARY (2025) (defining "terminated" as "having come or been brought to an end or conclusion"). The Court may look to dictionaries to "interpret" undefined terms. *Wisc. Central Ltd. v. United States*, 585 U.S. 274, 277 (2018).

never argued HMOLA has sought to consolidate to artificially inflate its scores (it did not). Nor is there any record evidence to support that contention in any event. A plan cannot just consolidate on a whim to game the system. Consolidation requires *approval and review* by CMS, and to that end, the agency requires a plan to satisfy substantial requirements before any consolidation may proceed. *See, e.g.*, 42 C.F.R. § 422.530. Having approved HMOLA's consolidation, CMS's baseless speculation is incredible. *See McDonnell Douglas Corp. v. U.S. Dep't of the Air Force*, 375 F.3d 1182, 1186–87 (D.C. Cir. 2004) (a court does not "defer to the agency's conclusory or unsupported suppositions.").

* * *

The bottom line here is this. CMS refused to "abide" by the plain text of its own regulations, and that is quintessentially arbitrary and capricious. *Exportal Ltda*, 902 F.2d at 51; *Loper Bright Enter.*, 603 U.S. at 392; JA194–195. Far from "consistent with the Social Security Act," Opp. at 23, CMS's calculation of HMOLA's 2025 Star Ratings plainly violates its regulations and statutory mandate, *Loper Bright Enter.*, 603 U.S. at 392. The District Court erred in holding otherwise.

II. CMS Failed To Provide Any Reasoned Explanation For Its Sudden Policy Departure In Violation Of The APA.

CMS's calculation of HMOLA's 2025 Star Ratings is entirely "inconsisten[t] with [its] earlier position," and as such, it cannot change positions without recognizing it has changed its interpretation. *Cf. Food & Drug Admin. v. Wages &*

White Lion Invs., L.L.C., 604 U.S. 542, 569–70 (2025) (articulating change-in-policy doctrine). While agencies may change their policies, they must provide a "reasoned analysis indicating that prior policies and standards are being deliberately changed, not casually ignored." *Ramprakash v. FAA*, 346 F.3d 1121, 1124–25 (D.C. Cir. 2023). Yet, in changing its position here to include Measure C05 data, CMS provided no reason or analysis. JA375; JA133. It merely stated it would collect and use Measure C05 data apparently at HMOLA's "request and after further consideration." JA375–376. This "gloss[ing] over" violates the APA. *Greater Bos. Television Corp. v. FCC*, 444 F.2d 841, 852 (D.C. Cir. 1970) ("[I]f an agency glosses over or swerves from prior precedent without discussion it may cross the line from tolerably terse to the intolerable mute."); *Commc'ns & Control, Inc.*, 374 F.3d at 1335-36 (the agency's "departure from [its] practice, with *no* explanation, renders its void *ab initio* rationale arbitrary and capricious").

CMS argues the change-in-policy doctrine has no application because its views expressed during the plan preview process are not "final." Opp. at 45–46. But just because CMS's plan preview process permits MA Plans to "submit questions and objections" about its projected Star Ratings does not make CMS's actions during that process immune from review. *See Better Gov't Ass'n v. Dep't of State*, 780 F.2d 86, 93 (D.C. Cir. 1986) (finding agency's "description of guidelines as 'informal'" not to be "definitive" in determining finality of agency action).

CMS's statements during the plan preview process articulate the agency's policy position and are of course subject to judicial review. *See UnitedHealthcare Benefits of Tex., Inc.*, 2024 WL 4870771, at *6; *Elevance Health*, 736 F. Supp. 3d at 12; *SCAN Health Plan*, 2024 WL 2815789, at *4.

That is exactly what the Supreme Court held in *Dep't of Homeland Sec. v. Regents of Univ. of Cal.* 591 U.S. 1 (2020). In *Regents*, the Supreme Court directly applied the change-in-policy doctrine to DHS's departure from its prior policy statement of non-enforcement. 591 U.S. at 18–19. The Court explained DHS's policy impacted the agency's "affirmative act of approval," which "provide[d] a focus for judicial review." *Id.* at 18. The same should go here. CMS operationalized its "interpretation of consumed contracts as terminated" by "key[ing]" its portal to exclude Measure C05 data for consumed contracts and suddenly reversed course. JA143. CMS's unexplained change in position directly affected the agency's ratings calculation and "approval" of quality bonus payments – which resulted in significant and harmful consequences for HMOLA. JA55–56; 42 C.F.R. §§ 422.160(b)(1) & (2); *see also* 42 C.F.R. § 422.510(a).

CMS nevertheless argues it made a "one-off error" in considering HMOLA's consumed contract as terminated. Opp. at 43. It then summarily directs the Court "not [to] place any interpretive weight" on such an error. *Id.* at 36. But the agency cannot create *de facto* regulations after-the-fact, let alone on appeal. *See Christensen*

v. Harris Cnty., 529 U.S. 576, 588 (2000) (refusing "to permit the agency, under the guise of interpreting a regulation, to create de facto a new regulation"). When it first calculated HMOLA's 2025 Star Ratings, CMS's "interpretation" of the Technical Notes was to treat "consumed contracts as terminated." JA143. This policy was further reflected – in fact, "keyed" – in the design of CMS's "health plan management system." JA143; *Garner*, 529 U.S. at 256; *cf. INS v. Yueh–Shaio Yang*, 519 U.S. 26, 32 (1996) (observing that the reasonableness of discretionary agency action can be gauged by reference to the agency's policies and practices). In line with this application, HMOLA was affirmatively blocked by the agency's computer system from submitting Measure C05 data for H5573, *see* JA377, and CMS calculated the Star Ratings without it, JA367. The record thus belies CMS's characterization of its calculation as a "one-off error." Programming a computer system to operate a certain way – and not allow certain data to be submitted – cannot reasonably described as an error. And, if it were some aberrant glitch, it should not have required the agency to undertake what it itself describes as "no small task" to "reprogram the portal" to consider data from a consumed contract. JA143. Rebooting might be an error, reprogramming is not.

CONCLUSION

The Court should reverse the judgment of the District Court and vacate CMS's calculation of HMOLA's 2025 Star Ratings with directions that the matter be

remanded to CMS for recalculation of the 2025 Star Ratings consistent with the Court's opinion and relief sought by HMOLA. JA21–22.

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