NOT YET SCHEDULED FOR ORAL ARGUMENT

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

BRIEF FOR PLAINTIFF-APPELLANT

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CERTIFICATE AS TO PARTIES, RULINGS, AND RELATED CASES

I. Parties And *Amici*.

Appellant. HMOLA was the sole Plaintiff before the District Court (Case No. 1:24-cv-02931), and is the sole appellant too.

Appellees. Appellees are the Department of Health and Human Services, Centers for Medicare and Medicaid Services, the Secretary of the Department of Health and Human Services acting in his or her official capacity, and the Administrator of CMS acting in his or her official capacity. Appellees were the only Defendants before the District Court (Case No. 1:24-cv-02931).

Intervenors/Amici. There were no intervenors or *amici* in the District Court proceedings. As of the date of this filing, there are no intervenors or *amici* on appeal.

II. Rulings Under Review.

The ruling on appeal is the Memorandum Opinion and Order issued by Judge Christopher R. Cooper in Case No. 1:24-cv-02931-CRC on July 9, 2025, denying HMOLA's Motion for Summary Judgment and granting Appellees' Cross-Motion for Summary Judgment. *See* JA99–111.

III. Related Cases.

This case has not been before this Court before and there are no related cases.

DISCLOSURE STATEMENT

Pursuant to Circuit Rule 26.1, Plaintiff-Appellant HMO Louisiana, Inc. ("HMOLA"), submits the following Corporate Disclosure Statement.

HMOLA is a Louisiana corporation and wholly owned subsidiary of Louisiana Health Service & Indemnity Company d/b/a Blue Cross and Blue Shield of Louisiana, a non-profit mutual insurance company.

HMOLA does not have any publicly held parent companies, subsidiaries, or affiliates that have a 10% or greater ownership interest in HMOLA. *See* Fed. R. App. P. 26.1(a); Circuit R. 26.1.

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GLOSSARY

APA: Administrative Procedure Act

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

HHS: U.S. Department of Health & Human Services

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

JURISDICTIONAL STATEMENT

The United States District Court for the District of Columbia properly exercised federal question jurisdiction over this action because HMOLA filed suit against CMS under the APA. *See* 5 U.S.C. §§ 701 *et seq.*; JA10, ¶ 18 & JA20 ¶¶ 92– 98. HMOLA's claims thus "aris[e] under" the laws of the United States. 28 U.S.C. § 1331.

Venue was proper in the District Court under 28 U.S.C. § 1391(e) because HMOLA brought this action against officers and agencies of the United States, and a substantial part of the events giving rise to HMOLA's claims occurred in that District. JA11 ¶ 19. HMOLA's Amended Complaint was also timely filed under 28 U.S.C. § 2401(a). *Id.* ¶ 20.

This Court has jurisdiction over the final judgment below under 28 U.S.C. § 1291. On July 9, 2025, the District Court granted Appellees' cross-motion for summary judgment and dismissed HMOLA's claims with prejudice. JA99. HMOLA timely appealed on July 21, 2025. Fed. R. App. P. 4(a)(1)(B); JA112.

STATEMENT OF ISSUES

Plaintiff-Appellant HMO Louisiana ("HMOLA") sued Defendants-Appellees Department of Health & Human Services ("HHS"), the Centers for Medicare & Medicaid Services, Xavier Becerra, in his official capacity as Secretary of HHS, and Chiquita Brooks-LaSure, in her official capacity as Administrator of CMS (collectively, "CMS"), for issuing erroneous Star Ratings in violation of the APA. The issues on appeal are:

1. Did the District Court err by holding CMS lawfully calculated HMOLA's 2025 Star Ratings, even though the agency suddenly and without explanation departed from its established methodology outlined by the plain language of its own regulations and Technical Notes (going so far as to re-configure its own computer system to contravene its historic practice) in order to calculate HMOLA's Star Ratings based on services it did not actually provide?

2. Did the District Court err by holding CMS's calculation of HMOLA's Star Ratings using a score for a service that it did not provide was not unreasonable or unlawful but instead fulfilled its statutory mandate to establish quality and performance measures that are "true reflections" of HMOLA's "services and care"?

3. Did the District Court err by holding CMS's generic statement that it changed a longstanding policy and practice "at [HMOLA's] request and after further consideration" was a sufficiently reasoned justification to pass APA muster?

STATUTES AND REGULATIONS

Pertinent statutes, regulations, and treaties are reproduced in the addendum.

STATEMENT OF THE CASE

I. Introduction.

Agencies supposedly "fall into grooves . . . and when they get into grooves, then God save you to get them out."[1] CMS, at least here, is not one of them.

Among its responsibilities, CMS contracts with private insurers to offer beneficiaries Medicare Advantage Plans, which the agency annually rates according to a congressionally mandated five-star scale intended to accurately reflect a plan's quality of care and services. These ratings, appropriately dubbed Star Ratings, are determined through complex methodologies CMS publishes in the code of federal regulations, and as further detailed in measure-specific Technical Notes.

CMS's ratings are intended to be a useful shopping tool for beneficiaries so they can make informed choices when selecting a given plan, and they carry significant benefits and consequences for plans, including for funding allocations. Well-performing plans are rewarded with substantial bonus payments that a plan then uses to provide more services and better care to its beneficiaries. Poor performing plans may be sanctioned and even removed from the program. Because Star Ratings control the fate of plans and the care for tens of millions of beneficiaries,

[1] *Ramprakash v. FAA*, 346 F.3d 1121, 1122 n.1 (D.C. Cir. 2003) (quoting *Hearings to Study Senate Concurrent Resolution 21 Before a Subcommittee of the Senate Committee on Labor and Public Welfare*, 82nd Cong., 1st Sess. 224 (1951)).

plans are actively engaged in the ratings process, and frequently question and even challenge the basis for changed ratings.[2]

Enter HMOLA, an MA Plan serving thousands of beneficiaries in Louisiana, which has historically received high ratings reflecting its high-quality care and services. That changed in 2025. After it obtained CMS approval to consolidate two MA Plans into one go-forward plan to improve its services and maximize its offerings to beneficiaries in 2024, HMOLA's ratings precipitously and unexpectedly dropped. As do other MA Plans, HMOLA immediately sought to understand why its ratings fell following consolidation, and toward that end engaged in extensive discussions and even settlement communications with CMS to resolve a number of errors that it identified with the agency's calculations that were directly responsible for the lower ratings. But CMS refused to budge – until after HMOLA filed suit.

And when the agency did finally engage substantively, instead of correcting its errors, and restoring HMOLA's high ratings, CMS made more errors that simply

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[2] *UnitedHealthcare Benefits of Tex., Inc. v. Ctrs. for Medicare & Medicaid Servs.*, No. 6:24-cv-00357, 2024 WL 4870771 (E.D. Tex. Nov. 22, 2024); *Scan Health Plan v. Dep't of Health & Human Servs.*, No. 1:23-cv-03910, 2024 WL 2815789 (D.D.C. June 3, 2024); *Elevance Health v. Becerra*, 736 F. Supp. 3d 1 (D.D.C. 2024); *see also* Susan Morse, *UnitedHealthcare wins lawsuit over star ratings* (Nov. 26, 2024), https://www.healthcarefinancenews.com/news/unitedhealthcare-wins-lawsuit-over-star-ratings; Paige Minemyer, *Judge sides with SCAN Health Plan in dispute with CMS over Medicare Advantage star ratings* (June 4, 2024), https://www.fiercehealthcare.com/payers/judge-sides-scan-health-plan-dispute-cms-over-medicare-advantage-star-ratings.

maintained the status quo – while discrete measure scores changed positively, HMOLA's overall ratings, lo and behold, remained exactly the same. As critically relevant here, CMS's Technical Notes direct the agency to collect various data for each measured service, including data related to Measure C05 for Special Needs Plans ("SNPs"). As provided for by the Notes, however, CMS is to exclude Measure C05 data for contracts with fewer than 30 eligible SNP beneficiaries, or contracts that terminate before July 1. In other words, for MA Plans that do not offer an SNP, or had one that terminated before July 1, CMS excludes C05 as a "no score."

Because both of HMOLA's consolidated contracts satisfied the C05 exclusions for the applicable measuring period (its consumed contract was terminated, and its surviving contract did not offer SNPs), CMS treated Measure C05 as a "no score" and excluded HMOLA's C05 data when calculating its ratings. But as part of purporting to address HMOLA's multiple concerns with its overall 2025 ratings, CMS suddenly switched positions, stating no more than that it would now accept C05 data on HMOLA's "request" and "further consideration." To do so, the agency actually had to overhaul and reprogram its electronic data collection system, which previously technologically prevented submission of that data. After it received the data, CMS used it to create an average score for the measure (combining it with the no score for the go-forward contract), which necessarily reduced HMOLA's score for that measure and left it with the same overall Star

Ratings based on services it did not offer and disqualified it from receiving any bonus payments.

CMS's changed approach to HMOLA's C05 data violates the plain text of its regulations and Technical Notes, which require the agency to exclude that data in simple and straightforward terms. If there were any doubt about that, one need look no further than the agency's computer system operationalizing that understanding by barring HMOLA even from submitting the data in the first place. And CMS's new approach, which dings a plan for services it does not even provide, undermines its core statutory mission to provide beneficiaries with helpful ratings reflecting a plan's true quality. Nor did the agency provide any explanation, let alone a sound one, for its departure from its existing policy and practice. All of these deficiencies together, or any one of them alone, warrants vacatur and remand to the agency for reconsideration.

Yet, the District Court granted summary judgment in favor of CMS. The court held that CMS's regulations trumped its Technical Notes, even though both are binding independently and operate in harmony to compute a plan's Star Ratings. While the agency's approach included data for an unoffered service, the District Court further speculated that including the data prevented gamesmanship in the contract consolidation process and that excluding the data would somehow result in *less* accurate ratings. And the court further reasoned that CMS's change in approach

requiring it to overhaul its computer system was just a "one-off error" and that, while its terse acknowledgement of the change did not "shed much light on the agency's reasoning," the agency "ha[d] done just enough to explain its shift."

The Court should reverse the District Court's judgment, vacate HMOLA's 2025 Star Ratings, and remand to the agency.

II. Regulatory Background.

A. The Medicare Advantage Program And Star Ratings.

Medicare 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 – a.k.a., the "Medicare Advantage" program. *See* 42 U.S.C. § 1395w-21. Under Medicare Advantage, CMS contracts with private insurance payors – known as MA Plans – to provide Medicare-covered benefits for beneficiaries who enroll in their plans. *See* 42 C.F.R. § 422.4(a); 42 U.S.C. § 1395w-23(a)(1)(A). In addition to arranging and paying for Medicare-covered benefits, MA Plans typically provide supplemental benefits as well as lower co-payments and other cost-sharing, which further reduce beneficiaries' costs of covered services. *See* 42 U.S.C. § 1395w-22(a)(3).

In enacting the SSA, Congress mandated that "the quality rating for a plan shall be determined according to a 5-star rating system," 42 U.S.C. § 1395w-

23(o)(4)(A), and directed the agency to ensure it properly measures "health outcomes and other indices of quality," 42 U.S.C. § 1395w-22(e)(3)(A)(i). To carry out that mandate, CMS issues "Star Ratings" that provide "information about plan quality and performance indicators," 83 Fed. Reg. 16,440, 16,520 (Apr. 16, 2018), and also represent a "true reflection of plan quality and enrollee experience," *id.* at 16,521. *See generally* 42 C.F.R. § 422.160. These Star Ratings are an important shopping tool for beneficiaries, as they provide information for comparing plans in the marketplace, and carry significant benefits and consequences for the plans themselves. 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. *See* 42 C.F.R. § 422.166(h).[3] That allows Medicare beneficiaries to weigh, consider, and rank each MA Plan to determine which plan best serves their needs and in which to enroll. *Id.*

The Star Ratings also directly impact MA Plans' funding and operations. CMS uses Star Ratings to allocate and award quality bonuses – usually worth tens,

[3] *See* CMS Medicare Plan Finder, *available at* https://www.medicare.gov/plan-compare/#/?year=2025&lang=en (last visited Dec. 5, 2025). The Court may take judicial notice of information posted on public websites of government agencies. *See, e.g.*, *Cannon v. District of Columbia*, 717 F.3d 200, 205 n.2 (D.C. Cir. 2013).

if not, hundreds, of millions of dollars – to well-performing MA Plans so they can improve their care and maximize services for beneficiaries and earn higher Star Ratings. *See* 42 U.S.C. § 1395w–23(o); 42 C.F.R. § 422.160(b)(1) & (2); JA13 ¶¶ 36–37. CMS awards these additional funds to MA Plans rated at or above 4.0 stars. *See* 42 U.S.C. § 1395w–23(o)(3)(A)(i).

CMS also uses Star Ratings to determine eligibility for participation in the MA program as well as disciplinary measures for underperforming plans. *See, e.g.*, 42 C.F.R. § 422.510(a)(4)(xi). Low ranked MA Plans may be disqualified from payments, incur monetary and operational sanctions, or even be removed from the MA program, resulting in devastating financial and coverage consequences for MA Plans and beneficiaries. 42 C.F.R. §§ 422.160(b)(1) & 422.510(a).

CMS's Star Ratings effectively control the success (or failure) and future of MA Plans as well as the care of tens of millions of beneficiaries. *Supra* at 7–8. Given that starkly consequential reality, Congress provided guardrails and direction in the SSA to ensure CMS implemented a coherent, specific, and predictable methodology to develop Star Ratings. Thus, Star Ratings must be calculated in a way that constitutes "a true reflection of [the] plan['s] quality," and, as such, are based on "complete, accurate, reliable, and valid" data. 83 Fed. Reg. at 16,520–21. Toward that end, CMS is statutorily required to measure "health outcomes and other

indices of quality" in developing the Star Ratings pursuant to specific methodologies set forth in its regulations. 42 U.S.C. § 1395w-22(e)(3)(A)(i).

B. The Calculation Of Star Ratings Under The SSA And CMS's Regulations.

CMS Regulations. Pursuant to the SSA, CMS promulgated regulations that establish the specific methodology used to calculate annual Star Ratings for MA Plans. *See generally* 42 C.F.R. §§ 422.162(b) & 422.166. CMS calculates Star Ratings based on numerous performance measures and data designed to assess member satisfaction and quality of care. *See* JA150–363. Specifically, the agency assesses approximately 42 measured services that each MA Plan provides, and then assigns ratings to each service (between 1 and 5) that are compiled together to develop an overall Star Ratings for each MA Plan. *See* JA187–262.[4]

Technical Notes. In addition to promulgating regulations in the CFR, CMS also publishes Technical Notes. The Technical Notes further, and more specifically and explicitly, provide the "methodology for creating" the Star Ratings for each MA Plan. JA158. These Notes are expressly incorporated into CMS's regulations and "bind" the agency. JA142; 42 C.F.R. § 422.164(a). Critically, the Technical Notes explain how CMS calculates the relevant "measures" that are "used for a particular

[4] Star Ratings are calculated based on the data reported for the full year prior to collection. For example, Star Ratings for 2025 are based on 2023 measurement-year data and published in October 2024. JA170.

Star Rating," as well as provide exclusions and requirements for data specific to each measure. 42 C.F.R. § 422.164(a); JA160–170 & JA187–262.

CMS's regulations and Technical Notes work together to establish and guide how CMS actually calculates Star Ratings. In calculating a plan's ratings, CMS must treat each MA Plan "fairly and equally," and adopt a methodology that "minimize[s] unintended consequences," is "transparent," and allows for "multi-stakeholder input." 83 Fed. Reg. at 16,521. It makes good sense then that, when assessing an MA Plan's measured services and ratings, the agency will only consider services "under the control" of the MA Plan. *Id.*

Measure C05. One of the measured services considered by CMS directly at issue here is Measure C05, known as Special Needs Plan Care Management ("SNP"). *See* JA194–196. SNPs are intended for beneficiaries suffering from chronic diseases and conditions, or who live in an institution, such as a nursing home. JA194.

For CMS to consider a plan's Measure C05 data as part of its Star Ratings, the plan "must have 30 or more enrollees." JA195. 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," formally designated as "no data available." JA195 & 276. For the 2025 Star Ratings, CMS is also to exclude from its calculation of Measure C05

contracts "with an effective termination date on or before . . . June 15, 2024." JA194 & 276.

To ensure the absence of an SNP score does not skew a plan's Star Ratings, CMS will "exclude" consideration of that measure as a "no score" in the Star Ratings calculation. JA276. That is because, by not offering an SNP, the measured service is not under the MA Plan's "control" for Star Ratings purposes. 83 Fed. Reg. at 16,521. Otherwise, the MA Plan would be penalized by receiving a "zero" for a measured service it does not offer, thus resulting in lower Star Ratings that fail to reflect the true "quality" of the plan's provided services. *Id.*

Notably, the exclusions for measured services may vary by each measure. For example, while Measure C05 excludes contracts depending on the termination date or number of enrollees, Measure C08 (which relates to osteoporosis management for women) excludes data for members based on certain lab results, claim encounters, death, and age, among other criteria. JA199–200. Similarly, Measure C01 (relating to breast cancer screenings) excludes consideration of contracts with fewer than 500 enrollees and members receiving palliative care. JA187–188; *see also* JA208–209 (excluding C13 when fewer than 100 enrollees are participating). Accounting for these exclusions specific to each measure and MA Plan offerings ensures CMS only considers accurate information about "health outcomes" and the "quality" of

services that are actually provided "and under the control" of an MA Plan. 42 U.S.C. § 1395w-22(e)(3)(A)(i); 83 Fed. Reg. at 16,521.

C. Calculating Star Ratings For Consolidated Contracts.

An MA Plan may choose to consolidate its 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). That occurs when a "contract that no longer exists at a contract year's end as a result of a consolidation" – *i.e.*, the "consumed contract" – is combined with the contract that continues after consolidation – *i.e.*, the "surviving contract." *Id.*. An MA Plan may consolidate for a variety of reasons, including to reduce administrative burdens, improve the quality of its offerings, and expand the care options for beneficiaries. *See, e.g.*, JA55 ¶ 25.

To consolidate contracts, an MA Plan must first obtain approval from CMS. *See* 42 C.F.R. § 422.162(b)(3). That is an intensive multi-year process that requires the MA Plan to prepare and submit a lengthy application to CMS, potentially assign and novate prior contracts, and engage in other significant tasks directed by CMS. *See generally* 42 C.F.R. §§ 422.550–422.552.[5]

[5] *See Medicare Managed Care Manual: Chapter 12 – Effect of Change of Ownership*, *available at* https://www.cms.gov/regulations-and-guidance/guidance/manuals/downloads/mc86c12.pdf (outlining the requirements for consolidating plans).

Typically, when contracts are consolidated, CMS calculates 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)(i); JA182. But if a surviving or consumed contract has a measured service that satisfies an exclusion under the Technical Notes, it is designated as "no data available" and excluded for both contracts. 42 C.F.R. § 422.162(b)(3); JA194–196. That is entirely consistent with the SSA, CMS's regulations, and Technical Notes. Otherwise, the Star Ratings for a plan undergoing consolidation would be incorrectly weighted by having only one – as opposed to two – measures for averaging. 42 C.F.R. § 422.162(b)(3); JA194–196. The resulting score would in turn mislead beneficiaries about the MA Plan's true quality because the Star Ratings would be factoring in non-existent services. *Supra* Section II.B.

III. Factual Background.

A. HMOLA's Services And Historical Star Ratings.

HMOLA is one of the nation's largest MA Plans, currently serving approximately 34,000 members in Louisiana. JA8 & JA53. HMOLA has historically earned high Star Ratings for its high-quality care and services. JA53 ¶ 13. HMOLA received Star Ratings of 4.5 in 2023 and 2024 and expected similar ratings for 2025. JA54. Based on its high Star Ratings, HMOLA has regularly

qualified for substantial quality bonus payments, which it has used to reduce cost sharing, eliminate premiums, and fund supplemental benefits. *Id.*

Following approval by CMS, on January 1, 2024, HMOLA's parent company consolidated two of its contracts – H5576 and H6453. *Id.* For the consolidation, H6453 was the surviving contract, and H5576 was the consumed contract. *Id.* Thus, effective January 1, 2024, H5576 "no longer exist[ed]" as a result of the consolidation – it was effectively terminated on that date. 42 C.F.R. § 422.162(a). H6453 did not offer an SNP in 2023. JA55.

B. CMS Issued Flawed 2025 Star Ratings For HMOLA.

In September 2024, CMS notified HMOLA of its plan preview for its 2025 Star Ratings. JA43 & JA364. Surprisingly, HMOLA's 2025 Star Ratings dropped precipitously to 3.5 Stars. JA55. HMOLA promptly contacted CMS to understand why its ratings has suddenly and surprisingly dropped. JA364–365. While HMOLA did not know all of the steps CMS had taken, it alerted CMS to three errors that it had identified in the agency's calculation of scores for Measures D11, C05, and HMOLA's CAI adjustment factor. *Id.* HMOLA also noted that it had been "unable to submit relevant measurement information data" for two measures, including Measure C05. JA364.

In response, CMS explained that "[d]ata are not collected and validated for contracts that terminate prior to July 1 in the following year after the contract year

(CY) reporting period" – referring to contract H5776, which terminated as of January 1, 2024. JA367. CMS thus determined HMOLA's contract H5576 terminated, and it therefore "did not receive" or accept "data for H5576 to use for these measures [including C05] in the 2025 Star Ratings." *Id.* Additionally, because "H6453 [the surviving contract] did not offer SNP plans during the measurement year," the agency determined there was "no data for H6453 for the SNP care management measure." *Id.* As such, CMS treated C05 as "no data available" and excluded it when calculating HMOLA's Star Ratings. JA194–196; JA367.

HMOLA continued discussions with CMS about the three known errors and its resulting lower Star Ratings, including after it filed suit. JA371–376. Those discussions and settlement communications led to CMS informing HMOLA the agency "accepted" H5576's previously excluded 2023 SNP data at its "request and after further consideration." JA375. The agency did not provide any explanation or reasoning for this move, or cite any regulation or legal basis for doing so. *Id.*

After CMS recalculated HMOLA's Star Ratings, however, the ratings for the individual measures changed while its overall Star Ratings did not. JA376. For C05, CMS calculated HMOLA's Star Ratings by combining the surviving contract's "no score" with the consumed contract's 3.0 Star Ratings, which necessarily generated a lower overall Star Ratings for HMOLA. *Id.* As a result, the agency issued Star Ratings based on services not actually offered as part of the surviving

H6453 contract. JA376. Needless to say, issuing Star Ratings based on non-existent services – and over which HMOLA obviously had no "control" – cannot possibly represent a "true reflection" of HMOLA's services and care. 83 Fed. Reg. at 16,520–16,521. And in doing so, CMS did not articulate any specific reason why, or on what basis, it adopted a newfound policy that resulted in an unchanged overall rating. JA375.

C. HMOLA Has Suffered Substantial And Irreparable Harm.

CMS's flawed and unsupported calculation of HMOLA's Star Ratings has caused it substantial and irreparable harm. JA47–49. By publishing lower – and erroneous – Star Ratings for HMOLA online and in publications, prospective members have been deterred from enrolling while existing members have been encouraged to disenroll from HMOLA. JA56. Because of CMS's flawed rating methodology and reliance on improper data, beneficiaries could, based on its Star Ratings, mistakenly conclude HMOLA's offerings are inferior or lower in quality compared to the offerings of other plans. JA56. That has naturally caused harm to HMOLA's competitive position, reputation, and goodwill. JA48–49 & 56.

Additionally, by reducing HMOLA's Star Ratings, CMS rendered HMOLA ineligible for quality bonus payments worth approximately $23 million in 2026. JA56. That has directly harmed HMOLA's operations and prevented it from offering its 34,000 beneficiaries enhanced benefits and lower premiums. *Id.*

IV. Procedural History.

On February 14, 2025, HMOLA filed its Amended Complaint against CMS. JA8. HMOLA alleged CMS violated the APA by acting arbitrarily, capriciously, and not in accordance with the law in calculating its 2025 Star Ratings. JA17–19. In particular, CMS failed to abide its statutory mandate as well as its own regulations and Technical Notes by improperly considering C05 data for HMOLA's consumed contract. JA18. CMS further failed to provide a reasoned explanation for its abrupt departure from its long-standing regulations and policy. JA18. For relief, HMOLA sought an order enjoining CMS from disclosing and relying on its flawed Star Ratings, and directing the agency to recalculate its Star Ratings and publicly correct its errors, and declaratory relief. JA21–22.

The parties filed cross-motions for summary judgment, JA30 & JA58, and on July 2, 2025, the Court heard argument. JA115. At argument, CMS conceded the Technical Notes are "binding." JA142. It then argued for the first time that excluding Measure C05 data, as it had originally done, was "incorrect." JA133. The agency further explained, again for the first time, that the exclusions under the Technical Notes "did not apply" because CMS "improperly regarded that contract as terminated." *Id.* None of the justifications it offered at argument had been provided to HMOLA at any time. *Compare id.*, *with* JA367–368 & JA375–376. The agency indeed conceded that its earlier statement that it would accept HMOLA's

data at its request and on "further consideration" was "the sum and substance of CMS's explanation for why it changes its position," JA133, and that was allegedly "sufficient." JA134.

And as part of that change in policy, CMS explained it had to "reprogram" its submission portal to adopt an entirely different data collection process for HMOLA to submit data on Measure C05. JA143. The reason: CMS's submission portal was "keyed" to operate in accordance with its Technical Notes. *Id.* As such, before the agency decided to change its policy, HMOLA was barred from submitting data on its "consumed contract[ ]" because it was treated as "terminated" and otherwise excluded based on CMS's regulations and Technical Notes. *Id.* Again, CMS never explained the need for any reprogramming – until oral argument, that is. *Compare id.*, *with* JA367–368 & JA375–376.

On July 9, 2025, the District Court granted summary judgment in favor of CMS. JA99. The District Court held "none of CMS's rules, the relevant statute, or the Technical Notes" justified excluding Measure C05 data. JA104. It determined that, despite the express applicable exclusions under the Technical Notes, CMS's regulations required the inclusion of C05 data for the consumed and surviving contracts to develop an "enrollment-weighted mean" of the ratings. JA105.

While recognizing HMOLA's surviving contract did not offer an SNP, the Court determined that failing to consider the consumed contract's prior SNP offering

would "render [HMOLA's] overall rating less reflective of the contract's quality, not more." JA105. While it did not explain how so, it went on to speculate further that HMOLA's interpretation would somehow "encourage" MA Plans to "artificially inflate their scores" and "whitewash" poor ratings through consolidation – without recognizing that consolidations are heavily scrutinized and approved by CMS in advance. JA106. The District Court did not explain how any of that would work or identify any evidence supporting its hypothesis (there is none).

The District Court next considered the exclusions under the Technical Notes. JA106–108. It concluded the termination exclusion did not apply to the consumed contract because a consumed contract does not "terminate" as part of the consolidation process. JA106. It did not cite any definition of termination in support of that holding, and even ignored that CMS itself (and its computer system) considered and treated HMOLA's consumed contract as terminated. JA106–108. It also overlooked that the agency adopted a variety of exclusions for each measure, including C05. *Id.* Instead, the court applied the "specific-governs-the-general" canon to hold the regulations were more "specific" than CMS's Technical Notes and therefore required the data to be averaged instead of excluded. JA107.

The District Court also concluded CMS's original position the contracts were properly excluded was a "one-off error," not a change in "policy." JA109. While acknowledging CMS's explanation for its changed position "does not shed much

light on the agency's reasoning," the Court nevertheless held "CMS essentially adopted HMOLA's rationale for requesting the inclusion of C05 data," and "ha[d] done just enough to explain its shift." JA110. This appeal follows.

SUMMARY OF ARGUMENT

CMS's errors are numerous, glaring, and require vacatur.

I. CMS lowered HMOLA's 2025 Star Ratings based on a flagrant misapplication of its binding regulations as confirmed by its own implementation of those regulations. CMS's regulations, as further explicated by its more specific and binding Technical Notes, are entirely straightforward and clear. The agency must exclude from its calculation of Measure C05 any contracts "with an effective termination date on or before . . . June 15, 2024." But while HMOLA's subsumed contract here terminated following consolidation on January 1, 2024 – that is, it ended after that date – the agency nevertheless used Measure C05 data to calculate its 2025 Star Ratings.

That move not only conflicts with the plain language of the regulation, but the agency itself even operationalized that plain language by preventing its computer system from accepting Measure C05 data from HMOLA on the terminated contract. Excluding data from legacy services in terminated contacts where there is no go-forward service also fits with the overall intent of the statutory and regulatory

scheme CMS implements because including the data would improperly skew the go-forward plan ratings and affirmatively mislead beneficiaries about a plan's quality.

Instead of holding the agency to the plain language of its regulation and its actions putting that language to work, the District Court turned the familiar, *generalia specialibus non derogant* canon of construction into a cannon of interpretative destruction. While that canon – or cannon – has no proper application here, the court mistakenly invoked it to allow CMS's general contract consolidation regulation to control over the measure-specific, on-point Technical Notes. But that is not how the canon properly works and the District Court's deployment of it effectively subverted the proper role and function of the Technical Notes. 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. The District Court turned an interpretive canon on its head and construed the regulation to allow CMS to use data for terminated services to skew HMOLA's Star Ratings.

II. CMS's application of its regulations and Technical Notes further undermines its core statutory mandate to provide beneficiaries with useful information about a plan's quality. Despite the District Court's speculation, there is simply no world in which it is helpful to beneficiaries to provide them a plan rating based on services the plan does not actually offer. Far from reflecting a plan's true

quality, such flawed ratings are more akin to false and misleading advertising. Nor does the District Court's further speculation that including data about a service the plan does not offer prevents gamesmanship in the contract consolidation process make any sense or advance any statutory objective. Plan consolidation is a rigorous process overseen by CMS, no plan may consolidate without the agency's express approval, and there is nothing in the record to support any insinuation of gamesmanship here. To the contrary, up until CMS's shenanigans to lower HMOLA's scores, the plan consistently received high ratings that entitled it to substantial bonus payments to reward its quality care.

III. Agencies are of course free to change positions, but they are duty bound to provide a reasoned justification if and when they do so. CMS forgot that lesson when it turned on a dime here. It purported to justify a sweeping change that required it to reprogram its computer system to accept data it had previously barred by simply offering that it was doing so supposedly at HMOLA's "request and after further consideration." JA375–376. No way that will do with tens of millions of dollars, a plan's reputation and goodwill, and the care for thousands of beneficiaries on the line, as CMS's terse words provide no insight or explanation for the actual substantive reason the agency made a significant change. Nor can the agency backfill that glaring deficiency in this litigation with the obviously false assertion the agency was merely correcting an "error." And a reviewing court cannot, as the

District Court attempted here, play connect the dots and supply the agency's missing explanation either.

The Court should reverse the judgment of the District Court and vacate HMOLA's 2025 Star Ratings.

ARGUMENT

I. Standard of Review.

The Court reviews an APA challenge to an agency action *de novo*. *Safari Club Int'l v. Zinke*, 878 F.3d 316, 325 (D.C. Cir. 2017). Under the APA, the Court must set aside agency actions that are arbitrary, capricious, or not in accordance with the law. *See* 5 U.S.C. § 706(2)(A). An agency action is arbitrary and capricious if it "entirely fail[s] to consider an important aspect of the problem" or fails to "articulate a satisfactory explanation" for its action, or offer[s] an explanation for its decision that runs counter to the evidence" before it. *Motor Vehicle Mfrs. Ass'n of U.S., Inc. v. State Farm Mut. Auto. Ins. Co.*, 463 U.S. 29, 43 (1983). An agency action that violates its own regulations is, for example, a quintessential example of arbitrary and capricious decision-making. *Exportal Ltda v. United States*, 902 F.2d 45, 46 (D.C. Cir. 1990). So is an agency's interpretation and application of a statute, regulation, or guidance that is "inconsistent with a statutory mandate" or "frustrate[s] the congressional policy underlying a statute." *SEC v. Sloan*, 436 U.S. 103, 118 (1978). And it is also a foundational principle that, when agencies change their

policies, they must provide a "reasoned analysis indicating that prior policies and standards are being deliberately changed, not casually ignored." *Ramaprakash*, 346 F.3d at 1124–25 (citing *Greater Boston Television Corp. v. FCC*, 444 F.2d 841, 852 (D.C. Cir. 1970)). Here, CMS violated these core requirements in calculating HMOLA's 2025 Star Ratings and its violations require vacatur.

II. CMS Lowered HMOLA's 2025 Star Ratings By Flouting Its Own Binding Regulations And Statutory Mandate.

A. CMS Lowered HMOLA's 2025 Star Ratings In Derogation Of The Plain Text Of Its Regulations And Binding Technical Notes.

In upholding CMS's calculation of HMOLA's 2025 Star Ratings, the District Court concluded that CMS permissibly used HMOLA's Measure C05 data for the terminated contract. JA104–106. But CMS's approach cannot be squared with the plain language of its own regulations and Technical Notes.[6] 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.

[6] Contrary to the District Court's suggestion, 42 C.F.R. §§ 422.508–422.512 do not provide an exhaustive list of all the ways in which a contract could terminate. *See* JA101. 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). Clearly it has, since it "no longer exist[s]." 42 C.F.R. § 422.162(a).

While CMS's Technical Notes do not define "termination," there is nothing remotely unclear or ambiguous about its common meaning here: a "consumed contract" has obviously "come or been brought to an end or conclusion" after it is consumed by another surviving contract.[7] Nor is there anything confusing about the rule's application here: HMOLA's subsumed contract terminated following consolidation on January 1, 2024, because it "no longer exist[ed]" after that date – just as the agency previously determined. 42 CFR 422.162(a); JA367; *supra* Section III.A & B. And HMOLA's surviving contract did not have an SNP with more than "30 enrollees" – it did not offer an SNP at all. JA367.

The agency's own actions in calculating HMOLA's 2025 Star Ratings align with that plain language interpretation too. *Purepac Pharm. Co. v. Thompson*, 354 F.3d 877, 884–85 (D.C. Cir. 2004). At the outset, CMS recognized and treated 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. Indeed, CMS's own data submission computer system was programed to reject any submission of Measure C05 data from HMOLA because it was "keyed" to this same understanding of the regulations and Technical Notes. JA143.

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[7] 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. *See, e.g.*, *Wisc. Central Ltd. v. United States*, 585 U.S. 274, 277 (2018).

That reading and application fit perfectly with how the regulations and Technical Notes are intended to operate in practice too. *King v. Burwell*, 576 U.S. 473, 492 (2015). 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 is because, by not offering an SNP during the measuring period, 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. at 16,521. That makes perfect sense. 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, 520.

The bottom line here is that CMS's initial approach and determination was fully consistent with what CMS has long understood and interpreted its regulations and Technical Notes to require. *Purepac Pharm. Co.*, 354 F.3d at 884 (holding an agency violates the APA by failing "to justify seeming inconsistencies in its approach" and interpretation of its regulations); *see also State Farm*, 463 U.S. at 41. And CMS's refusal to "abide" its own regulations is quintessentially arbitrary and capricious. *Exportal Ltda*, 902 F.2d at 51; *Loper Bright Enter. v. Raimondo*, 603 U.S. 369, 392 (2024); JA194–196.

In approving CMS's changed interpretation, the District Court overlooked the plain language of the regulation and Technical Notes, the agency's historic practices, and even the agency's own technical barriers preventing it from implementing the approach it ultimately took to lower HMOLA's score. But in order to "infuse a measure of public accountability into administrative practices,"[8] *Exportal Ltda*, 902 F.2d at 50, courts must "enforce" the "plain meaning" of the text of a regulation, *King*, 576 U.S. at 486; *Exportal Ltda*, 902 F.2d at 46, keeping in mind "their context and with a view to their place in the overall" regulatory and statutory scheme, *King*, 576 U.S. at 486; *Al-Bihani v. Obama*, 619 F.3d 1, 45 n.25 (D.C. Cir. 2010) (same).

Rather than do any of that here, the District Court applied the "specific-governs-the-general" canon to conclude CMS's regulations on consolidation superseded its Technical Notes. JA107. There are two things wrong with that move. One, the canon has no real pertinence here. The Technical Notes have the same weight and force as regulations, 42 C.F.R. § 422.164(a), and are considered "binding" by the agency. JA142. Accordingly, numerous courts, including those in this District, have held that CMS's failure to abide its Technical Notes violates the

[8] The same canons of construction that apply to statutes apply to agency regulations and policies. *Kisor v. Wilkie*, 588 U.S. 558, 575 (2019).

APA.[9] As such, CMS's violation of its Technical Notes is a free-standing violation regardless of whether it also violated its regulations.

But, two, the District Court's reliance on the specific-governs-the-general canon is mistaken on its own terms in any event. That canon provides that "general language" of a regulation, "though broad enough to include" a certain agency action, "will not be held to apply to a matter specifically dealt with in another part of the enactment." *Bloate v. U.S.*, 559 U.S. 196, 207 (2010); *RadLAX Gateway Hotel, LLC v. Amalgamated Bank*, 566 U.S. 639, 646 (2012); *Genus Med. Tech. LLC v. FDA*, 994 F.3d 631, 638 (D.C. Cir. 2021); *cf. Pacific Ranger, LLC v. Pritzker*, 211 F.Supp.3d 196, 217 (D.D.C. 2016) ("[T]he specific governs the general also applies to the regulatory context.").

Properly applying that canon here leads to one result: The Technical Notes control how to treat HMOLA's Measure C05 data. *See Genus Med. Tech. LLC*, 994 F.3d at 638. CMS's consolidation regulations broadly direct CMS generally to use "the enrollment-weighted mean of the measure scores" of the "consumed and surviving contracts for all measures[.]" 42 C.F.R. § 422.162(b)(3)(iv)(B)(1). But

[9] *UnitedHealthcare Benefits of Tex., Inc. v. Ctrs. for Medicare & Medicaid Servs.*, No. 6:24-cv-00357, 2024 WL 4870771, at *3-4 (E.D. Tex. Nov. 22, 2024) (holding CMS action arbitrary and capricious where it deviates from its Technical Notes); *Scan Health Plan v. Dep't of Health & Human Servs.*, No. 1:23-cv-03910, 2024 WL 2815789, at *3 & 5 (D.D.C. June 3, 2024) (applying Technical Notes); *Elevance Health v. Becerra*, 736 F. Supp. 3d 1 (D.D.C. 2024) (same).

its regulations then require CMS 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). The Technical Notes for Measure C05 expressly exclude contracts terminated prior to June 15, 2024, as well as those with fewer than 30 enrollees – both of which HMOLA's contracts satisfy. JA194–196. Where, as here, the agency has adopted a "comprehensive scheme" while also "deliberately target[ing] specific problems with specific solutions," the specific terms in the Technical Notes naturally "govern." *RadLAX Gateway Hotel*, 566 U.S. at 645.

The District Court's application of the canon generated a construction of the agency's regulation that is "flatly inconsistent" with its "plain terms" as well as the agency's own understanding and practice. *Exportal Ltda*, 902 F.2d at 46; *Loper*, 603 U.S. at 392. This Court should not "sanction" CMS's newfound and "inconsistent" interpretations, none of which have any support in the plain text of its regulations or Technical Notes, and duly reverse the District Court's mistaken judgment. *Purepac Pharm. Co.*, 354 F.3d at 884.

B. CMS's Improper Use Of Measure C05 Data To Calculate HMOLA's 2025 Star Ratings Frustrates Its Central Statutory Command To Provide Beneficiaries With Useful Ratings Reflecting A Plan's True Quality.

Beyond flouting its regulations and past practice, CMS's reliance on Measure C05 to lower HMOLA's 2025 Star Ratings also undermined its core statutory mission to provide beneficiaries helpful information to "make informed plan choices." 83 Fed Reg at 16,520; *see generally* 42 U.S.C. § 1395w-21. Indeed, the agency's action here does not even properly measure any actual "health outcomes and other indices of quality." 42 U.S.C. § 1395w-22(e)(3)(A)(i).

Measure C05 is designed to measure the percentage of beneficiaries enrolled in a Special Needs Plan that received a health needs assessment "to help [them] get the care they need." JA194. Potential enrollees cannot make an informed decision based on a misleading Star Rating representing that HMOLA provides such assessments when, in fact, it does not. HMOLA's 2025 Star Rating results from the agency's arbitrary inclusion of skewed data about a service the plan does not offer, which misleads – rather than "help[s]" – beneficiaries in assessing HMOLA's services and care. *Id.*

The District Court's speculation that HMOLA's Star Ratings would be "less reflective" of the plan's quality if Measure C05 was excluded is baseless and incorrect. JA105. It of course flies in the face of the agency's own regulation,

historic understanding and computer programming, and the basic intent of the Technical Notes to prevent plan ratings from being skewed by zero scores for services that are not offered. But more fundamentally, there is simply no reasonable way a rating based on services a plan does not provide could somehow be "more" (rather than less) reflective of its true quality. The agency did not even advance that argument on brief or at argument for a good reason: It makes no sense and is obviously wrong. *See NLRB v. Brown*, 380 U.S. 278, 292 (1965); *FEC v. Democratic Senatorial Campaign Comm'n*, 454 U.S. 27, 32 (1981); *supra* Section IV.

The District Court further speculated that excluding C05 data would "encourage" plans to "whitewash" ratings by "strategically consolidating contracts," thereby undermining the agency's statutory mandate. JA106. This far-fetched and hopelessly baseless speculation, too, is deeply mistaken. Not only is there no record evidence to support the District Court's speculation, the agency itself did not present any argument along these lines. Again, there is a good reason for that too. An MA Plan cannot simply declare it is consolidating its contracts on a whim. Instead, an MA Plan must first obtain approval from CMS during the bid submission process and satisfy substantial requirements imposed by CMS. *Supra* Section II.C. And, critically, contract consolidation and exclusion of certain measures are both approved by CMS and work in harmony to ensure the resulting Star Ratings are a

"true reflection of plan quality and enrollee experience." 83 Fed. Reg. at 16,521; *see* 42 U.S.C. § 1395w-22(e)(3)(A)(i). As such, there is nothing "inconsistent" – let alone untoward – about HMOLA having certain measures excluded in compliance with CMS's regulations and Technical Notes as part of consolidating contracts to better care for its beneficiaries. *FEC*, 454 U.S. at 32.

III. CMS's Lowered HMOLA's 2025 Star Ratings Flow From An Unexplained Departure From Its Established Policy For Excluding Measure C05 Data.

In relying on Measure C05 data to calculate HMOLA's ratings, CMS committed yet another cardinal APA sin. It departed from its existing policy and approach for treating consolidated contracts without any explanation – let alone a reasonable one. That too warrants vacatur. *See* 5 U.S.C. § 706(2)(A).

While agencies may change their policies, they cannot do so willy-nilly without rational explanation. Instead, they must provide a "reasoned analysis indicating that prior policies and standards are being deliberately changed, not casually ignored." *Ramaprakash*, 346 F.3d at 1124–25; *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."). Fundamentally, they must also "show that there are good reasons for the new policy." *Encino Motorcars, LLC v. Navarro*, 579 U.S. 211, 221–222 (2016); *State Farm*, 463 U.S. at 42–43. This requirement applies with

full force to informal adjudications and policy statements, *Dep't of Homeland Sec. v. Regents of Univ. of Cal.*, 591 U.S. 1, 18 (2020) (applying change-in-position doctrine to informal proceeding involving agency policy statement); *see also Food & Drug Admin. v. Wages & White Lion Investments, LLC*, 604 U.S. 542, 569 n.5 (2025), and ensures the regulated public is not subjected to "unfair surprise," *Christopher v. SmithKline Beecham Corp.*, 567 U.S. 142, 156 (2012); *see FCC v. Fox Television Stations*, 556 U.S. 502, 515–16 (2009) (explaining agency "must" provide justification for new policy because of "serious reliance interests" "engendered" by prior policy).

Yet here, CMS completely reversed its prior policy with no reasoned explanation whatsoever. *See Christopher*, 567 U.S. at 156. The agency initially calculated HMOLA's Star Ratings in accordance with its regulations and Technical Notes. *Supra* Section III.B. It explained that it did so because HMOLA's consumed contract terminated on January 1, 2024, as a result of consolidation, and therefore had no "July enrollment data for consideration." JA367. As such, CMS excluded data from its surviving contract given it did not offer SNPs, thus designating both contracts as "no data available." *Id.* CMS's data collection computer system was in fact "keyed" to that understanding, technologically preventing HMOLA from submitting any data for either contract. JA143. But when HMOLA continued questioning the agency about various aspects of how it had calculated the Star

Ratings, CMS suddenly reversed course and collected and used Measure C05 data apparently at HMOLA's "request and after further consideration." JA375–376.

While the District Court held these five words were enough to justify the agency's changed position, they surely are not with millions of dollars, a plan's reputation and goodwill, and the care of so many beneficiaries on the line. CMS's terse statement indeed provides no insight into any reasons, let alone any "good reasons," for the agency's changed approach. *Nat'l Lifeline Ass'n v. Fed. Commc'ns Comm'n*, 921 F.3d 1102, 1111 (D.C. Cir. 2019) (citing *Fox Television Stations*, 556 U.S. at 515–16); *Ramaprakash*, 346 F.3d at 1124–25. CMS did not even forthrightly acknowledge that it was changing its policy, explain its newfound interpretation of its regulations and Technical Notes, or offer how its new interpretation better served its statutory objective to provide beneficiaries useful information about plan quality.

Given our federal agencies are asked to do all manner of things for all manner of reasons by all manner of parties, an agency saying it changed its position simply because someone asked it to cannot possibly constitute a sufficient APA reasoned explanation. If that were the case, there would be little of substance to the requirement that an agency must actually provide a reasoned basis for a changed policy. Nor can empty banalities like "on further consideration" pass for reasoned decision-making either. Since that is all that CMS offered here, its 5-word "justification" "cross[ed] the line from the tolerably terse to the intolerably mute."

Cf. Greater Bos. Television Corp. v. F.C.C., 444 F.2d 841, 852 (D.C. Cir. 1970).

CMS cannot now "glos[s] over or swerv[e] from," *id.*, its sudden change "*sub silentio*" either, *Fox Television Stations*, 556 U.S. at 515–16 (vacating agency decision that was neither explained nor justified). Thus, while its counsel has argued its prior policy was some kind of "error," that post hoc rationale will not do. JA137. CMS never offered that its earlier approach was a mistake in need of correction. JA367–368 & JA375–376; *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"). It did not offer that justification because it would not have been correct. CMS's policy and practice simply carried out the plain language of its regulations and Technical Notes. It was not an "error" that CMS's computer system was programmed to implement that historic practice and interpretation, and the agency did not "fix" that error by reprogramming its system to accept HMOLA's C05 data here.

Nor can a reviewing court cure the agency's failure with its own speculation that it "essentially adopt[ed] HMOLA's rationale for requesting the inclusion of C05 data." JA110; *State Farm*, 436 U.S. at 43. The agency itself never said that, and a reviewing court cannot prop up CMS's changed policy by "supply[ing] a reasoned basis for the agency's action that the agency itself has not given." *State Farm*, 436 U.S. at 43. The entire point of requiring an agency to expressly articulate its

reasoning is so regulated parties and reviewing courts are not left to "guess at the theory underlying the agency's action." *Farrell v. Blinken*, 4 F.4th 124, 137 (D.C. Cir. 2021) (citing *SEC v. Chenery Corp.*, 332 U.S. 194, 196–97 (1947)). Because that is exactly what CMS has done here, its guessing game for its sudden but profound change is arbitrary and capricious and its action is properly vacated.

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 further consideration consistent with the Court's opinion and relief sought by HMOLA. JA21–22.

Dated: December 5, 2025

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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 8,511 words.

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ADDENDUM

ADDENDUM OF PERTINENT STATUTES

Pursuant to Circuit Rule 28(a)(5), this addendum includes the following pertinent statutory provisions and rules, reproduced verbatim:

ADD1

42 U.S.C. § 1395w-22

Title 42—The Public Health and Welfare

Chapter 7—Social Security

Subchapter XVIII—Health Insurance for Aged and Disabled

Part C—Medicare+Choice Program

§ 1395w-22. Benefits and beneficiary protections

(a) Basic Benefits

…

(3) Supplemental benefits

(A) Benefits included subject to Secretary's approval

Subject to subparagraph (D), each Medicare+Choice organization may provide to individuals enrolled under this part, other than under an MSA plan (without affording those individuals an option to decline the coverage), supplemental health care benefits that the Secretary may approve. The Secretary shall approve any such supplemental benefits unless the Secretary determines that including such supplemental benefits would substantially discourage enrollment by Medicare+Choice eligible individuals with the organization.

(B) At enrollees' option

(i) In general

Subject to clause (ii), a Medicare+Choice organization may provide to individuals enrolled under this part supplemental health care benefits that the individuals may elect, at their option, to have covered.

(ii) Special rule for MSA plans

A Medicare+Choice organization may not provide, under an MSA plan, supplemental health care benefits that cover the deductible described in section 1395w–28(b)(2)(B) of this title.

In applying the previous sentence, health benefits described in section 1395ss(u)(2)(B) of this title shall not be treated as covering such deductible.

(C) Application to Medicare+Choice private fee-for-service plans

Nothing in this paragraph shall be construed as preventing a Medicare+Choice private fee-for-service plan from offering supplemental benefits that include payment for some or all of the balance billing amounts permitted consistent with subsection (k) and coverage of additional services that the plan finds to be medically necessary. Such benefits may include reductions in cost-sharing below the actuarial value specified in section 1395w–24(e)(4)(B) of this title.

(D) Expanding supplemental benefits to meet the needs of chronically ill enrollees

(i) In general

For plan year 2020 and subsequent plan years, in addition to any supplemental health care benefits otherwise provided under this paragraph, an MA plan, including a specialized MA plan for special needs individuals (as defined in section 1395w–28(b)(6) of this title), may provide supplemental benefits described in clause (ii) to a chronically ill enrollee (as defined in clause (iii)).

(ii) Supplemental benefits described

(I) In general

Supplemental benefits described in this clause are supplemental benefits that, with respect to a chronically ill enrollee, have a reasonable expectation of improving or maintaining the health or overall function of the chronically ill enrollee and may not be limited to being primarily health related benefits.

(II) Authority to waive uniformity requirements

The Secretary may, only with respect to supplemental benefits provided to a chronically ill enrollee under this

subparagraph, waive the uniformity requirements under this part, as determined appropriate by the Secretary.

(iii) Chronically ill enrollee defined

In this subparagraph, the term "chronically ill enrollee" means an enrollee in an MA plan that the Secretary determines—

(I) has one or more comorbid and medically complex chronic conditions that is life threatening or significantly limits the overall health or function of the enrollee;

(II) has a high risk of hospitalization or other adverse health outcomes; and

(III) requires intensive care coordination.

…

(e) Quality Improvement Program

…

(3)Data

(A) Collection, analysis, and reporting

(i) In general

Except as provided in clauses (ii) and (iii) with respect to plans described in such clauses and subject to subparagraph (B), as part of the quality improvement program under paragraph (1), each MA organization shall provide for the collection, analysis, and reporting of data that permits the measurement of health outcomes and other indices of quality. With respect to MA private fee-for-service plans and MSA plans, the requirements under the preceding sentence may not exceed the requirements under this subparagraph with respect to MA local plans that are preferred provider organization plans, except that, for plan year 2010, the limitation under clause (iii) shall not apply and such requirements shall apply only with respect to administrative claims data.

ADD2

42 U.S.C. § 1395w-23

Title 42—The Public Health and Welfare

Chapter 7—Social Security

Subchapter XVIII—Health Insurance for Aged and Disabled

Part C—Medicare+Choice Program

§ 1395w-23. Payments to Medicare+Choice organizations

(a) Payments to organizations

(1) Monthly payments

(A) In general

Under a contract under section 1395w–27 of this title and subject to subsections (e), (g), (i), and (l) and section 1395w–28(e)(4) of this title, the Secretary shall make monthly payments under this section in advance to each Medicare+Choice organization, with respect to coverage of an individual under this part in a Medicare+Choice payment area for a month, in an amount determined as follows:

…

(o) Applicable Percentage Quality Increases

(3) Qualifying plans and qualifying county defined; application of increases to low enrollment and new plans

For purposes of this subsection:

(A) Qualifying plan

(i) In general

The term "qualifying plan" means, for a year and subject to paragraph (4), a plan that had a quality rating under paragraph (4) of 4 stars or higher based on the most recent data available for such year.

…

(4) Quality determinations for application of increase

(A) Quality determination

The quality rating for a plan shall be determined according to a 5-star rating system (based on the data collected under section 1395w–22(e) of this title).

ADD3

42 C.F.R § 422.160

Title 42—Public Health

Chapter IV—Centers for Medicare & Medicaid Services, Department of Health and Human Services

Subchapter B—Medicare Program

Part 422—Medicare Advantage Program

Subpart D—Quality Improvement

(a) Basis. This subpart is based on sections 1851(d), 1852(e), 1853(o) and 1854(b)(3)(iii), (v), and (vi) of the Act and the general authority under section 1856(b) of the Act requiring the establishment of standards consistent with and to carry out Part C.

(b) Purpose. Ratings calculated and assigned under this subpart will be used by CMS for the following purposes:

(1) To provide comparative information on plan quality and performance to beneficiaries for their use in making knowledgeable enrollment and coverage decisions in the Medicare program.

(2) To provide quality ratings on a 5-star rating system to be used in determining quality bonus payment (QBP) status and in determining rebate retention allowances.

(3) To provide a means to evaluate and oversee overall and specific compliance with certain regulatory and contract requirements by MA plans, where appropriate and possible to use data of the type described in § 422.162(c).

ADD4

42 C.F.R § 422.162

Title 42—Public Health

Chapter IV—Centers for Medicare & Medicaid Services, Department of Health and Human Services

Subchapter B—Medicare Program

Part 422—Medicare Advantage Program

Subpart D—Quality Improvement

(a) Definitions. In this subpart the following terms have the meanings:

…

Consolidation means when an MA organization that has at least two contracts for health and/or drug services of the same plan type under the same parent organization in a year combines multiple contracts into a single contract for the start of the subsequent contract year.

Consumed contract means a contract that will no longer exist after a contract year's end as a result of a consolidation.

…

Surviving contract means the contact that will still exist under a consolidation, and all of the beneficiaries enrolled in the consumed contract(s) are moved to the surviving contracts.

…

(b) Contract ratings —

…

(3) Contract consolidations.

(i) In the case of contract consolidations involving two or more contracts for health or drug services of the same plan type under the same parent organization, CMS assigns Star Ratings for the first and

second years following the consolidation based on the enrollment-weighted mean of the measure scores of the surviving and consumed contract(s) as provided in paragraph (b)(3)(iv) of this section. Paragraph (b)(3)(iii) of this section is applied to subsequent years that are not addressed in paragraph (b)(3)(ii) of this section for assigning the QBP rating.

…

(iv) The Star Ratings posted on Medicare Plan Finder for contracts that consolidate are as follows:

…

(B)

(1) For the second year after consolidation, CMS uses the enrollment-weighted measure scores using the July enrollment of the measurement year of the consumed and surviving contracts for all measures except for HEDIS, CAHPS, and HOS. HEDIS and HOS measure data are scored as reported. CMS ensures that the CAHPS survey sample includes enrollees in the sample frame from both the surviving and consumed contracts.

ADD5

42 C.F.R § 422.164

Title 42—Public Health

Chapter IV—Centers for Medicare & Medicaid Services, Department of Health and Human Services

Subchapter B—Medicare Program

Part 422—Medicare Advantage Program

Subpart D—Quality Improvement

(a) General. CMS adds, updates, and removes measures used to calculate the Star Ratings as provided in this section. CMS lists the measures used for a particular Star Rating each year in the Technical Notes or similar guidance document with publication of the Star Ratings.

ADD6

42 C.F.R § 422.166

Title 42—Public Health

Chapter IV—Centers for Medicare & Medicaid Services, Department of Health and Human Services

Subchapter B—Medicare Program

Part 422—Medicare Advantage Program

Subpart D—Quality Improvement

(b) Domain Star Ratings

…

(2) CMS calculates the domain ratings as the unweighted mean of the Star Ratings of the included measures.

(i) A contract must have scores for at least 50 percent of the measures required to be reported for that contract type for that domain to have a domain rating calculated.

(ii) The domain ratings are on a 1- to 5-star scale ranging from 1 (worst rating) to 5 (best rating) in whole star increments using traditional rounding rules.

…

(h) Posting and display of ratings. For all ratings at the measure, domain, summary and overall level, posting and display of the ratings is based on there being sufficient data to calculate and assign ratings. If a contract does not have sufficient data to calculate a rating, the posting and display would be the flag "Not enough data available." If the measurement period is prior to one year past the contract's effective date, the posting and display would be the flag "Plan too new to be measured".

(1) Medicare Plan Finder Performance icons. Icons are displayed on Medicare Plan Finder to note performance as provided in this paragraph (h)(1):

(i) High-performing icon. The high performing icon is assigned to an MA-only contract for achieving a 5-star Part C summary rating and an MA-PD contract for a 5-star overall rating.

(ii) Low-performing icon.

(A) A contract receives a low performing icon as a result of its performance on the Part C or Part D summary ratings. The low performing icon is calculated by evaluating the Part C and Part D summary ratings for the current year and the past 2 years. If the contract had any combination of Part C or Part D summary ratings of 2.5 or lower in all 3 years of data, it is marked with a low performing icon. A contract must have a rating in either Part C or Part D for all 3 years to be considered for this icon.

(B) CMS may disable the Medicare Plan Finder online enrollment function (in Medicare Plan Finder) for Medicare health and prescription drug plans with the low performing icon; beneficiaries will be directed to contact the plan directly to enroll in the low-performing plan.

(2) Plan preview of the Star Ratings. CMS will have plan preview periods before each Star Ratings release during which MA organizations can preview their Star Ratings data in HPMS prior to display on the Medicare Plan Finder.

ADD7

42 C.F.R § 422.4

Title 42—Public Health

Chapter IV—Centers for Medicare & Medicaid Services, Department of Health and Human Services

Subchapter B—Medicare Program

Part 422—Medicare Advantage Program

Subpart A—General Provisions

(a) General rule. An MA plan may be a coordinated care plan, a combination of an MA MSA plan and a contribution into an MA MSA established in accordance with § 422.262, or an MA private fee-for-service plan.

ADD8

42 C.F.R § 422.510

Title 42—Public Health

Chapter IV—Centers for Medicare & Medicaid Services, Department of Health and Human Services

Subchapter B—Medicare Program

Part 422—Medicare Advantage Program

Subpart K—Application Procedures and Contracts for Medicare Advantage Organizations

(a) Termination by CMS. CMS may at any time terminate a contract if CMS determines that the MA organization meets any of the following:

(1) Has failed substantially to carry out the contract.

(2) Is carrying out the contract in a manner that is inconsistent with the efficient and effective administration of this part.

(3) No longer substantially meets the applicable conditions of this part.

(4) CMS may make a determination under paragraph (a)(1), (2), or (3) of this section if the MA organization has had one or more of the following occur:

(i) Based on creditable evidence, has committed or participated in false, fraudulent or abusive activities affecting the Medicare, Medicaid or other State or Federal health care programs, including submission of false or fraudulent data.

(ii) Substantially failed to comply with the requirements in subpart M of this part relating to grievances and appeals.

(iii) Failed to provide CMS with valid data as required under § 422.310.

(iv) Failed to implement an acceptable quality assessment and performance improvement program as required under subpart D of this part.

(v) Substantially failed to comply with the prompt payment requirements in § 422.520.

(vi) Substantially failed to comply with the service access requirements in § 422.112 or § 422.114.

(vii) Failed to comply with the requirements of § 422.208 regarding physician incentive plans.

(viii) Substantially fails to comply with the requirements in subpart V of this part.

(ix) Failed to comply with the regulatory requirements contained in this part or part 423 of this chapter or both.

(x) Failed to meet CMS performance requirements in carrying out the regulatory requirements contained in this part or part 423 of this chapter or both.

(xi) Achieves a Part C summary plan rating of less than 3 stars for 3 consecutive contract years. Plan ratings issued by CMS before September 1, 2012 are not included in the calculation of the 3-year period.

(xii) Has failed to report MLR data in a timely and accurate manner in accordance with § 422.2460 or that any MLR data required by this subpart is found to be materially incorrect or fraudulent.

(xiii) Fails to meet the preclusion list requirements in accordance with § 422.222 and 422.224.

(xiv) The MA organization has committed any of the acts in § 422.752(a) that support the imposition of intermediate sanctions or civil money penalties under subpart O of this part.

(xv) Following the issuance of a notice to the MA organization no later than August 1, CMS must terminate, effective December 31 of the same year, an individual MA plan if that plan does not have a sufficient number of enrollees to establish that it is a viable independent plan option.

(xvi) Meets the criteria in § 422.514(d)(1) or (2).…