ORAL ARGUMENT SCHEDULED FOR FEBRUARY 12, 2026

No. 25-5269

IN THE UNITED STATES COURT OF APPEALS
FOR THE DISTRICT OF COLUMBIA CIRCUIT

HMO LOUISIANA, INC.,

Plaintiff-Appellant,

v.

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES et al.,

Defendant-Appellees.

On Appeal from the United States district court for the District of Columbia

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CERTIFICATE AS TO PARTIES, RULINGS, AND RELATED CASES

Pursuant to D.C. Circuit Rule 28(a)(1), the undersigned counsel certifies as follows:

A. Parties and Amici

Plaintiff-appellant is HMO Louisiana, Inc ("HMOLA") and defendant-appellees are the Department of Health and Human Services, the Centers for Medicare & Medicaid Services, Robert F. Kennedy, Jr., in his official capacity as the Secretary for the Department of Health and Human Services (HHS), and Mehmet Oz, in his official capacity as Administrator for the Centers for Medicare & Medicaid Services (CMS).

B. Rulings Under Review

This appeal arises from a memorandum opinion and order issued by Judge Christopher R. Cooper in Case No. 1:24-cv-02931-CRC on July 9, 2025, which is available at 793 F. Supp. 3d 150.

C. Related Cases

There are no related cases.

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GLOSSARY

APA	Administrative Procedure Act
CMS	Centers for Medicare & Medicaid Services
HHS	Department of Health and Human Services
HMOLA	HMO Louisiana, Inc.
JA	Joint Appendix
MA	Medicare Advantage

STATEMENT OF JURISDICTION

HMOLA invoked the district court's jurisdiction under 28 U.S.C. § 1291. Br. 1. The district court entered summary judgment for the Government on July 9, 2025. *See* JA99, 100, 111. Plaintiff filed a timely notice of appeal on August 16, 2025. JA112. This Court has jurisdiction under 28 U.S.C. § 1291.

STATEMENT OF THE ISSUES

Pursuant to Congress's mandate, the Centers for Medicare & Medicaid Services ("CMS") calculates Medicare Advantage Star Ratings on a one through five-star scale in half-star increments, which allows Medicare beneficiaries to comparison shop among hundreds of private health insurance plans. CMS bases Medicare Advantage Organizations' Star Ratings scores on their contracts' performance on up to forty quality measures. When two contracts consolidate, one becomes the consumed contract and the other becomes the surviving contract, under which the consolidated contract continues. This matter concerns CMS's Star Ratings calculation for one quality measure after a contract consolidation, C05—Special Needs Plan Care Management, aimed at

evaluating whether health plans assessed the health needs and risks of their members.

HMOLA requested that CMS consider the measure C05 score for its consumed contract in calculating the Star Rating for HMOLA's consolidated contract. CMS agreed to do so, finding that HMOLA's requested approach was consistent with CMS's regulations, which require CMS to assign Star Ratings for the first and second years following a contract consolidation based on the enrollment-weighted mean of available measure scores of the surviving and consumed contracts.

CMS's recalculation of the overall rating for the consolidated contract reflecting HMOLA's preferred approach resulted in no change in the consolidated contract's Star Rating. HMOLA filed suit, now arguing that CMS's regulations and guidance require that CMS not consider the measure C05 score for its consumed contract in calculating the Star Rating for the consolidated contract. The district court rejected HMOLA's arguments. The issues presented are the following:

1. Whether CMS violated its regulations and technical guidance by considering the measure C05 data for HMOLA's consumed contract in calculating the Star Rating for HMOLA's consolidated contract;

2. Whether CMS's consideration of measure C05 for HMOLA's consolidated contract is consistent with the Social Security Act;

3. Whether CMS's acceptance of HMOLA's request to consider its consumed contract's measure C05 data in calculating the Star Rating for HMOLA's consolidated contract was sufficiently explained.

PERTINENT STATUTES AND REGULATIONS

Pertinent statutes and regulations are reproduced in the addendum to this brief.

STATEMENT OF THE CASE

A. Statutory and Regulatory Background

Title XVIII of the Social Security Act, 42 U.S.C. § 1395 *et seq*. ("Medicare statute"), establishes the Medicare program, a federally funded and administered health insurance program for eligible elderly and disabled persons and certain individuals with end stage renal disease. *See* 42 U.S.C. § 1395c. The Secretary administers the Medicare program through the CMS, a component agency of the United States Department of Health and Human Services.

Under Part C, the Medicare Advantage program, a Medicare beneficiary can elect to receive his or her Medicare benefits through a public or private healthcare plan. *See* 42 U.S.C. § 1395w-21 *et seq*. Under Medicare Advantage, the federal government pays private insurers to provide the coverage that participating beneficiaries would otherwise receive from the government through Parts A and B (sometimes known, collectively, as "original Medicare"). *Id.* § 1395w-22(a). These insurers, known as Medicare Advantage Organizations, contract to provide coverage in a particular geographic area. Beneficiaries can then choose among the plans available where they reside. *Id.* § 1395w-21(b). Medicare Advantage Organizations receive a predetermined sum for providing coverage to each beneficiary, based in part on the demographic and health characteristics of that beneficiary. *Id.* § 1395w-23(a)(1)(A), (C).

To calculate payments to Medicare Advantage Organizations, CMS first determines its "benchmark," based on the per-capita cost of covering Medicare beneficiaries under Parts A and B in the relevant geographic area. *Id.* § 1395w-23(n); 42 C.F.R. § 422.258. Each Medicare Advantage Organization then submits a "bid," telling CMS what payment the

Medicare Advantage Organization will accept to cover a beneficiary with an average risk profile in that area. 42 C.F.R. § 422.254. If the insurer's bid is less than the benchmark, the bid becomes its "base payment"—the amount it is paid for covering a beneficiary of average risk—and the insurer receives a portion of the difference between its bid and the benchmark as a "rebate" that the Medicare Advantage Organization can use to fund supplemental benefits for beneficiaries or reduce plan premiums. 42 U.S.C. § 1395w-24(b)(1)(C); 42 C.F.R. § 422.260. If the Medicare Advantage Organization's bid is greater than the benchmark, then the benchmark becomes its base payment, and the insurer must charge beneficiaries a premium to make up the difference. *See* 42 U.S.C. §§ 1395w-23(a)(1)(B)(ii), 1395w-24(b)(2)(A).

Star Ratings are a means by which CMS measures the quality of Medicare Advantage plans on a scale of one to five "stars" in half-star increments based on Medicare Advantage data collected by CMS. 42 U.S.C. § 1395w-23(o)(4)(A); *see also* § 1395w-22(e)(3). Star Ratings reflect the experiences of beneficiaries in these plans and assist beneficiaries in finding the best plans for their needs. Advance Notice of Methodological Changes for Calendar Year (CY) 2026 for Medicare

Advantage Capitation Rates and Part C and Part D Payment Policies, at 109 (Jan. 10, 2025), *available at* https://perma.cc/KWB8-VLWK.

CMS has released Star Ratings for Medicare Advantage contracts since 2008. Medicare Program; Contract Year 2019 Policy & Technical Changes to the Medicare Advantage, Medicare Cost Plan, Medicare Fee-for-Service, the Medicare Prescription Drug Benefit Programs, and the PACE Program, 83 Fed. Reg. 16,440, 16,520 (Apr. 16, 2018). In 2018, CMS adopted the regulatory framework for the Star Ratings and since then has used rulemaking to adopt changes in the methodology and add new measures. *Id.*; *see also* 42 C.F.R. §§ 422.164(c), (d). The regulations require CMS, in advance of a measurement period, to announce potential new measures and solicit feedback. *Id.* § 422.164(c)(2). Subsequently, CMS is required to propose and finalize new measures through rulemaking. *Id.* § 422.164(c)(2). "New measures added to the Part C Star Ratings program will be on the display page on *www.cms.gov* for a minimum of 2 years prior to becoming a Star Ratings measure." *Id.* § 422.164(c)(3). Section 422.164(a) requires CMS to "add[], update[], and remove[] measures used to calculate the Star Ratings" and instructs CMS to "list[] the measures used for a particular Star Rating each year in the

Technical Notes or similar guidance document with publication of the Star Ratings." *Id.* § 422.164(a). The 2018 final rule describes the purpose of the Star Ratings system: it "is designed to provide information to the beneficiary that is a true reflection of the plan's quality and encompasses multiple dimensions of high-quality care." 83 Fed. Reg. at 16,520.

Star Ratings are assigned to each individual contract held by a Medicare Advantage Organization. The overall Star Ratings are based on a 5-star scale, set in half-star increments, with 1 star being the lowest rating and 5 stars being the highest. *See* 42 U.S.C. §§ 1395w-23(o)(4)(A), 1395w-24(b)(1)(C)(v); 42 C.F.R. §§ 422.162(b); 422.166(h)(1)(ii). Star Ratings affect payments to Medicare Advantage Organizations in two main ways. First, Medicare Advantage plans that earn a rating of four stars or higher qualify for Medicare Advantage Quality Bonus Payments in the form of an increased benchmark for the contract year following the ratings year (*e.g.*, the 2025 Star Ratings can increase the Medicare Advantage bidding benchmarks for contract year 2026). 42 U.S.C. § 1395w-23(o)(1) (increasing, for qualifying plans, the applicable percentage that calculates the benchmark); *Id.* § 1395w-23(o)(3)(A)(i) (a qualifying plan is one that earns a rating of four stars or higher). This in

turn can allow a Medicare Advantage plan to increase its bid, receive higher rebates, or lower premiums. *See id.* § 1395w-24(b)(1)(C); 42 C.F.R. § 422.260.

Second, Star Ratings affect the level of rebate received by plans that bid below their benchmarks for the contract year following the ratings year (e.g., the 2025 Star Ratings are used to set plans' rebate percentages for contract year 2026). Plans that earn a rating of four-and-a-half stars or five stars receive a rebate of seventy percent of the difference between their bid and the benchmark, while plans that earn three-and-a-half or four stars receive a rebate of sixty-five percent of that difference, and plans that earn less than three-and-a-half stars are eligible for a rebate of fifty percent of that difference. 42 U.S.C. § 1395w-24(b)(1)(C)(v) (listing the "final applicable rebate percentage[s]" by rating); 42 C.F.R. § 422.166(a)(2)(ii).

CMS publishes the Star Ratings each October for the upcoming year at the contract level, with each plan offered under that contract assigned the contract's rating. *See* 42 C.F.R. §§ 422.162(b), 422.166. CMS published the 2025 Star Ratings in October 2024. CMS, Fact Sheet – 2025 Medicare Advantage and Part D Star Ratings (Oct. 10, 2024)

("Fact Sheet"), *available at* https://www.cms.gov/newsroom/fact-sheets/2025-medicare-advantage-and-part-d-star-ratings. The 2025 Star Ratings are calculated based mostly on 2023 measurement year data. JA274 ("data time frame" for each quality measure is primarily 2023).

To calculate overall Star Ratings, CMS scores Medicare Advantage contracts on approximately thirty to forty unique quality measures, depending on whether the plan is Medicare Advantage-only (covering hospitals and doctor visits) or also includes Part D coverage (prescription drug benefits). JA162. These measures relate to five broad categories—improvement, outcomes, and intermediate outcomes, patient experience and complaints, access, and process. *See id.* at 9. To evaluate these categories, CMS uses a variety of data including administrative and medical record review data collected as part of the Healthcare Effectiveness Data and Information Set ("Healthcare Effectiveness Data" or "HEDIS") and survey-based data from the Health Outcomes Survey and from the Consumer Assessment of Healthcare Providers and Systems ("CAHPS"). 83 Fed. Reg. at 16,520, 16,525. These measure-level scores are also translated into "stars" but are awarded in whole-star

increments, not half stars like the overall Star Ratings. 42 C.F.R. § 422.166(a)(4).

Some quality measures relate specifically to Special Needs Plans. Special Needs Plans are Medicare Advantage plans designed to provide targeted care to special needs individuals. JA182. Special Needs Plans are for those with certain chronic diseases and conditions, who have both Medicare and Medicaid, and for those who live in an institution such as a nursing home. JA194. There are three specific Special Needs Plan measures that are part of the 2025 Star Ratings: C05—Special Needs Plan Care Management; C06 Care for Older Adults—Medication Review; and C07: Care for Older Adults—Pain Assessment. *Id* at 194-98. This case primarily concerns measure C05, entitled Special Needs Plan Care Management. Unless an exclusion applies, *see* JA194-95, a contract offering Special Needs Plans is evaluated on all three measures, including measure C05.

In the 2025 Technical Guidance, CMS provides more details about each of the specific quality measures, including measure C05. Measure C05 evaluates the percent of members whose plan did an assessment of their health needs and risks in the past year. *Id.* at 194. Measure C05

is based on data reported by contracts through the Medicare Part C Reporting Requirements. *Id.* These are data that CMS requires Medicare Advantage Organizations to report pursuant to its authority under 42 C.F.R. § 422.516(a). Data reported by contracts to CMS per the 2023 Part C Reporting Requirements are validated retrospectively during the 2024 data validation cycle. *Id.* "Contracts and [plan benefit packages] with an effective termination date on or before the deadline to submit data validation results to CMS (June 15, 2024) are excluded and listed as 'No data available.'" *Id.* If a Special Needs Plan benefit package under a contract terminates "at any time in the [contract year] reporting period and the contract remains active through July 1 of the following year, the contract must still report data for all [plan benefit packages], including the terminated [plan benefit packages]." JA276.

CMS calculates summary and overall ratings using approximately forty unique quality measures. The overall rating for a contract is calculated using the weighted average of the Part C and Part D measure Star Ratings. 42 C.F.R. § 422.166(d)(1); JA169. For the 2025 Star Ratings, CMS assigned the highest weight to the improvement measures, followed by patient experience, complaints and access measures, then

outcome and intermediate outcome measures, and finally process measures. *See Id.* § 422.166(e). CMS includes the Star Ratings measures in the overall ratings that are associated with the contract type for the Star Ratings year. *See Id.* § 422.162(b)(1). This means that if, for example, a contract offered Special Needs plans in the 2023 measurement year but is no longer offering Special Needs plans in 2025, the Special Needs Plan-related quality measures would be excluded in the calculation of the 2025 Star Ratings for that plan. If, however, a plan continues to offer Special Needs plans in 2025, the Special Needs plan-related quality measures would be included in the calculation of the 2025 Star Ratings for that contract.

CMS's regulations governing the calculation of Star Ratings address consolidations. Consolidation occurs "when a [Medicare Advantage] 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." 42 C.F.R. § 422.162(a). The consumed contract "means a contract that will no longer exist after a contract year's end as a result of a consolidation." *Id.* The surviving contract "means

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

When two contracts consolidate, 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 contracts." § 422.162(b)(3); JA182. For the first and second years after the consolidation, "CMS uses enrollment-weighted measure scores using the July enrollment of the measurement period of the consumed and final contracts for all measures," with certain exceptions not relevant here. *Id.* §§ 422.162(b)(3)(iv)(A)(1), (B)(1). Because Star Ratings following a consolidation are based on "the enrollment-weighted mean of the measure scores of the surviving and consumed contract(s)," *Id.* § 422.162(b)(3)(i), 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.

B. Factual Background

On January 1, 2024, HMOLA's parent company, Blue Cross and Blue Shield of Louisiana ("Louisiana Blue"), consolidated two of its contracts—H6453 and H5576. JA54. H6453 is the surviving contract, and H5576 is the consumed contract. *Id.* For the 2024 Star Ratings year—the first year of the consolidation—CMS combined the data from contracts H6453 and H5576. JA80. In 2022, only contract H5576 offered a Special Needs Plan benefit package. *Id.* Per CMS's regulation, CMS took the "weighted mean of the measure scores of the surviving and consumed contracts," not counting in the mean any contracts that did not have scores for a particular measure. CMS calculated the mean of contracts H6453 and H5576's C05 measure scores to be contract H5576's C05 score, and this resulted in a rating of four stars on that measure. *Id.*

CMS permits Medicare Advantage Organizations the ability to "preview their Star Ratings data in [Health Plan Management System] prior to display on the Medicare Plan Finder" before each Star Ratings release. 42 C.F.R. § 422.166(h)(2). As part of the second plan preview in September 2024, HMOLA was permitted to provide feedback on its Star Ratings calculation prior to publication. JA364.

On September 12, 2024, HMOLA requested that CMS include data from both contracts H5576 and H6453 in calculating measure C05 for its consolidated contract, citing § 422.162(b)(3)(ii). JA364-66, 55. HMOLA expected that if CMS made three changes (including two changes not relevant to measure C05), its overall score would increase from 3.74957 to 3.80839. JA364, 55 (explaining that HMOLA expected to receive 4.0 stars in September 2024). On October 23, 2024, CMS indicated that it would accept Special Needs Plan data for its consumed contract. JA373. CMS received HMOLA's consumed contract H5576's Special Needs Plan data on October 24, 2024, and HMOLA's data validation findings on October 30, 2024. *See* JA376. On November 15, 2024, the agency explained that "[a]t Louisiana Blue's request and after further consideration, CMS agreed to accept H5576's 2023 [Special Needs Plan data]." JA375.

For the 2025 Star Ratings year—the second year of consolidation—CMS combined these validated data from contracts H6453 and H5576. JA375-76, 81. Those data were from 2023. In 2023, only contract H5576, the consumed contract, offered a Special Needs Plan benefit package. JA81. Per CMS's regulation, CMS calculated the weighted mean of

contracts H6453 and H5576's surviving contracts' C05 measure scores to be contract H5576's C05 score. The consumed contract's measure C05 score equaled 70 percent for C05. JA376. That score of 70 percent translated into three stars. *Id.*, *see also* JA196 (table showing that 70 percent converts to a three-star measure rating for measure C05). This resulted in a rating of three stars on the C05 Measure for the surviving, consolidated contract. *Id.*, JA81. Following their formula for calculating an overall Star Ratings score, CMS combined HMOLA's C05 score with the other applicable quality measures and calculated a final overall score of 3.603658. JA81. This resulted in an overall Star Rating of 3.5 stars. *Id.*

C. Prior Proceedings

HMOLA filed its Amended Complaint on February 14, 2025, JA8, challenging under the Administrative Procedure Act ("APA") CMS's consideration of its consumed contract's data to calculate measure C05 for its consolidated contract for the 2025 Star Ratings year. JA21-22.

The district court granted summary judgment to the government. JA99, 100, 111. The district court concluded that the plain language of 42 C.F.R. § 422.162(b) required CMS to consider the C05 measure score

for HMOLA's consumed contract in calculating the Star Rating for HMOLA's consolidated contract for the 2025 Star Ratings year. The court observed that "'[i]n 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)[.]'" JA104-05 (quoting 42 C.F.R. § 422.162(b)(3)(i)). Additionally, "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[.]'" JA105 (quoting 42 C.F.R. § 422.162(b)(3)(iv)(B)(1)).

The court reasoned that the "plain language" of these regulations required CMS to combine the consumed contract's 70 percent score for measure C05 with the surviving contract's no score on measure C05 (having not offered a Special Needs Plan in 2023) to reach an enrollment-weighted mean of 70 percent which translates to three stars. JA105.

The court rejected HMOLA's contention that CMS's calculation was inconsistent with its statutory mandate. *Id.* It reasoned that not scoring

measure C05 would render HMOLA's consolidated contract's overall rating less reflective of the contract's quality, at odds with the statute because the consolidated contract is made up of two components, one of which offered Special Needs Plans in 2023. *Id.*

The court rejected HMOLA's contention that its consumed contract was a terminated contract under a provision of CMS's guidance providing that contracts that terminate on or before June 15, 2024 are excluded from the C05 measure for the 2025 Star Ratings. JA106-07. Citing the plain language of CMS's regulations as requiring CMS to consider data from a consumed contract for two years post-consolidation, the court observed that because consolidated contracts always take effect on January 1, their data would never be considered under HMOLA's interpretation. JA107. The court reasoned that HMOLA's conflation of consumed and terminated contracts is inconsistent with CMS's regulations, which establish the grounds for terminations, none of which applied. JA108.

The court rejected HMOLA's contention that CMS's explanation for including Special Needs Plan data for its consumed contract was insufficient. Skeptical that the change-in-position doctrine applied, the

court observed that "HMOLA cites no evidence indicating that CMS had an 'existing policy' of excluding the consumed contract's C05 data after consolidation." JA109. Even assuming that the change-in-policy doctrine applied, the court concluded that CMS sufficiently explained its shift. The court reasoned that "[i]n context, CMS essentially adopted HMOLA's rationale for requesting the inclusion of C05 data." JA110.

SUMMARY OF ARGUMENT

The district court correctly concluded that the plain language of 42 C.F.R. § 422.162(b) required CMS to consider the measure C05 score for HMOLA's consumed contract in calculating the 2025 Star Rating for HMOLA's consolidated contract. JA104-06. In the event of a consolidation, CMS's regulations provide that if a measure is applicable to either the consumed or surviving contract during the relevant measurement year and the consolidated contract in the Star Ratings year provides the services that were measured, that measure will be included in the consolidated contract's overall score. *See* 42 C.F.R. §§ 422.162(b)(1), (b)(3)(i), (b)(3)(iv)(B)(1). HMOLA's consolidated contract offered Special Needs Plans during the 2023 measurement period through its consumed contract, one of its two component contracts. Its

consolidated contract offered Special Needs Plans during the 2025 Star Ratings period. Consequently, CMS correctly evaluated HMOLA's consolidated contract measure C05 for the 2025 Star Ratings period. The district court rightly rejected HMOLA's contention that its consumed contract was a "terminated" contract under CMS's Technical Notes and that it should consequently not be evaluated on measure C05. And HMOLA's preferred approach would negate CMS's regulatory framework for calculating Star Ratings following a contract consolidation, which aims to prevent Medicare Advantage Organizations from consolidating a low performing contract into a higher performing contract to shed the low scores.

HMOLA appears to contend that CMS's approach is at odds with the Social Security Act. HMOLA argues that rather than inform beneficiaries, evaluating its consolidated contract on Measure C05 frustrates CMS's mission to provide beneficiaries with helpful information to make informed plan choices. The consolidated contract, however, is made up of two components and one of them did offer Special Needs Plans in 2023. As the district court observed: "Not scoring

[Measure] C05 would therefore render the overall rating less reflective of the contract's quality, not more." JA105.

The district court also correctly concluded that CMS sufficiently explained its reasoning for accepting HMOLA's request to permit it to submit data related to measure C05. CMS's correspondence with HMOLA established that its rationale for considering Special Needs Plan data for HMOLA's consumed contract was the only rationale HMOLA provided to the agency—that its consumed contract was not terminated.

CMS did not change its policy as HMOLA contends. The district court was correct to observe that HMOLA failed to point to any record evidence establishing that CMS had a pre-existing policy of excluding the consumed contracts' measure C05 Special Needs Plan data after consolidation. Additionally, the plan preview process is an informal, iterative process wherein Medicare Advantage Organizations are permitted to provide feedback on their Star Ratings calculations before they are published and final. Consequently, the change-in-position doctrine is inapplicable.

Finally, a remand would be inappropriate. Because CMS's regulations required it to consider the C05 measure score for HMOLA's

consumed contract in calculating the Star Rating for HMOLA's consolidated contract, a remand would not result in a different outcome.

STANDARD OF REVIEW

The district court's entry of summary judgment is subject to de novo review in this Court. *New LifeCare Hosps. of N.C., LLC v. Becerra*, 7 F.4th 1215, 1222 (D.C. Cir. 2021). The Medicare statute incorporates the standard of review for the APA. *Id.* That standard is whether a decision is "arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with law," 5 U.S.C. § 706(2)(A), or "unsupported by substantial evidence," *id.* § 706(2)(E).

ARGUMENT

I. CMS's Regulations Required CMS to Consider Special Needs Plan Data from HMOLA's Consumed Contract.

The district court correctly concluded that the plain language of 42 C.F.R. § 422.162(b) required CMS to consider the measure C05 score for HMOLA's consumed contract in calculating the Star Rating for HMOLA's consolidated contract. JA104-06. In the event of a consolidation, CMS's regulations require that if a measure is applicable *either* to the consumed or the surviving contract during the relevant measurement year *and* those applicable measures are associated with the consolidated contract's

type for the Star Ratings year, that measure will be included in the consolidated contract's overall rating. *See* 42 C.F.R. §§ 422.162(b)(1), (b)(3)(i), (b)(3)(iv)(B)(1). The 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. This two-step process is consistent with the Social Security Act, which requires that CMS adjust the consolidated contract's Star Rating "to reflect an enrollment-weighted average of scores or ratings for the continuing and closed contracts, as determined appropriate by the Secretary." 42 U.S.C. § 1395w-23(o)(4)(D)(i).

At step one, CMS asks whether either the consumed or surviving contracts were evaluated on measure C05 in the measurement year because they offered a Special Needs Plan. *See* 42 C.F.R. §§ 422.162(b)(3)(i) ("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)[.]"); 422.162(b)(3)(iv)(B)(1) ("CMS uses the enrollment-weighted measure scores using the July enrollment of the measurement year of the

consumed and surviving contracts for all measures[.]"); *see also* 42 U.S.C. § 1395w-23(o)(4)(D)(i) (CMS adjusts consolidated contracts' Star Rating "to reflect an enrollment-weighted average of scores or ratings for the continuing and closed contracts, as determined appropriate by the Secretary."). If neither the consumed nor the surviving contract offered a Special Needs Plan in the measurement year, CMS does not include measure C05 in a contract's overall score. If either did so, however, CMS proceeds to step two.

At step two, CMS asks whether the consolidated contract is offering a Special Needs Plan during the Star Ratings year. 42 C.F.R. § 422.162(b)(1) ("CMS includes the Star Ratings measures in the overall and summary ratings that are associated with the contract type for the Star Ratings year."); *id.* § 422.162(b)(3)(i) ("In the case of contract consolidation 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 consolidation." (emphasis added)). If either the consumed or surviving contract offered Special Needs Plans and were evaluated on measure C05 during the measurement year, but the consolidated contract no longer offers a

Special Needs Plan in the Star Ratings year, the consolidated contract would not be evaluated on measure C05. If, however, the consolidated contract continues to offer a Special Needs Plan in the Star Ratings year, the consolidated contract would be evaluated on measure C05.

The district court correctly concluded that CMS followed its regulations. JA 105. For the 2023 measurement year, HMOLA's consumed contract offered a Special Needs Plan, and it earned three stars for measure C05. JA81. In 2023, the surviving contract did not offer Special Needs Plans and accordingly had no data available for that measure. JA367. The consolidated contract offered Special Needs Plans in the 2025 Star Ratings year. JA81, 365 (noting that Special Needs Plan data was relevant to HMOLA's surviving, consolidated contract). Consequently, CMS correctly evaluated HMOLA's consolidated contract on the C05 measure. CMS found the enrollment-weighted mean for the consumed and surviving contracts: because the surviving contract had no C05 score, the enrollment-weighted mean of the measure scores of the surviving contract's no score and consumed contract's 70 percent score equaled 70 percent for measure C05 for the consolidated contract. *See* JA376. The score of 70 percent translated into three stars for the

surviving, consolidated contract's measure C05 score. *Id.*, *see also* JA196 (table showing that 70 percent converts to a 3-star measure rating for measure C05).

To summarize, HMOLA's consumed contract offered Special Needs Plans during the 2023 measurement period. Its consolidated contract offered Special Needs Plans during the 2025 Star Ratings period. As a result, the district court correctly concluded that CMS acted in accordance with its regulations and guidance when it evaluated HMOLA's consolidated contract measure C05 in the 2025 Star Ratings period based on the 2023 data from the consumed contract.

HMOLA's attempts to argue that CMS improperly evaluated its consolidated contract on measure C05 are unconvincing. HMOLA primarily contends that CMS's guidance—its 2025 Technical Notes—required CMS to exclude Special Needs Plan data for its consumed contract in calculating measure C05 for its consolidated contract because the consumed contract "terminated." *See* Br. 26-31. As an initial matter, HMOLA advances this argument despite the fact that another measure, D11, includes the same exclusion for terminated contracts in Technical Guidance. Tellingly, HMOLA does not contend that its consumed

contract "terminated" with regard to measure D11. This is likely because HMOLA benefited from consideration of its consumed contract's measure D11-specific data. JA376. The district court rightly rejected HMOLA's contention that its consumed contract was a terminated contract under the applicable regulations and related guidance.

The Technical Notes HMOLA references explain how contracts are evaluated on measure C05 when they terminate during the measurement year: "contracts . . . with an effective termination date on or before the deadline to submit data validation results to CMS (June 15, 2024) are excluded and listed as 'No data available.'" JA194. HMOLA contends that its consumed contract terminated on the date of its merger with the surviving contract, January 1, 2024 because "it was brought to an end or conclusion," and consequently, that it should be excluded from calculation of the consolidated contract's C05 measure. Br. 27. This is not a plausible reading of the Technical Notes.

CMS's regulations define a consumed contract as one "that will no longer exist after a contract year's end *as a result of consolidation*." *See* § 422.162(a) (emphasis added). The regulations define consolidation as when a Medicare Advantage Organization "combines multiple contracts

into a single contract for the start of the subsequent contract year." *Id.* A consumed contract is thus not one that simply "no longer exists" or is "brought to an end or conclusion," as HMOLA contends, Br. 27 (citing Oxford Dictionary), but one that no longer exists because it is continuing as part of a larger, comprehensive contract. By contrast, a terminated contract is one which will cease to exist following its termination. As HMOLA, at least at one point, agreed: "[T]he process for calculating Star Ratings following a consolidation is distinct from the process following a termination." JA369 (email correspondence on behalf of HMOLA to CMS, Oct. 14, 2024). This distinction, HMOLA explained, "is necessary to allow CMS to continue to reflect performance of a consumed contract, which effectively continues as part of the surviving contract." *Id.*

The district court correctly observed that CMS's regulations treat consumed contracts differently from terminated contracts. JA108. While 42 C.F.R § 422.162(b) establishes the rules for when contracts consolidate, 42 C.F.R §§ 422.500[1] and 422.508-12 establish the rules around contract termination; the regulations do not conflate contract

[1] Section 422.500(b) repeatedly lists "consolidate[ion], nonrew[al], [and] terminat[ions]" as three separate, mutually exclusive events. § 422.500(b).

consolidation and contract termination. The regulations establish three types of contract terminations: (1) by "written mutual consent" between CMS and the Medicare Advantage Organization; (2) by CMS's sole determination; or (3) by the Medicare Advantage Organization if "CMS fails to substantially carry out the terms of the contract." *Id.* §§ 422.508–422.512. These regulations do not list contract consolidation as a basis for contract termination. HMOLA contends that §§ 422.508-422.512 "do not provide an exhaustive list of all the ways in which a contract could terminate." Br. 26 n.6. Not so. By establishing that contract termination occurs by mutual consent, by CMS, or by the Medicare Advantage Organization, CMS has provided for every possible kind of contract termination. And if, as HMOLA contends, a contract consolidation is a termination, HMOLA would be required to comply with both the requisite consolidation and termination requirements. If, for example, HMOLA's contract consolidation was a termination by mutual consent, HMOLA would be prohibited from applying for new contracts or service area expansions for two years. *See* 42 C.F.R. § 422.508(c). But HMOLA has offered no evidence that it assented to that condition as part of a

termination agreement or that it would enter into such an agreement containing that and other conditions.

HMOLA in effect argues that it is neither required to follow CMS's regulations as they pertain to consolidation—which, as established, require CMS to assign Star Ratings for the first and second years following a consolidation based on the measure scores of the surviving and consumed contract—nor CMS's regulations as they pertain to termination. CMS's regulations do not provide this sort of HMOLA-shaped exception.

HMOLA argues that its theory that its consumed contract terminated upon its consolidation "fit[s] perfectly with how the regulations and Technical Notes are intended to operate in practice." Br. 28. But its theory works an end-run around CMS's regulations. As the district court observed, and as HMOLA pointed out in its correspondence with CMS, because contract consolidations are always effective on January 1, before June 15, 2024, data for consumed contracts would never be considered—in violation of § 422.162(b)(3)(i), which requires CMS to assign Star Ratings for the first and second year after consolidation based on the measure scores of the surviving and

consolidated contract. JA106-07, 370 (email correspondence on behalf of HMOLA to CMS, Oct. 14, 2024). As HMOLA argued to CMS, "termination upon consumption 'would negate the entire regulatory framework for calculating Star Ratings following a contract consolidation, which aims to prevent [Medicare Advantage Organizations] from consolidating a low performing contract into a higher performing contract in order to shed the low scores.'" JA107 (quoting JA370 (email correspondence on behalf of HMOLA to CMS, Oct. 14, 2024)); *see also* JA141 (hearing transcript). Additionally, HMOLA's proposed methodology would encourage Medicare Advantage plans to artificially inflate their scores by strategically consolidating contracts. JA106. As discussed below, such gamesmanship is at odds with the purpose of the Star Ratings system: "to provide information to the beneficiary that is a true reflection of the plan's quality." 83 Fed. Reg. 16,520.

HMOLA argues that the district court should have applied the specific-governs-the-general canon to create an exception to the general rule that CMS assigns Star Ratings for the first and second years following the consolidation based on the measure scores of both the

surviving and consumed contract. Br. 29-31. The specific-governs-the-general canon has no application here. First, CMS's regulations do not conflict with its Technical Notes. Second, if CMS's regulations and guidance did conflict, CMS's regulations would supersede its Technical Notes.

As established, CMS's regulations governing consolidation and Technical Notes pertaining to measure C05 and contract terminations accord; contract consumption and termination are distinct events. The specific-governs-the-general canon of interpretation applies when a general permission or prohibition is contradicted by a specific prohibition or permission. *See RadLAX Gateway Hotel, LLC v. Amalgamated Bank*, 566 U.S. 639, 645 (2012). "But this canon does not apply unless the competing provisions are 'irreconcilably conflicting.'" *Changji Esquel Textile Co. Ltd. v. Raimondo*, 40 F.4th 716, 724 (D.C. Cir. 2022) (quoting *Adirondack Med. Ctr. v. Sebelius*, 740 F.3d 692, 697 (D.C. Cir. 2014)). Even if the regulatory provisions governing consolidation and the guidance provisions governing measure C05's application to contract terminations were at odds, absent clear intent to the contrary, this Court

is required "to harmonize the provisions and render each effective." *Adirondack*, 740 F.3d at 698-99.

CMS's regulations directing CMS to "assign[] 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)," 42 C.F.R. §§ 422.162(b)(3)(i), do not conflict with its guidance directing it to exclude measure C05 for contracts that terminated prior to June 15, 2024. JA194-96. To accept that CMS's rules governing consolidation "irreconcilably conflict" with its guidance on how to consider measure C05 when contracts terminate, this Court would be required to accept HMOLA's premise that its consumed contract was terminated. But for the reasons already explained, HMOLA's consumed contract was not terminated—it was consolidated. *See* 42 C.F.R. § 422.162(a) (defining a consumed contract as one "that will no longer exist after a contract year's end as a result of a consolidation").

Additionally, "[i]t is 'axiomatic that an agency is bound by its own regulations.'" *Nat'l Environ. Dev. Ass'ns Clean Air Project v. EPA*, 752 F.3d 999, 1009 (D.C. Cir. 2014) (quoting *Panhandle Eastern Pipe Line Co. v. FERC*, 613 F.2d 1120, 1135 (D.C. Cir. 1979)). CMS may not adopt

guidance that conflicts with or disregards duly promulgated regulations. *See U.S. Telecom Ass'n v. FCC*, 400 F.3d 29, 35-36 (D.C. Cir. 2005) (holding that substantive changes to regulations must be promulgated through notice-and-comment rulemaking). To the extent CMS's Technical Notes create an exception to its rules established in its regulations pertaining to consolidation for consumed contracts because they terminated prior to June 15, 2024, as HMOLA contends, the Technical Notes must be disregarded.

HMOLA argues that CMS's Technical Notes "have the same weight and force as regulations." Br. 29 (citing 42 C.F.R. § 422.164(a)). It contends that the Technical Notes have been "incorporated into the regulations." JA41, 122. HMOLA misapprehends CMS's regulations. Section 422.164(c) requires CMS to add Star Ratings measures through the advance notice and rate announcement process and then propose and finalize those measures through rulemaking. 42 C.F.R. 422.164(c). Section 422.164(a) instructs CMS to "list[] the measures used for a particular Star Rating each year in the Technical Notes or similar guidance document with publication of the Star Ratings." § 422.164(a), (c). Nowhere does § 422.164(a)—which explicitly instructs CMS to issue

guidance—elevate the Technical Notes to the status of regulations. Consequently, any conflict between CMS's regulations and Technical Notes must be resolved in favor of CMS's regulations, regardless of specificity. HMOLA also points out that CMS regards its Technical Notes as binding. Br. 29-30. But that CMS is bound to follow its guidance does not elevate them to the status of regulations.

In short, the specific-governs-the-general canon has no application here. However, if the Court determines to apply the specific-governs-the general-canon, it should conclude, as the district court did, that the regulatory provisions governing consolidation are more specific: "[t]he regulations governing the calculation of ratings following a contract consolidation cover the specific situation at issue here" and "[t]he Technical Notes' C05 termination provision, on the other hand, applies across the board, irrespective of consolidation." JA107. The district court correctly concluded that because the Technical Notes clarify "exactly which measures require consideration of data from both the consumed and surviving contracts following a consolidation," and "[g]iven that [Measure] C05 is not excluded [from ordinary post-consolidation

calculations], the general consolidation formula applies to that measure like any other." JA108 (citing JA271).

HMOLA places substantial weight on the fact that CMS initially regarded HMOLA's consumed contract as terminated. *See, e.g.*, Br. 27. But HMOLA has repeatedly described its inability to submit data relating to measure C05 for its consolidated contract as an "error." JA25-28. And CMS has repeatedly acknowledged that regarding HMOLA's consumed contract as terminated initially was erroneous, an error it corrected in the final decision at issue before this Court. *See, e.g.*, JA136 ("[T]he error that CMS made was in regarding the consumed contract as terminated."), 137-38 ("CMS's error was in classifying the consumed contract as terminated."). The district court was correct to conclude that CMS's initial calculation is "best understood as a one-off error" and not as "existing precedent." JA109. This Court should not place any interpretive weight on a position that both parties have described as erroneous.

II. CMS's Consideration of Measure C05 for HMOLA's Consolidated Contract Is Consistent with the Statute and Provides a More Accurate Reflection of Plan Quality.

HMOLA appears to contend that CMS's approach is at odds with the Social Security Act. *See* Br. 32-34. HMOLA argues that rather than inform beneficiaries, evaluating its consolidated contract on measure C05 frustrates CMS's statutory obligation to provide beneficiaries with helpful information to "make informed plan choices." Br. 32 (quoting 83 Fed. Reg. 16,520). In support, HMOLA contends that its consolidated contract did not offer Special Needs Plans in the 2025 Star Ratings year. *See* Br. 32-33. This is incorrect because HMOLA's consolidated contract offered Special Needs Plans for the 2025 Star Ratings year. Nowhere does HMOLA directly challenge the district court's factual conclusion that "H6453, the contract that survived after consolidation, offers a [Special Needs Plan] for 2025." JA102.

Accepting that HMOLA's consolidated contract offered Special Needs Plans in 2025, HMOLA's argument amounts to a bare assertion that when a consumed contract offers Special Needs Plans, but the other, "surviving" contract does not, the resulting consolidated contract should

not be evaluated on measure C05.[2] These assertions defy CMS's regulations, which state that "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 contracts." 42 C.F.R. § 422.162(b)(3)(i). As the district court recognized, "the consolidated contract is made up of two components" and "[o]ne of them did offer [Special Needs Plans] in 2023." JA. 105. Consequently, "[n]ot scoring [Measure] C05 would therefore render the overall rating less reflective of the contract's quality, not more." *Id.*

HMOLA contends that CMS did not advance the argument that evaluating its consolidated contract on a service its surviving component did not provide could be "'more' (rather than less) reflective of its true quality." Br. 33. Not so. CMS argued in its summary judgment brief that "for CMS not to include measure C05 in the [consolidated contract]'s overall score would constitute a failure to account for a major contributor

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[2] HMOLA does not challenge inclusion of Special Needs Plan data from its consumed contract for the consolidated contract when it is beneficial. For measures C06, Care for Older Adults—Medication Review, and C07, Care for Older Adults—Pain Assessment, JA196-200, HMOLA's consumed contract received five stars and its consolidated contract benefited from its consumed contract's Special Needs Plan data. *See* JA81.

in its 2025 overall score for the 2023 measurement year"—its consumed contract—and consequently make its Star Rating less reflective of true quality. *See* JA77 ("Accounting for HMOLA's consumed contract provides beneficiaries with a truer reflection of plan quality and enrollee experience for the 2023 measurement period than excluding it from measure C05.").

HMOLA neither cites to any statutory requirement that requires Star Ratings to be a "true reflection of plan quality and enrollee experience." *See* Br. 33-34 (quoting 83 Fed. Reg. at 16,521), nor explains why HMOLA's Star Ratings are not reflective of enrollee experience. Although HMOLA focuses on the statute's requirement that Medicare Advantage Organizations provide data that permits the measurement of "health outcomes and other indices of quality," Br. 32 (citing 42 U.S.C. § 1395w-22(e)(3)(A)(i)), it fails to recognize the statute's mandate, consistent with CMS's regulations, that CMS adjust consolidated contracts' Star Rating "to reflect an enrollment-weighted average of scores or ratings for the continuing and closed contracts, as determined appropriate by the Secretary." 42 U.S.C. § 1395w-23(o)(4)(D)(i). In enacting the Star Ratings program, Congress made a judgment that both

the continuing and closed contracts—surviving and consumed contracts—contribute to a consolidated contract and reflect plan quality.

The district court correctly concluded that HMOLA's proposed methodology "would encourage [Medicare Advantage] Plans to artificially inflate their scores by strategically consolidating contracts." JA106. HMOLA describes this conclusion as "far-fetched" and "hopelessly baseless speculation," and contends both that there is "no record evidence to support the district court's speculation" and that CMS "did not present any argument along these lines." Br. 33. But in correspondence with CMS, HMOLA itself explained that classifying consumed contracts as terminated contracts would "negate the entire regulatory framework for calculating Star Ratings following a contract consolidation, which aims to prevent [Medicare Advantage Organizations] from consolidating a low performing contract into a higher performing contract in order to shed the low scores." JA370 (email correspondence on behalf of HMOLA to CMS, Oct. 14, 2024). In briefing and during oral argument before the district court, the government repeatedly advanced this point. *See* JA96, 141. The district court was not required to point to specific record evidence of gamesmanship to conclude

that HMOLA's litigation position could encourage plans to whitewash the performance of consumed contracts and that such gamesmanship would be at odds with CMS's regulations and the statute.

III. CMS's Explanation for Including Measure C05 Data Was Sufficient.

The district court correctly concluded that CMS sufficiently explained its reasoning for accepting HMOLA's request to permit it to submit data related to measure C05. Although informal, CMS's email correspondence with HMOLA established that its rationale for considering Special Needs Plan data of HMOLA's consumed contract was the only rationale HMOLA presented to the agency—that its consumed contract was not terminated. In short, CMS agreed with the rationale HMOLA presented during the plan preview process.

HMOLA explained in email correspondence on October 14, 2024 that CMS failed to collect Special Needs Plan data related to measure C05 "based on the mistaken premise that the consumed contract was terminated prior to July 1" and that "the consumed contract was not terminated; it was consumed during a consolidation, and its measure data is necessary for evaluation of the performance of the surviving contract, as required by 42 C.F.R. § 422.162(b)(3)(ii)." JA369. On October

23, 2024, CMS responded that CMS would permit HMOLA to submit Special Needs Plan data. JA372-73. On November 15, 2024, CMS explained its October 23 email: "At Louisiana Blue's request and after further consideration, CMS agreed to accept H5576's 2023 [Special Needs Plan data]." JA375. CMS's reference to HMOLA's request demonstrates that, as the district court concluded, CMS adopted HMOLA's rationale that its consumed contract was not terminated as its basis for considering HMOLA's measure C05 data. JA110.

HMOLA describes CMS's acceptance of HMOLA's request as a change in policy. Such a change occurs when "an agency acts inconsistently with an earlier position," "performs a reversal of its former views as to the proper course," or "disavows prior inconsistent agency action as no longer good law." *Food & Drug Admin. v. Wages & White Lion Invs., L.L.C.*, 604 U.S. 542, 569-70 (2025) (cleaned up). This arises when an agency "rescind[s] a prior regulation," "expand[s] the scope of its enforcement authority," and "abandon[s] a decade-old practice." *Id.* at 570. None of these circumstances apply here.

More to the point, the district court correctly observed that HMOLA failed to cite any record evidence establishing that CMS had a pre-

existing policy of excluding the consumed contracts' measure C05 Special Needs Plan data after consolidation. JA109 ("HMOLA cites no evidence indicating that CMS had an 'existing policy' of excluding the consumed contract's C05 data after consolidation."). In initially explaining why it did not consider Special Needs Plan data for HMOLA's consumed contract on October 3, 2024, CMS stated:

> Data are not collected and validated for contracts that terminate prior to July 1 in the following year after the contract year (CY) reporting period. . . . Based on this, we did not receive data for H5576 [the consumed contract] to use for [the C05] measure[] in the 2025 Star Ratings.

Nowhere in its explanation to HMOLA did CMS represent that it regarded consumed contracts as terminated contracts. This is because, as the district court stated, CMS's initial calculation is "best understood as a one-off error." JA109. Although CMS may have mistakenly regarded HMOLA's consumed contract as terminated, CMS has never articulated the position—in its informal correspondence with HMOLA, in guidance, or in rulemaking—that for purposes of determining whether to apply measure C05, it regarded consumed contracts as terminated contracts.

Additionally, the change-in-position doctrine has no application to CMS's plan preview process. That doctrine traditionally applies "when an agency shifts from a position expressed in a more formal setting." *Wages & White Lion Invs., L.L.C.*, 604 U.S. at 570 n.5 (citing *FCC v. Fox Television Stations, Inc.*, 556 U.S. 502, 517 (2009)). CMS permits Medicare Advantage Organizations the ability to "preview their Star Ratings data in [Health Plan Management System] prior to display on the Medicare Plan Finder" before each Star Ratings release. 42 C.F.R. § 422.166(h)(2). The plan preview process is not a "formal setting." *See Fox Television Stations, Inc.* 556 U.S. at 511 (citing *In the Matter of Complaints Regarding Various Television Broadcasts Between February 2, 2002 and March 8, 2005*, 21 F.C.C.R. 13299, 13299, 2006 WL 3207085, at *1). The plan preview process is meant to be an iterative process wherein plans are permitted to informally submit questions and objections to CMS pertaining to the calculation of their Star Ratings before publication so that CMS can consider addressing any concerns or errors before issuing the final Star Ratings determination. *See* JA134, 364-66 (email correspondence on behalf of HMOLA, Sep. 12, 2024, subject line "Plan Preview #2 H6453").

CMS's views expressed in correspondence with a Medicare Advantage Organization as part of an informal process prior to publication of a Medicare Advantage Organization's Star Ratings do not qualify as "action[s] [that] provide[] a focus for judicial review," and consequently, the change-in-position doctrine has no application. *See Dep't of Homeland Sec. v. Regents of Univ. of Cal.*, 591 U.S. 1, 18 (2020) (quoting *Heckler v. Chaney*, 470 U.S. 821, 832 (1985)). Although the Supreme Court has applied the change-in-position doctrine on one occasion to an instance where an agency altered a position first stated in a policy statement, that policy statement created the Deferred Action for Childhood Arrival program—a program for conferring affirmative immigration relief, under which hundreds of thousands of program beneficiaries could request work authorization and eligibility for Social Security and Medicare. *Regents of Univ. of Cal.*, 591 U.S. at 18-19.

By contrast, because they are not final, CMS's views expressed in informal email correspondence with Medicare Advantage Organizations during the plan preview process create no similar consequences. HMOLA recognized in its September 12, 2024, email that it was providing "feedback on the Star Rating calculation prior to finalization"

with the expectation that the errors it identified would be corrected "prior to finalization of CY 2025 Star Ratings data." JA364-65. Indeed, through the informal plan preview process, CMS ultimately agreed with HMOLA's rationale and corrected its error. JA375. Because CMS's views expressed in the plan preview process did not "mark the consummation of the agency's decisionmaking process," and at that stage were "merely tentative [and] interlocutory," *Safari Club International v. Jewell*, 842 F.3d 1280, 1289 (D.C. Cir. 2016), they are not the kind of final agency actions that are subject to the change-in-position doctrine.

HMOLA argues that the change-in-position doctrine ensures that "the regulated public is not subjected to 'unfair surprise,'" Br. 35 (quoting *Christopher v. SmithKline Beecham Corp.*, 567 U.S. 142, 156 (2012)) and that "serious reliance interests" may be imperiled by insufficient justification, *id.* (quoting *Fox Television Stations, Inc.*, 556 U.S. at 515-16). But the regulated public was not subjected to surprise because CMS did not have a policy of regarding consumed contracts as terminated contracts upon which they could rely. And HMOLA could not have been unfairly surprised that Special Needs Plan data from the consumed contract was used in calculating the 2025 Star Ratings for the

consolidated contract—as that was precisely what HMOLA asked CMS to do during the plan preview process. JA364-66.

Finally, even if the Court were to find that CMS's explanation for accepting HMOLA's request to include Special Needs Plan data from its consumed contract in calculating measure C05 was insufficient, remand to the agency would be improper. "[T]he better course when an agency error is identified is for the reviewing court, except in rare circumstances, to remand to the agency for additional investigation or explanation." *Wages & White Lion Invs., L.L.C.*, 604 U.S. at 587 (cleaned up). However, remand may at times be unwarranted. *See id.* at 589-91. Remand is especially unwarranted where "there is not the slightest uncertainty as to the outcome of the agency's proceedings on remand" because "the agency was required to take a particular action." *Calcutt v. Federal Deposit Ins. Corp.*, 598 U.S. 623, 630 (2023) (internal quotations omitted). As the district court correctly noted, "CMS would likely be able to easily cure any defects by explaining that it adopted HMOLA's reasoning in making the requested change." JA110. Additionally, as established, CMS's regulations required it to consider the C05 measure score for HMOLA's consumed contract in calculating the Star Rating for HMOLA's

consolidated contract. *See* 42 C.F.R. §§ 422.162(b)(1), (b)(3)(i), (b)(3)(iv)(B)(1). A remand would not result in a different outcome.

* * *

CMS's regulations do not require the surviving contract to be the contract that offered Special Needs Plans in the 2023 measurement year to determine the rating for the consolidated contract in 2025. *See* 42 C.F.R. § 422.162(b)(3) (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 contracts."). It is sufficient that the consumed contract offered a Special Needs Plan in the 2023 measurement year, that the relevant data were available, and that the consolidated contract offered Special Needs Plans in 2025. *See id.* That is what happened here.

CONCLUSION

For the foregoing reasons, the judgment of the district court should be affirmed.

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CERTIFICATE OF COMPLIANCE

This brief complies with the type-volume limit of Federal Rule of Appellate Procedure 32(a)(7)(B) because it contains 8,933 words. This brief also complies with the typeface and type-style requirements of Federal Rule of Appellate Procedure 32(a)(5)-(6) because it was prepared using Word for Microsoft 365 in Century Schoolbook 14-point font, a proportionally spaced typeface.

/s/ John J. Bardo

CERTIFICATE OF SERVICE

I hereby certify that on January 16, 2026, I electronically filed the foregoing brief with the Clerk of the Court for the United States Court of Appeals for the District of Columbia Circuit by using the appellate CM/ECF system. Service will be accomplished by the appellate CM/ECF system.

/s/ John J. Bardo

ADDENDUM

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ADD1

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).

(B) Plans that failed to report

An MA plan which does not report data that enables the Secretary to rate the plan for purposes of this paragraph shall be counted as having a rating of fewer than 3.5 stars.

(C) Special rule for first 3 plan years for plans that were converted from a reasonable cost reimbursement contract

For purposes of applying paragraph (1) and section 1395w–24(b)(1)(C) of this title for the first 3 plan years under this part in the case of an MA plan to which deemed enrollment applies under section 1395w–21(c)(4) of this title-

(i) such plan shall not be treated as a new MA plan (as defined in paragraph (3)(A)(iii)(II)); and

(ii) in determining the star rating of the plan under subparagraph (A), to the extent that Medicare Advantage data for such plan is not available for a measure used to determine such star rating, the Secretary shall use data from the period in which such plan was a reasonable cost reimbursement contract.

(D) Special rule to prevent the artificial inflation of star ratings after the consolidation of Medicare Advantage plans offered by a single organization

(i) In general

If-

(I) a Medicare Advantage organization has entered into more than one contract with the Secretary with respect

to the offering of Medicare Advantage plans; and

(II) on or after January 1, 2019, the Secretary approves a request from the organization to consolidate the plans under one or more contract (in this subparagraph referred to as a "closed contract") with the plans offered under a separate contract (in this subparagraph referred to as the "continuing contract");

with respect to the continuing contract, the Secretary shall adjust the quality rating under the 5-star rating system and any quality increase under this subsection and rebate amounts under section 1395w–24 of this title to reflect an enrollment-weighted average of scores or ratings for the continuing and closed contracts, as determined appropriate by the Secretary.

(ii) Application

An adjustment under clause (i) shall apply for any year for which the quality rating of the continuing contract is based primarily on a measurement period that is prior to the first year in which a closed contract is no longer offered.

ADD2

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).

ADD3

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.

ADD4

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.

(b) Review of data quality. CMS reviews the quality of the data on which performance, scoring and rating of a measure is based before using the data to score and rate performance or in calculating a Star Rating. This includes review of variation in scores among MA organizations and Part D plan sponsors, and the accuracy, reliability, and validity of measures and performance data before making a final determination about inclusion of measures in each year's Star Ratings.

(c) Adding measures.

> (1) CMS will continue to review measures that are nationally endorsed and in alignment with the private sector, such as measures developed by National Committee for Quality Assurance (NCQA) and the Pharmacy Quality Alliance (PQA), or endorsed by the National Quality Forum for adoption and use in the Part C and Part D Quality Ratings System. CMS may develop its own measures as well when appropriate to measure and reflect performance specific to the Medicare program.

(2) In advance of the measurement period, CMS will announce potential new measures and solicit feedback through the process described for changes in and adoption of payment and risk adjustment policies in section 1853(b) of the Act and then subsequently will propose and finalize new measures through rulemaking.
(3) New measures added to the Part C Star Ratings program will be on the display page on www.cms.gov for a minimum of 2 years prior to becoming a Star Ratings measure.

(4) A measure will remain on the display page for longer than 2 years if CMS finds reliability or validity issues with the measure specification.

ADD5

42 C.F.R § 422.166

Title 42—Public Health

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Subchapter B—Medicare

Program Part 422—Medicare

Advantage Program

Subpart D—Quality Improvement

(b) Domain Star Ratings

…

(5) 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.

ADD6

42 C.F.R. § 422.508

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) A contract may be modified or terminated at any time by written mutual consent.

(1) If the contract is terminated by mutual consent, except as provided in paragraph (b) of this section, the MA organization must provide notice to its Medicare enrollees and the general public as provided in § 422.512(b)(2) and (b)(3).

(2) If the contract is modified by mutual consent, the MA organization must notify its Medicare enrollees of any changes that CMS determines are appropriate for notification within timeframes specified by CMS.

(3) If the organization submits a request to end the term of its contract after the deadline provided in § 422.506(a)(2)(i), the contract may be terminated by mutual consent in accordance with paragraphs (a) through (d) of this section. CMS may mutually consent to the contract termination if the contract termination does not negatively affect the administration of the Medicare program.

(b) If the contract terminated by mutual consent is replaced the day following such termination by a new MA contract, the MA organization is not required to provide the notice specified in paragraph (a)(1) of this section.

(c) Agreement to limit new MA applications. As a condition of the consent to a mutual termination CMS will require, as a provision of the termination agreement language prohibiting the MA organization from applying for new contracts or service area expansions for a period of 2 years, absent circumstances warranting special consideration. This prohibition may apply regardless of the product type, contract type or service area of the previous contract.

(d) Prohibition against Part C program participation by organizations whose owners, directors, or management employees served in a similar capacity with another organization that mutually terminated its Medicare contract within the previous 2 years. During the same 2–year period, CMS will not contract with an organization whose covered persons also served as covered persons for the mutually terminating sponsor. A "covered person" as used in this paragraph means one of the following:

(1) All owners of nonrenewal or terminated organizations who are natural persons, other than shareholders who have an ownership interest of less than 5 percent.

(2) An owner in whole or part interest in any mortgage, deed of trust, note or other obligation secured (in whole or in part) by the organization, or any of the property or assets thereof, which whole or part interest is equal to or exceeds 5 percent of the total property, and assets of the organization.

(3) A member of the board of directors of the entity, if the organization is organized as a corporation.

ADD7

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)….

ADD8

42 C.F.R § 422.512

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

(a) Cause for termination. The MA organization may terminate the MA contract if CMS fails to substantially carry out the terms of the contract.

(b) Notice. The MA organization must give advance notice as follows:

(1) To CMS, at least 90 days before the intended date of termination. This notice must specify the reasons why the MA organization is requesting contract termination.

(2) To its Medicare enrollees, at least 60 days before the termination effective date. This notice must include a written description of alternatives available for obtaining Medicare services within the services area, including alternative MA plans, Medigap options, original Medicare and must receive CMS approval.

(3) To the general public at least 60 days before the termination effective date by publishing an CMS–approved notice in one or more newspapers of general circulation in each community or county located in the MA organization's geographic area.

(c) Effective date of termination. The effective date of the termination is determined by CMS and is at least 90 days after the date CMS receives the MA organization's notice of intent to terminate.

(d) CMS's liability. CMS's liability for payment to the MA organization ends as of the first day of the month after the last month for which the contract is in effect.

(e) Effect of termination by the organization.

(1) CMS may deny an application for a new contract or a service area expansion from an MA organization that has terminated its contract within the preceding 2 years unless there are circumstances that warrant special consideration, as determined by CMS. This prohibition may apply regardless of the contract type, product type, or service area of the previous contract.

(2) During the same 2–year period specified in paragraph (e)(1) of this section, CMS will not contract with an organization whose covered persons also served as covered persons for the terminating sponsor. A "covered person" as used in this paragraph means one of the following:

(i) All owners of nonrenewal or terminated organizations who are natural persons, other than shareholders who have an ownership interest of less than 5 percent.

(ii) An owner in whole or part interest in any mortgage, deed of trust, note or other obligation secured (in whole or in part) by the organization, or any of the property or assets thereof, which whole or part interest is equal to or exceeds 5 percent of the total property and assets of the organization.

(iii) A member of the board of directors of the entity, if the organization is organized as a corporation.