ORAL ARGUMENT HEARD ON ON FEBRUARY 12, 2026, AT 9:30AM

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

SUPPLEMENTAL BRIEF FOR PLAINTIFF-APPELLANT

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The Court ordered the parties to provide supplemental briefing on whether CMS correctly applied 42 U.S.C. § 1395w-23(o)(4)(D)(i) and 42 C.F.R. § 422.162(b)(3)(i) when it pronounced that the enrollment-weighted mean of the Measure C05 score for the consumed contract (3 Stars) and the surviving contract (no score) was 3 Stars. The answer is no.

CMS violated its governing statute and implementing regulations and flouted its obligation to explain its actions. CMS's Technical Notes 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 eligible enrollees." CMS did not do that, and it failed to explain why it failed to follow its own regulations.

CMS's violations of law carried substantial consequences for HMOLA – it suffered a lower Star Rating that harmed its reputation in the marketplace and cost it $23 million in bonus payments to provide better and more affordable care to its 34,000 beneficiaries. This Court simply cannot bless CMS's unlawful and wholly unexplained move in accordance with bedrock APA principles and this Court's binding precedent. Accordingly, the Court should vacate and remand.

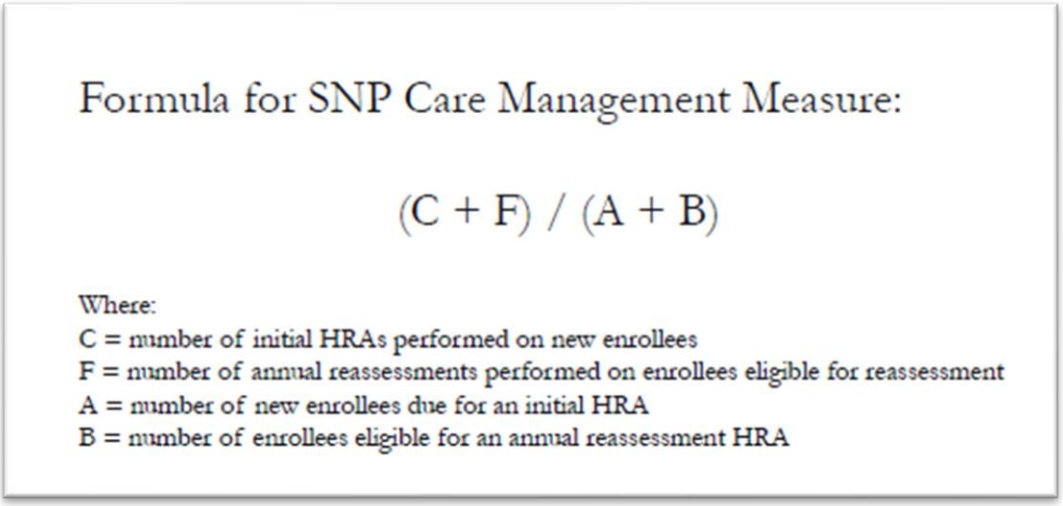
ARGUMENT

1. CMS's calculation of Measure C05 here violates the plain language of its statute and regulations. *King v. Burwell*, 576 U.S. 473, 486 (2015). CMS's

governing statute, as implemented by its regulations, and as further explicated by the Technical Notes incorporated into its regulations, operate as a how-to guide for calculating star ratings for consolidated plans. *See* 42 C.F.R. § 422.164(a). The SSA directs CMS to "adjust the quality rating" of consolidated contracts. *See* 42 U.S.C. § 1395w-23(o)(4)(D)(i). The agency's implementing regulation in turn direct that the ratings are to reflect the enrollment-weighted mean of the measure scores of the surviving and consumed contracts. 42 C.F.R. § 422.162(b)(3)(i).

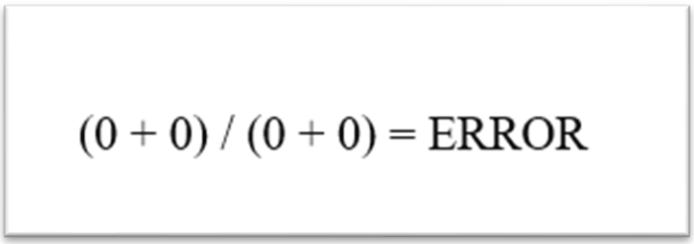
The agency's Technical Notes – which are binding[1] – provide specific guidance on how that mean is to be calculated. JA194–195 & 276. For Measure C05, the Technical Notes critically require the agency to exclude from its calculation of Measure C05 any contracts "with an effective termination date on or before . . . June 15, 2024," and contracts with fewer than "30 eligible enrollees." JA194–195. This mandate is specific and clear: CO5 is one of only two measures that excludes the data of terminated – *i.e.*, consumed – contracts. JA194–196 & JA257–259. The Technical Notes further provide a formula for calculating the SNP Care Management Measure (Measure C05) of each plan:

[1] Even CMS agrees its Technical Notes are "binding," just like its regulations. JA142; *Gen. Elec. Co. v. EPA*, 290 F.3d 377, 384-85 (D.C. Cir. 2002). And the agency itself made that clear in its regulations by specifically incorporating its Technical Notes. 42 C.F.R. § 422.164(a) ("CMS lists the measures used for a particular Star Rating each year in the Technical Notes.").

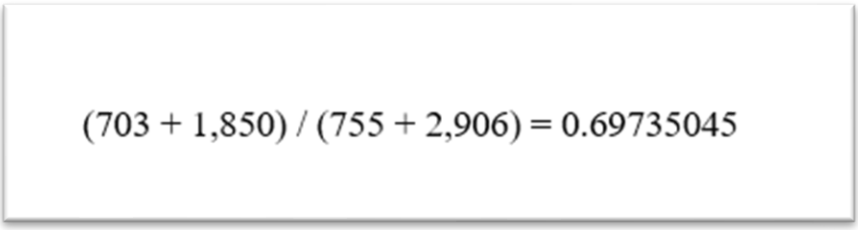


See JA194–195 & JA276.

HMOLA's surviving contract did not have an SNP with more than "30 eligible enrollees" and its consumed contract obviously terminated after January 1, 2024. As a result, under CMS's original calculation, HMOLA's surviving contract properly received a "no score" or "error" for Measure C05, because it did not offer an SNP Plan. JA55. It had no "initial HRAs performed on new enrollees," no "annual reassessments performed on enrollees eligible for reassessment," no "new enrollees due for an initial HRA," and no "enrollees eligible for an annual reassessment HRA." *Id.*; JA194–195 & JA276. That, consistent with the Technical Notes, results in an error. JA194–195:



But rather than follow the directive to exclude any contracts "with an effective termination date on or before . . . June 15, 2024," CMS eventually calculated HMOLA's Measure C05 Star Rating using data from the *consumed* contract. JA375–76. Based on the consumed contract's data, HMOLA's consumed contract received a raw score of 69.7% (0.69735045), translating to a 3 Star Rating. *Id.*; *see* JA196.



But HMOLA's consumed contract "terminat[ed]" on January 1, 2024, when it was consolidated because it "no longer exist[ed]" after that date.[2] 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. While HMOLA's consumed contract had data for its SNP Plan, it should have been

[2] While the 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. OXFORD MOD. DICTIONARY (2025) (defining "terminated" as "having come or been brought to an end or conclusion"). That reading and application is entirely consistent with the "regulatory scheme" at issue, and CMS's own initial interpretation and application here. *Food & Drug Admin. v. Brown & Williamson Tobacco Corp.*, 529 U.S. 120, 133 (2000).

excluded for a Star Rating of "no score." Properly excluding the consumed contract from consideration in Measure C05 results in an overall "no score" for Measure C05:

$$\frac{(No\ Score)+(No\ Score)}{(Total\ Enrollment)} = \text{No Score}$$

See JA271.

Instead, CMS calculated the enrollment-weighted mean of the measure scores of the surviving and consumed contracts, 42 C.F.R. § 422.162(b)(3)(i), and issued an overall 3 Star Rating for Measure C05. JA375–76. This was no small mistake. By improperly considering the consumed contract's 3 Stars, CMS's (mis)calculation results in an overall 3 Star Rating for Measure C05:

$$\frac{(No\ Score)+(3*Enrollment\ of\ Consumed\ Contract)}{(Total\ Enrollment)} = 3\ \text{Stars}$$

2. CMS's violation of its regulations and binding Technical Notes is a wholly unexplained departure from its existing policy. When it first calculated HMOLA's 2025 Star Ratings, CMS properly concluded – and told HMOLA – that consumed contracts are "terminated" as a result of consolidation, and therefore had no July enrollment data for consideration. JA367. That interpretation was far from a one-

off error or glitch: CMS had operationalized its policy as explicated by the Technical Notes by programming its own data submission computer system to *reject* submission of data from HMOLA for the consumed/terminated contract based on that very straightforward, plain language interpretation of its regulations and Technical Notes. JA143 & 373; *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"); *see* Appellee Br. at 43. It was not until after HMOLA initiated litigation *that CMS switched positions*.

3. 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). This case is on all fours with and therefore controlled by this Court's decision in *Purepac Pharm. Co*. In that case, the FDA relied on its 'Orange Book' publication to permit the use of a patent for neurodegenerative diseases. *Id.* at 884. When the agency made an "unexplained reversal" by permitting the drug for treatment of epilepsy, the Court held its action was "the height of arbitrary and capricious decision making," because the agency had "change[d] course" with zero explanation. *Id.*

That is exactly the same as what CMS did here: CMS affirmatively and technologically prevented HMOLA from submitting Measure C05 data for H5573, *see* JA367, before switching positions in litigation. This Court should not "sanction" CMS's newfound, unsupported, and "inconsistent" approach to its regulations. *Purepac Pharm. Co.*, 354 F.3d at 884. It cannot do so under *Purepac Pharma* or core APA principles.

4. CMS's *post-hoc* explanations cannot cure its arbitrary and capricious action either. Throughout briefing and oral argument, CMS has advanced numerous explanations and justifications, including that "termination" and "consumed" are read to be mutually exclusive and that its programming was a "one-off error." Appellee Br. at 28–30 & 36. CMS never offered any of these justifications during its plan preview communications, and they cannot support its action on appeal now. *Id.*; *see also* JA367 & JA375–376. 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"). CMS's initial approach and determination plainly carried out the language of its regulations and Technical Notes; it cannot substitute a new rationale nowhere in the record at this stage. *SEC v. Chenery*, 318 U.S. 80, 92 (1943); *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"); JA367.

* * * * *

The bottom line is that CMS refused to "abide" by the plain text of its own regulations or offer any explanation for why it did not. *Exportal Ltda*, 902 F.2d at 51; *Loper Bright Enter.*, 603 U.S. at 392; JA194–195. Accordingly, because CMS's calculation improperly applied 42 C.F.R. § 422.162(b)(3)(i) and 42 U.S.C.§ 1395w-23(o)(4)(D)(i), 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.

Dated: March 2, 2026

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CERTIFICATE OF COMPLIANCE

1. This brief or other document complies with type-volume limits because, excluding the parts of the document exempted by Fed. R. App. R. 32(f) and Circuit Rule 32(e)(1), this brief contains 1,551 words.

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