IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF TEXAS
FORT WORTH DIVISION

HUMANA INC., and AMERICANS FOR BENEFICIARY CHOICE, Plaintiffs, v. U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES; CENTERS FOR MEDICARE & MEDICAID SERVICES; ROBERT F. KENNEDY, JR., in his official capacity as Secretary of Health and Human Services; and STEPHANIE CARLTON, in her official capacity as Acting Administrator of the Centers for Medicare and Medicaid Services, Defendants.[1]	Civil Action No. 4:24-cv-01004-O

DEFENDANTS' CONSOLIDATED REPLY BRIEF IN SUPPORT OF THEIR MOTION TO DISMISS AND CROSS MOTION FOR SUMMARY-JUDGMENT

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[1] Robert F. Kennedy, Jr. is substituted for Dorothy Fink as Secretary of the United States Department of Health and Human Services pursuant to Federal Rule of Civil Procedure 25(d).

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I. Summary

Humana's Opposition and Reply—in which it urges this Court to adopt its merits positions based in part on a new declaration and its description of secret reports generated by its call-monitoring software—helpfully underscores the value and purpose of the agency review process. This Court does not need to, and should not, reach Humana's merits claims at all until they have been channeled through agency review and properly exhausted. Humana's arguments to the contrary are unavailing. It proposes a novel application of the Supreme Court's standard in *Illinois Council* that finds no support in the caselaw and directly contradicts Fifth Circuit precedent on the Medicare statute's channeling requirement. And it wrongly asserts that the regulatory process for review of Quality Bonus Payment status determinations is not required before judicial review. Finally, it fails to explain why this Court should resolve a dispute that it is simultaneously pursuing through agency review channels.

Humana's latest brief attempts to offer new evidence—or, in one circumstance, its own characterization of software reports that it does not share with the Court—in a case that, it says, "arises under the Administrative Procedure Act."[2] It is black-letter law that judicial review in an APA case is based on the administrative record—not based on new declarations generated during APA litigation and certainly not based on a party's description of secret reports that it has not produced. Humana could have provided this new evidence to the Agency during the informal plan preview period, and Humana still can submit this material via the Agency's administrative review process, thereby facilitating eventual judicial review of a properly channeled claim on a complete administrative record. Instead, Humana asks this Court to resolve an APA case based on

[2] Pls.' Consolidated Reply in Supp. of Mot. for Summ. J. and Opp'n to Defs.' Mot. to Dismiss and Cross-Mot. for Summ. J. ("Pls. Opp.") 10, ECF No. 41.

materials outside the administrative record. This Court should dismiss for lack of jurisdiction, both because the Medicare statute so requires and because Plaintiffs' attempt to rely on extra-record materials adds credence to Defendants' arguments regarding agency channeling.

If this Court does proceed to the merits, Humana should not prevail. Humana challenges three test calls that were graded "unsuccessful" because, in each call, Humana's call center terminated the connection prematurely—twice after putting the caller on hold to connect with an interpreter and once before the caller had any communication with a Customer Service Representative ("CSR"). No Medicare beneficiary would consider an unexpected hangup a "successful" call to an insurance company. With respect to the two calls that Humana terminated after putting the caller on hold, Humana's latest declaration does not support its position. While it contends that Humana can generally identify Centers for Medicare & Medicaid Services ("CMS") test callers, it does not actually say that it identified the two test calls at issue as CMS test calls. And while Humana's counsel has repeatedly said that Humana would have performed successfully on the test calls but for CMS's no-callback policy, Humana's employee notably avoids making that factual asserting in her declaration. Rather, her declaration says only that the customer service representatives would have been required to *attempt* callbacks. Even with Plaintiffs' belated attempt to add new evidence, the point Defendants made in their opening brief still stands: the claim that the call failed because of the no-callback policy is nothing more than Humana's say-so. This, without more, is insufficient to support judgment for Plaintiffs.

Humana also cannot show that CMS promulgated the no-callback policy improperly, that the policy is arbitrary and capricious, or that it was unfairly applied to

Humana. Humana's arguments about the promulgation of the policy cite an inapposite portion of the Medicare statute on which the Agency never relied. As CMS has shown, there is a notice-and-comment provision applicable to communications with Medicare Advantage Organizations (MAOs) about Star Ratings that CMS has used since a 2018 rulemaking to update its Star Ratings measures. Humana's claim that an "Accuracy and Accessibility Study" that tests, in part, the "availability of interpreters for Limited English Proficient Callers" cannot count disconnections against a plan is questionable on its face and does not stand up to scrutiny. Humana cannot dispute that these hangups rendered interpreters unavailable for the test callers. With respect to Humana's *Elevance* comparison, Humana ignores the points made in Defendants' opening brief and mischaracterizes the record.

Humana fares no better on its other challenged call. Once again, the record shows that the test caller never contacted a customer service representative and Humana's call center terminated the call. Humana's argument otherwise rests on what it says its "call recording software . . . shows" about the challenged call. Pls. Opp. 29 n.3. But Humana does not provide an output of that software to this Court, nor has it ever (despite numerous opportunities) shared its secret evidence with the Agency. A party's characterization in a litigation brief of its own hidden records is not a basis for overturning an agency determination.

Finally, Humana says that its unlawful subdelegation claim is based on more than just the Fifth Circuit's decision in *Consumers' Research v. FCC*, and that the Supreme Court's grant of certiorari is irrelevant to its arguments. But having done so, Humana continues to cite only *Consumers' Research* and a decision from the Eastern District of Texas that relied entirely on *Consumers' Research*. Humana's attempt to disclaim its

reliance on that case thus rings hollow. In any event, Humana would have this Court hold—going well beyond *Consumers' Research* itself—that an agency cannot agree with a contractor's recommendation without running afoul of the subdelegation doctrine. There is nothing to support such a sweeping holding.

II. Argument and Authorities

A. This Court Lacks Jurisdiction Over Humana's Unexhausted Claims.

The Supreme Court has held that, for claims arising under the Medicare statute, Section 405(h) "demands the channeling of virtually all legal attacks through the agency." *Shalala v. Illinois Council on Long Term Care, Inc.*, 529 U.S. 1, 13 (2000). In *Physician Hospitals of America v. Sebelius*, the Fifth Circuit held that the *Illinois Council* rule precluded jurisdiction over a lawsuit by a physician-owned hospital and an organization that supports such hospitals seeking to raise a constitutional challenge to a provision of the Medicare statute. 691 F.3d 649, 652 (5th Cir. 2012). Whether section 405(h) applies does not, as Humana would have it, depend on whether Congress has, "at discrete points, for limited purposes" incorporated sections 405(b) or (g) into the Medicare statute. Pls. Opp. at 5-6. Quite the opposite. "'[T]he third sentence of § 405(h) is . . . sweeping and direct and [] states that no action shall be brought under § 1331, not merely that only those actions shall be brought in which administrative remedies have been exhausted.'" *Physician Hosps.*, 691 F.3d at 654 (quoting *Weinberger v. Salfi*, 422 U.S. 749, 757 (1975)).

The Fifth Circuit in *Physician Hospitals* did not search through the Medicare statute for a provision in which Congress said specifically that constitutional challenges to legislation must be channeled through the Medicare statute's review provisions. (There is no such provision.) Rather, it looked to Supreme Court precedent and to the language

of 42 U.S.C. §§ 405(h) and 1395ii and concluded that the question before it was "whether the plaintiffs' claims here arise under the Medicare Act." *Id.* at 657. The statute at issue in that case was assuredly not an "'initial determination[] of benefits within the meaning of Section 1395ff(a)(1).'" *See* Pls. Opp. at 6 (quoting *D&G Holdings v. Becerra*, 22 F.4th 470, 474 n.4 (5th Cir. 2022)). Under Humana's view, then, the statute challenged in *Physician Hospitals* must not have been "eligible for § 405(g) judicial review under § 1395ff(b)(1)(A) and therefore need not be (indeed, cannot be) exhausted first via Section 405(b)." *Id.* (internal quotation marks omitted). But the Fifth Circuit nonetheless held that a jurisdictional dismissal was warranted. Humana's proposed novel application of *Illinois Council*—which would require courts to determine whether Congress has cross-referenced Sections 405(b) and/or (g) in the specific provision of the Medicare statute at issue—has no support in caselaw. *See RICU LLC v. Dep't of Health & Human Serv's.*, 22 F.4th 1031, 1035 (D.C. Cir. 2022) (explaining that "the Supreme Court . . . has treated Section 405(g) as effectively incorporated as the exception herein provided") (cleaned up). Worse, Humana's position is inconsistent with controlling Fifth Circuit precedent. Either the Fifth Circuit in *Physicians Hospitals* was wrong, or Humana is wrong here.

Even the case containing the footnote on which Humana extensively relies does not support Humana's preferred approach. *See D&G Holdings*, 22 F.4th at 474 n.4; *accord* Pls. Opp. at 4, 6, 9. In that case, the plaintiff exhausted its administrative appeals and prevailed before the agency tribunal, then filed a lawsuit to obtain recouped funds that the agency tribunal itself had found could not be measured accurately based on the record before it. *D&G Holdings*, 22 F.4th at 472-473. At issue was whether the court had jurisdiction over plaintiff's lawsuit to effectuate an existing favorable judgment by an

agency tribunal. The Fifth Circuit held that jurisdiction was proper, relying on language in *Illinois Council* holding that courts reviewing properly channeled agency determinations can "'resolve any statutory or constitutional contention that the agency does not, or cannot decide.'" *Id.* at 475 (quoting *Illinois Council*, 429 U.S. at 23). "The district court had jurisdiction under § 405(g) to resolve this dispute because 'effectuations' are inextricably intertwined with the initial exhausted agency action." *Id.* at 476.

D&G Holdings is thus beside the point. This Court is not being asked to determine whether it can effectuate a judgment made by an agency tribunal. Rather, Humana is asking this Court to allow it to proceed with the same claims in two forums simultaneously. And the Defendants are asking this Court to conclude, consistent with a long line of Supreme Court and Fifth Circuit precedent, that this Court lacks jurisdiction over Humana's claims because they arise under the Medicare statute and can be channeled administratively.

Humana suggests that a jurisdictional dismissal here "would mean that Congress 'intended no review at all of substantial statutory and constitutional challenges to the Secretary's administration of . . . the Medicare program.'" Pls. Opp. at 7 (quoting *Bowen v. Michigan Acad. of Family Physicians*, 476 U.S. 667, 680 (1986)). The basis for its contention is unclear. CMS has never taken the position that Humana or another MAO cannot seek judicial review following a final and binding Quality Bonus Payment ("QBP") status determination by the Agency. Rather, the "nearly absolute channeling requirement assures the agency greater opportunity to apply, interpret, or revise policies, regulations, or statutes without possibly premature interference by individual courts applying 'ripeness' and 'exhaustion' exceptions case by case." *Illinois Council*, 529 U.S.

at 13. That judicial review is premature *now*—while Humana is still participating in the agency's administrative review process[3]—does not mean that there will be "no review at all." Pls. Opp. at 7. Judicial review can and presumably will occur if Humana is dissatisfied with the Agency's "final and binding" decision resulting from the administrative appeal (if the final Agency decision is in Humana's favor, judicial review would presumably be unnecessary). At that point, the reviewing court would have the benefit of assessing a reasoned decision by the CMS hearing officer or, as appropriate, the Administrator. And the reviewing court would also have the benefit of conducting its review based on an administrative record developed before the Agency.[4] *Weinberger*, 422 U.S. at 765 ("Exhaustion is generally required as a matter of preventing premature interference with agency processes, so that the agency may function efficiently and so that it may have an opportunity to correct its own errors, to afford the parties and the courts the benefit of its experience and expertise, and to compile a record which is adequate for judicial review."). In any event, there is no basis for Humana's invocation of the narrow "no review at all" exception to the channeling required by *Illinois Council*—judicial review remains available after administrative review is complete.

Humana insists that its case "arises under the Administrative Procedure Act." Pls. Opp. at 10. There are two problems with that argument. First, this case arises under the Medicare Act—not the APA—because "[a] claim arises under the Medicare Act if 'both the standing and the substantive basis for the presentation' of the claim is the Medicare

[3] On February 14, 2025, Humana requested an informal hearing concerning its Quality Bonus Payment determinations.

[4] Assuming, of course, that the plaintiff actually provides its supporting evidence to the Agency during the administrative review process. For reasons Humana never explains, it has chosen not to provide CMS with the extra-record declaration it submitted to this Court. *See* Declaration of Marla Sanders ("Sanders Dec.") 1, ECF No. 41-1.

Act." *RenCare, Ltd. v. Humana Health Plan of Texas, Inc.*, 395 F.3d 555, 557 (5th Cir. 2004) (quoting *Heckler v. Ringer*, 466 U.S. 602, 606 (1984)). This case easily meets that test. Humana alleges that it is injured because CMS, the agency responsible for administering the Medicare statute, has misapplied its regulations (promulgated under authority of the Medicare statute) to deprive Humana of various financial incentives that it claims to be entitled to under the Medicare statute. Second, even if this case somehow "arises under" the APA and not the Medicare statute, the APA does not apply "to the extent that [] statutes preclude judicial review." 5 U.S.C. § 701(a)(1). Because 42 U.S.C. § 1395ii is such a statute, Plaintiffs' invocation of other sections of the APA does not allow them to establish jurisdiction under the Act.

Humana's claim that administrative review is "purely optional for MAOs" similarly fails. It is of course true that the regulation says that "[a]n MA organization may request reconsideration of its QBP status." 42 C.F.R. § 422.260(c)(1). That use of the word "may" is because not every MAO is likely to be dissatisfied with its QBP status, and mirrors similar wording in other review provisions, including one cited by Plaintiffs. Pls. Opp. at 8 (citing 42 U.S.C. § 1395oo); *see* 42 U.S.C. § 1395oo(a) ("Any provider of services which has filed a required cost report . . . may obtain a hearing"). *Illinois Council* and its progeny do not require that the relevant regulations describe the appeal process as mandatory. Moreover, Humana is wrong that it has a "final and binding" decision regarding its entitlement to Quality Bonus Payments before administrative exhaustion. Pls. Opp. at 11-12. The regulations do not say that the initial determination is final and binding, and CMS specifically retains authority to "revise an MA organization's QBP status at any time after the initial release of the QBP determinations through April 1 of each year." 42 C.F.R. § 422.260(d). As described in Defendants' first brief, Humana

sought reconsideration of its QBP status, and the CMS Reconsideration Letter declined to grant the relief Humana sought.[5] Five days before filing its Opposition-Reply in this Court, Humana requested an informal hearing on the reconsideration official's adverse determination. Under the regulations, there is thus no "final and binding" agency determination of its QBP status. "The reconsideration official's decision is final and binding *unless* a request for an informal hearing is filed in accordance with paragraph (2) of this section." 42 C.F.R. § 422.260(c)(1)(ii) (emphasis added). It is untrue that "there remains a 'final and binding' agency decision in force and effect, *no matter what*." Pls. Opp. at 11-12. If an MAO requests an informal hearing—as Humana has done—there is no judicially-reviewable decision in force with respect to the MAO's QBP status determination until the hearing officer issues a decision and the CMS Administrator reviews and modifies it or ten business days pass without Administrator action. 42 C.F.R. § 422.260(c)(2)(vii). Nor can Humana show that it can challenge its Quality Bonus Payment status without first channeling its claims; an initial status determination is not "final and binding."

A few more points bear mentioning. First, the Fifth Circuit has rejected Humana's argument that the presence of its co-plaintiff, Americans for Beneficiary Choice, in this litigation somehow exempts it from exhaustion requirements. In *National Athletic Trainers' Ass'n v. U.S. Department of Health & Human Services*, the parties agreed that neither the plaintiff association nor its members could obtain administrative review. 455 F.3d 500, 504 (5th Cir. 2006). But the Secretary argued—and the Court agreed—that exhaustion was still required because the physicians who employed athletic trainers could

[5] Defs. Consolidated Br. in Supp. of Their Mot. to Dismiss, Resp. to Pls.' Mot. for Summ. J., and Cross-Mot. for Summ. J. ("Defs. MSJ") 15-16, ECF No. 38.

seek administrative and, if necessary, judicial review. *Id.* at 504, 507-08. ABC's presence is thus irrelevant to the jurisdictional question, because there is no doubt that Humana can obtain—indeed, is currently obtaining—administrative review. Similarly, while Humana argues that it is seeking relief from this Court that is unavailable administratively, that too is irrelevant under *Illinois Council*. "[I]t is the 'action' arising under the Medicare Act that must be channeled through the agency." *Illinois Council*, 529 U.S. at 23. Once its claims are administratively exhausted, Humana may "contest in court the lawfulness of any regulation or statute upon which an agency determination depends." *Id.* Humana also does not dispute that, if it prevails in the administrative review process, it would obtain "recalculation of [its] 2025 Star Ratings and quality bonus payments"—precisely the non-declaratory relief it is seeking in this Court. Pls. MSJ at 37.

Moreover, Humana does not dispute Defendants' arguments that this Court lacks jurisdiction under the Declaratory Judgment Act unless this Court has jurisdiction over the underlying claims, which the Court doesn't have. *See* Defs. MSJ at 35-36. Humana contends for the first time in its Opposition and Reply that it is seeking "injunctive relief requiring CMS to abide by its own regulations." Pls. Opp. at 12. But that relief was absent from Humana's summary-judgment motion, and it does not appear in the Prayer for Relief or anywhere else in its complaint.[6] According to its complaint, Humana is in this Court seeking 1) an order instructing CMS to modify its Quality Bonus Payment status based on alleged errors by CMS in its treatment of three test calls, and 2) various forms of declaratory relief connected to that underlying claim.[7] It is of no import that no administrative review is available for the methodology of calculating the Star Ratings or

[6] Am. Compl. 39, ECF No. 21.

[7] Am. Compl. 39.

the measures included in the Star Ratings system because Humana is not making a methodological challenge or requesting review of the measures included.[8] Instead, Humana is simultaneously pursuing—and has continued to pursue, even after Defendants filed their motion to dismiss—the same relief through an agency review process. Under the Medicare statute's channeling requirement, judicial review is unavailable until Humana has presented and exhausted its claims before the Agency.

Finally, a prudential point. Humana does not appear to disagree that its simultaneous pursuit of administrative review and judicial review implicates "economy of time and effort for [this Court], for counsel and for litigants." Defs. MSJ at 21 (quoting *Dresser v. Ohio Hempery, Inc.*, No. 98-2425, 2010 WL 3720420, at *2 (E.D. La. Sept. 13, 2010) (internal quotation marks omitted)). Indeed, as discussed more fully below, Humana is now attempting to provide information to this Court that it has (so far) neglected to provide to the Agency, thereby undercutting the effectiveness of the administrative review process. To the extent that Humana wishes to develop a more fulsome administrative record that facilitates judicial review, it may do so via the process laid out in the applicable regulation: 42 C.F.R. § 422.260.[9] And consistent with the fundamental principle of administrative law that "the focal point for judicial review should be the administrative record already in existence, not some new record made initially in the reviewing court," *Camp v. Pitts*, 411 U.S. 138, 142 (1973), this Court should decline to countenance Humana's attempt to add extra-record evidence by (at a

[8] Count I of Humana's Amended Complaint raised a methodological challenge. Am. Compl. 32-34. But Humana abandoned Count I. *See* Defs. MSJ at 39-40.

[9] As discussed more below, Humana has provided a declaration to this Court that it did not provide to the Agency, and it has also described the contents of records that it has not disclosed to either this Court or to the Agency. In the event that the Hearing Officer does not side with Humana, nothing in the applicable regulations prohibits Humana from submitting materials to the CMS Administrator during the ten-business-day review period of Hearing Officer determinations. 42 C.F.R. § 422.260(c)(2)(vii).

minimum) staying this matter pending resolution of the agency appeals process, through which Humana may submit whatever additional materials it deems relevant.

B. Humana's Reply on the Merits Highlights Its Inability to Show Entitlement to Relief Based on the Evidence in the Record.

Humana challenges three test calls that CMS marked "unsuccessful." Pls. Opp. 13-29. In their opening brief, Defendants showed that all three calls Humana now challenges were, indeed, unsuccessful under any criteria. Defs. MSJ 22-34. In two calls, a customer service representative put callers on hold while attempting to connect to an interpreter. AR15-16. While the callers were on hold, Humana's customer service center hung up on them. AR15-16. In another call, Humana's Interactive Voice Response ("IVR") (i.e., an automated system with a menu of options) answered a caller. AR12. Because the automated system did not have a prompt for the caller's language, the caller stayed on the line (consistent with CMS policy). No person was ever audible on the other end of the line, and once again the call center disconnected the call. AR12. Humana wants an order from this Court directing the agency to invalidate all three calls, but it marshals nothing in the record to contest the above facts. The call center study is part of CMS's assessment of MAOs' "Customer Service." Defs. MSJ at 29-30. In these three instances, Humana provided poor customer service: it hung up on a caller attempting to use its call center to get a question answered. No Medicare beneficiary would consider such a call to be successful. Humana's request for a mulligan lacks merit. Moreover, Humana's request serves to highlight why this case does not belong in federal district court now: at this late stage of the proceedings, despite pursuing relief in two forums simultaneously, Humana is offering brand-new evidence that it has never presented to the Agency.

1. The hangups were properly marked as "unsuccessful."

Two of Humana's calls as were marked as "unsuccessful" because Humana's call center hung up on two test callers while the customer service representative was attempting to connect to an interpreter. AR 15-16. Humana resists this conclusion, asserting "[t]here is . . . no doubt that the no-callback policy is the sole and independent basis upon which CMS (really, its third-party contractor) rejected Humana's objections during the plan preview period." Pls. Opp. at 17. But the evidence in the record does not support Humana's contention—something that Humana tacitly acknowledges by seeking to introduce more evidence, never shared with the Agency, via a declaration attached to its Opposition. *See* Ex. A, ECF No. 41-1 ("Sanders Dec."). But even if this Court agrees with Humana's entirely hypothetical assertion that it could have succeeded but for the no-callback policy, Humana cannot show that the no-callback policy was unlawful.

Humana has abandoned its claim that the no-callback policy "contradicts the agency's existing guidance." Pls. MSJ at 23; *see* Pls. Opp. at 19. Plaintiffs now claim only that CMS had to adopt its no-callback policy via notice-and-comment rulemaking (Pls. Opp. at 19), that it is arbitrary and capricious (Pls. Opp. at 22), and that it was unfairly applied (Pls. Opp. at 24). None of these claims has merit.

a. Humana's unsupported theory about what it "would have" done is insufficient.

Both failed calls that Humana challenges were Spanish foreign language calls. AR 469.[10] Both test callers selected the IVR prompts to speak to a Spanish-speaking

[10] The data for this call is included in an Excel spreadsheet with the file name "O5.Attachment SII_RawCall_Log2024_Full_H1019-H0028.xlsx." The relevant column is Column Y; the data dictionary at AR 70-76 shows that the entry "2" corresponds with Spanish.

customer-service representative. *Id.*[11] A CSR then joined the line and put each caller on hold for an interpreter. There is no evidence in the record that the CSR requested either caller's phone number at this point. To be fair, Humana also says it attempts callbacks using caller ID information. Sanders Dec. ¶ 3. But it's undisputed that caller ID information is not always available. For example, callers using a private number have no caller ID information.[12] So Humana cannot, consistent with the guidance, contend that the Agency's "no callback" policy is the only thing that prevents Humana from returning dropped calls.

Humana says its "standard sales script" includes asking a caller for a callback number. Sanders Dec. ¶ 3. But Humana trains its CSRs to deviate from their standard sales script when speaking with a CMS caller. *Id.* ¶ 5. And Humana says it can identify CMS callers based either on "standard scripts that are easily identified," citing the "are you the right person to answer questions about" portion of the script, or on numbers that are re-used. *Id.* ¶ 4.

Here's the problem: the test callers never had the chance, in either challenged call, to ask the standard questions. Those questions must be answered through an interpreter, and Humana hung up on the test callers before an interpreter ever joined the line. And while Humana says that the *other* call it challenges was the sixth it received from the same number, Sanders Dec. ¶ 4.b, it does not say anything about the numbers that placed the two calls in which Humana's call center hung up on the caller after initiating a hold to connect an interpreter. Humana's employee's sworn declaration studiously avoids saying

[11] The data for this call is included in an Excel spreadsheet with the file name "O5.Attachment SII_RawCall_Log2024_Full_H1019-H0028.xlsx." The relevant columns are BZ and CA.

[12] As Defendants have already pointed out—and Humana does not rebut, CMS guidance requires that MAO call centers be able to accept calls from private numbers. Defs. MSJ. 26-27.

Humana knew at the time that *these two challenged calls* were CMS test calls. Indeed, the Humana declarant states that she "recently" dialed the numbers associated with the two hangups and received a message indicating the call could not be completed. Sanders Dec. ¶ 7. There is no evidence—either in the record or in the extra-record declaration—that Humana knew at the time of the test calls that they were indeed test calls, and that it failed to attempt a callback for that reason.

Another problem is that Humana's theory that it "would have" succeeded is just that: a hypothetical. Perhaps Humana has internal data showing that, for a significant percentage of attempted calls disconnected between three-and-a-half and four minutes after being answered, Humana CSRs successfully made a callback, connected to an interpreter, and answered an initial question through that interpreter. Were such data in the record, this Court would have more to rely on than Humana's assertion that it "would have" succeeded. All Humana's declaration says on that front is that, but for the no-callback policy, the customer service representatives "would have been required to *attempt callbacks*." Sanders Dec. ¶ 9 (emphasis added). Humana's attorneys say that, but for CMS's policy, the calls would have been successful. Pls. MSJ at 24-25; Pls. Opp. at 13. Its employee does not go so far—she says only that an attempt would have been "required." Sanders Dec. ¶ 9. On substantial evidence review, a party's unsupported claim about what it "would have" done is insufficient—and particularly so here, where Humana's sworn declaration does not say Humana would have been able to successfully complete the measure.

Much of the above discussion is academic because the material on which Humana relies is not in the administrative record. Humana contends that the declaration goes to its standing, which can be shown in an APA case via extra-record materials. *See* Pls. Opp. at

15 n.2. But Defendants did not challenge Plaintiffs' standing in their Motion to Dismiss. In reality, the declaration is part of an impermissible attempt by Plaintiffs to rely on matters outside the administrative record to shore up their argument that the calls should not be classified as "unsuccessful." As such, the declaration only highlights the gaps in Humana's argument based on the administrative record. Humana's reliance on the declaration also underscores why a jurisdictional dismissal is appropriate; Humana should submit the declaration (and any other relevant evidence) to CMS, not to this Court in the first instance.

b. The Agency properly promulgated its no-callback policy.

Defendants showed that the special rulemaking requirements at 42 U.S.C. § 1395hh(a)(2) do not apply to the policies at issue in this case. Plaintiffs respond that the Star Ratings govern their "eligibility . . . to furnish . . . benefits." *See* Pls. Opp. at 20. This contention, which rests on Humana's view that the phrase "health benefits" colloquially refers to insurance coverage, is unsustainable under the Medicare statute.

The Medicare statute is far from colloquial, and it distinguishes "coverage" from "benefits." Take 42 U.S.C. § 1395w-21(d)(3), for example. Under that statute, "general information . . . with respect to *coverage* under this part during a year, shall include the following." Among "the following," in a section headed "Benefits under original medicare fee-for-service program option," is "A general description of the *benefits covered* under the original medicare fee-for-service program under parts A and B." *Id.* § 1395w-21(d)(3)(A) (emphasis added). If "coverage" were a "benefit," then that statute could refer to the "coverage covered." And in a section devoted to the information that should be included about Medicare+Choice plans is the following: "the extent to which an enrollee may obtain benefits through out-of-network health care providers." *Id.*

§ 1395w-21(d)(4)(A)(vi). If "coverage" were a "benefit," this provision would not make sense. Or take § 1395w-22(a)(B)(i), which defines "benefits under the original medicare fee-for-service program option" to mean "items and services . . . for which benefits are available under parts A and B." "Coverage," as Plaintiffs agree, is not a "service." It is also not an "item" as Medicare uses the term. So while "health benefits" may mean "health insurance coverage" in a job posting, "coverage" is not a "benefit" under the Medicare statute.

Moreover, the regulation Plaintiffs cite does not "establish[] or change[] a substantive legal standard governing . . . the eligibility" of MAOs to furnish anything. A quality bonus payment is not a payment for a service, and eligibility to *receive* quality bonus payments is not the same as eligibility to offer coverage to Medicare beneficiaries. There are MAO plans that do not receive quality bonus payments and nonetheless offer coverage. The ability to enroll new participants outside of open enrollment is similarly not an eligibility criterion; an MAO that cannot enroll outside of open enrollment may still offer coverage to beneficiaries. And while repeated low Star Ratings may affect an MAO's eligibility to participate in Medicare, that possibility does not imply that every regulation discussing the data included in the Star Ratings governs the eligibility of MAO plans. Rather, the regulations "governing" eligibility with respect to repeated low Star Ratings are the ones Plaintiffs cite: 42 C.F.R. §§ 422.502(b)(1)(i)(D) and 423.503(b)(1)(i)(D). Pls. Opp. at 20.

Indeed, Section 422.111(h) is not about Star Ratings at all. It is part of a regulation governing "mechanisms for providing specific information on a timely basis to current and prospective enrollees upon request." *Id.* A different regulation—42 C.F.R. § 422.164—describes the process for "[a]dding, updating, and removing measures" to the

Part C Star Ratings.[13] That regulation states that non-substantive updates will be made "through the process described for changes in and adoption of payment and risk adjustment policies in [42 U.S.C. § 1395w-23]," exactly as Defendants described in their opening brief. 42 C.F.R. § 422.164(d)(1); *see* Defs. MSJ at 29.[14] And Section 1395w-23(b) contains a notice-and-comment provision. The Advance Notice and Rate Announcement materials describing the Star Ratings measures have, since the 2018 rulemaking adding Sections 422.164 and 423.184, been subject to the notice-and-comment procedures at Section 1395w-23(b)(2). It is true that the Star Ratings interpreter-availability measure includes an eight-minute standard, similar to the one found in Section 422.111(h). But the details of the Star Ratings measures, including the single-call requirement, do not come from Section 422.111(h)—they are promulgated under Section 422.164 (and, as they apply to Part D, Section 423.184), in a manner consistent with the special notice-and-comment provisions applicable to communications with MAOs discussed at 42 U.S.C. § 1395w-23(b). Humana could have raised concerns with the single-call requirement—which, as Defendants showed, has been plain for years—at any time. But Humana never argues that it has done so, and its claims that there was a violation of the Section 1395hh notice-and-comment requirement fall flat.

c. The no-callback policy is not arbitrary and capricious.

Humana asserts that a policy marking calls "unsuccessful" when a plan hangs up on a foreign-language caller while its customer service representative is attempting to get

[13] An analogous regulation, 42 C.F.R. § 423.184, applies to Part D Star Ratings.

[14] Humana points to a statute Defendants never cited, 42 U.S.C. § 1395w-26, and say it is "manifestly not the appropriate vehicle for conducting notice and comment on proposals to modify Star Ratings measures." Pls. Opp. at 21 (internal quotations omitted). Fair enough, but Defendants did not rely on Section 1395w-26, so it is unclear why Plaintiffs are discussing the inapplicability of that provision.

an interpreter on the line "does nothing to advance" the objectives of the Accuracy and Accessibility Study, among which is "testing the availability of interpreters for Limited English Proficient Callers." Pls. Opp. at 22-23 (internal quotations omitted). This is self-refuting. One way that an interpreter can be unavailable to a caller is if the call center, despite employing interpreters, fails to connect callers to interpreters and hangs up on those callers in the process. That is what happened here. Humana was unsuccessful in providing an interpreter because it disconnected the test calls. There is no basis for it to suggest that it should not have a lower rating because the *reason* it failed to provide an interpreter was a disconnection.[15] Nor is CMS wrong to point more broadly to the "Customer Service" purpose of the call-center measures. Calling an insurer and being unable to get assistance because of a dropped call is a frustrating experience that, as Humana has acknowledged, "pose[s] a risk to beneficiary access." AR 16. Yet Humana would have this Court hold that CMS's "Accuracy and Accessibility Study" must ignore dropped calls.

d. The Elevance case is a red herring.

Humana continues to argue that the CMS Reconsideration Official's decision in favor of another MAO, Elevance, regarding a disconnected TTY call mandates reversal of Humana's unsuccessful ratings. Pls. Opp. at 25. Humana does not respond to the points made in Defendants' opening brief regarding the distinction between TTY and foreign language calls, nor does Humana point to anything in the record comparable to

[15] Humana continues to insist that CMS double-counts disconnections, despite CMS showing that the separate study that also counts disconnections involves a non-overlapping population of callers. But the disconnections at issue here were not counted against Humana in the Timeliness Study, and any disconnections in the Timeliness Study did not count against Humana in the Accuracy and Accessibility Study. There is thus no double-counting, unless Humana's position is that the broad *concept* of calls being disconnected can only be captured by one measure, a position for which Humana offers no support.

the showing in Elevance that the disconnection occurred between the CMS test caller and the TTY relay. *See* Defs. MSJ at 23. Instead, Humana speculates that the error "may have been" on CMS's end and asserts that "CMS does not (likely cannot) say" whether Humana's newfound speculation is correct. Pls. Opp. at 25. Humana's speculation is unsupported by the record, which contains unrefuted evidence that Humana hung up on the callers. AR 469.[16] Humana was free to provide its own evidence to CMS, as Elevance did, either during the plan preview period or during the Quality Bonus Payment status appeal process. But Humana did not provide any such evidence, and the APA substantial evidence standard does not allow a Court to overturn an agency determination on the basis of speculation about "an ISP connectivity issue" or "a power outage" or "an unreliable connection on the caller's side." *See* Pls. Opp. at 25-26. The evidence in the record supports CMS's determination and further supports the distinctions between the Elevance call and Humana's calls.

2. CMS correctly assessed the "silent call."

Humana separately challenges a Tagalog call in which the test caller stayed on the line through the Interactive Voice Response prompts, never contacted a CSR, and received an unexpected disconnection.[17] Once again, Humana does not dispute these key facts from the record, nor did Humana (unlike UnitedHealthcare) provide a recording of the call that is in the administrative record. Nor does Humana ever explain why, despite

[16] The data for these calls is included in an Excel spreadsheet with the file name "O5.Attachment SII_RawCall_Log2024_Full_H1019-H0028.xlsx." The relevant columns are F, H, and I. *See also* AR 70 (data dictionary showing ERC code 296.01 means "unexpected breakoff: CSR hung up."

[17] The data for this call is contained in an Excel spreadsheet with the file name "03.An Attachment SII_RawCallLog_2024_Full_C0701002." Columns F, H, and I show that the call center disconnected the call. *See also* AR 70 (data dictionary showing ERC code 293.5 means "Plan Call Center Dropped Call – Disconnected"). The five-and-a-half minutes figure is a sum of column AX, IVR_Time, and column AY, HOLD-TIME, i.e. 328 seconds.

previously arguing the facts of its case are "analytically identical" to the *UnitedHealthcare* case in the Eastern District of Texas, it thinks this Court should make a different holding than the court in that case. Pls. Br. at 34-35; *see* Defs. MSJ at 32. The *UnitedHealthcare* court clearly held that the call "connected." *UnitedHealthcare Benefits of Tex., Inc. v. Ctrs. for Medicare & Medicaid Servs.*, No. 6:24-cv-357, 2024 WL 4870771, at *4 (E.D. Tex. Nov. 22, 2024). Humana here, by contrast says the call "accordingly never connected within the meaning of the guidelines." Pls. MSJ at 34. Plaintiffs cannot seek the same holding from this Court as in *UnitedHealthcare* because they cannot escape the fact that the call at issue in that case lasted more than eight minutes—a critical factor in the Court's decision. But this of course underscores that the cases are not "analytically identical."

Once again, Humana tries to put evidence before this Court that it never shared with CMS. But instead of a sworn declaration, Humana offers in a footnote its own characterization of what its "call recording software . . . shows" about call C0701002. *See* Pls. MSJ at 29 n.3. Plaintiffs asks this Court to take it at its word about what Humana's secret data shows, and to accept Humana's claim that it "would have made this evidence available to the agency" if the Agency had responded differently during the plan preview process.[18] Pls. Opp. at 29 n.3. This is not how APA cases work. Humana could have provided this secret data to the Agency not only during the plan preview process but also

[18] During the plan preview process, CMS told Humana that the call disconnected "before the CMS caller could make contact with a CSR," AR 12, and shared the spreadsheet with raw call data with Humana including the notation "hold was silent." Humana did not provide anything showing that the CSR was on the call. It is reasonable to infer—from the uncontested record evidence that the CMS caller did not make contact with a customer service representative—that there was no customer service representative on the line. Nothing prevents Humana from providing data to CMS showing that its test caller was mistaken in believing there was no CSR contact.

during the QBP appeals process, but it has (so far) chosen not to. It cannot now obtain relief based on its representation about what its software says.

Humana's core contention—that a Tagalog speaker who had waited through an Interactive Voice Response menu with no Tagalog option and had heard nothing after the automated menu finished should have asked a question in Tagalog to a silent line—is unsustainable on its face. And Humana does not dispute that it hung up on the caller before the caller heard anything from a live person. Yet Humana would nonetheless have this Court intervene to have its unsuccessful call invalidated based not on evidence in the record, but on its representations about data that it has not shared with anyone.

3. There was no unlawful delegation to contractors.

As Defendants demonstrated in their opening brief, Humana cannot show that CMS violated any rule against subdelegation when it agreed with its contractors' recommendations about the challenged calls. Humana responds that *Consumers' Research*, "broke no new ground," so this case should not be held in abeyance pending further guidance from the Supreme Court. Pls. Br. at 32 (citing *Consumers' Research v. FCC*, 109 F.4th 743 (5th Cir. 2024) *cert granted*, ___S. Ct.___, 2024 WL4864036 (2024)). Then, in arguing that CMS violated the non-delegation doctrine, it cites no caselaw other than *Consumers' Research* and *UnitedHealthcare*, which explicitly relied on *Consumers' Research* and rejected CMS's arguments that an agency could subdelegate "fact gathering" and "advice giving" tasks to contractors. *See UnitedHealthcare*, 2024 WL 4870771, at *8 (citing *Int'l Dark-Sky Ass'n, Inc. v. FCC*, 106 F.4th 1206 (D.C. Cir. 2024)). If *Consumers' Research* truly broke no new ground, Plaintiffs would presumably rely on another Fifth Circuit case for the proposition that an agency cannot lawfully agree with its contractors' recommendations without running

afoul of the subdelegation doctrine. Plaintiffs cannot simply disclaim their reliance on a case that is subject to Supreme Court review, particularly where they do not cite any other case supporting their proposition. That *Consumers' Research* itself cites other precedents does not save Humana's position, because the conception of "ministerial tasks" on which they rely comes directly from *Consumers' Research* and was hotly contested in that case. *See, e.g.*, *Consumer's Research*, 109 F.4th at 793-96 (Stewart, J., dissenting) (criticizing the majority for adopting the petitioners' "exaggerated conception of USAC's role and discretion to create a private nondelegation doctrine where none exists").

Defendants also showed that the CMS contractor's role with respect to the challenged calls was limited to providing recommendations upon which the Agency, not the contractor, affirmatively acted. Defs. MSJ at 38. Humana responds that the Agency's oversight is "beside the point." Pls. Opp. at 34. But that response is inconsistent with even *Consumers' Research*, in which the Fifth Circuit held that the "FCC may solicit advice from" its contractor and private carriers. *Consumers' Research*, 109 F.4th at 771. Ultimately, Humana does not disagree that its position has no logical end. *See* Pls. Opp. at 35. It would have this Court hold that, if an agency accepts a recommendation from a contractor, an unlawful subdelegation has occurred. There is no precedent for such a holding—not even *Consumers' Research*, the main case on which Plaintiffs rely.

III. Conclusion

For the reasons described above and in their earlier Consolidated Brief, Defendants respectfully request that this Court dismiss Plaintiffs' amended complaint for lack of jurisdiction, pursuant to Rule 12(b)(1). In the alternative, Defendants respectfully request that this Court deny Plaintiffs' summary-judgment motion and grant summary judgment to Defendants on all counts, pursuant to Rule 56.

Respectfully submitted,

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Certificate of Service

On February 28, 2025, I electronically submitted the foregoing document with the clerk of court for the U.S. District Court, Northern District of Texas, using the electronic case filing system of the court. I hereby certify that I have served all parties electronically or by another manner authorized by Federal Rule of Civil Procedure 5(b)(2).

/s/ Andrea Hyatt
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