IN THE UNITED STATES DISTRICT COURT FOR THE EASTERN DISTRICT OF TEXAS, TEXARKANA DIVISION

HEALTH CARE SERVICE CORPORATION, A MUTUAL LEGAL RESERVE COMPANY,	)	
Plaintiff,	)	
v.	)	**Case No. 5:25-cv-00186-RWS**
ZOTEC PARTNERS, LLC,	)	**Judge Robert W. Schroeder III**
Defendant.	)	

DEFENDANT ZOTEC PARTNERS, LLC'S REPLY IN SUPPORT OF MOTION TO DISMISS PLAINTIFF'S FIRST AMENDED COMPLAINT, OR IN THE ALTERNATIVE, FOR MORE DEFINITE STATEMENT AND TO PARTIALLY STRIKE PLAINTIFF'S FIRST AMENDED COMPLAINT

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I. INTRODUCTION

Congress built the No Surprises Act ("NSA"), 42 U.S.C. § 300gg-111 *et seq.*, around a simple bargain: fast, binding resolution through the federal independent dispute resolution ("IDR") process, paired with sharply limited judicial review. Health Care Service Corporation's ("HCSC") First Amended Complaint, Dkt. No. 22 ("FAC"), asks this Court to rewrite that bargain. It seeks to unwind "thousands" of claim-level IDR determinations issued by certified independent dispute resolution entities ("IDREs") and to recover damages and injunctive relief pegged to those determinations and the fees they triggered. That relief requires dispute-by-dispute relitigation and strips binding determinations of legal effect. The NSA bars such relief.

Two courts have now confronted this same payor-side "IDR fraud" playbook and dismissed it at the threshold. In *Anthem Blue Cross Life & Health Insurance Co. v. HaloMD, LLC*, the Central District of California concluded that an IDRE's payment determination "necessarily includes a determination of eligibility" and that claims and remedies that functionally require a court to revisit IDR outcomes fall within the NSA's bar on judicial review. No. 8:25-cv-01467-KES, 2026 WL 982629, at *9–10 (C.D. Cal. Apr. 9, 2026) ("*HaloMD – CA*"). And in *Aetna Health Inc. v. Radiology Partners, Inc.*, the Middle District of Florida dismissed a payor's attempt to vacate IDR outcomes and recover IDR-driven costs, holding that the payor's state law claims were an "end-around the NSA and FAA strictures[,]" that the court was "not empowered" to conduct a claim-by-claim review outside the avenues Congress created, and that the payor could not excuse its failure to raise its issues in the IDR disputes themselves. *Aetna Health Inc. v. Radiology Partners, Inc.*, No. 3:24-cv-1343-BJD-LLL, 2026 U.S. Dist. LEXIS 84866, at *9–10 (M.D. Fla. Apr. 16, 2026) ("*Radiology Partners*").[1] This case belongs on the same track.

[1] Copies of *HaloMD – CA* and *Radiology Partners* are attached hereto as **Exhibits A** and **B**, respectively.

HCSC's labels do not change the mechanics. Its damages and injunction theories still depend on a judicial finding that IDR determinations should not have issued because the IDREs got eligibility and the merits wrong. That is exactly the type of collateral merits review the NSA channels away from district courts. *HaloMD – CA*, 2026 WL 982629, at *9–10; *Radiology Partners*, 2026 U.S. Dist. LEXIS 84866, at *9–10. And the NSA already supplies the dispute-specific lanes HCSC now wants to bypass. HCSC could raise its eligibility objections in the IDR process itself.[2] And if a jurisdictional or procedural error is identified after dispute closure, including certain eligibility-related errors, the Departments'[3] guidance provides a back-end administrative mechanism to reopen and correct the dispute through the Federal IDR portal.[4] HCSC does not allege it used that mechanism it now seeks to bypass. Nor did it pursue the narrow Federal Arbitration Act ("FAA") vacatur lane Congress incorporated. *See* 42 U.S.C. § 300gg-111(c)(5)(E)(i). Instead, it collapses thousands of determinations into one sweeping tort suit.

And the Blue Cross Blue Shield Association ("BCBSA"), of which HCSC's division health plans are licensees, has done exactly what the statute expects when a participant believes the IDR system needs guardrails: it took its grievances to CMS and asked for operational reforms, like baseline eligibility checks, an "IDR Gateway," and related rulemaking solutions designed to keep ineligible disputes out of IDR in the first place.[5] That is the proper forum for such complaints.

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[2] *See* 45 C.F.R. § 149.510(c)(1)(iii) ("[I]f the non-initiating party believes that the Federal IDR process is not applicable, the non-initiating party must also provide information regarding the Federal IDR process's inapplicability through the Federal IDR portal[.]").

[3] "Departments" refers to the U.S. Departments of Health and Human Services, Labor, and Treasury, which are the agencies tasked with implementing the NSA.

[4] *See* U.S. Dep't of Health & Hum. Servs., U.S. Dep't of Labor & U.S. Dep't of the Treasury, *Federal Independent Dispute Resolution (IDR) Technical Assistance for Certified IDR Entities and Disputing Parties: Errors Identified After Dispute Closure (June 2025)*, https://www.cms.gov/files/document/idr-ta-errors-after-dispute-closure.pdf (attached hereto as **Exhibit C**) (hereinafter, "2025 Reopening Guidance").

[5] *See* Letter from Amanda Lincoln, Vice President, Policy & Advocacy, Blue Cross Blue Shield Ass'n, to Mehmet Oz, Adm'r, Ctrs. for Medicare & Medicaid Servs., re: Request for Information Related to Comprehensive Regulations to Uncover Suspicious Healthcare (CRUSH) (Mar. 30, 2026), at 7–10 (attached hereto as **Exhibit D**) (hereinafter, "BCBSA Letter"); *see also* Amicus Curiae Br. of the Emergency Department Practice Management Association in

The NSA's bargain is finality. HCSC wants a do-over. For the reasons set forth in Zotec's Motion[6] and this Reply, this Court should reject HCSC's arguments within its Response in Opposition to Zotec's Motion[7] and dismiss all five counts with prejudice.

II. ARGUMENT

A. This Suit Is a Barred Collateral Attack on Binding IDR Determinations.

HCSC's response never escapes the same basic problem. This suit works only if the Court does what the NSA forbids: relitigate eligibility and strip thousands of binding, claim-level determinations of legal effect. The statute provides narrow, award-specific review and a dispute-specific administrative reopening mechanism. HCSC chose neither.

1. Congress Limited Review to FAA Vacatur and Agency Reopening.

Congress designed the NSA to give efficient finality to payment disputes. It did that by making IDR determinations final and binding and by limiting judicial review to the narrow vacatur grounds in Section 10 of the FAA. *See* 42 U.S.C. § 300gg-111(c)(5)(E)(i). That is the statute's bargain. Either party can pursue the limited vacatur path Congress allowed when seeking to challenge an IDR determination. Nobody gets plenary re-review in district court.

The IDR process includes an administrative fix for process-level problems, including disputes that should be reopened or corrected due to eligibility issues. *See* Mot. at 13–14 n.6; *see generally* Ex. C, 2025 Reopening Guidance (outlining the process for reopening IDR disputes to correct errors made during the IDR process).

Supp. of Def.'s Mot. to Dismiss, Dkt. 32-1, at 7 (describing payors' lobbying efforts to "fix" IDR by "anchoring arbitration decisions to the QPA" and "requiring arbitrators to reject ineligible claims").

[6] *See* Def. Zotec Partners, LLC's Mot. to Dismiss Pl.'s First Am. Compl., or in the Alternative, for a More Definite Statement and to Partially Strike Pl.'s First Am. Compl., Dkt. 25; Corrected Mot. to Dismiss Pl.'s First Am. Compl., or in the Alternative, for a More Definite Statement and to Partially Strike Pl.'s First Am. Compl., Dkt. 28 (hereinafter, "Motion" or "Mot.").

[7] *See* Pl.'s Resp. in Opp. to Def.'s Mot. to Dismiss, or, in the Alternative, for a More Definite Statement and to Partially Strike Pl.'s First Am. Compl., Dkt. 44 (hereinafter, "Response" or "Resp.").

HCSC is trying to route around that structure. It asks this Court to revisit eligibility across "thousands" of IDR disputes and award relief on the premise that the determinations were invalid from the start. That is exactly the kind of collateral litigation the NSA's review structure is designed to prevent, and courts have now squarely rejected that end-run. *HaloMD – CA*, 2026 WL 982629, at *9–10; *Radiology Partners*, 2026 U.S. Dist. LEXIS 84866, at *9–10.

Another recent NSA decision further confirms that HCSC improperly seeks judicial review. *See Agag v. Cigna Health & Life Insurance Co*., No. 3:25-cv-00498 (SRU), 2026 WL 1021213 (D. Conn. Apr. 15, 2026). In *Agag*, the District of Connecticut distinguished between confirmation or enforcement of an IDR award, which according to that court is purely ministerial, and merits re-examination, which is judicial review. *Id*. at *10–12, *14–15. Here, HCSC's FAC asks for the second. But Congress foreclosed that review outside FAA vacatur, and HCSC pleads no vacatur claim.[8] *See* 42 U.S.C. § 300gg-111(c)(5)(E)(i).

HCSC's mandatory process refrain does not help. *See* Resp. at 28. Mandatory participation does not come with a judicial back door that Congress never authorized. If HCSC thinks the available remedies are inadequate, that is a policy complaint about the statutory design. That complaint belongs with Congress and the Departments, not in a tort suit that expands judicial review beyond the statute's limits. *See HaloMD – CA*, 2026 WL 982629, at *9. BCBSA's own March 2026 letter confirms the same practical reality: alleged "abuse" and ineligible disputes are being addressed through agency operations and rulemaking tools (eligibility screening, an "IDR Gateway," and operational reforms), not by turning district courts into back-end IDR tribunals. *See* Ex. D, BCBSA Letter, at 7–11.

The Court should reject HCSC's bid. It would transform narrow, award-specific review

[8] Even if HCSC had pled vacatur, the FAA's fraud ground targets misconduct in the procurement of a particular award, not a generalized "scheme" theory spanning thousands of disputes. *See HaloMD – CA,* 2026 WL 982629, at *8.

into plenary oversight of "thousands" of IDR disputes—exactly what Congress foreclosed.

2. HCSC's Requested Relief Requires Award Nullification.

HCSC tries to rebrand this case as one about "misconduct" in the IDR process. *See* Resp. at 33. But the relief HCSC seeks gives the game away. HCSC asks for declarations that IDR determinations are not binding, injunctions prohibiting their enforcement, and damages tied to specific IDR determinations, including the amounts awarded, statutory fees, and overhead costs. FAC ¶¶ 179, 194, 209, 214, 216. That relief does not exist without treating the IDR determinations as legally ineffective.

What HCSC seeks is judicial review by another name. To grant HCSC what it wants, the Court would have to reopen completed IDR disputes, relitigate the eligibility issues baked into them, and then strip the resulting awards of their binding force. Labels do not change the mechanics. Courts have rejected the same attempt to separate "schemes" from IDR determinations, holding that claims and remedies that functionally seek review of IDR outcomes fall within the NSA's bar, however styled. *See HaloMD – CA*, 2026 WL 982629, at *7 (rejecting the plaintiffs' argument that Anthem was seeking judicial review of defendants' "NSA schemes, and not any individual IDR determination at issue"); *Radiology Partners*, 2026 U.S. Dist. LEXIS 84866, at *9–10 (holding the payor's state law claims were an "end-around the NSA and FAA strictures" and emphasizing that it was "not empowered" to conduct a claim-by-claim review outside the process Congress created).

HCSC's fallback request for forward-looking injunctive relief does not fix the problem. *See* Resp. at 9. A prospective injunction would not sit on the sidelines. It would require the Court to police IDR submissions going forward, decide whether particular eligibility attestations are false, and adjudicate compliance through follow-on enforcement proceedings. That is exactly the kind of court supervision the NSA forbids. The Central District of California made this point

directly, noting that this kind of relief would "insert[] the district court in overseeing future IDR awards." *HaloMD – CA*, 2026 WL 982629, at *10. The Middle District of Florida similarly held the court was "not empowered" to conduct a preliminary dispute-by-dispute review of claims that had not yet been submitted to IDR. *Radiology Partners*, 2026 U.S. Dist. LEXIS 84866, at *10.

3. Eligibility Is Part of the IDR Determination.

HCSC's whole theory depends on a clean split that the statute and regulations do not recognize. It tries to sever "eligibility" from the IDRE's determination so it can say it is only challenging eligibility, not payment determinations. *See* Resp. at 10–12. That framing fails because eligibility is not outside the IDR process. It is the front door. The regulations confirm that, before issuing a payment determination, the IDRE "must review the information submitted . . . to determine whether the Federal IDR process applies." 45 C.F.R. § 149.510(c)(1)(v). And that eligibility ruling is embedded in the payment determination the statute makes binding. *See* 42 U.S.C. § 300gg-111(c)(5)(A), (E). Departmental guidance further confirms that the IDRE must decide eligibility before anything else can happen.[9] The Central District of California put it plainly: "An IDRE's payment determination necessarily includes a determination of eligibility." *HaloMD – CA*, 2026 WL 982629, at *9. And the District of Connecticut recently made the same point from the other side of the "binding award" debate. *See Agag*, 2026 WL 1021213, at *14–15. The court in *Agag* applied the same principle in rejecting an eligibility-based merits challenge in

[9] U.S. Dep't of Health & Hum. Servs., U.S. Dep't of Labor & U.S. Dep't of the Treasury, *Federal Independent Dispute Resolution (IDR) Process Guidance for Certified IDR Entities: December 2023 Update to March 2023 Guidance*, https://www.cms.gov/files/document/federal-idr-guidance-idr-entities-march-2023.pdf, at 40–43 (outlining the steps of the IDR process and demonstrating the IDRE must first determine whether the federal IDR process applies before it issues its final payment determination) (attached hereto as **Exhibit E**) (hereinafter, "March 2023 Departmental Guidance"); *see also* U.S. Dep't of Health & Hum. Servs., U.S. Dep't of Labor & U.S. Dep't of the Treasury, *Supplemental Background on Federal Independent Dispute Resolution Public Use Files January 1, 2025 – June 30, 2025*, https://www.cms.gov/files/document/federal-idr-supplemental-background-2025-q1-2025-q2.pdf, at 3 ("For all disputes, the certified IDR entity must confirm dispute eligibility before the dispute can proceed.") (attached hereto as **Exhibit F**) (hereinafter, "Supplemental Background on IDR").

a confirmation posture. *Id*.

HCSC's fallback position reads the statute upside down. It argues that the NSA bars judicial review only of "payment determinations," not eligibility determinations, leaning heavily on the subsection title "Payment Determination." *See* Resp. at 10–11; *see also* 42 U.S.C. § 300gg-111(c)(5). But headings do not do that work. "[T]he heading of a section cannot limit the plain meaning of the text." *United States v. Johnson*, 632 F.3d 912, 924 (5th Cir. 2011) (quoting *Brotherhood of R.R. Trainmen v. Balt. & Ohio R.R. Co.*, 331 U.S. 519, 529 (1947)). And the operative text forecloses the carveout. The statute speaks in terms of a "determination for a qualified IDR item or service[,]" 42 U.S.C. § 300gg-111(c)(5)(A), and "qualified" is the eligibility concept. If the item or service is not eligible, it is not "qualified," and there is no determination to make. Eligibility is not a detachable threshold issue for later court litigation. It is part of the determination itself. *See HaloMD – CA*, 2026 WL 982629, at *9.

HCSC's "arbitrability" analogy does not rescue it. *See* Resp. at 11. Arbitrability is about who gets to decide a dispute in the first instance. Eligibility is different. The statute and regulations assign that question to the IDRE as part of resolving each IDR dispute. *See* 42 U.S.C. § 300gg-111(c)(5); 45 C.F.R. § 149.510(c)(1)(v). Recasting eligibility as a court-controlled gateway does not interpret the NSA. It rewrites it.

4. HCSC's Collateral Attack Workarounds Fail.

HCSC tries to dodge the collateral attack problem in three different ways. Each falls flat. First, HCSC says the IDR process is "fundamentally different" from traditional arbitration, so the collateral attack doctrine supposedly does not apply. *See* Resp. at 7–8. But the cases HCSC cites do not address collateral attacks at all. They address whether an IDR award can be enforced in

court.[10] And neither case suggests IDR determinations lack binding effect. If anything, they recognize the opposite: the statute makes these determinations binding and imposes mandatory payment consequences. *Modern Orthopaedics*, 2025 WL 3063648, at *4, *9; *T.V. Seshan*, 2025 WL 3496382, at *4, *7–8. That is exactly the kind of finality collateral attack principles are designed to protect.

Second, HCSC argues its damages are "independent" of the IDR determinations, so it is not attacking awards at all.[11] That's wordplay. The alleged injuries HCSC pleads exist only because IDR disputes were allowed to proceed and binding determinations issued. Fees followed determinations. "Overhead" follows participation in the process that Congress prescribed. And the largest claimed damages are pegged directly to award amounts and award-driven payments. The Central District of California rejected the same attempt to repackage an attack on determinations as supposed money damages and injunctive relief. *See HaloMD – CA*, 2026 WL 982629, at *9–10. *Gulf Petro* likewise forecloses HCSC's theory. The Fifth Circuit's question is functional: does the claimed injury exist apart from the adjudicative result? *See Gulf Petro*, 512 F.3d at 747–50. Here it does not. HCSC's damages theory depends on treating IDR determinations as legally defective, then charging Zotec for the consequences of those determinations. That is the same maneuver *Gulf Petro* rejected when a plaintiff sought to recover amounts tied to an arbitration result, including related "costs and expenses[.]" *Id*. at 749–50.[12]

Third, HCSC says the collateral attack doctrine is irrelevant because it wants forward-

[10] *See* Resp. at 7–8 (citing *Modern Orthopaedics of N.J. v. Premera Blue Cross*, No. 2:25-CV-010187 (BRM) (JSA), 2025 WL 3063648, at *5–7 (D.N.J. Nov. 3, 2025); *T.V. Seshan, M.D., P.C. v. Blue Cross Blue Shield Ass'n*, No. 25-CV-1255 (CS), 2025 WL 3496382, at *5–6 (S.D.N.Y. Dec. 5, 2025)).

[11] *See* Resp. at 8–9 (citing *Gulf Petro Trading Co., Inc. v. Nigerian Nat. Petroleum Corp.*, 512 F.3d 742, 749–51 & n.3, 5 (5th Cir. 2008)).

[12] HSCS's reliance on *Mian* is also misplaced. *See* Resp. at 8–9 (citing *Mian v. Donaldson, Lufkin & Jenrette Sec. Corp.*, 7 F.3d 1085, 1086–87 (2d Cir. 1993)). *Mian* involved racial discrimination causing harm wholly independent of the award. *Main*, 7 F.3d at 1086–87. Here, HCSC's claims rise or fall on the premise that the IDREs should not have found the disputes eligible, meaning the alleged injury is inseparable from the IDR determinations themselves.

looking injunctive relief, too. *See* Resp. at 9–10. But prospective relief is not a magic wand. HCSC still asks the Court to police eligibility and submissions going forward and, in doing so, to supervise the very process Congress assigned elsewhere. *See* FAC ¶ 216. The Central District of California already explained why that "end-run" is not allowed: it would drag the Court into overseeing future IDR awards and dispute administration despite the NSA's limits on judicial review. *HaloMD – CA*, 2026 WL 982629, at *9–10.

B. HCSC Is Collaterally Estopped from Relitigating Liability.

HCSC's own story triggers preclusion. It says it objected on eligibility, the IDR entities decided eligibility anyway, and binding determinations issued. That means the eligibility question was already litigated and decided in the only forum Congress picked to decide it. HCSC cannot repackage that loss as a tort "scheme" and take another run in district court. Finality is the point of the NSA. And because the FAC pleads the whole sequence, the Court can end this case now.

1. HCSC Pleads Every Element of Issue Preclusion.

All three elements of collateral estoppel are satisfied. *See* Mot. at 16–17; *see also Bradberry v. Jefferson Cnty.*, 732 F.3d 540, 548 (5th Cir. 2013) ("(1) the identical issue was previously adjudicated; (2) the issue was actually litigated; and (3) the previous determination was necessary to the decision." (citation modified)). The "identical issue" and "necessary to the decision" elements are straightforward. The issue here is whether the disputes were eligible for the federal IDR process. HCSC's claims rise or fall on that question, and the IDREs necessarily decided it as a prerequisite to every IDR determination HCSC now challenges. *See* Mot. at 16.

HCSC tries to dodge that reality by rebranding its case as a broader "scheme to defraud[.]" *See* Resp. at 17–18. But labels do not change the operative issue. HCSC still must prove that Zotec's submissions were improper because the disputes should not have proceeded through IDR in the first place. That is just another way of saying the IDREs got eligibility wrong. And that is

the same issue the IDREs necessarily decided.[13]

HCSC's "full and fair opportunity" argument fails for the same reason. *See* Resp. at 16–17. The Fifth Circuit does not require trial-like procedures for an issue to be "actually litigated." *In re Keaty*, 397 F.3d 264, 272 (5th Cir. 2005). It asks a functional question: was the issue raised, contested, submitted for determination, and decided. *Id*. Discovery, live testimony, and cross-examination are not prerequisites. *See id*. at 271–73 (holding that an issue was "actually litigated" even though it was resolved without a trial or evidentiary hearing).

That is exactly what the FAC pleads. The NSA creates a streamlined adjudicative process designed to resolve disputes efficiently, not to replicate federal litigation. *See HaloMD – CA*, 2026 WL 982629, at *8. And HCSC alleges the critical sequence: Zotec attested to eligibility, HCSC raised eligibility objections, the IDREs determined the disputes were eligible, and IDR determinations followed. *See generally* FAC; *see, e.g.*, FAC ¶¶ 113–16. On those allegations, eligibility was presented and resolved. That is an issue being actually litigated. *Cf. HaloMD – CA*, 2026 WL 982629, at *8 (rejecting argument that "in-person hearings, cross-examination, and written decisions" were necessary "to bring allegedly fraudulent eligibility attestations to an IDRE's attention" and emphasizing such procedures would be "inconsistent with the NSA's creation of a streamlined IDR process").

HCSC's remaining objections do not change the analysis. Nothing in the NSA requires an IDRE to issue a "reasoned opinion on eligibility." *See* Resp. at 17.[14] And the supposed "honor system" narrative is beside the point. *See id.* at 2, 17. Even if eligibility were some kind of "honor

[13] *See* Ex. E, March 2023 Departmental Guidance, at 40–43 (showing that the IDRE must first determine that the dispute is eligible for the IDR process before proceeding to the final payment determination); *see* Ex. F, Supplemental Background on IDR, at 3 ("For all disputes, the certified IDR entity must confirm dispute eligibility before the dispute can proceed.").

[14] This is another policy grievance that HCSC dresses-up using tort labels. BCBSA likewise has urged CMS to require written eligibility determinations. *See* Ex. D, BCBSA Letter, Recommendation # 16, at 9–10.

system" (it is not), the non-initiating party "must" submit objections and supporting information if it believes the IDR process does not apply. 45 C.F.R. § 149.510(c)(1)(iii). Departmental guidance likewise confirms that IDREs must consider the parties' competing information when making eligibility determinations.[15] Finally, Departmental reports confirm that IDREs spend "considerable time and resources" analyzing eligibility and do determine certain disputes are ineligible.[16]

2. The NSA's Finality Interests Confirm Preclusion.

Federal interests strongly support applying collateral estoppel in this context. *See* Mot. at 17. The NSA is built for speed and finality. Letting payors relitigate IDR eligibility in follow-on tort suits would gut that design. It would invite courts to reopen past determinations and police future ones, dispute-by-dispute, in the very form Congress avoided. *See supra* Section II(A).

HCSC's response tries to turn this Motion into something it is not. *See* Resp. at 18. Zotec is not arguing that federal interests "override the elements of collateral estoppel[,]" and Zotec does not cite *Grimes* for that proposition. *See id.*; Mot. at 17. The point is simpler. The elements are satisfied on HCSC's own allegations, and the federal interests embedded in the NSA confirm that preclusion is appropriate once those elements are met. Mot. at 17 (citing *Grimes v. BNSF Ry. Co.*, 746 F.3d 184, 188 (5th Cir. 2014)).

3. Preclusion Can Be Resolved on the Pleadings.

HCSC says collateral estoppel is off-limits on a motion to dismiss. *See* Resp. at 16. That is not the rule. Courts can address preclusion at the pleading stage when the complaint itself supplies the necessary facts. *See Stevens v. St. Tammany Parish Gov't*, 17 F.4th 563, 570–71 (5th Cir. 2021)

[15] Ex. E, March 2023 Departmental Guidance, at 16 ("The certified IDR entity must review the information submitted in the Notice of IDR Initiation and the notification from the non-initiating party claiming the Federal IDR Process is inapplicable, if one has been submitted, to determine whether the Federal IDR Process applies." (emphasis omitted)).
[16] Ex. F, Supplemental Background on IDR, at 3.

(recognizing that dismissal under Rule 12(b)(6) on *res judicata* grounds is appropriate when the elements appear on the face of the complaint) (collecting cases).

This is that case. The FAC alleges the sequence needed to tee-up preclusion now. HCSC alleges it raised eligibility objections, the IDREs proceeded, and IDR determinations issued anyway. Those are not disputed facts that require discovery. They are HCSC's story. Because the elements of collateral estoppel are apparent from the pleadings, the Court can and should resolve the issue at the threshold.

C. HCSC Lacks Article III Standing.

Standing is not a pleading technicality. It is the Court's gatekeeper. HCSC's alleged injuries arise only after independent IDRE decisions, which breaks traceability. And the relief HCSC wants would require this Court to unwind or police those same determinations, which defeats redressability. Article III ends the case here.

1. No Traceability.

Traceability is HCSC's first Article III problem. The FAC does not allege a straight line from Zotec's alleged conduct to HCSC's alleged injury. It alleges a tribunal-driven process in which certified IDREs make independent eligibility and payment decisions. Those intervening decisions break traceability. *See* Mot. at 14–15. HCSC's criticism of Zotec's reliance on *Benchellal* also misses the point. *See* Resp. at 15. Zotec cites *Benchellal* for the governing principle, not its fact pattern.[17]

HCSC tries to salvage traceability by invoking indirect causation, multiple contributing causes, and predictable events. *See* Resp. at 13–15.[18] But Article III still requires a non-speculative

[17] *See* Mot. at 14 (citing *Benchellal v. Okonite Co., Inc.*, No. 4:22-CV-4435, 2024 WL 1057475, at *5 (S.D. Tex. Mar. 11, 2024) (collecting cases)).

[18] Each of the cases HCSC cites for support are factually distinguishable and fail to support HCSC's traceability argument. *See, e.g.*, *Est. of Parker v. Miss. Dep't of Pub. Safety*, 140 F.4th 226, 237 (5th Cir. 2025) (finding traceability

causal chain. *Lujan v. Defenders of Wildlife*, 504 U.S. 555, 560–61 (1992). And while indirect effects can sometimes suffice, that principle does not extend to harms that hinge on the independent action of decisionmakers exercising independent judgment. *See id.* at 560–62; *see also Dep't of Comm.*, 588 U.S. at 768 (finding traceability where the challenged action had a "predictable effect" on third-party conduct that was supported by empirical evidence, not "mere speculation").

That is exactly what defeats traceability here. The FAC's alleged injuries arise only if IDREs made eligibility determinations and issued awards. Those determinations are discretionary and evaluative, not mechanical. IDREs are certified neutrals who must weigh competing submissions and apply governing criteria before deciding eligibility and issuing determinations. *See* 42 U.S.C. § 300gg-111(c)(5); 45 C.F.R. § 149.510(a)(2)(xi); Ex. E, March 2023 Departmental Guidance, at 16. HCSC's argument using the predictable outcome framing is therefore untenable, and it conflicts with Departmental guidance and reports describing the complexity of eligibility determinations and confirming the IDREs do find disputes ineligible. *See* Resp. at 13–15; Ex. F, Supplemental Background on IDR, at 3.

2. No Redressability.

Redressability is missing for a simple reason. HCSC's theory depends on outcomes the Court cannot deliver through a judgment against Zotec. HCSC argues that damages or an injunction would "lessen" its injury. *See* Resp. at 16. But redressability still requires a non-speculative showing that the requested relief is ***likely*** to remedy the alleged injury at least in part; relief need not "completely cure" the injury, but it must do more than provide no remedy at all.

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where defendants allegedly participated in the same use-of-force event or failed to intervene, such that the injury was "not merely 'the result of the independent action' of [another officer]"); *Dep't of Comm. v. New York*, 588 U.S. 752, 767–68 (2019) (finding traceability based on evidence that government action would predictably alter third-party behavior in a consistent, empirically supported way); *Wieland v. U.S. Dep't of Health & Hum. Servs.*, 793 F.3d 949, 954–57 (8th Cir. 2015) (finding traceability where challenged government action had a "determinative or coercive effect" on a third party's conduct rather than leaving independent judgment).

See Inclusive Cmtys. Project, Inc. v. Dep't of Treasury, 946 F.3d 649, 655 (5th Cir. 2019) ("But relief that does not remedy the injury suffered cannot bootstrap a plaintiff into federal court." (citation modified)). HCSC never bridges that gap. It assumes this Court can reduce its claimed injury even though the alleged harm flows from participation in a statutory IDR process run by independent IDREs.

Start with damages. HCSC's alleged injuries are process costs: administrative fees, IDRE fees, and overhead tied to participating in IDR. An award of damages against Zotec would not eliminate those costs or change HCSC's statutory obligation to participate when disputes are initiated. It would simply transfer money after the fact. That is not redressability.

An injunction fares no better. Even if the Court entered the forward-looking injunction HCSC seeks, HCSC would still be pulled into IDR, still incur the same process costs, and still face eligibility and payment determinations made by certified neutral IDREs applying federal criteria. Any reduction in HCSC's alleged harm would therefore turn on how those independent actors apply the scheme in future disputes. That kind of contingent chain is not "likely" redressability. Where redressability "depends on the unfettered choices made by independent actors not before the courts[,]" it is "substantially more difficult" to establish and requires non-speculative facts showing that those actors will likely act in a way that redresses the injury. *Lujan*, 504 U.S. at 562 (citation modified).[19] HCSC pleads no such facts here.

The practical implications confirm the same point. HCSC's real ask is award nullification by another name. But a judgment against Zotec cannot alter the legal effect of binding IDR

[19] HCSC's reliance on *Hancock County* is misplaced. *See* Resp. at 15. There, the requested relief would have directly remedied the plaintiffs' "one, person, one vote" injuries by replacing an unlawful election scheme with a lawful one. *See Hancock Cnty. Bd. of Sup'rs v. Ruhr*, 487 F. App'x 189, 196–97 (5th Cir. 2012). Here, by contrast, neither damages nor an injunction would directly alter the statutory process or the decisions that allegedly caused HCSC's injury. Because any supposed benefit remains contingent and speculative, redressability is lacking.

determinations, and any attempt to unwind them would necessarily impair payment rights held by non-party clinicians. *See infra* Section II(D). And the only way to police HCSC's requested prospective relief would be to pull the Court into ongoing supervision of IDR submissions and eligibility disputes, a role the NSA does not assign to the courts.

D. Rule 19 Requires Dismissal Because HCSC Seeks Award-Nullifying Relief Without the Award Holders.

HCSC seeks declarations that IDR awards are "not binding" and injunctions preventing their enforcement. *See* FAC ¶ 216. That relief would not operate in the abstract. It would strip clinicians of payment rights created by awards entered in their favor. Those clinicians are therefore required parties. HCSC all but concedes the point. *See* Resp. at. 18.

HCSC's attempt to avoid Rule 19(a)(1)(B) fails. *See* Resp. at 20. It tries to duck the Rule by suggesting that the clinicians have not claimed an interest. *Id.* But Rule 19 does not turn on formal appearances. It turns on consequences. It asks whether a judgment would impair a nonparty's protected interests. *See Pulitzer-Polster v. Pulitzer*, 784 F.2d 1305, 1308 (5th Cir. 1986). That standard is easily met when a plaintiff seeks to nullify awards and eliminate clinicians' payment rights in a case where the clinicians are nowhere to be found. *See* Mot. at 18–19.

HCSC's own pleading makes the Rule 19 problem worse. It alleges a sweeping scheme across "thousands" of IDR disputes, but it identifies only a few examples. *See* FAC ¶¶ 4, 81–133, 139–43, 153. So most award holders are not even identifiable from the FAC, much less positioned to intervene to protect their interests. That is not an accident. It is a consequence of how HCSC chose to plead this case.

Even if joinder is infeasible, Rule 19(b) points to dismissal, not a court-run substitute for the NSA's dispute resolution process *See* Fed. R. Civ. P. 19(b). The Court cannot assess prejudice or shape relief where the relevant awards and parties are not identified, and any judgment would

risk prejudice and inconsistent outcomes. That is precisely what Rule 19 is designed to prevent.

E. HCSC's Allegations Still Fail Rule 8 and Rule 9(b).[20]

Rule 9(b) is a particulars rule. HCSC offers scale and labels instead. It alleges fraud across thousands of IDR disputes, pleads only a handful of examples, and then asks the Court to infer a system-wide "scheme" across an undefined universe of disputes. *See* Resp. at 23; *see generally* FAC. That is not pleading fraud with particularity; it is pleading by atmosphere.

The same defect sinks the FAC under Rule 8. HCSC does not allege facts that make fraud more plausible than what the FAC itself describes: an adversarial, tribunal-driven process where parties submit competing views and IDREs decide eligibility and payment. *See generally* FAC.

HCSC's "representative examples" theory does not fix either problem. The cases HCSC cites require more than a few anecdotes.[21] In each case, the plaintiff relied on representative examples, but it also identified the full universe of transactions at issue. *SC Shine*, 2023 WL 4216989, at *20; *El Paso*, 766 F. Supp. 3d at 707–08. HCSC does the opposite. It pleads "thousands" but never identifies which disputes are actually in this case. *See* FAC ¶¶ 4, 133. That is insufficient under Rule 9(b). *See HaloMD – CA*, 2026 WL at 982629, *9 n.5 (finding the plaintiffs' allegations failed to meet Rule 9(b)'s particularity requirement because they lacked specificity "as to every challenged IDR determination").

F. Petitioning Immunities and Privileges Independently Bar HCSC's Claims.

HCSC is trying to turn losing positions in a federal adjudicatory program into tort damages. That framing runs headlong into two independent protections. *Noerr-Pennington* blocks liability for petitioning, and Texas law separately bars tort claims based on advocacy in quasi-judicial

[20] Zotec incorporates and stands on its arguments that, at a minimum, HCSC should be required to provide a more definite statement identifying the specific IDR disputes at issue and that immaterial and prejudicial allegations should be stricken. *See* Mot. at 37–42. For purposes of efficiency, Zotec does not repeat those arguments here.

[21] *See* Resp. at 23 (citing *El Paso Disposal, LP v. Ecube Labs Co.*, 766 F. Supp. 3d 692, 708 (W.D. Tex. 2025); *SC Shine PLLC v. Aetna Dental, Inc.*, No. SA-22-CV-0834, 2023 WL 4216989, at *20 (W.D. Tex. June 26, 2023)).

proceedings.

1. *Noerr-Pennington* Bars Tort Liability for IDR Petitioning.

HCSC's tort claims target one thing: advocacy in the federal IDR process. That is petitioning. *See* Resp. at 25. *Noerr-Pennington* exists to stop exactly what HCSC is trying to do here, turning positions taken in an adjudicatory forum into after-the-fact tort liability whenever the other side loses.

HCSC tries to avoid *Noerr-Pennington* by calling IDR "private." *See* Resp. at 25. That label does not fit. The IDR process is not a private commercial arbitration the parties voluntarily created. It is a congressionally mandated, agency-supervised adjudicatory program in which certified IDREs apply federal standards and issue determinations that federal law makes binding. *See* 42 U.S.C. § 300gg-111 *et seq*. Submitting disputes, making eligibility attestations, and presenting positions to obtain a determination are efforts to secure governmental action in a government-created forum. That is petitioning activity. *See* Mot. at 23–25.

In re Morrison does not help HCSC.[22] *In re Morrison* declined to extend *Noerr-Pennington* to a purely private arbitration scheme. *In re Morrison*, 2009 WL 1856064, at *3 (emphasizing that the doctrine does not extend to "private adjudications carried out before a privately selected arbitrator rather than . . . a governmental entity"). That distinction cuts against HCSC. IDR is the opposite of *In re Morrison*'s "private adjudication." IDREs operate only by federal certification, under federal rules, within a federally administered process. *See* 42 U.S.C. § 300gg-111 *et seq*.

HCSC's fallback on the sham exception fares no better. *See* Resp. at 26–27. The sham exception is not a pleading shortcut. It is a narrow exception with a high bar. It requires a threshold showing that the challenged petitioning is "objectively baseless" before intent is even relevant.

[22] *See* Resp. at 25 (citing *In re Morrison*, No. 05-45926, 2009 WL 1856064, at *3 (Bankr. S.D. Tex. June 26, 2009)).

Prof'l Real Estate Inv'rs, Inc. v. Columbia Pictures Indus., Inc., 508 U.S. 49, 60–61 (1993). And the Fifth Circuit has not adopted a free-floating fraud exception. *See Constr. Cost Data, L.L.C. v. Gordian Grp., Inc.*, 814 F. App'x 860, 868 n.27 (5th Cir. 2020) ("Because the evidence of the Defendants' 'alleged fraud' was properly excluded, we need not decide whether misrepresentations and false statements can be immunized under the *Noerr-Pennington* doctrine.").

HCSC cannot plausibly plead objective baselessness here. It alleges that disputes proceeded through the federal IDR process, both sides submitted information and objections, and certified IDREs evaluated those submissions and issued determinations. *See generally* FAC. That is not objectively baseless petitioning. It is participation in an adversarial process that produced adjudicatory outcomes. And because the sham exception fails on the face of the pleadings, it can be resolved now. *See, e.g.*, *Tricon Precast, Ltd. v. Easi Set Indus., Inc.*, 395 F. Supp. 3d 871, 883–86 (S.D. Tex. 2019) (dismissing claims where alleged petitioning activity was not plausibly a sham).

2. Texas Absolute Privilege Bars Claims Based on IDR Submissions.

Texas law supplies a second, independent bar. Statements made during the course of a judicial or quasi-judicial proceeding are "absolutely privileged." *Wal-Mart Stores, Inc. v. Lane*, 31 S.W.3d 282, 290 (Tex. Ct. App. 2000). HCSC is suing over IDR submissions and eligibility positions made to obtain IDR determinations. *See generally* FAC. That is exactly the kind of advocacy the privilege protects. *See* Mot. at 25–26.

HCSC tries to turn the privilege into a checklist and then argue IDR doesn't count. *See* Resp. at 27–28. That framing is wrong. The factors listed in *Hernandez* are guideposts, not rigid elements, and courts do not require each one to be met. *Hernandez v. Hayes*, 931 S.W.2d 648, 651–52 (Tex. App. 1996). Properly applied, the factors point the same way here. IDREs resolve

contested disputes under governing standards and issue binding determinations that directly affect the parties' payment rights and obligations. *See* Mot. at 25–26. That is a quasi-judicial function in every practical sense.

Nor do HCSC's cases support its position. *See* Resp. at 27–28. In *Consultants in Pain Medicine, PLLC v. Ellen Boyle Duncan, PLLC*, the court declined to apply quasi-judicial immunity because the CMS contractor lacked authority to issue binding decisions or adjudicate private rights. 690 S.W.3d 739, 762–64 (Tex. Ct. App. 2024). Here, IDREs do both. Federal IDR is designed to culminate in a binding determination, and the IDRE's decision is the event that fixes the payment obligation the statute imposes.

HCSC also misreads *Shell Oil Co. v. Writt*, 464 S.W.3d 650 (Tex. 2015). *See* Resp. at 28. *Shell* recognizes quasi-judicial proceedings as a separate and independent category to which the privilege applies. *Shell*, 464 S.W.3d at 655. The public benefit language HCSC invokes is not a requirement that swallows the quasi-judicial rule. It describes an additional, limited set of circumstances where the privilege may extend beyond judicial and quasi-judicial proceedings. *Id*. When the proceeding is quasi-judicial, the privilege attaches because the law protects the process from collateral tort litigation, not because the plaintiff can relabel advocacy as supposed misrepresentation.

At bottom, if HCSC's theory were viable, every contested submission in IDR would become tort exposure whenever the plan loses. Texas privilege doctrine exists to prevent that result. HCSC's claims should be dismissed on this independent basis.

G. Each of HCSC's Claims Still Fail as a Matter of Law.

1. Count I Fails For Lack of Reliance, Causation, or Damages.

HCSC's response does not fix the basics. The fraud claim still fails on reliance, causation, and damages.

First, HCSC does not plead actual and justifiable reliance.[23] *See* Mot. at 27–28. It alleges that it knew Zotec's eligibility positions were wrong, objected in the IDR process, and urged the IDREs to reject them. FAC ¶¶ 75, 115, 126–128. In other words, HCSC pleads contemporaneous knowledge and objection. That defeats any plausible reliance theory. *Cf. HaloMD – CA*, 2026 WL 982629, at *8 (explaining Anthem "pleaded itself out of court" on fraud-based vacatur because the alleged fraud was known during IDR and disclosed to the IDRE). HCSC's attempt to salvage its claims by saying it objected to "some but not all" disputes changes nothing. *See* Resp. at 28. Silence in a mandatory, tribunal-run process is not reliance on an adversary's position.[24] Even in the narrow FAA vacatur lane, fraud is not a backdoor do-over when the alleged problem was knowable during the proceeding. *See Radiology Partners*, 2026 U.S. Dist. LEXIS 84866, at *7–9 (rejecting FAA vacatur theory where the payor's own allegations showed it knew the core conduct prior to and during IDR and therefore could not satisfy due-diligence requirements).

Second, HCSC's "forced reliance" theory collapses on contact. *See* Resp. at 28–29. Mandatory participation is not reliance. A statute can require a party to appear; that does not turn disputed advocacy into an actionable representation one supposedly accepted as true. And *In re Mounce* does not supply a back door for collateral tort suits to unwind binding adjudicative outcomes entered through a statutory process. *See* Resp. at 29 (citing *In re Mounce*, 390 B.R. 233, 255 & n.27 (Bankr. W.D. Tex. 2008)).

Third, causation is too attenuated to be plausible. Even taking the FAC at face value, HCSC's alleged injuries arise only after IDREs make eligibility and payment decisions. That

[23] HCSC's point that the IDREs and the Departments allegedly relied on Zotec's misrepresentations misses the mark. *See* Resp. at 29. None of the authorities it cites dispense with the foundational requirement that HCSC, as the plaintiff, must plead actual and justifiable reliance. Here, HCSC specifically alleges that it actively objected to eligibility. That forecloses reliance.

[24] To the extent HCSC blames its failure to object on Zotec's batching of claims, a practice that the NSA expressly permits, Zotec would note that HCSC, which operates one of the largest insurance companies in the United States, could undoubtedly garner the resources to object in a timely manner if it wished to do so.

breaks the chain. HCSC's own authorities underscore the point.[25] Texas law requires that the complained-of conduct be a "substantial factor in causing the injury" and rejects theories built on "mere conjecture, guess, or speculation[,]" including those that depend on stacking multiple inferences. *Marathon*, 106 S.W.3d at 727–29; *see also In re Enron*, 623 F. Supp. 2d at 811–12, 830 n.29 (reinforcing that something more than "mere conjecture, guess, or speculation" is required). HCSC's theory does exactly that. Its theory is based on contingency piled on contingency: Zotec's submissions lead to IDR initiation, which leads to IDRE consideration, which leads to eligibility and payment determinations, which then produce alleged losses. And, its alleged injuries arise only after IDREs make independent eligibility and payment determinations. That is not a plausible causal mechanism. It is a guess about what other neutral decisionmakers would have done in thousands of dispute-specific proceedings.

Finally, HCSC's damages argument misses the point. *See* Resp. at 30. The defect is not that HCSC fails to plead a sum certain. The defect is that it does not tie any specific loss to any specific actionable misrepresentation. *See* Mot. at 28–29. Without dispute-level linkage, Count I still does not state a claim.

2. Count II Fails for the Same Reasons HCSC's Fraud Claim Fails.

Count II falls with Count I. HCSC still cannot plead justifiable reliance or a plausible causal link to its alleged losses. *See supra* Section II(G)(1). Begin with reliance. HCSC pleads that it disputed eligibility in real time and presented contrary information to the IDREs. FAC ¶¶ 75, 115, 126–128. That is the opposite of relying on Zotec's statements. And it defeats negligent misrepresentation for the same reason it defeats fraud. *See supra* Section II(G)(1). Causation fails for the same structural reason. HCSC's theory still depends on independent IDRE decisions

[25] *See* Resp. at 29–30 (citing *Marathon Corp. v. Pitzner*, 106 S.W.3d 724, 727 (Tex. 2003) and *In re Enron Corp. Sec., Derivative & ERISA Litig.*, 623 F. Supp. 2d 798, 812 (S.D. Tex. 2009)).

applying a federal statutory scheme. Those intervening determinations break any plausible "because of" link between Zotec's alleged statements and HCSC's claimed injuries. *See supra* Section II(G)(1).

HCSC's attempt to narrow the adversarial-setting principle is also wrong. *See* Resp. at 29–31. Although the cases HCSC cites arise in the context of opposing counsel, they do not limit the principle to that context.[26] Instead, in finding no justifiable reliance as a matter of law, the courts' analysis turned on the adversarial nature of the relationship between the parties, not the role of the speaker. *Valls*, 314 S.W.3d at 635–36 (focusing on the adversarial nature of the relationship in finding no justifiable reliance); *Mitchell*, 10 S.W.3d at 811–12 (same); *Ortiz*, 203 S.W.3d at 422 (same). IDR is exactly that kind of setting. It is a formal, adversarial dispute resolution process with opposing submissions presented to a neutral decisionmaker. In that forum, parties are expected to contest each other's positions, not accept them as guidance.

HCSC's reliance on *Ed & F Man Biofuels* and *IP Investments* does not save its claims.[27] At most, those cases reject a categorical rule that adversarial context alone always defeats reliance. They do not suggest reliance is reasonable where the alleged statements are made as contested advocacy in a statutorily governed adjudication before neutral decision makers. And both recognize that the presence of additional factors, when paired with an adversarial context, may negate reliance as a matter of law. *IP Invs.*, 2014 WL 991819, at *5–6; *Ed & F Man*, 728 F. Supp. 2d at 882. That is the case here. The alleged statements were made in a formal, statutorily governed dispute-resolution process involving opposing parties and neutral adjudicators charged with evaluating competing submissions. In that setting, the parties are not expected to rely on each

[26] *See* Resp. at 31 (citing *Valls v. Johanson & Fairless, L.L.P.*, 314 S.W.3d 624, 635 (Tex. Ct. App. 2010); *Mitchell v. Chapman*, 10 S.W.3d 810, 811– 12 (Tex. Ct. App. 2000); *Ortiz v. Collins*, 203 S.W.3d 414, 422 (Tex. Ct. App. 2006)).
[27] *See* Resp. at 31 (citing *Ed & F Man Biofuels Ltd. v. MV FASE*, 728 F. Supp. 2d 862, 882 (S.D. Tex. 2010) and *IP Invs., LLC v. Velsicol Chem., LLC*, No. H-13-629, 2014 WL 991819, at *6 (S.D. Tex. Mar. 13, 2014)).

other's representations; they are expected to contest them. Nothing in *Ed & F Man* or *IP Investments* suggests that reliance is reasonable in that kind of adjudicative process. Count II should be dismissed.

3. Count III Fails Because HCSC Does Not Plead a Contract it was Induced to Sign.

Count III still fails at the threshold. Fraudulent inducement requires a misrepresentation that induces the plaintiff to enter a contract. *Anderson v. Durant*, 550 S.W.3d 605, 614 (Tex. 2018). It "arises only in the context of a contract," making "the existence of a contract [] an essential part of its proof." *Id*. Again, HCSC does not plead that contract, nor does HCSC identify one in its FAC. *See* Mot. at 31; *see generally* FAC. The conduct HCSC challenges is participation in a statutory dispute resolution process, not contract formation between HCSC and Zotec. *Id*.

HCSC gestures at settlements Zotec allegedly caused it to enter on ineligible IDR awards to bridge that gap. *See* Resp. at 32. This does not save its claim. Setting the privity issue aside,[28] the FAC does not allege any specific settlement agreements that it entered in reliance on Zotec's alleged misrepresentations. *See generally* FAC. That is fatal. And, even if HCSC had alleged specific settlement agreements, HCSC's allegations still fail to plead inducement. *See* Mot. at 31. Without allegations tying a specific misrepresentation to a specific agreement, HCSC's fraudulent inducement claim fails. *See id*.

4. Count IV Fails Because HCSC Does Not Plead that Zotec Holds HCSC's Money.

Count IV is not a free-floating fairness claim. It requires HCSC to plead that Zotec "holds

[28] HCSC argues that it is irrelevant that Zotec was not in privity to the alleged settlement agreements. *See* Resp. at 32 (citing *Escopeta Oil & Gas Corp. v. Songa Mgmt., Inc.*, No. 1:06-cv-386, 2007 WL 171721, at *7 (E.D. Tex. Jan. 17, 2007)). HCSC's reliance on *Escopeta* is misplaced. There, the alleged misrepresentations were made directly by the defendant (through its officer) to the plaintiff while negotiating the very contract at issue and were allegedly intended to induce that specific agreement. *See Escopeta*, 2007 WL 171721, at *1–2. Here, the FAC does not identify any specific settlement agreement or allege Zotec negotiated, formed, or made representations to induce an agreement.

money which in equity and good conscience belongs to [HCSC]." *MGA Ins. Co. v. Charles R. Chestnutt, P.C.*, 358 S.W.3d 808, 814 (Tex. Ct. App. 2012). And it is "not premised on wrongdoing[.]" *Id*. at 813.

HCSC does not plead the required position. It pleads an attenuated chain: HCSC paid clinicians, and clinicians paid "some portion" to Zotec. FAC ¶¶ 211–12. That is speculation dressed up as equity. It does not allege that Zotec holds identifiable funds that belong to HCSC, or that Zotec received money from HCSC at all. *See MGA*, 358 S.W.3d at 813–14. HCSC's conclusory allegation that Zotec presumably received some "portion" of amounts awarded at IDR in exchange for its services does not satisfy Texas law and does not salvage Count IV. *See* Resp. at 32; FAC ¶¶ 212; Mot. at 31–32.

Count IV also fails because HCSC has an adequate remedy at law. *See* Mot. at 32. HCSC's reliance on *Official Stanford* is misplaced.[29] There, the court simply permitted alternative pleading where an adequate remedy at law was "possible, but not guaranteed." *Off. Standard*, 2014 WL 12572881, at *10. That case does not allow a plaintiff to repackage what is, in substance, a challenge to binding IDR determinations into an equitable claim.[30]

5. Count V Fails Because the Requested Relief Would Unwind Binding IDR Determinations and Require Ongoing Supervision.

HCSC's declaratory and injunctive relief claims fail for the same reason as its other claims: they depend on unwinding binding IDR determinations and would require ongoing judicial supervision of the IDR process. *See* Mot. at 33. Labeling the relief as "declaratory" or "injunctive" does not change that. Nor is HCSC's proposed injunction meaningfully distinct from an "obey-

[29] *See* Resp. at 33(citing *Off. Stanford Invs. Comm. v. Greenberg Traurig, LLP*, No. 3:12-CV-4641-N, 2014 WL 12572881, at *10 (N.D. Tex. Dec. 17, 2014)).

[30] As previously discussed, the NSA provides an administrative mechanism to reopen and correct alleged eligibility errors, and HCSC cannot bypass that framework by recasting dispute-specific challenges as an equitable claim. *See supra* Section II(A).

the-law" decree. *See* Resp. at 33. It would require the Court to decide, on an ongoing basis, whether particular attestations are "false" and disputes are "ineligible"—the very determinations the NSA assigns to IDREs and makes binding. *See HaloMD – CA*, 2026 WL 982629, at *10.

H. Personal Jurisdiction and Venue Still Remain Independently Defective.

1. No Personal Jurisdiction.

HCSC's theory improperly equates Texas-centered claims with Texas-directed conduct. *See* Resp. at 34–36. That is not the law. *See* Mot. at 35–36. Specific jurisdiction requires that the defendant itself create suit-related contacts with the forum, not that the underlying dispute happens to involve Texas providers, patients, or claims. *See Walden v. Fiore*, 571 U.S. 277, 284–86 (2014). HCSC relies on alleged effects in Texas, not conduct that Zotec specifically directed at Texas.

2. Venue is Improper.

HCSC's venue theory suffers from the same flaw as its jurisdictional argument. It substitutes Texas-centered background facts for the location of the operative conduct. *See* Resp. at 36–37. That is not enough. *See* Mot. at 36–37. Venue turns on where "a substantial part of the events or omissions giving rise to the claim occurred," and the focus is on where the defendant's actions took place. *Bigham v. Envirocare of Utah, Inc.*, 123 F. Supp. 2d 1046, 1047–48 (S.D. Tex. 2000) (quoting 28 U.S.C. § 1391(b)(2)). Here, HCSC points to where the underlying healthcare services occurred and the fact that HCSC administers plans for members across this District, not where the alleged misrepresentations giving rise to its claims occurred.

III. CONCLUSION

WHEREFORE, the Court should grant Zotec's Motion and dismiss the FAC in its entirety with prejudice. Alternatively, the Court should order HCSC to replead and provide a more definite statement and partially strike the FAC.

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Dated the 24th day of April 2026.

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EXHIBIT A

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v.
HALOMD LLC, et al., Defendants.

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|
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MEMORANDUM OPINION AND ORDER

KAREN E. SCOTT United States Magistrate Judge

I.

INTRODUCTION

***1** In July 2025, Anthem Blue Cross Life and Health Insurance Company and Blue Cross of California d/b/a Anthem Blue Cross ("Plaintiffs" or "Anthem") filed this civil lawsuit. (Dkt. 1.) The operative First Amended Complaint ("FAC" at Dkt. 50) names the following Defendants:

(1) HaloMD, LLC ("HaloMD") and its president, Alla LaRoque (collectively, the "HaloMD Defendants");

(2) MPOWERHealth Practice Management, LLC and its CEO, Scott LaRoque (collectively, the "MPOWERHealth Defendants");

(3) Bruin Neurophysiology, P.C.; iNeurology, PC; N Express, PC; and North American Neurological Associates, PC (collectively, the "LaRoque Family Providers");

(4) Sound Physicians Emergency Medicine of Southern California, P.C. and Sound Physicians Anesthesiology of California, P.C. (collectively, the "Sound Physicians Providers").

(FAC at 2.)

Plaintiffs' claims arise out of the mandatory, independent dispute resolution ("IDR") process to resolve certain types of billing disputes between health plans and out-of-network providers established by the federal No Suprises Act ("NSA"). The FAC provides this overview of the NSA's IDR process:

> [T]he NSA created a separate framework outside the judicial process

> for health plans and providers to resolve specific types of eligible surprise billing disputes. See 42 U.S.C. § 300gg-111(c). The framework consists of (1) open negotiations—a required 30-business-day period to try resolving the dispute informally; (2) an IDR process for "qualified IDR items and services" if no agreement is reached; and (3) if applicable, a payment determination from private parties called certified IDR entities ("IDREs").

(FAC at 12, ¶ 43.)

Most of the Defendants are healthcare providers. HaloMD "initiates and administers IDR proceedings on behalf of healthcare providers" like the other Defendants. (Id. at 4, ¶ 6.)

The FAC asserts the following federal claims:

Count One: Violations of the Racketeering Influenced and Corruption Organizations Act ("RICO"), 18 U.S.C. § 1962(d), against the LaRoque Family Providers, the HaloMD Defendants, and the MPOWERHealth Defendants (alleged to be the "LaRoque Family Enterprise"), based on allegations that these Defendants engaged in mail and wire fraud, or conspired in such fraud, by submitting billing disputes to the IDR process that they knew were ineligible, accompanied by false attestations of eligibility. (Id. at 3, ¶ 3; id. at 24, ¶ 93.)

Count Two: Similar violations of RICO, 18 U.S.C. § 1962(d), against the Sound Physicians Providers and HaloMD (alleged to be the "Sound Physicians Enterprise").

Count Three: Similar violations of RICO, 18 U.S.C. § 1962(c), against the LaRoque Family Enterprise.

Count Four: Similar violations of RICO, 18 U.S.C. § 1962(c), against the Sound Physicians Enterprise.

Count Eleven: Vacatur of IDR determinations under the NSA, 42 U.S.C. § 300gg-111(c)(5)(E), against all Defendants.

Count Twelve: Equitable relief under the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. § 1132(a)(3).

***2** Count Thirteen: Declaratory and injunctive relief.

The FAC asserts the following state law claims:

Count Five: Fraudulent misrepresentation against all members of the LaRoque Family Enterprise.

Count Six: Fraudulent misrepresentation against all members of the Sound Physicians Enterprise.

Count Seven: Negligent misrepresentation against all members of the LaRoque Family Enterprise.

Count Eight: Negligent misrepresentation against all members of the Sound Physicians Enterprise.

Count Nine: Violations of the Unfair Competition Law ("UCL") at California Business & Professions Code §§ 17200 et seq. against all members of the LaRoque Family Enterprise.

Count Ten: Violations of the UCL against all members of the Sound Physicians Enterprise.

Defendants responded to the FAC by filing the following motions:

> Dkt. 69 72 73 76 77 68 78 74 Motion Motion to Dismiss FRCP 12(b)(1) & (6) Motion to Dismiss FRCP 12(b)(2) Motion to Dismiss FRCP 12(b)(6) Motion to Dismiss FRCP 12(b)(1), (2) & (6) Motion to Dismiss FRCP 12(b)(1), (2) & (6) Special Motion to Strike (Anti-SLAPP) Special Motion to Strike (Anti-SLAPP) Joinder in Dkt. 68 & 78 Movants Sound Physicians Providers MPOWERHealth Practice Management, LLC MPOWERHealth Practice Management, LLC and LaRoque Family Providers HaloMD Alla & Scott Laroque Sound Physicians Providers HaloMD Defendants MPOWERHealth Practice Management, LLC and LaRoque Family Providers Briefs [1] Oppo: 93 Reply: 117 Oppo: 93 Reply: 123 Oppo: 93 Reply: 124 Oppo: 93 Reply: 120

Oppo: 93 Reply: 121 Oppo: 92 Reply: 118 Oppo: 92 Reply: 122 See above

On March 10, 2026, the Court held oral argument. (Dkt. 127 (minutes); Dkt. 132 (hearing transcript); Dkt. 134 (presentation decks).) For reasons explained in detail below, the Court:

(1) GRANTS, without leave to amend, the motions to dismiss brought under Federal Rule of Civil Procedure 12(b)(6) challenging Count Eleven for vacatur (Dkt. 69, 73, 76, 77), because the facts alleged in the FAC establish no authorized basis for the district court to vacate any IDR determinations;

(2) GRANTS, without leave to amend, the motions to dismiss brought under Federal Rule of Civil Procedure 12(b)(1) asserting lack of subject matter jurisdiction over the remaining federal claims (Dkt. 69, 76, 77) because, aside from vacatur authorized by 42 U.S.C. § 300gg111(c)(5)(E)(i)(II), the NSA precludes judicial review of IDR determinations, regardless of the legal theory under which judicial review is sought;

(3) DECLINES to exercise supplemental jurisdiction over the FAC's state law claims and DISMISSES them without prejudice (see 28 U.S.C. § 1367(c)); and

(4) DENIES, without prejudice, the anti-SLAPP motions to strike the state law claims (Dkt. 68, 74, 78) as moot because the Court dismissed the state law claims rather than exercising supplemental jurisdiction.

II.

SUMMARY OF THE FAC'S FACTUAL ALLEGATIONS

A. The NSA's IDR Process.

"Effective January 1, 2022, the NSA banned surprise billing for three categories of out-of-network care: (1) emergency services; (2) non-emergency services at in-network facilities; and (3) air ambulance services. See 42 U.S.C. §§ 300gg-131, 300gg-132, 300gg-135." (FAC at 12, ¶ 42.) When a health plan like Anthem receives a claim for out-of-network services subject to the NSA ..., the health plan is supposed to make "an initial payment or issue a notice of denial of payment within 30 days. See 42 U.S.C. § 300gg-111(a)(1)(C)(iv)(I)." (Id. ¶ 44.)

***3** "If the provider is dissatisfied with the initial payment, then the provider or its designee may initiate open negotiations with the health plan by providing formal written notice to the health plan within 30 business days of the initial payment or notice of denial. 42 U.S.C. § 300gg-111(c)(1)(A)." (Id. ¶ 45.) "After initiating open negotiations, the provider must attempt in good faith to negotiate a resolution with the health plan over the 30-business-day open negotiations period." (Id. at 12-13, ¶ 45.) "If the provider initiates and exhausts the 30-day open negotiations period, and 'the open negotiations ... do not result in a determination of an amount of payment for [the] item or service,' then the provider may initiate the IDR process. See 42 U.S.C. § 300gg-111(c)(1)(B); 45 C.F.R. § 149.510(b)(2)(i)." (Id. at 13, ¶ 46.) Providers must initiate the IDR process within four business days after exhausting the open negotiations period. (Id.)

"When initiating the IDR process, providers must, among other things, submit an attestation that the items and services in dispute are qualified IDR items or services within the scope of the IDR process." (Id. at 15, ¶ 53.) To be qualified, the following conditions must be met:

a. The underlying services are within the NSA's scope, meaning they are out-of-network emergency services, non-emergency services at participating facilities, or air ambulance services;

b. The services involve a patient with healthcare coverage through a group plan or health insurer subject to the NSA (e.g., not coverage through government programs like Medicare or Medicaid);

c. A state surprise billing law (referred to as a "specified state law" in the NSA) does not apply to the dispute;

d. The underlying services were covered by the patient's health benefit plan (i.e., payment was not denied);

e. The patient did not waive the NSA's balance billing protections;

f. The provider initiated and exhausted open negotiations;

g. The provider initiated the IDR process within 4 business days after the open negotiations period was exhausted; and

h. The provider has not had a previous IDR determination on the same services and against the same payor in the previous 90 calendar days.

(Id. at 13-14, ¶ 48 (citing 42 U.S.C. § 300gg-111(c)(1)(B); 45 C.F.R. § 149.510(a)(2)(xi), (b)(2)).)

Providers initiating the IDR process must do so "online through a federal 'IDR Portal.' " (Id. at 16, ¶ 54.) The initiating party must agree to certain terms and conditions, including a notice that they will need to submit an "[a]ttestation that qualified IDR items or services are within the scope of the Federal IDR process." (Id. ¶ 58.) "After agreeing to the terms and conditions, initiating parties must answer certain 'Qualification Questions' through an online form. If the answers to the Qualification Questions indicate that the dispute is not eligible for IDR, the form will provide an alert and prevent the initiating party from proceeding." (Id. at 17, ¶ 59.) "After successfully completing the Qualification Questions, the initiating party is asked to complete the Notice of IDR Initiation Form," which requires inputting "a variety of relevant information." (Id. at 18, ¶ 63.) At the end of this process, the initiating party must attest, via electronic signature, that the "item(s) and/or service(s) at issue are qualified item(s) and/or services(s) within the scope of the Federal IDR process." (Id. ¶ 64.)

A copy of the Notice of IDR Initiation is sent electronically to "the non-initiating party (i.e., the health plan), the IDRE, and the Departments."[2] (Id. ¶ 65.) "[T]he parties select, or HHS appoints, an IDRE. 42 U.S.C. § 300gg-111(c)(4)(F)." (Id. at 19-20, ¶ 72.) The IDRE is directed by regulation to " 'determine whether the Federal IDR process applies.' 45 C.F.R. § 149.510(c)(1)(v)." (Id. at 20, ¶ 73.) Guidance published by the government agencies that oversee the IDR process instruct non-initiating parties who believe that the IDR process does not apply how to submit relevant information through the portal. (Dkt. 76-5 at 18, § 5.5.[3]) The IDRE "must determine whether the Federal IDR Process is applicable." (Id.) IDREs can and do reject some disputes as ineligible for IDR. (FAC at 22, ¶ 80 (citing 42 U.S.C. § 300gg-111(c)(5)(F)).)

***4** "[I]f the IDRE determines the IDR process applies, then the IDRE proceeds to a payment determination. 42 U.S.C. § 300gg-111(c)(5)(A)." (Id. at 20, ¶ 74.) "IDR payment determinations resemble a baseball-style dispute resolution where the provider and health plan each submit an offer, and the IDRE selects one party's offer as the out-of-network rate. 42 U.S.C. § 300gg-111(c)(5)(B)." (Id. ¶ 75.) "An IDR determination for a 'qualified IDR item or service' is 'binding' unless there was 'a fraudulent claim or evidence of misrepresentation of facts presented to the IDR entity involved regarding such claim[.]' 42 U.S.C. § 300gg-111(c)(5)(E)(i)." (Id. at 21, ¶ 77.) There is, however, a "process for reopening disputes to correct errors" and rescind payment determinations, including errors in eligibility determinations. (Dkt. 76-8 at 2, 4.) Additionally, the government can revoke an IDRE's certification for submitting false data or exhibiting a "pattern or practice of noncompliance" with the applicable requirements. (Dkt. 76-6 at 37, § 12.)

"Parties to IDR proceedings are responsible for payment of two fees. First, both parties must pay a non-refundable administrative fee—currently $115—when the dispute is initiated. This fee is not recoverable even when the IDRE determines that the dispute does not qualify for IDR, or even when the initiating party later voluntarily withdraws the dispute. Second, both parties must pay an IDRE fee before the IDRE makes the payment determination. The IDRE fee is set by the specific IDRE and depends on the type of IDR submitted, but ranges from $200 to $1,173." (FAC at 21, ¶ 79.) The non-prevailing party is responsible for paying both its administrative fee and the whole IDRE fee. (Id. at 21-22, ¶ 79.)

B. Defendants' Alleged Wrongdoing.

Plaintiffs allege that Defendants use three "tactics" to turn the NSA's IDR process "into a vehicle for fraud." (Id. at 25, ¶ 94.) First, "Defendants manipulate the IDR process by strategically submitting massive numbers of open negotiations and IDR initiations—hundreds of which are patently ineligible for IDR—in an attempt to overwhelm the ability of health plans like Anthem to contest claims, confuse and swamp IDREs, and manipulate the IDR process." (Id. at 24, ¶ 93.) The NSA does not impose a numeric limit on IDR claims, but it does have batching rules. (Id. at 53, ¶ 226; Dkt. 76-5 at 22, § 6.1.3.)

Second, "Defendants capitalize on flaws in the IDR process by submitting—and often prevailing with—outrageous payment offers that they could never receive on the open market, including many that exceed the Provider Defendants'[4] own billed charges." (FAC at 24, ¶ 93.) As discussed above, the mandatory IDR process is a baseball-style arbitration where the IDRE must pick the

more reasonable number based on certain authorized considerations. (Id. at 20, ¶ 75.)

Third, "Defendants make repeated false statements, representations, and attestations of eligibility to Anthem, the IDREs, and the Departments" via the submission portal. (Id. at 24, ¶ 93.) Plaintiffs allege that between January 2024 and August 2025, Defendants initiated at least 1,500 IDR proceedings against Anthem consisting of more than 2,000 separate services. (Id. at 32-33, ¶ 127.) Plaintiffs "determined that approximately 47 percent of these disputes were ineligible for IDR ...." (Id. at 33, ¶ 128.) But in many of those cases, the IDREs found the claim eligibility despite Anthem's evidence, so "Defendants illicitly secured millions of dollars in improper IDR awards." (Id.) Plaintiffs allege that the IDREs routinely make errors in eligibility determinations because (1) they are only compensated when a dispute reaches a payment determination, and (2) they are overwhelmed by a "staggering volume of disputes" and "cannot complete fulsome reviews [of eligibility evidence] in the timeline provided by the NSA." (Id. at 22, ¶ 80; id. at 28, ¶¶ 105-06.)

***5** The FAC describes the following eleven IDR determinations as examples of outcomes that IDREs wrongly decided because of these tactics:

> 1 2 3 4 5 6 7 8 9 10 11 **No.** DISP-918898 DISP-1455557 DISP-1455555 DISP-2193991 DISP-2193967 DISP-945678 DISP-937342 DISP-932222 DISP-1289721 DISP-1568233 DISP-2639953 **Defendant** Bruin Neuro-physiology North American Neurological Associates ("NANA") NANA N Express N Express N Express iNeurology Sound Physicians Emergency Medicine of Southern California ("SPEMSC") SPEMSC SPEMSC Sound Physicians Anesthesiology of California **Ineligibility Reason** Plaintiff Anthem Blue Cross Life and Health Insurance Company ("ABCLH") "submitted an objection to eligibility asserting that Bruin had not filed its IDR proceeding within the required time." FAC at 44, ¶ 171. "Anthem Payment Disputes, on behalf of ABCLH, submitted an objection to eligibility" stating that NANA "failed to engage in the 30-business day open negotiation period." Id. at 44-45, ¶ 176. Same as above. Id. at 45-46, ¶ 181. Plaintiff Anthem Blue Cross ("ABC") "submitted an objection to eligibility" stating that the claim was "ineligible for IDR under the NSA because a state surprise billing law applies." Id. at 46-47, ¶ 187. Same as above. Id. at 47, ¶ 193. Same as above. Id. at 48, ¶ 199. ABC told HaloMD that the service was ineligible because it was "a service for which no plan benefits were payable in the first place," but HaloMD still initiated IDR. Id. at 49, ¶¶ 203-05. "The notice of open negotiation attached a spreadsheet with dozens of claims ...." Id. at 53, ¶ 226. The claims were for services "rendered to members of self-funded Anthem plans and non-Anthem plans in addition to the services rendered to a member of a fully insured Anthem plan." Id. at 54, ¶ 227. Plaintiffs objected to the IDR initiation, stating, "Batched services include multiple Membership types." Id. ¶ 228. ABC "submitted an objection to eligibility" stating that the claim was "ineligible for IDR under the NSA because it involved a Medicare/ Medicaid claim ...." Id. at 55, ¶ 234. ABCLH "submitted an objection to eligibility" stating that the claim was ineligible for IDR under the NSA because "a state surprise billing law applies." Id. at 56, ¶ 240. ABC "submitted an objection to eligibility" stating that the claim was ineligible for IDR under the NSA because "a state surprise billing law applies." Id. at 57, ¶ 247.

III.

DISCUSSION

A. Count Eleven: Vacatur.

1. Applicable Law.

The NSA's provision for baseball-style arbitration requires the IDRE to select one of the party's offers to resolve qualified IDR billing disputes, as follows:

> (5) Payment Determination
>
> (A) In general
>
> Not later than 30 days after the date of selection of the certified IDR entity with respect to a determination for a qualified IDR item or service, the certified IDR entity shall —
>
> (i) taking into account the considerations specified in subparagraph (C), select one of the offers submitted under subparagraph (B) to be the amount of payment for such item or service determined under this subsection for purposes of subsection (a)(1) or (b)(1), as applicable; and
>
> (ii) notify the provider or facility and the group health plan or health insurance issuer offering group or individual health insurance coverage party to such determination of the offer selected under clause (i).

***6** 42 U.S.C. § 300gg111(c)(5)(A).

The NSA limits judicial review of IDRE determinations, as follows:

> (E) Effects of determination
>
> (i) In general
>
> A determination of a certified IDR entity under subparagraph (A) —
>
> (I) shall be binding upon the parties involved, in the absence of a fraudulent claim or evidence of misrepresentation of facts presented to the IDR entity involved regarding such claim; and
>
> (II) ***shall not be subject to judicial review, except in a case described in any of paragraphs (1) through (4) of section 10(a) of title 9.***

42 U.S.C. § 300gg111(c)(5)(E)(i) (emphasis added). The reference to "paragraphs (1) through (4) of section 10(a) of title 9" is a reference to the Federal Arbitration Act ("FAA"). Those paragraphs describe the four circumstances under which a district court can vacate an arbitrator's award under the FAA, as follows:

> (a) In any of the following cases the United States court in and for the district wherein the award was made may make an order vacating the award upon the application of any party to the arbitration—
>
> (1) where the award was procured by corruption, ***fraud***, or ***undue means;***
>
> (2) where there was evident partiality or corruption in the arbitrators, or either of them;
>
> (3) where the arbitrators were guilty of misconduct in refusing to postpone the hearing, upon sufficient cause shown, or in refusing to hear evidence pertinent and material to the controversy; or of any other misbehavior by which the rights of any party have been prejudiced; or
>
> (4) where ***the arbitrators exceeded their powers***, or so imperfectly executed them that a mutual, final, and definite award upon the subject matter submitted was not made.

9 U.S.C. § 10(a)(1)-(4) (emphasis added to identify the grounds for vacatur alleged in the FAC at 85, ¶¶ 357-58).

While the NSA is a recent law, Congress enacted the FAA years ago. As a result, case law defines what circumstances satisfy subparagraphs (1) and (4). A party moving for vacatur under § 10(a)(1) must establish: (1) fraud, by clear and convincing evidence, (2) which was not discoverable upon the exercise of due diligence prior to or during the arbitration, and (3) which was materially related to an issue in the arbitration. Pac. & Arctic Ry. & Navigation Co. v. United Transp. Union, 952 F.2d 1144, 1148 (9th Cir. 1991). "[W]here the fraud or undue means is not only discoverable, but discovered and brought to the attention of the arbitrators, a disappointed party will not be given a second bite at the apple." A.G. Edwards & Sons, Inc. v. McCollough, 967 F.2d 1401, 1404 (9th Cir. 1992).

"Undue means" in the context of § 10(a)(1) refers to conduct that "is immoral if not illegal." Id. at 1403. Vacatur under this provision "requires a showing of bad faith during the arbitration proceedings, such as bribery, undisclosed bias of the arbitrator, or willfully destroying evidence, and further requires that such evidence of fraud was unavailable to the arbitrator during the course of the proceeding." Dandong Shuguang Axel Corp. v. Brilliance Mach. Co., No. C 00-4480 SC, 2001 WL 637446, at *5, 2001 U.S. Dist. LEXIS 7493, at *18 (N.D. Cal. June 1, 2001) (citation omitted). Like fraud, the undue means must be (1) not discoverable upon the exercise of due diligence prior to or during the arbitration, (2) materially related to an issue in the arbitration, and (3) established by clear and convincing evidence. A.G. Edwards, 967 F.2d at 1404.

***7** For vacatur under § 10(a)(4), arbitrators "exceed their powers when they express a 'manifest disregard of law,' or when they issue an award that is 'completely irrational.' " Bosack v. Soward, 586 F.3d 1096, 1104 (9th Cir. 2009) (citation omitted). "For an arbitrator's award to be in manifest disregard of the law, it must be clear from the record that the arbitrator recognized the applicable law and then ignored it." Id. (citation modified). Mere "misinterpretations of the law" do not justify vacatur. French v. Merrill Lynch, Pierce, Fenner & Smith, Inc., 784 F.2d 902, 906 (9th Cir. 1986).

Sometimes an arbitration agreement delegates the issue of arbitrability to the arbitrator. When that happens, "the arbitrator's interpretation of the scope of his powers is entitled to the same level of deference as his determination on the merits." See Schoenduve Corp. v. Lucent Techs., Inc., 442 F.3d 727, 733 (9th Cir. 2006).

2. Relevant Allegations.

Plaintiffs seek "vacatur of individual IDR determinations under 42 U.S.C. § 300gg-111(c)(5)(E)" because "[e]ach individual IDR determination at issue" was procured by fraud and undue means in the form of false eligibility attestations, and "the IDREs exceeded their powers by issuing payment determinations on items and services that are not qualified IDR items and services within the scope of the NSA's IDR process." (FAC at 85, ¶¶ 356-58.) Plaintiffs do not list all the IDR determinations they seek to vacate, but they allege that "the list of IDR payment determinations subject to vacatur is expected to increase during the pendency of the case." (Id. ¶ 359.) Plaintiffs pray for "vacatur of the underlying IDR determinations." (Id. at 88 (prayer for relief).)

3. Analysis.

Plaintiffs argue, "Anthem is seeking judicial review of Defendants' NSA Schemes, and not any individual IDRE payment determination." (Dkt. 93 at 48.) But Plaintiffs' claim for vacatur, while pled in the alternative, seeks to vacate "each individual IDR determination at issue." (FAC at 85, ¶ 356.) Plaintiffs' other fraud-based claims, like RICO, could not be litigated without deciding whether Defendants made false eligibility attestations, a decision that would necessarily re-examine eligibility determinations made by IDREs.

a. Fraud.

First, Plaintiffs urge the Court not to follow the above-cited Ninth Circuit cases and instead look to Eleventh Circuit cases. (Dkt. 93 at 49.) But Ninth Circuit cases are binding on this district court.

Next, Plaintiffs argue that the requirements discussed in Pacific & Artic Railway and A.G. Edwards cannot be fairly applied to the NSA IDR process because the Ninth Circuit test "presumes the existence of an opportunity to litigate the alleged fraud" before the arbitrator. (Id.) Plaintiffs did not allege facts showing that Anthem cannot litigate eligibility within the IDR process. Indeed, the FAC's allegations show that participants in the IDR process can tell the IDRE if they believe a dispute is ineligible and why. (FAC at 30, ¶¶ 115, 118 (describing how Anthem objects to unqualified items).) "The baseball-style dispute resolution process ... is premised on the notion that ineligible claims will be weeded out at the outset." (Id. at 30, ¶ 113; see also Dkt. 76-5 at 18, § 5.5 ("If the non-initiating party believes that the Federal IDR Process is not applicable, the non-initiating party must notify the Departments by submitting the relevant information through the Federal IDR portal as part of the certified IDR entity selection process.").

***8** Plaintiffs objected to eligibility for all the sample determinations identified in the FAC and summarized in the chart on pages 10 to 11, above. IDREs are instructed that they "must determine whether the Federal IDR Process is applicable." (Dkt. 76-5 at 18, § 5.5.) IDREs can, and sometimes do, determine that a billing dispute is not eligible. (FAC at 30, ¶ 115 (alleging that most, but not all, of "Defendants' ineligible disputes reach a payment determination" despite "Anthem's objections").)

Plaintiffs point to procedural rules for arbitration in other forums, such as rules providing for in-person hearings, cross-examination, and written decisions explaining the arbitrator's reasoning. (Dkt. 93 at 49.) But such procedures are not necessary to bring allegedly fraudulent eligibility attestations to an IDRE's attention. If the Court were to adopt Plaintiffs' position, then nearly every eligibility determination disputed by an IDR participant would be subject to review in federal court. That would be inconsistent with the NSA's creation of a streamlined IDR process for resolving surprise billing disputes and its limitations on judicial review.

As aptly put by the Sound Physicians Providers, by alleging that Plaintiffs knew about the false eligibility attestations and objected, "Anthem has pleaded itself out of court," at least as to vacatur based on fraud, because the "fraud" was known during the IDR and disclosed to the IDRE. (Dkt. 69-1 at 22.) As a result, the FAC's allegations, even if accepted as true, do not establish the kind of "fraud" that justifies vacatur under § 10(a)(1). Plaintiffs have not identified even one example of an IDR determination for which they could amend and allege that a Defendant made a false eligibility attestation based on facts that Plaintiffs did not know, and could not reasonably have known, before or during the IDR process.

b. Undue Means.

Plaintiffs argue that the IDREs are "financially incentivized" to disregard objections to eligibility. (Dkt. 93 at 50.) The FAC describes how IDREs only receive fees if they find a dispute eligible. (FAC at 22, ¶ 80; id. at 30, ¶ 116.) But this fee structure is part of the IDR rules established by Congress. See 42 U.S.C. § 300gg-111(c)(5)(F). Such financial incentives are

not akin to bad faith or bribery. In any event, the FAC does not allege that improper financial incentives motivated an IDRE's decision-making for any particular award. Plaintiffs have not suggested that they could amend and add such facts.

c. Excess of Authority.

Plaintiffs argue that they are "entitled to judicial review where, as here, the IDREs 'exceeded their powers' by issuing payment determinations on disputes that were ineligible for IDR." (Dkt. 93 at 48.) The FAC alleges that IDREs issued hundreds of payment determinations for services that were not a qualified IDR item or service. (FAC at 33, ¶ 128 (referring to 47% of 1,500 IDR proceedings).)

The IDREs, however, are authorized to decide eligibility. "First, the IDRE is directed by regulation (though not by the Act itself) to 'determine whether the Federal IDR process applies.' 45 C.F.R. § 149.510(c)(1)(v)." (Id. at 20, ¶ 73.) It makes no difference whether the directive to first determine eligibility is in the NSA's text or the implementing regulations.

The moving parties cite Reach Air Med. Servs. LLC v. Kaiser Found. Health Plan Inc., 160 F.4th 1110, 1114 (11th Cir. 2025). In that case, a medical service provider (an air ambulance) challenged an IDR award in which the IDRE chose Kaiser's number. Reach Air, 160 F.4th at 1114-15. The air ambulance company sued to vacate the award under § 10(a)(4), alleging that the IDRE exceeded its authority "by applying an illegal presumption in favor of Kaiser." Id. at 1119. The Eleventh Circuit noted, "An arbitrator's actual reasoning is of such little importance to our review that it need not be explained .... Our sole question under § 10(a)(4) is whether the arbitrator (even arguably) performed the assigned task, not whether she got the outcome right or wrong." Id. at 1120 (citation modified). The examples given included "awarding relief on a statutory claim when the arbitration agreement allows only for arbitration of contractual claims" or "failing to give preclusive effect to an issue previously decided by a court." Id.

***9** Here, Plaintiffs argue that IDREs have issued awards for ineligible claims and thus strayed from their "assigned task." (Dkt. 93 at 48 n.11.) But movants counter that part of the IDREs' assigned task is to decide eligibility. (Dkt. 117 at 19.) Plaintiffs do not (and cannot) allege that IDREs failed to rule in Anthem's favor in the complete absence of factual support for eligibility, because Plaintiffs allege that Defendants consistently represent (albeit falsely) to the IDREs that the claims are eligible. (FAC at 3, ¶ 3; id. at 23, ¶ 90.) Such allegations collapse the analysis under § 10(a)(4) into the same test as § 10(a)(1). Plaintiffs raised Defendants' allegedly false eligibility attestations to the IDREs, and the IDREs were authorized to determine eligibility. This means that judicial review of the IDREs' eligibility determinations premised on the same allegedly false eligibility attestations is not available. Pac. & Arctic Ry., 952 F.2d at 1148.

Because Plaintiffs' allegations do not meet the substantive requirements for claiming vacatur under 9 U.S.C. § 10(a)(1) or (4), the Court need not decide whether any of the FAA's procedural requirements for seeking vacatur (like timing and venue) apply to claims seeking vacatur of NSA IDRE determinations. [5]

B. Subject Matter Jurisdiction over Remaining Federal Counts (1-4, 12, 13).

Movants argue that the NSA's above-discussed limitations on judicial review bar the Court from exercising subject matter jurisdiction over Plaintiffs' other federal claims, because those claims seek review of IDRE determinations, regardless of the legal label. (Dkt. 69-1 at 26.) None of Plaintiffs' responses to this argument (discussed below) are persuasive.

1. The Statutory Interpretation Argument.

In a novel argument unsupported by any case law, Plaintiffs contend that the NSA's limitations on judicial review apply only to "[a] determination of a certified IDR entity ***under subparagraph (A)***," and subparagraph (A) refers only to payment determinations, not eligibility determinations. (Dkt. 93 at 43 (emphasis added).) But as set forth in full above, subparagraph (A) refers to "a determination for a qualified IDR item or service." 42 U.S.C. § 300gg111(c)(5)(A). An IDRE's payment determination necessarily includes a determination of eligibility. Plaintiffs' proposed reading of 42 U.S.C. § 300gg111(c)(5)(E)(i), which would impose *no* limits on judicial review of IDREs' eligibility determinations, would be clearly contrary to the streamlined dispute resolution process that Congress intended when it created the NSA's IDR process.

2. The Policy Argument.

Next, Plaintiffs urge the Court not to apply the NSA's limits on judicial review because the IDR process is deeply flawed

and there is no readily available remedy for erroneous IDR awards. (Dkt. 93 at 23-27.) But such policy-based arguments would be better directed at Congress which alone has the power to rewrite the NSA. Moreover, the FAC alleges that false attestations to the federal government can violate 18 U.S.C. § 1001, providing a strong incentive against making false attestations. (FAC at 18-19, ¶ 67.)

3. The "Outside the Scope" Argument.

Next, Plaintiffs argue that the NSA's limits on judicial review apply only to claims seeking to vacate IDR awards, but Plaintiffs' claims for monetary damages for time spent addressing fraudulent submissions and for prospective injunctive relief can be adjudicated without reviewing any IDR awards. (Dkt. 93 at 51-52.) Therefore, Plaintiffs argue that their claims fall outside the scope of the NSA's jurisdiction-stripping provisions. (Id.)

***10** Plaintiffs' federal claims cannot be adjudicated without reviewing the correctness of past IDR awards or inserting the district court in overseeing future IDR awards. The district court could not, for example, award damages measured by time spent addressing a fraudulent eligibility attestation without first deciding that the eligibility attestation was false. Similarly, the district court could not order Defendants to pay damages measured by IDR administrative fees for disputes ineligible for the IDR process without first deciding that the dispute was ineligible for IDR. And if, for example, the district court entered a follow-the-law injunction that prohibited Defendants from making future false eligibility attestations, then Plaintiffs would be able to come back into court to request a contempt remedy for violations of such an injunction, a remedy that would require litigating whether the challenged attestation was false. These theories are all end runs around the NSA's limits on judicial review.

4. The "Other Statutory Basis" Argument.

Plaintiffs argue that jurisdiction to hear its federal claims is conferred by ERISA or the federal Declaratory Judgment Act. (Dkt. 93 at 84.) These laws generally provide that district courts can hear certain kinds of claims, but neither specifically allows claims that require judicial review of IDR awards, as Plaintiffs' federal claims do. These federal laws' general jurisdictional language does not supplant the NSA's specific limitations on judicial review.

C. Supplemental Jurisdiction over Counts 5-10.

The Court has discretion to exercise supplemental jurisdiction over state law claims that do not, themselves, have a basis for federal subject matter jurisdiction once the Court has dismissed the claims over which it has original jurisdiction. 28 U.S.C. § 1367(c)(3). Here, Plaintiffs' federal claims all fail for the reasons stated above. The Court declines to exercise supplemental jurisdiction over Plaintiffs' remaining state law claims.

D. The Anti-SLAPP Motions.

"California law provides for the pre-trial dismissal of certain actions, known as Strategic Lawsuits Against Public Participation, or SLAPPs, that masquerade as ordinary lawsuits but are intended to deter ordinary people from exercising their political or legal rights or to punish them for doing so." Planet Aid, Inc. v. Reveal, 44 F.4th 918, 923 (9th Cir. 2022) (quoting Makaeff v. Trump Univ., LLC, 715 F.3d 254, 261 (9th Cir. 2013)); see Cal. Civ. Proc. Code § 425.16. The Ninth Circuit has held that California Code of Civil Procedure section 425.16 is, in part, a substantive law that applies in federal court to state law claims. See United States ex rel. Newsham v. Lockheed Missiles & Space Co., 190 F.3d 963, 972-73 (9th Cir. 1999).

To prevail on an anti-SLAPP motion, "the moving defendant must make a prima facie showing that the plaintiff's suit arises from an act in furtherance of the defendant's constitutional right to free speech." Makaeff, 715 F.3d at 261. "Once it is determined that an act in furtherance of protected expression is being challenged, the plaintiff must show a 'reasonable probability' of prevailing in its claims for those claims to survive dismissal." Metabolife Int'l, Inc. v. Wornick, 264 F.3d 832, 840 (9th Cir. 2001) (citation omitted); see also Makaeff, 715 F.3d at 261. Under this standard, "the claim should be dismissed if the plaintiff presents an insufficient legal basis for it, or if, on the basis of the facts shown by the plaintiff, 'no reasonable jury could find for the plaintiff.' " Makaeff, 715 F.3d at 261 (quoting Metabolife, 264 F.3d at 840).

Here, movants argue (primarily) that all of Plaintiffs' state law claims (1) arise from petitioning activity protected by the First Amendment and (2) are unlikely to succeed because the same limitations on judicial review that deprive the Court of jurisdiction over Plaintiffs' federal claims apply equally to Plaintiffs' state law claims. (Dkt. 68, 78.)

The Court has already dismissed the state law claims, exercising its discretion under 28 U.S.C. § 1367(c)(3) not to assert supplemental jurisdiction. Without any state law

claims, district courts may properly decline to address anti-SLAPP motions. See Hilton v. Hallmark Cards, 599 F.3d 894, 901 (9th Cir. 2010) ("[A] federal court can only entertain anti-SLAPP special motions to strike in connection with state law claims ...."); McMillan v. Chaker, 791 F. App'x 666, 667 (9th Cir. 2020) (holding that the district court, after dismissing all federal claims, did not abuse its discretion in not exercising supplemental jurisdiction over the remaining state law claims and not addressing the anti-SLAPP motion).

***11** Movants urge the Court to retain jurisdiction to rule on the anti-SLAPP motions. The Court declines to do so. Applying California's anti-SLAPP law requires analysis under the two-part test described above, which goes beyond the analysis needed to dismiss the federal claims. Furthermore, Plaintiffs ask the Court to consider (1) a new Supreme Court decision that Plaintiffs believe limits or eliminates anti-SLAPP motions in federal court, and (2) the timing of the motions, both issues the Court need not reach if it declines to retain jurisdiction. (Dkt. 92 at 13-14, 23.) Finally, the Court has inherent power "to control the disposition of the causes on its docket with economy of time and effort for itself, for counsel, and for litigants." Landis v. N. Am. Co., 299 U.S. 248, 254 (1936). Declining to address the anti-SLAPP motions serves the interest of judicial economy.

E. Leave to Amend.

If a district court finds that a complaint should be dismissed for failure to state a claim, the court has discretion to dismiss with or without leave to amend. Lopez v. Smith, 203 F.3d 1122, 1126-30 (9th Cir. 2000) (en banc). The court may dismiss a complaint without leave to amend if further amendment would be futile. Cahill v. Liberty Mut. Ins. Co., 80 F.3d 336, 339 (9th Cir. 1996). If, after careful consideration, it is clear that a complaint cannot be cured by amendment, then the district court may dismiss without leave to amend. See, e.g., Chaset v. Fleer/Skybox Int'l, 300 F.3d 1083, 1088 (9th Cir. 2002) (holding that "there is no need to prolong the litigation by permitting further amendment" where the "basic flaw" in the pleading cannot be cured by amendment).

Plaintiffs request leave to amend. (Dkt. 93 at 87.) But in neither briefing nor oral argument have Plaintiffs identified any facts that they could add that would (1) qualify a particular IDE determination for vacatur or (2) put its other federal claims beyond the jurisdiction-stripping provisions of 42 U.S.C. § 300gg111(c)(5)(E)(i)(II). Since leave to amend would be futile, the Court declines to grant leave to amend.

V.

CONCLUSION

Based on the foregoing, **IT IS ORDERED** that (1) the motions to dismiss (Dkt. 69, 73, 76, 77) shall be granted for the reasons stated above; (2) all other pending motions (Dkt. 68, 72, 74, 78) shall be denied as moot; and (3) the FAC shall be dismissed in its entirety, without leave to amend.

All Citations

Slip Copy, 2026 WL 982629

Footnotes

1 In addition to the briefs listed in the chart, the Court reviewed amicus briefs filed at Dkt. 80-1, 99, and 101.

2 The FAC defines the "Departments" as the Department of Health and Human Services ("HSS"), the Department of Labor, and the Department of the Treasury. (FAC at 15 n.9.) The Centers for Medicare & Medicaid Services ("CMS") is the federal agency within HSS primarily charged with implementing the IDR process. (Id. ¶ 52.)

3 The Court GRANTS the request for judicial notice (Dkt. 76-2) and considers the guidance documents as a factual description of how the IDR process is supposed to work, not as evidence of how it actually worked for any particular billing dispute.

4 The FAC defines "Provider Defendants" to include the LaRoque Family Providers and the Sound Physicians Providers. (FAC at 2.)

5 Count Eleven also fails because the alleged fraud is not pled with specificity as to every challenged IDR determination, as required by Federal Rule of Civil Procedure 9(b). This order does not rely on Rule 9(b), because non-compliance with Rule 9(b) could potentially be cured by amendment.

End of Document

EXHIBIT B

Aetna Health Inc. v. Radiology Partners, Inc.

United States District Court for the Middle District of Florida, Jacksonville Division

April 16, 2026, Decided; April 16, 2026, Filed

Case No. 3:24-cv-1343-BJD-LLL

Reporter
2026 U.S. Dist. LEXIS 84866 *; 2026 LX 104440

AETNA HEALTH INC. et al., Plaintiff, v. RADIOLOGY PARTNERS, INC., and MORI, BEAN AND BROOKS, INC., Defendants.

Prior History: *Aetna Health Inc. v. Radiology Partners, Inc., 2025 U.S. Dist. LEXIS 154463, 2025 WL 3251652 (Aug. 11, 2025)*

Core Terms

arbitrate, in-network, out-of-network, reimbursement, terminate, air

Counsel: **[*1]** For Aetna Health Inc., Aetna Health Insurance Company, Aetna Life Insurance Company, Plaintiffs: Jared Joseph Burns, Crowell & Moring LLP, Washington, DC; Nathaniel Moore, Kyle D. Nelson, Marcus A. Guith, LEAD ATTORNEYS, PRO HAC VICE, Robins Kaplan LLP, Minneapolis, MN; Paul D. Weller, PRO HAC VICE, Robins Kaplan LLP, New York, NY.

For Baptist Hospital of Miami Inc., Interested Party: Maria Dolores Garcia, Kozyak Tropin & Throckmorton LLP, Miami, FL.

For Mori Bean and Brooks Inc., Radiology Partners Inc., Defendants: Brian P. Miller, King & Spalding, Miami, FL; Samantha Joy Kavanaugh, King & Spalding LLP, Miami, FL; Glenn E. Solomon, Christopher Charles Jew, LEAD ATTORNEYS, PRO HAC VICE, King & Spalding, Los Angeles, CA; Michael H. Thompson, PRO HAC VICE, King & Spalding, Atlanta, GA; Sara Ann Brinkmann, PRO HAC VICE, King & Spalding LLP, Houston, TX.

For SMH Health Care Inc., Movant: Jennifer Lodge Grosso, Bentley & Bruning PA, Sarasota, FL.

Judges: BRIAN J. DAVIS, United States District Judge.

Opinion by: BRIAN J. DAVIS

Opinion

ORDER

THIS CAUSE is before the Court on Defendants' Motion to Dismiss the Amended Complaint (Doc. 84), Plaintiffs' Response in Opposition (Doc. 90), and Defendants' Notice of Supplemental Authority **[*2]** (Doc. 91).

Plaintiffs are a tripartite conglomeration that make up the nationally known Aetna health insurance brand. (Doc. 80 ¶1; AC). Defendant Radiology Partners, Inc., ("RP"), is a "private equity-backed aggregator of radiology practices across" the United States. Id. ¶3. Once RP acquires a practice, it essentially controls and manages all aspects of the practice but conceals the extent of that control to "appear compliant" with state regulations, including potential prohibitions on the "corporate practice of medicine." Id.

One of the nine practices RP acquired in Florida was Defendant Mori, Bean and Brooks, Inc., ("MBB"), which had the most lucrative reimbursement contact with Aetna within the state. Id. ¶5. After RP acquired MBB, MBB's claim submissions skyrocketed. Id. ¶6. Aetna contends—and for purposes of this Motion, the Court accepts that contention—that RP funneled its other Florida radiology practices' claims through MBB to obtain higher reimbursements. Id. ¶6. Aetna inquired into the increase in the number of claims but MBB "deflected Aetna's inquiries." Id. Aetna responded by terminating MBB's in-network contract, which meant MBB would now be considered an "out-of-network" **[*3]** provider. Id. The other Florida RP radiology providers remained "in-network."[1]

[1] The critical difference between an in-network provider and out-of-network provider is the former means there is a predetermined amount negotiated between the provider and insurance company that limits the cost passed on to the patient, while the latter leaves the uncovered amounts uncapped and owed by the patient.

The gravamen of the Amended Complaint is that once Aetna terminated its contract with MBB, RP continued submitting its other practices' claim through MBB forcing Aetna to reimburse MBB at an even higher rate out-of-network rate. Id. ¶8. The other RP entities billing through MBB did so despite not actually being fairly classified as a MBB provider. Id. This allowed RP to collect "significantly more for the same services provided by the same physicians at the same hospitals." Id. ¶9.

The scheme relied on the recent enactment of the *No Surprises Act ("NSA" or the "Act") 42. U.S.C. §§ 300gg-111*, which, as its name implies, aims to reduce surprise billing by out-of-network providers to unwitting patients.[2] Id. ¶10; see also *Med-Trans Corp. v. Cap. Health Plan, Inc., 700 F. Supp. 3d 1076, 1079 (M.D. Fla. 2023)*, aff'd sub nom. *Reach Air Med. Servs. LLC v. Kaiser Found. Health Plan Inc., 160 F.4th 1110 (11th Cir. 2025)* ("Its main purpose was to end surprise medical billing by ensuring that certain out-of-network providers . . . are treated the same as in-network providers."). To that end, the Act requires the out-of-network provider to submit its bill to the patient's insurer, who must offer to settle the claim or refuse to pay the claim altogether. *Med-Trans Corp., 700 F. Supp. 3d at 1079*.

If the insurer and provider fail to agree, the dispute is forwarded **[*4]** to the Independent Dispute Resolution ("IDR") for "baseball style" arbitration. Id. After an arbitrator is assigned (or mutually agreed upon), the parties submit their best offers to the arbitrator, who must pick just one (no compromises or adjustments can be made) that the arbitrator believes best represents the equivalent in-network reimbursement rate. Id. The decision is "not . . . subject to judicial review except on the same grounds as are available to review awards under the Federal Arbitration Act[,]" such as the existence of a fraudulent claim or evidence of misrepresentation of facts. *Id at 1080* (citing *§ 300gg-111(c)(5)(E)(i)(II)* (citing *9 U.S.C. § 10(a)(1)-(4)*)) (internal quotations omitted).

RP, using MBB, submitted tens of thousands of disputes under the NSA's IDR process that were premised on Defendants' misrepresentations that the services were provided by MBB, when they had been performed by other non-MBB providers. AC ¶11. Defendants knowingly and falsely certified the claims to both Aetna and the IDR administrators and obtained millions in awards from the IDR process. Id. ¶¶12-15. Aetna now seeks to have the IDR awards vacated and to recover damages from the fees associated with having to participate in the IDR process, and further to have disputed **[*5]** claims not yet filed with the IDR to be limited. Defendants responded with their Motion to Dismiss contending that there was no fraud; any fraud was not sufficiently pled, and further, the IDR awards are not reviewable.

Where a complaint alleges acts of fraud, it "must satisfy two pleading requirements [: *Fed. R. Civ. P. 8(a)(2)* and *Rule 9(b)*]." *U.S. ex rel. Matheny v. Medco Health Solutions, Inc., 671 F.3d 1217, 1225 (11th Cir. 2012)*. In satisfying *Rule 8(a)(2)*, a complaint needs to allege "enough facts to state a claim to relief that is plausible on its face." *Bell Atlantic Corp. v. Twombly, 550 U.S. 544, 570, 127 S.Ct. 1955, 167 L. Ed. 2d 929 (2007)*. While "detailed factual allegations" are not required, mere "labels and conclusions" or "a formulaic recitation of the elements of a cause of action" are not enough. *Ashcroft v. Iqbal, 556 U.S. 662, 678, 129 S.Ct. 1937, 173 L. Ed. 2d 868 (2009)*. In assessing the factual allegations "[w]e . . . construe them in the light most favorable to the plaintiff." *Pereda v. Brookdale Senior Living Communties, Inc., 666 F.3d 1269, 1272 (11th Cir. 2012)* (citation and quotations omitted). Pleadings "must" be "a short and plain statement of the claim[s] showing that the pleader is entitled to relief[.]" *Fed. R. Civ. P 8(a)(2)*.

Plaintiff must also meet *Rule 9(b)*'s heightened standard by "stat[ing] with particularity the circumstances constituting fraud." *U.S. ex rel. Schubert v. All Child.'s Health Sys. Inc., No. 8:11-CV-1687-T-27EAJ, 2013 U.S. Dist. LEXIS 53932, 2013 WL 1651811, at *1 (M.D. Fla. Apr. 16, 2013)* (quoting *Fed. R. Civ. P. 9(b)*). "The particularity requirement of *Rule 9(b)* is satisfied if the complaint alleges "facts as to time, place, and substance of the defendant's alleged fraud, specifically the details of the defendant's allegedly **[*6]** fraudulent acts, when they occurred, and who engaged in them." Id. (citing *Hopper v. Solvay Pharms., Inc., 588 F.3d 1318, 1324 (11th Cir. 2009)* (quotations omitted)). However, "knowledge . . . may be alleged generally." *Fed. R. Civ. P. 9(b)*. "The purpose of *Rule 9(b)* is to alert defendants to the precise misconduct with which they are charged and protect defendants against spurious charges." *Matheny, 671 F.3d at 1222* (citations and quotation omitted). *Rule 9(b)*'s heightened standard is tempered, however, in situations when the "alleged fraud occurred over an extended period of time and

[2] An example of this would be a patient receiving emergency services or undergoing a procedure at an in-network hospital who then contracted with an out-of-network anesthesiologist to assist with a patient's surgery.

consisted of numerous acts." *U.S. ex rel. Butler v. Magellan Health Servs., Inc., 74 F. Supp. 2d 1201, 1215 (M.D. Fla. 1999)*.

Starting with *Rule 8*'s less demanding standard, the Court finds that the Complaint is anything but short but it does not necessarily violate *Rule 8* for that reason alone. The Complaint sets forth the facts in numbered and organized paragraphs, most of which are pertinent to the claims, and clearly states the nature of Plaintiffs' claims. As to *Rule 9*, in *Linville v. Ginn Real Est. Co., LLC 697 F. Supp. 2d 1302, 1309 (M.D. Fla. 2010)*, the court held that allegations failed to meet *Rule 9(b)*'s requirements where they failed to specify "which" agents made the statements, "when" the statements were made and "where" the statements were made.

Aetna does not make those same fatal mistakes. For example, Aetna listed a September 18, 2022 claim from Dr. Nouri billed under MBB's provider tax identification number despite **[*7]** Dr. Nouri working for Radiology Associates of South Florida on the opposite end of the state. AC ¶ 69. The location, date, and individual/entity are all specifically identified. Further, Aetna was harmed because it ultimately was ordered by the IDR arbitrator to pay MBB an out-of-network amount of $752.00 instead of the in-network fee of $78.89. Id. ¶¶69-70.

Outside of stating a claim for fraud, the Court must determine whether the fraud is alleged in a manner to allow for review of the IDR awards. With limited exceptions as described by the Federal Arbitration Act, IDR decisions under the NSA are not reviewable. *Reach Air Med. Servs. LLC v. Kaiser Found. Health Plan Inc., 160 F.4th 1110, 1118 (11th Cir. 2025)*. A plaintiff bears a "heavy burden of demonstrating that vacatur is appropriate . . . by proving the existence of one or more of four statutorily enumerated causes for reversal set forth in *9 U.S.C. § 10(a)(1)-(4)*." *Wiand v. Schneiderman, 778 F.3d 917, 925 (11th Cir. 2015)* (internal citation omitted). Fraud is one of those enumerated causes. Id.; *Reach Air Med. Servs. LLC, 160 F.4th at 1121* ("FAA *Section 10(a)(1)* [ ] permits vacatur of an arbitration award when 'the award was procured by . . . fraud,' *9 U.S.C. § 10(a)(1)*[.]").

To establish fraud, the plaintiff must:

> [(1)] establish the fraud by clear and convincing evidence"; (2) "the fraud must not have been discoverable upon the exercise of due diligence prior to or during the arbitration"; and (3) "the **[*8]** person seeking to vacate the award must demonstrate that the fraud materially related to an issue in the arbitration."

Reach Air Med. Servs. LLC, 160 F.4th at 1121 (quoting *Bonar v. Dean Witter Reynolds, Inc., 835 F.2d 1378, 1383 (11th Cir. 1988)*).

As discussed above, Aetna has sufficiently alleged Defendants fraudulently submitted claims for reimbursement as out-of-network providers. Those claims resulted in IDR awards that injured Aetna by causing Aetna to incur arbitration fees and to pay at a rate higher than it would have if the claims were submitted as being performed by in-network providers.

Defendants strongest defense is that the fraud was discoverable upon the exercise of due diligence prior to or during arbitration. In the Amended Complaint, Aetna states that it terminated its contract with MBB because MBB was submitting in-network claims from providers across the state that were not employees of MBB. This occurred, necessarily, before MBB became an out-of-network provider through which non-MBB providers submitted claims. Though Aetna attempts to describe Defendants' efforts to shield the true origin of the claims, the Court is mindful of Aetna's "heavy burden" to upend administrative decisions on the basis of fraud. While a close call, the allegations presented in the Amended Complaint fail **[*9]** to establish a sufficient basis excusing Aetna from challenging the IDR disputes on the basis that they were wrongfully submitted by in-network providers. Aetna's own admission that it knew RP and MBB were engaged in that very act as the reason for the termination of the in-network contract is fatal to Aetna's position. While Aetna cites the thousands of claim submissions and Defendants' efforts to conceal the nature of the fraud, it cannot excuse Aetna's failure to raise the issue in the IDR disputes.

As to the remaining claims, they are all premised on the same facts as Aetna's claims of fraud but rely on different legal theories for recovery. Aetna's attempt to end-around the NSA and FAA strictures is preempted. The NSA adopts the ferocity of the FAA in defending arbitration awards. *Reach Air Med. Servs. LLC,160 F.4th at 1115* ("We review arbitration decisions very narrowly, and there is a strong legal presumption that arbitration awards will be confirmed[,]" and there is nothing in the "newly codified NSA, which has expressly incorporated some sections of the Federal Arbitration Act [ ], that has altered that limited scope of judicial review [or preference]."). The FAA preempts state law claims that would otherwise frustrate its purpose. See

Marmet Health Care Ctr., Inc. v. Brown, 565 U.S. 530, 533, 132 S. Ct. 1201, 182 L. Ed. 2d 42 (2012). **[*10]** Allowing Aetna to recover for the IDR awards above what it otherwise would have paid would have the same effect as discarding the administrative process established by Congress. ***Because the NSA adopted those specific provisions of the FAA***, ***Aetna's remaining claims must also fall***—they are both preempted by the NSA and FAA and otherwise inadequate grounds to challenge the IDR awards. Regarding those claims yet to be submitted to the IDR, the Court is not empowered to take a preliminarily review. Indeed, Aetna possesses more than enough knowledge pertaining to their propriety and can, if appropriate, challenge those claims before the IDR.

Accordingly, after due consideration, it is

ORDERED:

> Defendants' Motion to Dismiss the Amended Complaint (Doc. 84) is **GRANTED**. Because amendment would be futile, the Amended Complaint is **DISMISSED with prejudice**. The Clerk of the Court shall close this file and terminate any pending motions.

DONE and **ORDERED** in Jacksonville, Florida this ***16th*** day of April, 2026.

/s/ Brian J. Davis

BRIAN J. DAVIS

United States District Judge

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EXHIBIT C

Federal Independent Dispute Resolution (IDR) Technical Assistance for Certified IDR Entities and Disputing Parties
June 2025

Topic: Errors Identified After Dispute Closure

Purpose:
The Departments of Health and Human Services (HHS), Labor, and the Treasury (collectively, the Departments) categorized three types of errors—clerical, jurisdictional, and procedural—that a certified Independent Dispute Resolution (IDR) entity may make, but is not identified until after a dispute is closed. These types of errors should be corrected by reopening a closed dispute to ensure the results of the Federal IDR process are aligned with the No Surprises Act (NSA) and that a certified IDR entity complies with the NSA and its implementing regulations. This Technical Assistance (TA) defines these types of errors and contains process guidelines to better ensure the efficient and logical correction of the certified IDR entity's errors, including when a closed dispute resulted in a payment determination.[1] It is intended only to provide clarity to the public regarding the Departments' process under their existing authority to establish an IDR process aligned with statutory and regulatory requirements. This TA is not intended to have the force of law or to impose substantive requirements on parties to the Federal IDR process or on certified IDR entities. It includes a general description of agency policy and sets forth operational guidance to the certified IDR entities.

Based on feedback from certified IDR entities and disputing parties, the Departments have determined that a process for reopening disputes to correct errors identified after dispute closure is needed to support disputing parties and certified IDR entities, and to ensure program integrity. This TA provides guidance to disputing parties and certified IDR entities on the error correction process and clarifies how certified IDR entities should treat three categories of errors identified after dispute closure. Specifically, this TA:

- Provides definitions and examples of the three categories of errors that may be corrected after dispute closure: (1) clerical, (2) jurisdictional, and (3) procedural;
- Includes instructions on correcting such errors;
- Clarifies the impact of a corrected error on the administrative and certified IDR entity fees; and
- Identifies types and examples of errors that may not be corrected after dispute closure.

To reduce errors, the Departments continue to strongly encourage certified IDR entities to have robust quality assurance (QA) programs to verify dispute eligibility and review payment determinations before transmitting determinations to disputing parties and/or closing disputes. A certified IDR entity that does not maintain an adequate QA process may be determined to not be

[1] Under section 9816(c)(5)(e) of the Internal Revenue Code (Code), section 716(c)(5)(E) of the Employee Retirement Income Security Act (ERISA), and section 2799A-1(c)(5)(E) of the Public Health Service Act (PHS Act), IDR payment determinations are generally binding, absent a claim of fraud or misrepresentation of facts, and are subject to judicial review only in limited circumstances described in 9 USC § 10(a).

fit or qualified to make determinations under the Federal IDR process.[2] The Departments will continue to monitor the volume of errors and emphasize that the certified IDR entities are responsible for ensuring that eligibility and payment determinations are accurate. This TA applies to requests to reopen closed disputes received by the Departments:

- On or after **June 6, 2025**; and
- Prior to **June 6, 2025**, but to which the Departments had not responded prior to **June 6, 2025**.

Eligible requests will be evaluated by the Departments in accordance with this TA document. Requests to reopen disputes that the Departments denied prior to **June 6, 2025** should not be resubmitted for reconsideration as they will not undergo additional review. This TA provides a streamlined approach to the requests to reopen closed disputes and ensures the process of correcting errors is uniform and consistent from publication of this TA onward.

Categories of Errors that Certified IDR Entities May Submit for Reopening and Correction After Dispute Closure:

Category 1: Clerical Error

The Departments define a clerical error as a typographical (typo), computational (user) error, or IT systems error impacting the operation or use of the Federal IDR portal made by the certified IDR entity while performing administrative tasks or functions that do not involve the certified IDR entity's discretion, judgment, or expertise.

Examples of clerical errors include, but are not limited to, the following:

1. Based on the documentation provided by the disputing parties, a certified IDR entity determines that the initiating party will be the prevailing party to a dispute. However, the certified IDR entity mistakenly selects the non-initiating party when identifying the prevailing party in the payment determination.

   If the Departments approve the request to reopen the dispute, the certified IDR entity should rescind the original payment determination and issue a new one in favor of the initiating party, which will supersede the payment determination made in error.

2. When issuing a payment determination, the certified IDR entity mistakenly fails to upload the required documentation that one or both disputing parties submitted to the Federal IDR portal. The certified IDR entity appropriately considered the information included in this documentation when rendering the payment determination but did not upload the documentation to the Federal IDR portal.

[2] 26 CFR 54.9816–8T(e)(6)(ii)(G), 29 CFR 2590.716-8(e)(6)(ii)(G), 45 CFR 149.510(e)(6)(ii)(G).

If the Departments approve the request to reopen the dispute, the certified IDR entity should re-issue the payment determination that has been corrected to include the previously omitted documentation.

3. When issuing a payment determination, the certified IDR entity makes a typo in the summary section of the payment determination by misspelling a party's name.

   If the Departments approve the request to reopen the dispute, the certified IDR entity should re-issue the payment determination reflecting the appropriate spelling.

4. When a disputing party receives a link from the Federal IDR portal to make an offer, the link is broken and cannot be accessed, and therefore an offer cannot be made in a timely manner.

   If the Departments approve the request to reopen the dispute, the certified IDR entity should proceed with the Federal IDR process.

Category 2: Jurisdictional Error

The Departments define a jurisdictional error as a situation when the certified IDR entity incorrectly determines that an item or service either is or is not a qualified IDR item or service eligible for the Federal IDR process under the requirements of the NSA.

Examples of jurisdictional errors include, but are not limited to, situations where the eligibility of the item or service was incorrectly determined based on the following considerations:

1. Whether it relates to an item or service furnished during a plan year beginning prior to January 1, 2022;

2. Whether it is subject to an All-Payer Model Agreement under section 1115A of the Social Security Act or a specified State law;

3. Whether it relates to an item or service payable by Medicare, Medicaid, CHIP, or TRICARE, Indian Health Service, Veterans Affairs Health Care, short-term limited duration insurance, or excepted benefits;

4. Whether it is furnished by a participating provider, a participating facility, or a participating provider of air ambulance services; or

5. Whether it would not have been covered in-network by the health plan or issuer.

The Departments have determined that jurisdictional errors should be corrected by reopening a dispute to ensure compliance with the NSA's requirements. If the Departments approve the request to reopen the dispute, the certified IDR entity should rescind the payment determination, correct the eligibility determination (to reverse a determination of eligibility), communicate to the disputing parties the change to the eligibility determination, refund or invoice the certified

IDR entity fees as appropriate, and send the resulting eligibility determination to the disputing parties.

Category 3: Procedural Error

The Departments define a procedural error as a situation when the certified IDR entity incorrectly determines the eligibility of an item or service for the Federal IDR process or incorrectly makes a determination because a disputing party satisfied, or failed to satisfy, a required procedural step to engage in the Federal IDR process, such as submitting required documentation or timely completion of a step in the process.

Examples of procedural errors include, but are not limited to, the following:

1. The certified IDR entity renders a payment determination for a dispute in which the initiating party failed to timely furnish the notice of initiation to the non-initiating party.

   If the Departments approve the request to reopen the dispute, the certified IDR entity should rescind the payment determination and update the eligibility determination to reflect that the dispute is ineligible for the Federal IDR process, close the dispute, and return the certified IDR entity fees, as applicable.

2. The certified IDR entity determines a dispute is ineligible for the Federal IDR process, believing the initiating party initiated the Federal IDR process before the open negotiation period expired when the party's initiation was, in fact, timely.

   If the Departments approve the request to reopen the dispute, the certified IDR entity should update the eligibility determination to reflect that the dispute is eligible and proceed with the Federal IDR process.

3. The certified IDR entity renders a payment determination for a dispute but did not evaluate documentation received from a party that the dispute was subject to the 90-day cooling off period at the time of IDR initiation.

   If the Departments approve the request to reopen the dispute, the certified IDR entity should rescind the payment determination and update the eligibility determination to reflect that the dispute is ineligible for the Federal IDR process, close the dispute, and return the certified IDR entity fees, as applicable. The initiating party may request an extension of time from the Departments to initiate the open negotiation period.

4. The certified IDR entity renders a payment determination on an item or service that has already received a payment determination through the Federal IDR process, either by the same or different certified IDR entity.

If the Departments approve the request to reopen the dispute, the certified IDR entity should rescind the second payment determination and update the eligibility determination to reflect that the dispute is ineligible for the Federal IDR process, close the dispute, and return the certified IDR entity fees for the second payment determination, as applicable.

5. Both parties requested to withdraw a dispute in a timely manner, but the certified IDR entity issued a payment determination before realizing the dispute was requested to be withdrawn.

   If the request to reopen the dispute is approved by the Departments, the certified IDR entity should complete the withdrawal of the dispute, retaining only half of the certified IDR entity fee from each party.[3]

6. The certified IDR entity does not realize it has received an offer and/or fees from one of the disputing parties in a timely manner and incorrectly issues a default judgment in favor of the other disputing party.

If the Departments approve the request to reopen the dispute, the certified IDR entity should rescind the default judgment and review the dispute, considering the offers and information submitted by both parties and issue a new, corrected payment determination, which will supersede the default judgment.

The Departments have determined that procedural errors should be corrected by reopening a dispute to ensure compliance with the NSA's requirements. If the Departments approve the request to reopen the dispute, the certified IDR entity should rescind the payment determination (if applicable), correct the eligibility determination (to reverse a determination of eligibility or ineligibility), communicate to the disputing parties the change to the eligibility determination, refund or invoice the certified IDR entity fees as appropriate, send the resulting eligibility determination to the disputing parties, and continue the Federal IDR process (if applicable).

Process of Reopening a Closed Dispute for Clerical, Jurisdictional, or Procedural Errors: A disputing party, the certified IDR entity, or the Departments may initiate the process for correcting a clerical, jurisdictional, or procedural error after dispute closure.

If a disputing party identifies an error after the certified IDR entity closes the dispute, one or both parties should report the error as soon as possible to the relevant certified IDR entity, which should validate the reported error by confirming its existence and that it falls into one of the three categories defined above. The certified IDR entity should then report the error to the Departments as soon as possible by submitting a request to reopen the closed dispute via the Federal IDR portal. If the Departments determine that the error is a clerical, jurisdictional, or procedural error, they will approve the reopening of the dispute in the Federal IDR portal, which will allow the certified IDR entity to make the appropriate adjustment to the dispute and/or

[3] 26 CFR 54.9816-8T(c)(2)(ii), 29 CFR 2590.716-8(c)(2)(ii), and 45 CFR 149.510(c)(2)(ii).

reissue the payment determination to both parties, as appropriate. Failure to promptly report errors to the Departments will result in processing delays. Disputing parties may lodge a complaint against the certified IDR entity if the certified IDR entity does not act on an error that falls into one of the three categories.[4]

If a certified IDR entity identifies an error after closing a dispute, it should submit a request to the Departments to reopen the closed dispute via the Federal IDR portal. If the Departments identify an error after a certified IDR entity closes a dispute, they will notify the certified IDR entity of the error, reopen the closed dispute, and instruct the certified IDR entity to correct the error.

The Departments recognize that the correction of an error could impact the amounts to be paid to the prevailing party or which party prevails in the dispute. Furthermore, the Departments recognize that the rescission of the original payment determination and issuance of a new payment determination impacts the deadline by which payments must be made under 26 CFR 54.9816–8T(c)(4)(ix), 29 CFR 2590.716-8(c)(4)(ix), and 45 CFR 149.510(c)(4)(ix), which is not later than 30-calendar days after a payment determination. If a payment determination is rescinded and reissued, the applicable party is no longer required to make a timely payment based on the withdrawn payment determination. Instead, a new 30-calendar-day period begins on the date the certified IDR entity issues a new binding payment determination following correction of a clerical, jurisdictional, or procedural error. The Departments will consider a party to be in compliance with 26 CFR 54.9816–8T(c)(4)(ix), 29 CFR 2590.716-8(c)(4)(ix), and 45 CFR 149.510(c)(4)(ix) if it makes the appropriate payment amount to the prevailing party within this time period.

Additionally, prior to the date on which the Departments reopen a closed dispute via the Federal IDR portal due to one of the categories of errors described in this TA, the applicable party remains subject to the requirement to pay the other party the applicable amount within 30 calendar days of the original payment determination, regardless of whether a request to reopen a closed dispute has been filed. If a payment determination is rescinded and is not replaced by a new payment determination, but rather, the dispute is closed as ineligible, the payment requirement associated with the rescinded determination is void.

The Departments expect that as soon as a dispute is closed following a correction, certified IDR entities will timely communicate any change to the dispute, such as a corrected payment or eligibility determination, and the appropriate next steps to both disputing parties and the Departments.

Administrative and Certified IDR Entity Fees:
The correction of an error does not change the requirement for both disputing parties to pay the administrative fee for all disputes for which a certified IDR entity is selected, including disputes where the certified IDR entity determines that the item(s) or service(s) under dispute are not

[4] Complaints against certified IDR entities may be submitted to the FederalIDRQuestions@cms.hhs.gov.

eligible for the Federal IDR process. With respect to the certified IDR entity fee, if the correction of an error reverses a determination that a dispute was or was not eligible for the Federal IDR process, the certified IDR entity must either refund or invoice the parties for the certified IDR entity fee as appropriate for the resulting eligibility determination.[5]

Denial of Request to Reopen a Closed Dispute:
The Departments will deny a request to reopen a dispute to correct an error identified after dispute closure if they determine that it is not a clerical, jurisdictional, or procedural error. In general, the Departments will deny a reopening request if the reopening would require the certified IDR entity to reconsider the factors described in 26 CFR 54.9816–8(c)(4)(iii), 29 CFR 2590.716-8(c)(4)(iii), and 45 CFR 149.510(c)(4)(iii). Additionally, the Departments will deny a request to reopen a dispute to correct a clerical, jurisdictional, or procedural error made by a disputing party, rather than the certified IDR entity.

Examples of a request to reopen a dispute that will be denied by the Departments include, but are not limited to, the following:

1. The certified IDR entity requests to reopen a closed dispute to reconsider its payment determination based on information it initially failed to consider, such as a document submitted by a disputing party containing information on the acuity of the participant receiving the qualified IDR item or service.

2. After a payment determination is issued, the certified IDR entity receives notification that the prevailing party made a typo in its offer, resulting in the party's actual offer amount differing from its intended offer amount. For example, the prevailing party submitted an offer of $1,000 but intended the offer amount to be $10,000.[6]

[5]As required by section 9816(c)(8)(A) of the Code, section 716(c)(8)(A) of ERISA, and section 2799A-1(c)(8)(A) of the PHS Act and 26 CFR 54.9816-8(d)(2), 29 CFR 2590.716-8(d)(2), and 45 CFR 149.510(d)(2), and as explained in the interim final rules titled, Requirements Related to Surprise Billing; Part II (published on October 7, 2021), each party to a determination for which a certified IDR entity is selected must, at the time the certified IDR entity is selected, pay to the certified IDR entity a non-refundable administrative fee due to the Secretary. Because the Departments expect that a large part of the expenditures in carrying out the Federal IDR process will come from the initiation of the Federal IDR process, the Departments will have incurred expenditures in instances in which the parties reach an agreement before the certified IDR entity makes a determination or in which the certified IDR entity determines that the dispute does not qualify for the Federal IDR process, and thus, it is appropriate that the parties should still be expected to pay the administrative fee for ineligible disputes. Therefore, if the correction of an error alters the eligibility determination of a dispute, both parties to a dispute must still pay an administrative fee.

[6] The Departments emphasize the importance of disputing parties ensuring accuracy in their Notice of Offer submissions to prevent such an error from occurring.

EXHIBIT D

BlueCross BlueShield Association

750 9th Street, N.W.
Washington, D.C. 20001
www.BCBS.com

March 30, 2026

The Honorable Dr. Mehmet Oz
Administrator
Department of Health and Human Services
Attention: CMS-6098-NC
P.O. Box 8013
Baltimore, MD 21244-8013

Submitted via the Federal Regulations Web Portal, http://www.regulations.gov

RE: Request for Information (RFI) Related to Comprehensive Regulations to Uncover Suspicious Healthcare (CRUSH)

Dear Administrator Oz:

Fraud, waste, and abuse in federal health care programs impose significant costs on taxpayers, undermine the integrity of government programs, and divert resources away from the patients and families who depend on them. Every dollar lost to fraud, waste, and abuse is a dollar that could have gone toward patient care. Ensuring integrity of government programs is one of the most direct ways to protect patients and keep care affordable and accessible for families, businesses and taxpayers. The Blue Cross Blue Shield Association (BCBSA) appreciates the opportunity to provide comments on the Request for Information (RFI) Related to Comprehensive Regulations to Uncover Suspicious Healthcare and leverage the work Blue Plans are doing to partner with the Center for Medicare & Medicaid Services (CMS) to protect the integrity of government programs.

BCBSA is a national federation of independent, community-based and locally operated Blue Cross Blue Shield (BCBS) companies (Plans) that collectively cover, serve, and support 1 in 3 Americans in every ZIP code across all 50 states and Puerto Rico. BCBS Plans contract with 97% of hospitals and 83% of doctors across the country and serve those who are covered through Medicare, Medicaid, an employer, or purchase coverage on their own.

BCBS Plans share CMS' deep commitment to protecting Medicare, Medicaid, the Children's Health Insurance Program (CHIP) and the Exchanges from fraud, waste, and abuse. Each BCBS company operates a dedicated Special Investigations Unit (SIU) that leverages data analytics, claims review, and referrals to identify potentially fraudulent or abusive billing

patterns. When SIUs detect suspected misconduct, they conduct comprehensive investigations to support overpayment recovery and inform appropriate administrative or criminal actions. Between 2020 and 2024, BCBS SIUs completed more than 67,000 investigations, preventing or recovering over $22 billion in fraudulent payments across markets. For example, after identifying a national Durable Medical Equipment (DME) scheme through member complaints and data monitoring, one BCBS Plan established a dedicated Provider Validation team in September 2024. The Provider Validation team was able to suspend all claims from out-of-network DME providers for review before payment and by the fourth quarter of 2025, the team had successfully identified 700 fraudulent providers and was able to prevent payment on $30 million in claims submitted by these bad actors. In September 2025, another BCBS Plan's SIU identified a similar scheme in which DME companies were submitting fraudulent Medicare Advantage claims and promptly applied an administrative stop code, preventing approximately $400,000 in lost funds. BCBS Plans' anti-fraud work spans all lines of business, reflecting BCBS Plans' unique position as a national health plan system operating at scale across every major government health care program.

BCBSA's National Anti-Fraud Department (NAFD) serves as a national coordinating hub for this work, aligning BCBS Plans, their SIUs, and external partners around a shared, integrated anti-fraud strategy. The NAFD enables the BCBS System (System) to function as a unified enterprise, facilitating inter-plan investigations, resolving cross-jurisdictional fraud issues, promoting consistent investigative standards, and distributing systemwide fraud intelligence so that schemes identified by one Plan benefit the entire System. Beyond the System, NAFD maintains active working partnerships with federal and state law enforcement and government agencies to coordinate investigative activity, share intelligence, and align private-sector fraud detection with public-sector enforcement priorities. Plans and the NAFD also are active leaders in the National Health Care Anti-Fraud Association (NHCAA) and the Healthcare Fraud Prevention Partnership (HFPP). Plan SIUs also participate in national working groups focused on the highest-risk fraud areas, including DME and substance use disorder (SUD) services. Plans share intelligence, investigative techniques, and emerging fraud trends in real time across Plans. These efforts directly help safeguard taxpayer dollars, reinforce public trust, and preserve program resources for the individuals and families who rely on Medicare, Medicaid, CHIP, and the Exchanges—ensuring that funds are directed to medically necessary services and legitimate providers rather than diverted through improper billing.

As dedicated partners in preventing, detecting and shutting down fraud, we commend CMS' leadership in advancing a comprehensive suite of program integrity tools to protect taxpayer dollars and safeguard government health care programs for the populations who depend on these critical sources of coverage. We appreciate the opportunity to provide input through this RFI on strategies and actions that can strengthen collaboration among CMS, states, health plans, and other leaders and enhance our collective ability to protect public programs from being preyed on by criminals and bad actors. We also encourage CMS to ensure that new fraud-fighting mechanisms do not introduce operational challenges, administrative burdens, or unclear enforcement frameworks that could create disruptions in access to care or jeopardize affordability. To support CMS' efforts to further strengthen federal and state anti-fraud capabilities while preserving access and affordability, BCBSA recommends that CMS focus on the following:

- **Provide Medicare Advantage (MA) plans and Medicare Supplement carriers with timely, structured notification of enforcement actions** that affect providers and suppliers billing MA plans, including payment suspensions, revocations, and credible allegations of fraud.
- **Implement safeguards to deter fraud by non-participating Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) suppliers**, including enhanced front-end claims processing and pre-payment review mechanisms as well as ensuring that the suppliers meet original Medicare accreditation and enrollment standards.
- **Require that AI tools used in MA coding oversight be subject to testing, evaluation, validation and verification (TEVV)** prior to deployment, at appropriate intervals post-deployment, and upon any material change to the tool, with expectations aligned to standards being developed by the National Institute of Standards and Technology (NIST) and other standards-setting organizations.
- **Permit Medicaid managed care organizations (MCOs) to temporarily suspend payments to providers facing credible allegations of fraud** prior to receiving government approval to suspend payments.
- **On the federal Marketplace, where unauthorized and fraudulent enrollments through unscrupulous agent and brokers have been particularly problematic, CMS should verify applicants' residency**, including when applicants are claiming a "permanent move" to qualify for a special enrollment period.
- **On the federal Marketplace require special enrollment period verification** for at least 75% of new enrollments.
- **Hold Marketplace agents and brokers accountable.** CMS should conduct timely investigations into patterns of agent and broker misconduct, including deceptive marketing, and should suspend Marketplace certifications until investigations are completed. Issuers and states should be notified promptly when agents or brokers are terminated or suspended for misconduct.
- **Protect the surprise billing Independent Dispute Resolution (IDR) process** from being abused by preventing ineligible claims from being submitted, delivering real transparency on decisions, and holding arbiters accountable. Absent these protections, the IDR process will continue to be flooded with claims that raise costs for businesses, patients, and taxpayers.

Below, we offer additional detailed recommendations that focus on specific actions that CMS can take to prevent and detect fraud in government programs. We appreciate your consideration of our comments and would be pleased to discuss any of these with you further. If you have any questions or would like additional information, please contact me or Monica Tencate, senior director, government programs at Monica.Tencate@bcbsa.com.

Sincerely,

Amanda Lincoln
Vice President, Policy & Advocacy
Blue Cross Blue Shield Association

BCBSA Detailed Comments on the CMS Request for Information Related to Comprehensive Regulation to Uncover Suspicious Healthcare

A. Modifications to Program Integrity Requirements

Issue #1: Program Integrity Policy Modifications

CMS solicits comments on ways to modify provider enrollment, medical review, audit, payment suspension, and other program integrity policies to provide CMS with increased authority and flexibility to prevent bad actors from engaging in fraud, waste, and abuse.

Recommendation #1: BCBSA recommends that CMS establish a regulatory requirement obligating CMS to provide MA organizations, Part D plan sponsors, and Medicare Supplement carriers with real-time notification when CMS suspends or escrows payments to a provider or supplier due to suspected fraud.

Rationale: Currently, downstream payers, including MA plans, receive no indication when CMS suspends or escrows original Medicare fee-for-service (FFS) payments and as a result, payers are put at a significant informational disadvantage and may continue making payments for the same fraudulent claims.

Bad actors deliberately exploit this information gap by shifting billing from original Medicare FFS to MA organizations after CMS has identified and acted on suspected fraud in FFS. CMS should therefore require Medicare Administrative Contractors (MACs) and the Unified Program Integrity Contractor (UPIC) to provide secondary payers (e.g., MA organizations and Medicare Supplement carriers) real-time notification of suspected fraudulent providers and claims, particularly when CMS suspends or escrows payments. This would allow secondary payers to pend claims, perform reviews, and take appropriate action. Real-time fraud signaling would allow MA plans to perform pre-payment claim reviews and take appropriate action to halt payments on suspect claims before losses accumulate. Extending this information sharing authority would close a significant and preventable fraud gap at minimal administrative cost.

CMS should also require MACs to provide opportunities for Medicare Supplement carriers to engage in timely peer-to-peer consultations on claims where fraud, waste, and abuse is suspected, and should establish a regular stakeholder dialogue—such as a standing meeting—with MA organizations and Medicare Supplement carriers regarding high-risk items and services.

Recommendation #2: BCBSA recommends that CMS remove any contractual, regulatory, or policy language that requires MA plans and Medicare Supplement carriers to continue paying claims when fraud is suspected, regardless of whether CMS has paid its portion of the claim.

Rationale: Removing language that requires payment regardless of CMS action is critical, as current policy effectively requires MA plans and Medicare Supplement carriers to fund fraud that CMS has already identified.

Recommendation #3: BCBSA recommends that CMS require that suspect claims be tagged with a unique code, or alternatively priced at zero member liability, at the time of CMS payment suspension or escrow, to alert MA plans and secondary payers to conduct their own pre-payment review of the affected claims.

Rationale: When CMS escrows a claim pending fraud review, that escrow status is not communicated to secondary payers — meaning the claim is cross walked to the secondary payer with no indication of an issue, leading the secondary payer to process and pay their portion of a claim that CMS has already flagged as potentially fraudulent. A standardized claim-level signal would allow MA plans and secondary payers to immediately identify claims associated with providers under CMS investigation, enabling proactive pre-payment review rather than costly post-payment recovery. Pricing suspect claims at zero member liability achieves the same result by halting further payment while the claim is under review. Either mechanism would dramatically reduce the volume of fraudulent payments that flow through MA plans after CMS has already acted in FFS, without requiring plans to independently identify every fraudulent provider.

Recommendation #4: BCBSA recommends that CMS require MACs to review the clinical appropriateness of suspicious claims.

Rationale: Improving MAC performance in fraud detection would reduce downstream exposure for Medicare Supplement carriers and MA organizations. It would also decrease the time between MAC identification of a suspect claim and notification to Medicare Supplement carriers, as well as strengthen MACs' authority to conduct prepayment reviews. MACs should serve as the first line of defense in fraud detection for all Medicare FFS beneficiaries, with their findings communicated promptly to downstream payers. When MACs identify and act on suspicious claims more quickly, secondary payers have the opportunity to take corresponding action before fraudulent payments accumulate across multiple payer types. Timely MAC-to-plan communication is a low-cost, high-impact mechanism for improving system-wide fraud detection.

Recommendation #5: BCBSA recommends the creation of a National Coverage Determination (NCD) within 6 months of any promulgated MAC local coverage determination (LCD) to ensure consistency, cost effectiveness, value-based care, and high-quality evidence-based medicine for all Medicare beneficiaries.

Rationale: All Medicare beneficiaries should receive high-quality care, regardless of geography. The MAC that first creates an LCD should take the lead in working with the other MACs to achieve consensus and ultimately issue the NCD. Once an initial LCD is published it should be used by all MACs until that MAC develops its own LCD or an NCD is finalized. A consistent LCD approach across MAC jurisdictions would prevent bad actors from moving from one MAC jurisdiction to another to game the system using different LCD criteria for the same condition, procedure, or service. In addition, this type of approach would efficiently leverage the expertise developed by the MACs to share with other jurisdictions.

Recommendation #6: CMS should require MACs to review a larger share of submitted claims to ensure provider adherence to documentation requirements and should oversample items and services prone to inappropriate use and fraud.

Rationale: Because there is no prior authorization process for original Medicare and Medicare Supplement, it is difficult to determine adherence to documentation requirements to ensure the practice of evidence-based medicine. Fraud is known to occur, but the amount of dollars involved in waste and abuse is still unknown and probably significant. This program integrity effort could leverage artificial intelligence tools to minimize administrative burden on MACs.

Recommendation #7: BCBSA recommends that CMS explicitly recognize patient brokering and third-party marketing arrangements as high-risk conduct across DME, genetic testing,

substance use disorder treatment, hospice, and remote patient monitoring services, and incorporate this designation into existing program integrity classification standards and contractor guidance.

Rationale: Patient brokers, call centers, and lead-generation firms have emerged across multiple service areas as a primary driver of medically unnecessary utilization and fraudulent billing in both Medicare Advantage and original Medicare. These arrangements function not as isolated bad actors but as repeat infrastructure for large-scale fraud — connecting complicit providers, suppliers, and marketers in schemes that are difficult to detect and prosecute without targeted program integrity tools. Formally designating these arrangements as high-risk conduct within existing program integrity standards would establish the regulatory foundation needed to justify enhanced oversight, prepayment controls, and disclosure requirements, and would align contractor guidance with fraud patterns that SIU investigations have consistently identified as among the most significant drivers of improper payments across multiple service areas.

Recommendation #8: BCBSA recommends that CMS classify Chronic Care Management (CCM) and time-based Evaluation and Management (E/M) services as high-risk for volume-based analytics and incorporate them into existing program integrity monitoring frameworks accordingly.

Rationale: Time-based billing continues to present substantial abuse risk across both original Medicare and MA. CCM and time-based E/M services are particularly vulnerable because reimbursement is tied to time spent rather than a discrete service delivered, creating opportunities for inflation that are difficult to detect without systematic volume-based monitoring. Designating these service types as high-risk within existing program integrity frameworks would direct contractor and plan oversight resources toward an area where the potential for abuse is well-documented and where early detection can prevent significant improper payments.

Recommendation #9: BCBSA recommends that CMS clarify documentation standards distinguishing non-complex and complex CCM to reduce exploitable ambiguity between the two coding levels.

Rationale: The ambiguity between non-complex and complex CCM documentation requirements creates a significant and exploitable gap that allows providers to upcode to the higher-reimbursing complex CCM code without meeting the clinical and documentation thresholds that justify the higher payment. Specifically, non-complex CCM (CPT 99490) requires at least 20 minutes of clinical staff time per month, while complex CCM (CPT 99487) requires at least 60 minutes and moderate or high complexity medical decision-making. The absence of specific, objective criteria defining what constitutes moderate or high complexity medical decision-making means providers can bill the higher-reimbursing complex code using templated or vague clinical notes that do not meaningfully distinguish the encounter from a non-complex service — making this one of the easier upcoding schemes to execute and one of the harder ones to audit and recover on after the fact. Clearer, more specific documentation standards—including objective clinical criteria that must be met and documented to support the complex CCM code—would reduce this ambiguity, give MA plans and contractors a consistent standard against which to evaluate claims, and deter the opportunistic upcoding that currently drives a meaningful share of CCM billing abuse.

Recommendation #10: BCBSA urges CMS - in partnership with the Departments of Labor and Treasury as well as the Office of Management and Budget (OMB)—to finalize an enhanced IDR Operations Final Rule as soon as possible.

Rationale: The IDR process, as outlined in the No Surprises Act, is intended as the mechanism of last resort for payers and a specific subset of out-of-network facility-based providers to resolve payment disputes. The current rulemaking implementing the IDR process is extremely challenging for parties to navigate and has significant opportunities for gaming, as demonstrated by the number of decisions being made on ineligible cases coupled with the volume of cases being submitted and the excessive success rate for providers under the process. The IDR process is highly biased, with payments amounts often awarded well in excess of market rates. The lack of effective regulations governing the IDR process is incentivizing providers not to contract with health plans in hopes of higher awards through IDR, distorting contract negotiations and incentivizing further provider consolidation in the market. This is imposing significant unnecessary costs upon the federal government, employers and private consumers.

There are clear actions the Departments can take to reduce burden, costs and misuse of the IDR process. Much of what was proposed in the Federal IDR Operations Proposed Rule (88 FR 75744) has the potential to address some of the issues with IDR and reduce burden on all stakeholders involved. The Departments have signaled an interest in finalizing this rule.

Recommendation #11: BCBSA recommends that CMS launch the IDR Gateway as soon as possible to serve as the primary entry point for initiation of disputes.

Rationale: BCBSA was pleased to see CMS announce the impending launch of the IDR Gateway. A truly dynamic IDR portal will meaningfully improve the efficiency and accuracy of the IDR process and support compliance with the requirements of the process. The lack of a standardized process for submitting initiation of disputes has caused inefficiencies, confusion and delays in processing. Providers submit disputes through various channels, including physical forms and various electronic channels, to multiple destinations. A clearly defined point of entry through the new IDR Gateway with a standardized set of instructions for initiating disputes would help streamline the process for all parties, reduce administrative burden and improve timeliness of the process. All of these improvements support a more accurate and transparency process that should help reduce the gaming that is happening today and driving up costs.

Recommendation #12: BCBSA recommends that CMS integrate mechanisms into the IDR Gateway to remove ineligible cases from the IDR process prior to Independent Dispute Resolution Entity (IDRE) review.

Rationale: In 2024, nearly 40% of disputes initiated were for ineligible claims that should not have been submitted to IDR (e.g., Medicare Advantage claims, state-eligible billing claims, the same surprise billing claim being resubmitted to different IDREs, claims involving in-network providers).[1] Despite their ineligibility, many of these cases still resulted in payment awards, creating waste and driving up costs without benefiting patients. A subset of providers is actively exploiting this gap, submitting ineligible claims at volume to overwhelm the system and undermine its capacity to render fair, impartial and timely decisions. Implementing baseline eligibility checks within the IDR Gateway – applied before fee payment or IDRE review – would address this abuse directly. Such screening would reduce administrative burden on the IDRE, improve compliance by educating plans and providers on eligibility criteria

[1] America's Health Insurance Plans. "New AHIP/BCBSA Survey Shows Nearly 40% of Providers' Surprise Billing Disputes Are Ineligible Under No Surprises Act." *AHIP*, 24 Oct. 2025, www.ahip.org/news/press-releases/new-ahip-bcbsa-survey-shows-nearly-40-of-providers-surprise-billing-disputes-are-ineligible-under-no-surprises-act.

and help curb the systemic cost drivers that have made IDR administration unsustainably expensive.

Recommendation #13: BCBSA recommends that CMS establish a process for parties to submit a request for review of an eligibility determination before the submission of offers.

Rationale: The current mechanisms for disputing eligibility determinations and for IDREs to assess case eligibility are inadequate — and certain providers are exploiting these gaps to introduce ineligible cases into the IDR process. Establishing a review process for incorrect eligibility determinations would reduce the burden of ineligible disputes on the IDR process and reduce the incentivizes for certain providers to flood the process with ineligible cases. This review process would be separate from the process to rectify errors in IDRE determinations because it should occur prior to submission of offers, and would allow remediation of ineligible cases before the case is determined reducing waste and the overall costs associated with IDR.

Recommendation #14: BCBSA recommends that if an eligibility review request is submitted, the process should be paused for up to four days to give IDREs additional time to review the appeal.

Rationale: Given the high volume of ineligible cases entering the IDR process, IDREs could receive substantial requests for formal appeals of eligibility determinations. Extending the timeline for IDREs to review would allow sufficient time for review of the appeal and ensure that IDREs do not have to rush other steps of the process following an appeal, improving the quality of the determinations being made.

Recommendation #15: BCBSA recommends that CMS establish an eligibility fee, paid by the initiating party at the time of initiating a dispute.

Rationale: As discussed above, the IDR system is overwhelmed with ineligible cases – including cases such as claims from in-network providers, Medicaid and Medicare claims, and claims for other health plans — that never should have been filed. Many still result in payment determinations, driving up costs without benefiting patients. An upfront eligibility fee would create a financial deterrent against bad-faith submissions and remunerate IDREs so that they are not overly incentivized to push ineligible claims through the process for reimbursement.

If a dispute is determined to be eligible, the eligibility fee would be applied to the IDR fee for that party. However, if the claim is determined ineligible, the fee would be forfeited by the initiating party and retained by the IDRE to cover their claim eligibility review time and process – ensuring those who burden the system bear its costs.

These ineligible submissions are heavily concentrated in a small number of providers who appear to be using these ineligible submissions as a deliberate strategy to overwhelm the IDR process to maximize profit. CMS should disincentivize this strategy in reasonable ways, consistent with the requirements and intent of the statute. An eligibility fee would reduce the incentive to file nonqualifying claims, reduce the incentives to push ineligible cases through to final determinations, lower the administrative burden on the federal government, and better protect patients from the downstream cost effects of a system under strain.

Recommendation #16: BCBSA recommends that CMS require IDREs to issue written notice to all parties of eligibility determination outcomes — including a clear explanation of the basis for the determination — before offers are required to be submitted.

Rationale: As discussed, ineligible cases are still being processed through IDR, often without consideration for documentation being submitted by the non-initiating party demonstrating the

ineligibility of the case. Requiring post-eligibility review notification with specific information on how the determination was made would ensure that there is an active review of eligibility before a case is fully reviewed, minimizing the number of ineligible cases that result in a final determination and discouraging the submission of ineligible cases. This will ultimately reduce the burden of the IDR process on all parties and reduce the wasteful costs of inappropriate determinations on cases that should never have been submitted.

Recommendation #17: BCBSA recommends that CMS require IDREs to provide robust rationale on the Final Determination notice, including reasoning as to why the non-prevailing party's offer was not selected and why the prevailing party won.

Rationale: IDRE rationales are frequently missing or vague. This insufficient insight into determinations limits parties' ability to contest inappropriate decisions and make more informed submissions in the future. It also limits CMS' ability to conduct oversight of IDRE performance. Without clear, concise rationales it is not possible for CMS to fully assess whether IDREs are making informed determinations, consistent with the statute and subsequent regulations and guidance. CMS should require IDREs to apply more rigor when complying with the statutory requirement to provide a rationale for their determination. Final Determinations should not be considered issued until such time as the IDRE has furnished all parties with the logistical information necessary to effectuate payment. These steps are essential to make sure decisions are not encouraging misuse of the process.

Recommendation #18: BCBSA recommends that the Departments require IDREs to share both parties' submissions with the other party along with the Final Determination Notice.

Rationale: Sharing both parties' submissions, ideally through a mutually accessible portal, would expedite the exchange of information and reduce back and forth with providers. It would also promote transparency, likely improving the quality of each party's submissions and the subsequent quality of the IDR decisions.

Without this transparency, non-initiating parties do not have an efficient way to identify or challenge errors in IDRE determinations – including cases where one party has submitted incorrect or fraudulent information. BCBS Plans have experienced providers submitting documentation on rates and contracting from one health plan and representing it as a different health plan's documentation in their IDR submission. Under the current process, there is no way to address these issues and no way to discourage entities from repeating the behavior. This encourages gaming of the process, driving up costs for all stakeholders, including patients.

Recommendation #19: BCBSA recommends that CMS establish a clear set of performance metrics tied to transparent penalties and corrective actions for IDREs associated with poor performance or lack of compliance.

Rationale: The IDR process is overrun with fraud, abuse and misuse. IDREs frequently demonstrate bias, conflicts of interest, a lack of consistency and accountability in determinations and a lack of awareness of eligibility criteria. IDREs are incentivized to favor providers as providers submit the vast majority of disputes, and IDR operates on a fee-for-service basis. As a result, dispute volume has grown year-over-year as providers increasingly win favorable determinations from IDREs. IDREs made over $1.1 billion on IDR fees in the law's first two years.[2]

[2] Chartock, Benjamin, and Whaley, Christopher, "Arbitration and Negotiated Prices: Evidence from Insurer–Doctor Disputes" (2026). Working Paper. https://doi.org/10.26300/mmce-z888

A robust approach is needed to monitor IDREs and enforce corrective actions and/or penalties for lack of compliance with the statutory and regulatory requirements or poor performance. By establishing clear performance metrics, tracking IDRE performance, and objectively assessing performance, CMS can identify and impose appropriately calibrated corrective actions and/or penalties when needed. This level of oversight and enforcement will help to ensure IDREs are making thoughtful, thorough reviews for all IDR determinations and complying with the program's requirements, supporting the consistency and impartiality in decisions necessary for an effective IDR process.

Recommendation #20: BCBSA recommends that the Departments develop a system to monitor for and apply penalties in response to problematic provider behaviors, as well as their contracted vendors.

Rationale: Current enforcement efforts have focused predominantly on health plans and issuers while a subset of provider groups are not acting in good faith regarding open negotiation and the IDR process. These actors are using IDR as a revenue model, exploiting loopholes to submit duplicative, ineligible or inflated disputes, undermining Congressional intent and driving up market-wide costs. For example, a subset of providers who frequently submit large numbers of ineligible disputes to IDR are providers: (1) with established contracts with health plans, (2) who file cases multiple times under different IDREs, or (3) who hugely inflate the submitted charges on disputes. The scale of this abuse is striking— in the first half of 2024, just three private-equity-backed provider groups accounted for 44% of arbitration cases.[3] Third-party billing firms have emerged solely to maximize provider revenue through aggressive IDR filing. HaloMD alone initiated 22% of disputes in Q2 of 2025.[4] This is not incidental misuse, but systematic exploitation of structural gaps in the process.

There are currently no consequences for entities that submit thousands of ineligible or duplicative claims. Since these providers and middlemen are successful with these practices and regularly are awarded reimbursement well above market rates, health plans are being pressured to offer higher than competitive rates to keep these and other providers in network. This increases costs for patients, going against the intention of the No Surprises Act (NSA). CMS and the Departments could address this accountability gap by developing a series of outlier performance metrics and reporting mechanisms to identify parties misusing the IDR process. The Departments should then align these metrics with a standardized set of associated penalties to disincentivize problematic behaviors. These behaviors could be identified through outlier performances on metrics such as percentage of disputes found ineligible, percentage of duplicate disputes, periodic spikes in filed dispute volumes, number of new disputes initiated during the cooling off period and frequency of disputes with clearly ineligible circumstances (e.g., in-network claims).

Recommendation #21: BCBSA recommends CMS reimplement heightened cancellation standards for urban hospitals reclassifying as Rural Referral Centers (RRCs) under the 275-

[3] Departments of Health and Human Services, Labor, and the Treasury. "Supplemental Background on Federal Independent Dispute Resolution Public Use Files: January 1, 2024 – June 30, 2024." *CMS*, 18 Mar. 2025, www.cms.gov/files/document/supplemental-background-federal-idr-puf-january-1-june-30-2024-march-18-2025.pdf.

[4] Centers for Medicare & Medicaid Services. "Independent Dispute Resolution Reports." *CMS*, last modified 19 Dec. 2025, www.cms.gov/nosurprises/policies-and-resources/reports.

bed loophole, increasing the time that a hospital must maintain their RRC and rural status to at least three full rate years.

Rationale: The strategic manipulation of Medicare's hospital reclassification system represents a form of payment gaming that undermines the integrity of Medicare rate setting, artificially inflates hospital reimbursement, and drives unnecessary administrative costs into the Medicare Advantage program. Many of the large, high-wage paying hospitals that are able to have the greatest impact on hospital IPPS rates rely on the ability to reclassify as an RRC by simply having more than 275 beds. See 42 CFR 412.96. Prior to the FY2020 rate year, CMS had imposed a higher standard for cancelling a hospital's rural reclassification based on its RRC reclassified status as compared to other reclassification tests. See 42 CFR 412.103(g). This was in part to prevent the type of reshuffling that is now occurring due to the ease with which hospitals can meet the 275-bed rule. Increasing the time that a hospital must maintain their RRC and rural status to at least three full rate years would reduce the frequency with which hospitals could potentially shuffle IPPS rates in their given states and create more predictability in cost and rate expectations across the entire health care industry. The three-year period is justified because it would still allow hospitals to revert to their urban status after making a conscious and considered decision to seek RRC reclassification and is consistent with the 3-year period that generally applies to geographic reclassification under section 1886(d)(10) as well as the 3-year industry standard term for many Plan-hospital contracts.

Recommendation #22: BCBSA recommends CMS apply heightened cancellation standards to other bases for reclassification where CMS identifies similar gaming trends or potential.

Rationale: The gaming behavior described in Recommendation #21 is not limited to RRC reclassification. The same incentive structure that drives hospitals to repeatedly reclassify and revert under the 275-bed rule exists wherever hospitals can test CMS' rate methodology to optimize reimbursement. Extending heightened cancellation standards to other reclassification bases where CMS identifies similar patterns would close additional avenues for systematic gaming before they are exploited at scale.

Recommendation #23: BCBSA recommends CMS create a single clearinghouse for all reclassification application submissions, including Lugar, (d)(8), and (d)(10) reclassifications**.**

Rationale: Currently, hospitals submit reclassification applications (and subsequent withdrawals or cancellation requests) to a myriad of different actors within CMS, including agency personnel, Medicare Administrative Contractors, and the MGCRB. The fragmentation of this process makes it difficult for CMS, Plans, and policymakers to track reclassification activity in any systematic way, limiting the agency's ability to identify and respond to gaming patterns. A single clearinghouse would consolidate this activity in one place, improving CMS' program integrity oversight and reducing the administrative burden on Plans that must currently monitor multiple channels to anticipate rate impacts.

Recommendation #24: BCBSA recommends CMS publish notice of all reclassification applications, withdrawal and cancellation requests, and agency decisions in real time.

Rationale: The relative anonymity with which hospitals may seek reclassification likely promotes gaming behavior and provides limited options to deter against opportunistic or poorly justified requests—making real-time public notice a direct and effective deterrent. With the

limited exception of applications to the MGCRB, notice of reclassification requests are not made public, and even those submitted to MGCRB are not published in anything close to real time. The lack of information about hospital reclassifications is a major impediment for Plans and others to track and prepare for how hospital rates may fluctuate over the near-to-medium future. This impact is particularly acute during the period between when Plans must submit MA bids to CMS but before CMS has issued the IPPS final rule, during which hospitals are permitted to submit reclassification and cancellation requests that can take effect for the upcoming IPPS rate year—yet Plans are already locked into their bids without visibility into these pending changes. In fact, in recent years, some Plan service areas have seen significant increases of more than 20% in hospital rates between the proposed and final IPPS rates. Making reclassification data publicly available would also strengthen CMS' own program integrity oversight by giving the agency and Congress better visibility into the scope and patterns of reclassification gaming, enabling more targeted and effective policy intervention.

Issue #2: Improvements to Information Gathering Processes

CMS solicits comments on changes the agency or its contractors can make to existing processes to more expeditiously gather actionable information.

Recommendation #1: BCBSA recommends that CMS create structured, real-time data sharing channels between CMS and MA plans to enable the timely exchange of fraud intelligence, including provider suspension and escrow actions, payment holds, and credible allegations of fraud.

Rationale: As discussed in Issue 1, MA plans currently operate without reliable, timely access to CMS' fraud intelligence. This information gap allows bad actors to continue billing MA plans after CMS has identified and acted on suspected fraud in FFS. Formalizing real-time data sharing channels would allow CMS to push actionable fraud signals to plans before losses accumulate and would allow MA plans to take corresponding pre-payment action on suspect claims without waiting for independent discovery of the same fraud.

Recommendation #2: BCBSA recommends that CMS expand its existing public-private collaboration infrastructure, including the Healthcare Fraud Prevention Partnership (HFPP).

Rationale: BCBS Plans participate actively in the HFPP and other CMS-led fraud prevention forums and their experience demonstrates that public-private data sharing produces meaningful fraud detection improvements. Plan SIUs currently operate national working groups on high-risk fraud areas including DME and SUD, sharing scheme intelligence, investigative techniques, and emerging fraud trends in real time across BCBS Plans. These existing infrastructure investments represent a ready and scalable model for the kind of bidirectional intelligence sharing CMS is seeking to build. Formalizing and expanding these channels would allow MA plans to share emerging fraud intelligence with CMS in near-real time, complementing the CMS-to-plan sharing described in Recommendation #1 above.

Recommendation #3: BCBSA recommends that CMS encourage cross-code time validation to identify implausible cumulative billing across CCM, E/M and telehealth services within a single day or billing period.

Rationale: A common abuse pattern in time-based billing involves providers accumulating CCM, E/M, and telehealth service times that, when combined, exceed what is physically possible within a given day or billing period. Cross-code time validation—systematically comparing cumulative billed time across related service codes for the same provider and

patient— is an effective analytical tool for identifying these implausible billing patterns before payment is made. Encouraging CMS contractors and MA plans to apply this validation as a standard information gathering and claims review practice would materially improve detection of time-based billing abuse across both original Medicare and MA.

Issue #3: Oversight and Enforcement Transparency

CMS solicits comments on how it can improve transparency in oversight and enforcement activities.

Recommendation #1: BCBSA recommends that CMS publish a clear enforcement sequencing framework that defines: the standards of evidence required to trigger each type of enforcement action; the timeline for each stage of the enforcement lifecycle; the appeals and corrective action processes available to affected parties; and how CMS will coordinate with MA plans throughout an investigation.

Rationale: The absence of clearly defined enforcement sequencing creates significant compliance risk for MA plans. When CMS moves to implement new enforcement mechanisms, as it has signaled it intends to do through this RFI, plans need sufficient notice and operational guidance to implement required processes without disrupting beneficiary access to care or triggering unintended consequences such as inaccurate fraud flagging, Medical Loss Ratio (MLR) implications from suspended or reprocessed payments, or legal exposure from provider contract disputes. BCBSA urges CMS to publish this enforcement framework before any new program integrity requirements take effect.

Recommendation #2: BCBSA recommends that CMS leverage Health Plan Management System (HPMS) memoranda to periodically issue advisories that summarize fraud, waste, and abuse schemes identified through audits and oversight activities.

Rationale: Periodic advisories would give plans advance insight into evolving fraud, waste, and abuse risks. Currently, CMS publishes alerts and program integrity updates, but these communications typically provide only high-level descriptions of the basis for enforcement. Expanding these communications to include anonymized summaries of identified schemes and indicators for detection would enhance transparency and allow plans to better anticipate emerging risks. It would also help direct plans' oversight efforts toward areas where CMS has already identified as presenting program integrity concerns.

Recommendation #3: BCBSA recommends that CMS provide anonymized, region-level data highlighting geographic hot spots where billing or utilization patterns indicate elevated risk of fraud, waste, or abuse.

Rationale: Making this information available would give plans advance insight into regional risk patterns, enabling more focused monitoring and oversight efforts. By highlighting areas with outlier trends, CMS can support proactive detection of potential fraud, waste, and abuse.

Recommendation #4: BCBSA recommends that CMS require the CMS Payment Suspension report to include the rationale for each suspension.

Rationale: Currently, MA plans receive little to no information about why CMS has suspended payments to a provider, making it difficult for plans to assess the scope of the fraud concern, determine which of their own claims may be affected, and take appropriate pre-payment or post-

payment action. Including the rationale in the suspension report would give MA plans the information they need to act as effective partners in fraud prevention.

Recommendation #5: BCBSA recommends that CMS expand and strengthen transparency mechanisms related to fraud, waste, and abuse referral coordination and engagement across its program integrity contractors, including the Medicare Drug Integrity Contractors (MEDICs), UPICs, and the National Benefit Integrity Medicare Drug Integrity Contractor (NBI MEDIC), by providing greater granularity into how referrals and overpayments are evaluated, clearer visibility into escalation pathways to the Office of the Inspector General (OIG) and Department of Justice (DOJ), and structured feedback to MA plans and MCOs on referral quality and outcomes.

Rationale: CMS transparency mechanisms related to fraud, waste, and abuse (FWA) referral coordination across MEDICs, UPICs, and the NBI MEDIC are helpful but would benefit from expansion. Without structured feedback on how referrals are acted upon and what outcomes they produce, MA plans and MCOs cannot assess the effectiveness of their own fraud detection and referral activities, align their efforts with federal enforcement priorities, or improve the quality of future referrals. Closing this feedback loop would strengthen the overall program integrity ecosystem and better position plans as active partners in CMS' enforcement efforts.

Recommendation #6: BCBSA recommends that CMS establish a structured feedback mechanism allowing MA plans to report billing migration attempts—instances where providers shift billing to other payers, service areas, or newly established provider entities following CMS enforcement actions.

Rationale: When CMS takes enforcement action against a provider, bad actors frequently respond by migrating their billing operations to MA plans or newly established provider entities to continue fraudulent activity. MA plans are often the first to observe these migration patterns through their SIU claims monitoring, but currently have no formal channel through which to report these observations back to CMS in a structured, actionable way. Establishing a dedicated feedback mechanism would give CMS early visibility into post-enforcement billing migration and help close the gap that allows bad actors to continue operating after federal enforcement action.

Recommendation #7: BCBSA recommends that CMS use MA plan feedback on billing migration and emerging fraud patterns to systematically refine preclusion list criteria, payment suspension thresholds, and analytic triggers over time.

Rationale: Program integrity tools are most effective when they are regularly updated to reflect real-world fraud patterns as they evolve. Currently, preclusion list criteria, suspension thresholds, and analytic triggers are set administratively without a formal mechanism for incorporating the ground-level intelligence that MA plans accumulate through their SIU operations. Creating a structured process for CMS to incorporate MA plan feedback into the ongoing refinement of these tools would strengthen the entire program integrity ecosystem and ensure that federal enforcement mechanisms keep pace with the increasingly sophisticated schemes that bad actors deploy in response to existing controls.

Issue #4: Payment Suspensions in MA and Part D

CMS solicits comments on whether it should establish regulatory requirements that allow MA organizations and Part D sponsors to implement payment suspensions under

circumstances similar to original Medicare's authority under 42 CFR 405.371, and require suspensions when directed.

Recommendation #1: BCBSA recommends that CMS proceed cautiously with mandatory payment suspension authority for MA plans and urges CMS to pilot and test any such authority before widespread regulatory implementation.

Rationale: While BCBSA shares CMS' commitment to stopping fraudulent payments as quickly as possible, mandatory payment suspension authority for MA plans carries significant operational, legal, and financial risks that must be carefully managed. MA plans currently lack the internal infrastructure to implement payment suspensions rapidly and accurately.

This is critically important because of the material differences between MA and original Medicare. In original Medicare, CMS functions as the payer to providers, making payment suspension a direct and targeted action. In contrast, CMS provides capitated payments to MA plans, who then pay providers. MA plans also bear the financial risk and must maintain provider network contracts, obligations that do not exist in the original Medicare context and may conflict with a mandatory suspension requirement. The substantial differences between the two programs mean that a direct application of 42 CFR 405.371 may not be well-suited to the MA program without significant modification. CMS should ensure that it accounts for the structural differences between the two programs before considering establishing this authority.

Moreover, without adequate lead time and clear operational guidance, swift enforcement actions risk inaccurately flagging routine or clerical billing errors as fraud, triggering costly remediation cycles, creating MLR complications if payments are withheld or later reprocessed, and accelerating compliance exposure faster than plans can complete thorough internal reviews. Provider contracts also require careful consideration—while CMS-directed suspension authority would provide MA plans with legal cover to act against providers without fear of breach of contract claims, plans would need time to develop notification procedures, appeals processes, and reinstatement workflows.

A mandatory suspension requirement imposed by CMS risks disrupting beneficiary access to care, delaying medically necessary services, and creating provider abrasion—all of which fall on the plan and its members. Beneficiaries who depend on suspended providers for ongoing care may face interruptions in treatment, challenges in identifying alternative providers within their network, and delays in receiving medically necessary items and services. Clarifying permissive authority respects the operational reality of MA plans and leverages their existing fraud prevention capabilities without imposing a top-down mandate that could cause more harm than it prevents.

MA plans already have strong financial incentives to stop payments to bad actors, and BCBSA encourages CMS to consider enhanced CMS-to-plan information sharing as a complementary or alternative mechanism before imposing mandatory suspension authority. A universal requirement for MA organizations to suspend payments when directed by CMS would reduce variability across the MA market and reduce the likelihood that bad actors are treated differently by different plans. We suggest CMS look to Medicaid's credible allegation of fraud (CAF) framework as a model for implementing payment suspensions—it provides a robust, government-driven process with strict evidentiary standards that could be adapted for MA.

Finally, if CMS moves forward, BCBSA recommends that any payment suspension framework include: (1) a phased implementation timeline that allows MA plans to build the necessary

operational infrastructure; (2) clearly defined evidentiary standards specifying what constitutes a credible allegation of fraud sufficient to trigger a suspension; (3) explicit due process requirements including provider notification and the right to appeal; (4) safe harbor protections for MA plans against provider breach of contract claims arising from CMS-directed suspensions; and (5) clear CMS guidance on the treatment of suspended payments under the medical loss ratio (MLR) calculation.

Recommendation #2: For claims associated with providers under CMS investigation, BCBSA recommends that CMS provide MA plans with the ability to deny a claim, including in cases where CMS appears to have paid its portion of the claim in Medicare FFS.

Rationale: Current CMS audit requirements and payment policies can conflict directly with MA plan efforts to prevent fraudulent payments. When CMS has an active investigation into a provider—identified by it suspending or escrowing FFS payments to that provider—MA plans should have the ability to similarly suspend payment to the provider's services pending their own internal review. This is a commonsense flexibility to ensure both Medicare FFS and MA plans are coordinated on fraud prevention efforts and collectively are being good stewards of the Medicare Trust Fund.

Recommendation #3: BCBSA recommends CMS provide exceptions to audit requirements to allow plans to conduct pre-payment reviews for claims associated with providers under CMS investigations.

Rationale: Providing a clear exception to audit requirements for claims under active fraud investigation would remove a significant barrier to proactive fraud prevention by MA plans and eliminate a structural inconsistency in the current framework.

Recommendation #4: BCBSA recommends that CMS clarify that MA plans have the permissive authority to pend claims when billing patterns demonstrate high correlation with known broker-driven schemes.

Rationale: MA plans are well-positioned to identify billing patterns highly correlated with known broker-driven schemes through their SIU analytics and claims review processes. However, plans currently lack clear regulatory authority to act on those patterns through prepayment controls. Providing explicit permissive authority to pend claims based on broker-correlated billing patterns would give MA plans a critical and currently absent tool to disrupt these schemes before fraudulent payments accumulate, consistent with plans' existing financial incentives and operational capabilities to identify and stop fraud at the point of payment.

B. Enhanced Identity Proofing and Ownership Requirements

Issue #1: Expanding Use of Finger Printing and Background Checks

CMS solicits comments on whether fingerprinting and criminal background checks should be expanded beyond current high-risk category owners to include managing employees, less-than-5% owners, or other affiliated individuals.

Recommendation #1: BCBSA recommends that CMS prioritize the expansion of fingerprinting and criminal background checks for provider and supplier types with the highest documented fraud risk, particularly DMEPOS suppliers.

Rationale: BCBSA supports expanding fingerprinting and criminal background check requirements to include managing employees and all individuals with any ownership interest in high-risk provider and supplier organizations, not only those with 5% or greater ownership. Expanding background checks to managing employees and smaller ownership stakes is a reasonable and proportionate program integrity measure. Fraudulent actors frequently structure ownership to fall below screening thresholds, and managing employees often exercise de facto control over billing and operations regardless of their formal ownership stake. However, BCBSA cautions that background check expansion alone is unlikely to be sufficient to address the full scope of Medicare fraud risk. As noted in recent analysis, the majority of FFS fraud stems from documentation deficiencies rather than identity-based fraud, and CMS should treat background check expansion as one component of a broader, layered fraud prevention strategy rather than a primary solution.

Issue #2: Alternative Identity Proofing Measures

CMS solicits comments on alternative identity proofing measures that could effectively verify the identity and location of owners while balancing program integrity with operational needs.

Recommendation #1: BCBSA recommends that CMS leverage existing identity verification infrastructure, including ID.me and CLEAR, as the primary mechanism for verifying the identity and location of owners associated with Medicare-enrolled entities, rather than developing duplicative or parallel verification systems.

Rationale: CMS already conducts identity verification at the provider and supplier enrollment stage using proven, scalable tools such as ID.me and CLEAR. Relying on these existing tools to ensure a centralized CMS process is more efficient and effective than requiring each Medicare Advantage (MA) plan to independently verify provider ownership structures, which are often complex, multi-layered, and difficult to assess without access to federal databases.

Recommendation #2: BCBSA recommends that CMS retain primary responsibility for identity verification at the provider and supplier enrollment stage, rather than placing this responsibility on individual MA plans.

Rationale: Placing identity verification responsibility on MA plans would create duplicative administrative burden across the MA market, increase costs, and produce inconsistent outcomes across plans. A CMS-led, centralized approach would achieve stronger program integrity results with less total system burden.

Recommendation #3: BCBSA recommends that CMS clearly define what constitutes an "ownership or control interest" for purposes of enhanced identity proofing and citizenship or residency requirements, as complex corporate structures can make ownership determination inherently difficult and produce inconsistent results across Medicare-enrolled entities without a clear regulatory definition.

Rationale: Provider and supplier ownership structures are often opaque and multi-layered, with ownership interests held through parent companies, holding entities, and investment vehicles that obscure who ultimately controls an organization. Without a clear regulatory definition of what constitutes an ownership or control interest, both MA plans and providers will face uncertainty in applying any new requirements, leading to inconsistent implementation, compliance disputes, and administrative costs that fall disproportionately on legitimate entities

with complex but lawful business structures. A clear, consistently applied definition is a foundational prerequisite to any workable identity proofing or citizenship requirement.

Issue #3: Priority Provider Types for Enhanced Identity Proofing

CMS solicits comments on provider or supplier types for which enhanced identity proofing and citizenship/residency requirements are most critical.

Recommendation #1: BCBSA recommends that CMS prioritize enhanced identity proofing requirements for Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS), home health agencies, clinical laboratories substance use disorder treatment facilities, and mental health providers.

Rationale: DMEPOS fraud, including fraudulent billing for equipment never delivered, medically unnecessary items, and services ordered by complicit or fabricated physicians, represents one of the most persistent and well-documented fraud risks in both original Medicare and Medicare Advantage. Recent DOJ cases have specifically identified foreign nationals exploiting opaque DMEPOS ownership structures to commit Medicare fraud, making this provider type the most logical starting point for enhanced identity proofing requirements. Notably, DMEPOS fraud is not confined to specific geographic markets – suppliers can bill MA plans from anywhere in the country, making a market-based threshold an insufficient filter for this provider type. A targeted approach that begins with the highest-risk provider types allows CMS to test and refine its verification processes before broader application, reducing the risk of unintended disruption to legitimate providers.

Issue #4: Enhanced Identity Proofing for Additional Individuals

CMS solicits comments on additional individuals on the enrollment record for whom enhanced identity proofing and citizenship or residency requirements would help prevent fraud.

Recommendation #1: BCBSA recommends that CMS require providers and suppliers operating in high-risk service areas—including DME, genetic testing, substance use disorder treatment, hospice, and remote patient monitoring — to disclose all marketing, call-center, and lead-generation relationships as part of the Medicare enrollment and revalidation process.

Rationale: The absence of any enrollment-stage disclosure requirement for marketing and lead-generation relationships allows patient brokering arrangements to operate invisibly within the Medicare program. Providers and suppliers in high-risk service areas routinely rely on third-party marketing firms, call centers, and lead-generation companies to generate patient referrals — arrangements that have repeatedly served as the infrastructure for large-scale fraud schemes documented in OIG reports and DOJ enforcement actions. Requiring affirmative disclosure of these relationships at enrollment and revalidation would give CMS visibility into financial arrangements that currently go unreported, create an accountability mechanism that deters bad actors, and generate data that CMS and MA plans can use to identify and monitor high-risk provider networks before fraudulent billing occurs.

Issue #5: Challenges Associated with Enhanced Identity Proofing and Citizenship/Residency Requirements

CMS solicits comments on challenges that these requirements would create for entities with foreign parent companies, international investors, or legitimate cross-border business structures.

Recommendation #1: BCBSA recommends that CMS establish alternative compliance pathways for entities with foreign parent companies or international investors that can demonstrate legitimate business structures, verified compliance histories, and ongoing accountability mechanisms.

Rationale: Not all entities with foreign ownership pose a fraud risk, and a well-designed identity proofing framework should distinguish between legitimate cross-border business structures and opaque ownership schemes designed to evade oversight. Many large, reputable health care organizations operate with international parent companies or investors and play an important role in Medicare provider networks.

Imposing blanket citizenship or residency requirements without alternative compliance pathways would impose significant administrative burden and cost on these entities - resources that would otherwise be directed toward beneficiary care - and could cause network adequacy deficiencies in markets where these organizations are significant providers. CMS should ensure that any enhanced requirements are proportionate to the actual fraud risk presented and include meaningful flexibility for entities that can demonstrate legitimate operations.

Recommendation #2: BCBSA recommends that CMS provide adequate transition timelines for entities currently enrolled in Medicare that would need to restructure ownership or satisfy new documentation requirements as a result of any enhanced identity proofing or citizenship and residency rules, to avoid abrupt disruptions to provider networks and beneficiary access to care.

Rationale: Medicare-enrolled entities with existing ownership structures that may not immediately satisfy new requirements will need sufficient time to assess their compliance posture, pursue any necessary restructuring, and gather required documentation. Abrupt implementation without adequate transition periods risks forcing providers to withdraw from Medicare networks before compliant structures can be established - reducing network adequacy, limiting beneficiary access, and creating market disruptions disproportionate to the fraud prevention benefit achieved. A reasonable transition timeline is consistent with how CMS has approached other major enrollment and ownership requirement changes and is essential to protecting both program integrity and beneficiary access simultaneously.

C. Preclusion List and Medicare Advantage Enrollment Requirements

Issue #1: Preventing Original Medicare-revoked Providers from Billing MA Plans

CMS solicits comments on changes CMS could make to better effectuate the preclusion list to prevent original Medicare-revoked providers from continuing to bill MA plans.

Recommendation #1: BCBSA recommends that CMS expand the preclusion list to include all providers and suppliers revoked from original Medicare, regardless of whether the revocation was determined to be “detrimental to the best interests of the Medicare program.”

Rationale: Under current policy, providers revoked for non-detrimental reasons are not placed on the preclusion list and can continue to bill MA plans—a well-documented and deliberately exploited loophole. All original Medicare revocations, regardless of reason, should result in automatic placement on the preclusion list and should trigger immediate notification to MA plans.

The current two-tiered preclusion list framework creates a structural gap that bad actors exploit by shifting billing operations from original Medicare to MA plans after an FFS revocation. CMS has itself acknowledged this problem in the RFI, noting that providers revoked for non-detrimental reasons "often shift their billing operations to MA plans, where they can continue to submit claims and receive payment." This is precisely the kind of fraud arbitrage the CRUSH initiative is designed to eliminate. Expanding the preclusion list to cover all revocations removes this escape route and creates a consistent program integrity standard across original Medicare and MA.

Issue #2: Current Preclusion List

CMS solicits comments on whether the current preclusion list adequately serves the needs of MA organizations in identifying fraud, waste, or abuse risks.

Recommendation #1: BCBSA recommends that CMS make the following specific improvements to the preclusion list to better serve the needs of MA organizations: (1) update the list more frequently, moving toward real-time or near-real-time updates rather than the current periodic refresh cadence; (2) include all revocation reasons, not only those deemed detrimental; (3) provide MA plans with structured data feeds rather than requiring manual lookups; and (4) include additional provider risk indicators beyond revocation status, such as payment suspensions, credible allegation of fraud findings, and open OIG investigations, to give MA plans a more complete picture of provider integrity risk.

Rationale: The preclusion list in its current form is both incomplete and insufficiently timely to serve as an effective MA program integrity tool. MA organizations have consistently found that the list does not adequately reflect the full population of providers posing active fraud risk, and the periodic update cadence means that newly revoked or suspended providers can bill MA plans for extended periods before plans are aware that action has been taken.

Further compounding this problem, the infraction underlying a revocation or suspension typically occurs months before the provider is placed on the preclusion list—meaning the gap between a provider's problematic conduct and their appearance on the list is even longer than the update cadence alone would suggest. By the time a plan can act, the gap between a provider's misconduct and the plan's ability to respond allows fraudulent or improper claims to continue to flow. Structural improvements to the list's content, frequency, and delivery format would materially improve its effectiveness as a fraud prevention tool without requiring new statutory authority.

Issue #3: Original Medicare Enrollment as a Condition of Billing MA Plans

CMS solicits comments on whether MA plans support a requirement for all providers and suppliers to enroll in original Medicare as a condition of billing MA plans, and whether such a requirement should only apply to high-risk provider and supplier types.

Recommendation #1: BCBSA recommends that CMS adopt a more targeted enrollment requirement limited to high-risk provider and supplier types—most critically DMEPOS suppliers—where the evidence of fraud from non-enrolled providers is most clearly documented.

Rationale: Tying billing privileges to the Medicare-approved provider list for high-risk provider and supplier types would directly address out-of-network fraud billing concerns without broadly burdening low-risk provider types. A universal enrollment requirement into original Medicare by contrast, would create significant network adequacy risks and operational burden without commensurate fraud prevention benefit for the majority of provider types. Many providers operate exclusively in MA and have legitimate reasons for not participating in original Medicare, including dentists, vision providers, and other supplemental benefit providers who have no FFS equivalent. Forcing these providers through FFS enrollment would impose administrative costs, create network disruptions, and potentially reduce beneficiary access to MA supplemental benefits that are a key differentiator of the MA program.

A targeted approach focused on DMEPOS and other provider types with documented fraud exposure from non-enrollment achieves the program integrity objective with far less collateral disruption. . Any such requirement should be accompanied by: (1) a clearly defined list of high-risk provider and supplier types subject to the requirement; (2) an adequate transition period allowing plans to assess network adequacy impacts and modify provider contracts; and (3) information sharing between original Medicare and MA plans so that enrollment data collected by CMS can be used to reduce duplicative credentialing burden on plans and providers.

BCBSA also encourages CMS to provide a designated review period before finalizing any rulemaking to allow plans to assess network adequacy impacts in advance.

Issue #4: Impacts of an Original Medicare Enrollment Requirement

CMS solicits comments on the operational, administrative, and financial impacts an original Medicare enrollment requirement would have on providers that currently only bill MA plans.

Recommendation #1: BCBSA recommends that CMS conduct a thorough impact analysis before finalizing any original Medicare enrollment requirement, with particular attention to: (1) network adequacy implications by geography and provider specialty; (2) the estimated number and type of providers currently billing MA plans who are not enrolled in original Medicare; (3) the administrative and financial burden on providers of completing FFS enrollment; and (4) the timeline required for MA plans to assess impacts and modify provider contracts if necessary.

Rationale: The operational and financial impacts of an original Medicare enrollment requirement on the MA provider ecosystem could be substantial and are not yet well understood. Providers that choose to bill exclusively in MA intentionally engage in a reimbursement system that involves private contracting rather than the original Medicare FFS reimbursement system. Forcing them through an enrollment process built for a different payment system would impose compliance costs and administrative burdens that many smaller or specialized providers may not be able to absorb—potentially leading to provider attrition and

reduced beneficiary access to supplemental benefits they have come to depend on. Beneficiaries who rely on these providers for specialized services, including vision, dental, hearing, and other supplemental services that have no equivalent in original Medicare could find their access disrupted or eliminated entirely if providers exit the MA market rather than navigate an enrollment process designed for a different payment system. We respectfully encourage CMS to consider that the MA program and original Medicare are structurally and operationally different in enrollment, billing, and compliance obligations. To require providers to engage in original Medicare enrollment requirements will require them to onboard into an entirely distinct payment system with different regulatory standards. This may require significant investment and lead time for those providers.

Further, provider networks are a critical tool through which MA plans manage health care costs and ensure beneficiary access. Reducing the pool of eligible network providers without a clear understanding of market-level impacts could disrupt beneficiary access to care, increase costs and create access gaps in markets where non-FFS-enrolled providers serve a significant portion of the MA population. MA plans would need time to compare their existing networks against Medicare enrollment data, identify providers who would not meet a new requirement, assess whether adequate substitutes exist in each market, and modify provider contracts accordingly. CMS should not finalize this requirement without first understanding these impacts, including the beneficiary impact of any network disruption. If CMS finalizes such a requirement, it should establish a transition period of no less than 18 to 24 months before the requirement takes effect. MA plans would also need to compare their provider lists against the Medicare approved provider list to assess any network adequacy concerns. CMS should provide a designated review period to allow plans to assess impacts in advance of any rulemaking.

Issue #5: Alternative Mechanism Beyond Original Medicare Enrollment

CMS solicits comments on alternative mechanisms that could achieve similar program integrity objectives without requiring original Medicare enrollment.

Recommendation #1: BCBSA recommends that CMS consider the following alternative mechanisms to achieve the program integrity objectives of a Original Medicare enrollment requirement, with less operational disruption: (1) establish a shared cross-plan provider integrity database that MA plans can access in real time, allowing plans to identify providers flagged by other plans or by CMS for fraud, waste, or abuse concerns; (2) expand and improve the preclusion list as described above so that it captures all revocation reasons and is updated in real time; (3) require MA plans to apply minimum credentialing standards to all network and non-participating providers billing MA claims, with CMS providing standardized credentialing criteria aligned to original Medicare enrollment standards for high-risk provider types; and (4) require non-participating DMEPOS suppliers to meet original Medicare accreditation standards as a condition of billing MA plans, without requiring full FFS enrollment.

Rationale: These alternative mechanisms target the core program integrity objective - ensuring that providers billing MA plans meet baseline screening and integrity standards - while avoiding the network adequacy risks, administrative burden, and provider disruption associated with a universal FFS enrollment mandate. A shared cross-plan provider integrity database is particularly powerful because it leverages the collective fraud detection capabilities of all MA plans and creates a network effect: fraud identified by one plan benefits the entire system. BCBS Plans already operate inter-Plan intelligence sharing through BCBSA's National Anti-

Fraud Department, which demonstrates the feasibility and effectiveness of this model at scale. CMS should invest in formalizing and expanding this kind of collaborative infrastructure rather than imposing enrollment mandates that address only a subset of the fraud risk while creating significant unintended consequences. Focusing preclusion list reforms and credentialing requirements on high-risk provider types, particularly DMEPOS suppliers, is preferable to a universal enrollment requirement. If CMS proceeds with any enrollment requirement, information sharing between FFS and MA plans should be required so that enrollment data already collected by CMS can be leveraged by plans rather than requiring duplicative data collection.

D. Reducing Medicare Fraud Related to Laboratory Tests Including Genetic Tests and Molecular Diagnostic Tests

Issue #1: Statutory and Regulatory Authorities to Combat Lab Test Fraud

CMS solicits comments on new statutory or regulatory authorities that would empower CMS to more effectively prevent, identify, and address fraud in lab tests, including genetic tests and molecular diagnostic tests.

Recommendation #1: BCBSA recommends that CMS pursue statutory authority to require ordering physician attestation for high-risk laboratory tests, including genetic tests and molecular diagnostic tests, as a condition of Medicare payment.

Rationale: Laboratory test fraud, particularly in genetic and molecular diagnostic testing, frequently exploits the gap between ordering and payment by using complicit or unwitting physicians to provide facially valid orders for tests that are medically unnecessary or never performed. Physician attestation requirements create a documented evidentiary trail that makes it significantly harder for fraudulent labs to fabricate or abuse the ordering process. Attestation requirements should confirm that the ordering physician has an established patient relationship with the beneficiary, that the test is medically necessary based on documented clinical criteria, and that the physician has not received remuneration in connection with the referral. Further, particular scrutiny should be applied to tests ordered via telehealth encounters, where the risk of fraudulent ordering is highest and the patient-physician relationship is most difficult to verify. Telehealth-ordered genetic tests have been specifically identified in multiple OIG reports and DOJ enforcement actions as a high-risk fraud vector, with schemes involving telemedicine companies recruiting Medicare beneficiaries for unnecessary tests as a gateway to fraudulent billing.

Recommendation #2: BCBSA recommends that CMS establish clear, evidence-based clinical coverage criteria for genetic and molecular diagnostic tests as a condition of Medicare payment, applicable across both original Medicare and MA.

Rationale: The absence of consistent, clearly defined clinical coverage criteria for genetic and molecular diagnostic tests creates exploitable ambiguity that fraudulent laboratories use to justify billing for tests that lack clinical necessity. Clear coverage criteria give CMS, MACs, and MA plans a consistent, enforceable standard against which to evaluate claims, reducing the discretion that fraud schemes rely on and enabling more effective pre-payment claims editing and post-payment review. Uniform criteria applied across both original Medicare and MA would also eliminate the current inconsistency in coverage standards across payer types and across

geographies when MAC coverage differs, which bad actors exploit by shifting billing between programs when one tightens its standards.

Recommendation #3: BCBSA recommends that CMS establish authority to implement pre-payment claims editing for high-risk laboratory tests, including automatic edits that flag claims exceeding defined volume thresholds, claims from laboratories with unusual billing patterns relative to peers, and claims for tests ordered by physicians with no documented patient relationship to the beneficiary.

Rationale: Pre-payment claims editing is one of the most effective and cost-efficient fraud prevention tools available. Applying automated edits to high-risk lab test claims before payment is made, rather than pursuing recovery after the fact, directly addresses the pay-and-chase problem that CMS has identified as a core program integrity weakness. Volume-based and pattern-based edits can be calibrated to flag the most anomalous billing without creating undue burden for legitimate laboratories, and can be refined over time as CMS accumulates data on effective thresholds.

Recommendation #4: BCBSA recommends CMS strengthen laboratory enrollment safeguards, including enhanced vetting of laboratories and ownership structures before they are permitted to bill Medicare.

Rationale: The most effective approach to reducing improper payments in laboratory services is to strengthen front-end enrollment safeguards and improve oversight mechanisms before laboratories begin billing the Medicare program. Current Clinical Laboratory Improvement Amendments (CLIA)-related processes allow laboratories to bill under a Certificate of Registration while awaiting inspection, which may occur months or years later. While the CLIA program provides an important framework for laboratory certification, additional safeguards are needed to ensure that laboratories are sufficiently vetted before billing Medicare.

Recommendation #5: BCBSA recommends CMS provide additional authority and resources to contractors, particularly MACs, to conduct more robust enrollment reviews, site visits, and targeted investigations when suspicious billing patterns are identified.

Rationale: Historically, MACs played a more active role in identifying and investigating problematic laboratories, including conducting site visits and enrollment verification activities. MACs have the operational expertise and proximity to claims data to identify suspicious patterns quickly; however, they often lack the authority, funding, or enforcement tools necessary to act decisively when issues are identified. In our experience, this shift away from contractor-led oversight has reduced the system's ability to detect and prevent fraudulent laboratory activity early in the process.

Recommendation #6: BCBSA recommends CMS improve coordination and information sharing between contractors responsible for claims processing and program integrity investigations to enable faster responses to emerging fraud schemes.

Rationale: Oversight responsibilities for laboratory investigations have increasingly shifted to third-party program integrity contractors. While these contractors play an important role, fragmentation of responsibilities can create inefficiencies and delays in enforcement. In many cases, concerns identified during claims processing must be referred to other contractors, such as UPICs, for further investigation. This process can slow response times while suspicious providers continue billing the program.

Issue #2: Tools and Methods to Increase Lab Test Program Integrity

CMS solicits comments on tools, data analytics, and methods that would assist CMS in increasing program integrity related to lab tests.

Recommendation #1: BCBSA recommends that CMS implement the following suite of analytical and operational tools to strengthen lab test program integrity: (1) claims velocity monitoring—daily or near-real-time review of lab test billing patterns post-adjudication and prior to payment to identify unusual volume spikes; (2) volume threshold triggers—establishing defined thresholds for changes in billing volume from quarter to quarter or month to month that automatically trigger enhanced review; (3) outlier data analysis—regular review of paid claim outlier data by program integrity staff to identify laboratories or ordering physicians whose billing patterns deviate significantly from peers; (4) expedited prepayment review—placing laboratories identified through investigative or analytical processes on prepayment review to halt fraudulent payments before they accumulate; and (5) network management—allowing MA plans to limit coverage of high-risk laboratory tests to accredited, in-network laboratories that have been vetted through a defined credentialing process.

Rationale: The analytical and operational tools described above represent a layered, proactive approach to lab test fraud prevention that addresses the problem at multiple points in the claims lifecycle. Front-end claims velocity and volume threshold monitoring catches emerging fraud schemes before significant losses accumulate. Regular outlier analysis identifies systemic patterns that may not be visible in individual claim reviews. Expedited prepayment review provides a rapid intervention mechanism once a suspect laboratory has been identified. Network management tools give MA plans direct control over which laboratories can bill for high-risk tests, creating a structural deterrent to fraud before it enters the claims system.

Suggested analytical approaches from Plan SIU operations include: performing daily claims velocity testing post-adjudication prior to payment; reviewing paid claim outlier data multiple times per week through SIU investigators; placing suspect phantom laboratory providers identified through SIU investigation on expedited prepayment review; identifying abusive and wasteful behavior through proactive data routines; leveraging fraud hotline member complaints; engaging in external fraud collaboration with other Plan SIUs and law enforcement; and conducting targeted spike billing outlier claims data review within a short timeframe post-adjudication through payment processing.

Issue #3: MolDX Registration Requirement

CMS solicits comments on what prompted other payors and MA organizations to require registration in the MolDX program.

Recommendation #1: BCBSA recommends that CMS consider expanding the MolDX program—administered by Palmetto GBA—as a national model for facilitating coverage determinations for high-risk laboratory services.

Rationale: The MolDX program was designed to address a persistent challenge in molecular diagnostic testing: the absence of consistent, evidence-based coverage policies across MACs. Where MA plans have required MolDX registration, this has generally been driven by a need for greater standardization in coverage and reimbursement for molecular diagnostic tests, consistency in applying clinical criteria across a diverse laboratory network, and a structured

mechanism for evaluating novel tests before coverage decisions are made. CMS should consider whether extending MolDX registration requirements more broadly, including to MA plans outside MolDX states, would produce similar program integrity benefits nationally.

By establishing a centralized registration and coverage determination process, MolDX creates a documented record of which tests have been evaluated for clinical validity and utility—making it harder for fraudulent laboratories to bill for tests that have never been assessed for Medicare coverage. In general, a MolDX-type program would be a useful model if implemented well for facilitating coverage determinations for high-risk items and services. CMS could consider setting a particular threshold - for example, a change in billing volume from quarter to quarter or month to month - to identify high-risk items and services where coverage determination criteria would be appropriate to reduce inappropriate use. It is also worth noting that Palmetto, one of the MACs administering MolDX, has been identified as missing certain FWA claims, which underscores the need for strong performance standards alongside any registration requirement.

Issue #4: MolDX Program Safeguards and Challenges

CMS solicits comments on safeguards or challenges the MolDX program provided to CMS regarding laboratory testing.

Recommendation #1: BCBSA recommends that CMS strengthen the performance standards and oversight requirements applicable to the MolDX program and the MACs administering it.

Rationale: The MolDX program's value as a fraud prevention tool is directly dependent on the quality of its administration. If MACs administering MolDX are not consistently identifying and acting on suspicious billing patterns—or are slow to communicate coverage determinations to downstream payers—the program's fraud prevention benefits are substantially diminished.

Clear MAC performance standards, combined with structured information sharing between MolDX administrators and MA plans, would significantly strengthen the program's effectiveness as a fraud deterrent. Further, MA plans would also benefit from a defined process to flag laboratories billing in patterns inconsistent with registered testing volumes.

E. Reducing Risks from Non-Participating Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Supplies in Medicare Advantage

Issue #1: Changes to Deter Fraud from Non-Participating DMEPOS Suppliers

CMS solicits comments on changes MA organizations would need to make to effectively deter fraud from non-participating DMEPOS suppliers.

Recommendation #1: BCBSA recommends that MA organizations shift their fraud, waste, and abuse detection for non-participating DMEPOS suppliers to the front end of the claims process, implementing pre-payment review mechanisms that can identify and stop suspect claims before payment is made.

Rationale: The OIG has documented millions of dollars in fraud from non-participating DMEPOS suppliers in MA, including suppliers billing for equipment never delivered, medically unnecessary items, and services ordered by complicit or fabricated physicians. Plan SIU experience corroborates these findings — improper payment rates for the DMEPOS category

align with CMS and OIG findings of approximately 20%, with the highest-risk categories including orthotics such as wrist, knee, and back braces, diabetic supplies including continuous glucose monitors and diabetic shoes, intermittent urinary catheters, and skin substitutes. Non-participating suppliers are not subject to original Medicare's accreditation, enrollment, and site-visit requirements, creating a structural fraud vulnerability that bad actors deliberately exploit.

Shifting detection to the front end of the claims process—before payment is made—is far more effective and less costly than post-payment recovery. This should include: (1) pre-payment claims editing for non-participating DMEPOS claims, including edits that flag claims from suppliers with unusual billing patterns, claims for high-risk DMEPOS categories such as power wheelchairs and respiratory equipment, and claims submitted without required documentation of medical necessity; (2) supplier verification processes that screen non-participating DMEPOS suppliers against available fraud intelligence databases before processing claims; and (3) systematic velocity monitoring that identifies spikes in non-participating DMEPOS billing within short timeframes as a real-time fraud indicator.

Recommendation #2: BCBSA recommends that CMS establish a central registry of non-participating DMEPOS suppliers that MA plans can access to screen suppliers before processing claims.

Rationale: A central registry would give MA plans a standardized, reliable mechanism for identifying high-risk non-participating DMEPOS suppliers that individual plans currently lack. Without a centralized source of supplier intelligence, MA plans must independently develop and maintain their own supplier screening processes—a duplicative and resource-intensive approach that produces inconsistent results across the MA market. The registry should include supplier identification information, accreditation status, billing history flags, and any enforcement actions or fraud alerts associated with the supplier. CMS should update this registry in real time and require MA plans to screen non-participating DMEPOS claims against it as a condition of payment. A shared registry would allow fraud intelligence to accumulate across all MA plans and CMS, creating a network effect where fraud identified by one plan benefits all plans. BCBS Plans already share DMEPOS fraud intelligence across Plan SIUs through BCBSA's National Ant-Fraud Department and national DME working groups, demonstrating that this collaborative model works in practice.

Issue #2: Alterations to Existing Requirements to Promote Non-Participating DMEPOS Suppliers' Payment Accuracy

CMS solicits comments on existing requirements that could be altered to increase MA organizations' ability to promote payment accuracy for non-participating DMEPOS suppliers.

Recommendation #1: BCBSA recommends that CMS modify existing regulatory restrictions to ensure MA plans retain the ability to apply targeted, risk-based prior authorization and other pre-payment review tools to non-participating DMEPOS suppliers, particularly for high-risk equipment categories.

Rationale: BCBSA's June 2025 prior authorization commitments are explicitly focused on reducing unnecessary prior authorization for routine, network care, while preserving the use of prior authorization where it protects patients, program integrity, and affordability—particularly for

high-risk, high-cost, and fraud-prone services. Non-participating DMEPOS suppliers fall squarely within this latter category.

Currently, certain prior authorization prohibitions applicable to out-of-network providers in PPO products limit MA plans' ability to require pre-authorization for non-participating DMEPOS claims—creating a gap in fraud prevention that fraudulent suppliers exploit. As a result, MA plans lack clear authority to apply prior authorization to high-risk- non-participating DMEPOS claims, particularly for equipment categories with documented fraud concerns, as a condition of payment.

Prior authorization is one of the most effective tools MA plans have to prevent fraudulent DMEPOS billing because it requires documentation of medical necessity before payment is committed. When applied in a targeted, risk-based manner, prior authorization allows plans to stop fraudulent claims upstream and avoid costly post-payment recovery, but existing regulatory restrictions limit MA plans' ability to use this tool where it is most needed.

Non-participating DMEPOS suppliers are precisely the population for which prior authorization should be most accessible, given their lack of original Medicare accreditation screening and their documented role in MA fraud schemes. Clarifying or modifying these restrictions would align DMEPOS fraud-prevention tools with the risk profile of the supplier population, without expanding prior authorization more broadly.

Recommendation #2: BCBSA recommends that CMS establish consistent guidelines for the use of prior authorization for DMEPOS, including standardized cost thresholds and quantity limits that apply to non-participating DMEPOS suppliers across all MA plans.

Rationale: The current absence of standardized prior authorization guidelines for DMEPOS creates a patchwork of plan-specific requirements that fraudulent suppliers can learn to navigate. Suppliers operating across multiple MA plans can identify which plans have weaker prior authorization requirements and concentrate fraudulent billing accordingly. Standardized guidelines would reduce administrative complexity, create a consistent fraud prevention floor across the MA market, and reduce the ability of fraudulent suppliers to identify and exploit variations in individual plan prior authorization requirements.

Issue #3: Approaches to Identifying Non-Participating DMEPOS Supplier Fraud

CMS solicits comments on analytics, methodologies, or data-driven approaches are most effective in identifying fraud indicators for non-participating DMEPOS suppliers.

Recommendation #1: BCBSA recommends that CMS and MA plans adopt the following suite of analytics and data-driven approaches to identify fraud indicators for non-participating DMEPOS suppliers: (1) daily claims velocity testing post-adjudication and prior to payment to identify unusual billing volume spikes from specific suppliers or geographic areas; (2) paid claim outlier analysis reviewed multiple times per week by SIU investigators to identify suppliers whose billing patterns deviate significantly from peers; (3) expedited prepayment review for suspect phantom DMEPOS suppliers identified through investigative processes; (4) proactive data routines to identify abusive and wasteful billing patterns before they reach payment; (5) fraud hotline member complaint analysis to surface beneficiary-reported concerns about DMEPOS suppliers; (6) cross-Plan intelligence sharing through Plan SIU collaboration and national working groups to identify fraud schemes operating across multiple

MA plans; and (7) targeted spike billing outlier claims data review within short timeframes post-adjudication through the payment processing window.

Rationale: Effective DMEPOS fraud detection requires a layered, real-time analytical approach that catches schemes at multiple points in the claims lifecycle. BCBS Plans have developed significant operational expertise in DMEPOS fraud detection through their Plan SIUs and through BCBSA's National Anti Fraud Department which coordinates a national DME working group that enables BCBS Plans to share scheme intelligence, investigative techniques, and emerging fraud trends in real time. This existing infrastructure represents the kind of data-driven, collaborative fraud detection model that CMS is seeking to build, and demonstrates that Blue Plans are already active partners in addressing the DMEPOS fraud problem CMS is concerned about.

In practice, BCBS Plan SIUs have demonstrated the effectiveness of these approaches. One Plan's SIU has developed a daily reporting structure that identifies any new provider requesting approval to submit a claim. Once a new provider ID is generated, the SIU is automatically notified, conducts an immediate investigation, and flags the provider for prepayment review before any claim is paid. This reporting structure has been highly effective in preventing payment of potentially fraudulent claims and represents the kind of proactive, front-end detection model that CMS should seek to encourage across the MA market.

Issue #4: DMEPOS Supplier Accreditation and Enrollment

CMS solicits comments on whether MA organizations would prefer DMEPOS suppliers to be accredited and enrolled similar to original Medicare.

Recommendation #1: BCBSA supports requiring non-participating DMEPOS suppliers to meet original Medicare accreditation and enrollment standards as a condition of billing MA plans, and recommends that CMS establish this as a regulatory requirement.

Rationale: Requiring DMEPOS suppliers to meet original Medicare accreditation and enrollment standards would close the most significant structural fraud gap in the MA DMEPOS market. Allowing non-participating DMEPOS suppliers to bypass the original Medicare's accreditation requirements entirely when billing MA plans creates a regulatory arbitrage that fraudulent suppliers deliberately exploit. Aligning MA standards with original Medicare standards for this supplier category would level the playing field, create a consistent fraud prevention floor, and significantly reduce the structural vulnerability that OIG has documented in its work on MA DMEPOS fraud.

Recommendation #2: If CMS finalizes a requirement that non-participating DMEPOS suppliers meet original Medicare accreditation and enrollment standards as a condition of billing MA plans, BCBSA recommends that CMS establish a transition period of no less than 12 to 18 months before the requirement takes effect.

Rationale: A transition period of no less than 12 to 18 months is necessary to allow the requirement to be implemented in a manner that achieves its fraud prevention objectives without disrupting beneficiary access to medically necessary DMEPOS items.

While we support CMS' objective, we note that MA plans operate under a distinct framework from original Medicare, including taking on financial risk for supplier payments and oversight

through contracted networks. Both MA plans and suppliers need additional time to implement these standards effectively.

Specifically, suppliers will need sufficient time to complete accreditation and enrollment processes, which can be administratively complex and time-intensive even for suppliers operating in good faith. MA plans will simultaneously need time to assess any network or access impacts resulting from suppliers that are unable or unwilling to meet the new standards, and to take steps to address coverage gaps before the requirement takes effect. Additionally, MA plans will need to modify provider and supplier contracts to reflect the new enrollment and accreditation standards. Without a structured transition period, a hard compliance deadline could result in sudden network disruptions that harm beneficiaries who depend on non-participating suppliers for ongoing DMEPOS needs—undermining the beneficiary protection goals that the requirement is intended to serve.

F. Reducing Fraudulent Medicare Parts A and B (Original Medicare) Claim Submissions

Issue #1: Reducing Back-Billing Schemes Through Shortened Filing Deadlines

Recommendation #1: BCBSA supports shortening the Medicare claim filing deadline to 90 days for high-risk services and recommends that CMS clearly define which services qualify as high-risk for purposes of this requirement.

Rationale: The current claim filing deadline creates an extended window during which fraudulent actors can execute large-scale back-billing schemes, particularly in high-risk areas such as DMEPOS. Shortening the deadline to 90 days compresses this window, reduces the total dollar exposure per fraudulent actor, and increases the likelihood of successful recovery actions when fraud is identified. This approach also aligns with private sector claims submission standards, which generally require more timely filing. A clear definition of high-risk services is essential to ensure the requirement is targeted effectively and does not create undue administrative burden for providers billing routine, lower-risk services.

G. Artificial Intelligence in Medicare Advantage Oversight and Hospital Billing

Issue #1: Key AI Features to Promote Accuracy

CMS solicits comments on key features and learning capabilities an AI solution should include to improve accuracy and prevent errors or “hallucinations”.

Recommendation #1: BCBSA recommends that CMS align TEVV expectations with standards being developed by the National Institute of Standards and Technology (NIST) and other standards-setting organizations.

Rationale: The field of AI testing for coding applications is still maturing, and consensus standards for evaluating AI-assisted coding accuracy have not yet been fully developed. Establishing prescriptive targets before use-case-specific standards are in place risks locking in benchmarks that are not meaningful to program integrity outcomes and may be impossible for good-faith adopters to meet. Until more granular standards can be developed through extensive

technical expert and industry input, requirements should focus on alignment to widely accepted frameworks with regulatory oversight rather than audit or penalty-based numeric thresholds.

Recommendation #2: BCBSA recommends that CMS require AI tools used in MA coding oversight implement testing, evaluation, validation, and verification (TEVV) prior to deployment, as well as at appropriate intervals post-deployment based on the use case and level of risk.

Rationale: These TEVV elements reflect best practices to ensure the accuracy and validity of any AI model. Specifically, pre-deployment testing demonstrates that an AI tool is safe and accurate for its intended coding purpose before it influences risk adjustment submissions. Ongoing post-deployment surveillance is equally important, as real-world conditions evolve in ways that can introduce drift or new risks not present at the time of initial deployment. The appropriate cadence for post-deployment testing will depend on factors specific to the use case and its associated risk level, and requirements should reflect that variability rather than imposing a uniform testing schedule across all AI coding tools.

Recommendation #3: BCBSA recommends that CMS require testing when a material change is made to an AI tool used in MA coding oversight, including a clear definition of what constitutes a material change in the context of the use cases.

Rationale: Consistent with AI model oversight best practices, material changes to an AI system, such as updates to the underlying model, training data, or coding logic, can alter outputs in ways that meaningfully affect coding accuracy and risk adjustment integrity, even when the intended purpose of the tool remains unchanged. Requiring re-testing upon material change ensures that any such alterations are validated before the updated tool influences payment determinations. A clear, stakeholder-informed definition of what constitutes a material change is essential to ensure this requirement is applied consistently and does not create undue burden for routine maintenance updates.

Recommendation #4: BCBSA recommends that CMS require AI tools used in MA coding oversight include mechanisms that capture coder feedback to enable continuous improvement of model performance over time.

Rationale: Given the significance of this use case in the context of MA, it is essential that feedback mechanisms are explicitly embedded in the model management expectations. AI-assisted coding tools that cannot incorporate real-world coder feedback could degrade in accuracy relative to evolving clinical documentation practices and coding standards, creating growing risk of coding errors over time. Feedback loops that systematically capture coder decisions allow models to learn from corrections, improve consistency and reduce recurring errors. Requiring feedback capture mechanisms also supports the audit readiness of deployers by creating a documented record of how AI recommendations were reviewed and acted upon.

Recommendation #5: BCBSA recommends further development and standardization of AI structured disclosure documents that include key facts about an AI tool—by an appropriate standards body such as NIST—establishing the information and format AI tool developers are required to disclose to CMS and MA plans specific to the tool's design, training data, intended use, known limitations, and key performance characteristics.

Rationale: Developer-to-deployer transparency is a foundational principle for responsible AI deployment across all contexts, deployers cannot fulfill compliance obligations if they lack visibility into how the tools they rely on function and what limitations may affect their performance. This principle applies regardless of use case, whether AI tools are used for clinical

decision support, administrative automation or coding oversight. Standardized disclosure of key facts about AI tools used in coding audits would enable CMS to make more informed procurement and deployment decisions, better evaluate whether audit findings are attributable to genuine coding errors or limitations of the AI tool itself, and ensure that its oversight activities are grounded in a clear understanding of how those tools function. Additionally, the integrity of the oversight process depends on whether the plans subject to audit have sufficient visibility into how those tools function to meaningfully evaluate the accuracy of findings directed at them.

Today, there is no standardized framework governing what AI tool developers must disclose about their products to CMS or to the plans whose coding practices those products are used to scrutinize. An AI tool trained on data that does not reflect the full diversity of MA coding practices, or that performs inconsistently across different record types or clinical contexts, could systematically misclassify legitimate coding decisions as errors. Without standardized disclosure, neither CMS nor the plans subject to audit can readily identify whether a pattern of findings reflects actual noncompliance or a limitation of the tool itself, creating a risk that enforcement actions are taken based on AI-generated findings that would not withstand scrutiny if the tool's performance characteristics were fully understood. Standardized disclosure documents, developed through a consensus-driven process by an appropriate standards body such as NIST, would address this gap by establishing a common baseline of what developers must communicate about their AI tools to CMS and to the plans subject to their use.

Recommendation #6: BCBSA recommends that CMS require that entities deploying AI tools for MA coding oversight establish an internal AI governance program to ensure compliance with applicable requirements.

Rationale: The deployment of AI tools in MA coding oversight represents a consequential operational decision—one with direct implications for payment accuracy, program integrity, and regulatory compliance. As CMS considers how to structure requirements for AI-assisted medical record review, BCBSA urges the agency to establish an internal AI governance mandate as a foundational compliance obligation for any entity deploying these tools, consistent with broader AI oversight best practices. This requirement would not prescribe the specific AI technologies entities must use but rather ensure that whatever tools are deployed are subject to meaningful organizational accountability.

It is worth noting that AI-assisted coding tools occupy a distinctive position in the compliance landscape: they are not merely administrative conveniences, but systems capable of influencing payment determinations at scale, across large volumes of records, and with a speed and consistency that amplifies both the benefit of accurate recommendations and the harm of systematic errors. A miscalibrated model applied to thousands of records can generate a pattern of erroneous coding that, left undetected, could result in significant overpayments or underpayments—precisely the outcomes CRUSH is designed to prevent. The compliance frameworks MA organizations currently operate under—including existing audit, medical review, and anti-fraud requirements—were designed around human-directed processes and do not inherently account for the risks that arise when AI is introduced into the coding workflow. An AI governance mandate would close that gap, ensuring that entities deploying these tools have explicitly considered and addressed the compliance risks they introduce.

An internal AI governance program would require entities to designate accountability for AI performance, establish documented processes for ongoing monitoring and validation, create clear escalation pathways when errors are identified, and maintain audit trails that allow those errors to be detected and remediated. Without a governance mandate, there is no structural

assurance that any of these mechanisms are in place. An entity could deploy a poorly validated or systematically biased AI tool with no formal process for identifying the problem—and CMS would have limited visibility into that risk until it materialized in audit findings or payment discrepancies.

Recommendation #7: BCBSA recommends that CMS require AI tools used in MA coding oversight to base coding recommendations on verifiable, supporting clinical documentation rather than generating outputs independent of the underlying record.

Rationale: A core risk of AI-assisted coding specifically is the generation of "hallucinated" or unsupported diagnoses which can result in inaccurate risk adjustment submissions and program integrity violations. Technical approaches such as retrieval-augmented generation (RAG), which anchor AI outputs to specific passages in the medical record rather than relying on the model's internalized patterns, materially reduce this risk by ensuring that each coding recommendation can be traced back to documented clinical evidence. Any such requirement should be principles-based and technology-neutral, avoiding mandating specific technical implementations that may become obsolete as the field evolves.

Recommendation #8: BCBSA recommends that CMS require AI tool developers to attest that their tools are maintained and updated to reflect current coding guidance, including ICD-10 updates and CMS Hierarchical Condition Category (HCC) rules.

Rationale: Coding guidance governing MA risk adjustment is updated regularly, and AI tools trained on outdated coding rules can systematically generate inaccurate recommendations that result in improper payments without any intentional wrongdoing by the deployer. Requiring developer attestation to currency of coding guidance is important for developers to bear accountability for the design and maintenance of the tools they bring to market. Disclosure of the update cadence and process to deployers is equally important: MA plans cannot fulfill their own compliance obligations with respect to coding accuracy if they lack visibility into whether the AI tool they are relying on reflects current CMS requirements.

Issue #2: Display of AI-Recommended Coding Recommendations to Human Reviewers

CMS solicits comments on whether AI-generated coding recommendations should be displayed to human reviewers, and what compliance risks should be mitigated.

Recommendation #1: BCBSA recommends that AI-generated coding recommendations be presented in a clear and actionable format for human reviewers.

Rationale: The manner in which AI coding recommendations are displayed to human reviewers directly affects both the accuracy of coding outcomes and the integrity of the compliance process. At minimum, recommendations should be presented alongside supporting text from the underlying clinical record, giving reviewers the context necessary to meaningfully evaluate whether a suggested code is clinically supported—rather than leaving reviewers to function as passive validators of AI outputs. Without this grounding, there is a material risk that unsupported diagnoses enter the risk adjustment process unchallenged. Beyond this baseline, the specific features and workflows that best support accurate, compliant human review will vary by operational context, and standards for AI coding review display should be developed through a collaborative process with industry stakeholders rather than prescribed through regulation.

Recommendation #2: BCBSA recommends that CMS encourage AI coding tools to incorporate tiered review workflows that direct human reviewer attention in proportion to the risk of error associated with a given recommendation, with standards for how this is achieved developed collaboratively with industry stakeholders rather than mandated in regulation.

Rationale: tiered workflows are a promising mechanism for managing the tradeoff between review efficiency and accuracy in AI-assisted coding. Under this approach, each AI-generated coding recommendation would be presented with an indicator of the model's certainty in the recommendation. Higher-confidence recommendations may be eligible for a streamlined validation workflow, while lower-confidence recommendations would require closer review before any coding action is taken. In both cases, the confidence indicator should be displayed alongside supporting text from the clinical record, giving human reviewers the information they need to make an independent, informed judgment. By directing human reviewer attention to the recommendations most likely to contain errors, tiered workflows allow plans to focus compliance resources where they are most needed without requiring full manual review of every recommendation. This approach directly addresses CMS' concern that AI coding recommendations may be accepted without adequate human scrutiny, while preserving efficiency benefits from AI implementation. However, the specific implementation of tiered workflows will vary by operational context and standards for display should be developed through a collaborative process with industry stakeholders rather than prescribed in regulation.

Issue #3: AI Solutions to Address Overpayments and Underpayments

CMS solicits comments on whether there are any AI solutions that address coding issues related to both overpayments and underpayments, and whether those solutions can be used for compliance oversight.

Recommendation #1: BCBSA recommends that CMS not prescribe specific AI tool types, vendors or product categories in regulation. Instead, BCBSA recommends providing a framework for what constitutes a tool that is effective and efficient and which reflects a risk-based approach for assessing requirements for individual use cases.

Rationale: The AI landscape is evolving too rapidly for technology-specific regulation to remain fit for purpose. CMS' RFI asks what types of AI solutions—including commercial off-the-shelf (COTS) products—are most effective and efficient for assisting human coders with large volumes of records, and what key features and learning capabilities an AI solution should include. Yet, a product category or technical architecture that represents state-of-the-art performance today may be materially superseded within months. Regulation that specifies solution types or endorsed vendor classes would limiting CMS' capacity to evolve as the underlying science advances. This is especially problematic for program integrity applications, where the adversarial nature of fraud means that static tools are progressively easier to evade.

In addition, use cases vary significantly in risk profile, and a one-size-fits-all approach would create compliance burdens disproportionate to actual risk. In the context of coding, the risks associated with AI-assisted coding review of routine outpatient claims are meaningfully different from those associated with AI-generated recommendations in high-dollar inpatient risk adjustment contexts. A framework that applies the same requirements across all use cases—regardless of claim volume, financial materiality, clinical complexity, or the degree of human oversight in the workflow—would impose unnecessary burden on lower-risk applications while potentially under-regulating higher-risk ones. A risk-based framework, by contrast, with clear

guidance on what constitutes an effective and efficient product would calibrate regulatory requirements to the actual stakes of each use case: requiring more rigorous validation, audit trails, and human review for high-risk applications while allowing more flexible, lower-cost tools where the consequences of error are limited and correctable.

The MA coding context also illustrates why use-case specificity matters. The majority of clinically relevant diagnosis information in MA medical records is contained in unstructured narrative documentation rather than structured data fields, meaning that the capabilities and risk profiles of AI tools suited to this context differ meaningfully from those designed for structured claims or administrative data processing. A risk-based framework should account for these distinctions, ensuring that governance requirements reflect the actual characteristics of the tools being deployed rather than applying uniform standards across fundamentally different technical approaches.

Recommendation #2: If CMS deploys AI tools in Risk Adjustment Data Validation (RADV) audits, AI should not be used as the sole basis for medical necessity determinations, diagnosis validation, or payment recovery decisions.

Rationale: AI tools may improve the efficiency and consistency of certain RADV audit support functions, such as identifying records with a higher likelihood of coding discrepancies, document triage, data extraction, and pattern detection across large volumes of medical records. Used appropriately, these tools can help CMS target audit resources and improve workflow efficiency while maintaining the primacy of human clinical and coding judgment.

However, consistent with how health plans ensure humans are the final arbiter of any adverse coverage decision, AI should not replace qualified clinical and coding professionals in making determinations that directly impact diagnosis validation, medical necessity assessments, or payment recovery. These determinations require nuanced clinical judgment, evaluation of documentation context, and application of established RADV standards in ways that AI tools cannot reliably perform. Any RADV audit determination must ultimately rest on a human reviewer applying current RADV requirements to the medical record, with AI outputs serving only as decision support rather than audit findings.

Recommendation #3: BCBSA recommends that any AI-supported RADV workflows be evaluated and calibrated to identify potential coding errors associated with both overpayments and underpayments, with performance assessed for false positives and false negatives.

Rationale: CMS' inquiry appropriately recognizes that coding errors may result in both overpayments and underpayments. To promote payment accuracy and fairness, AI tools used in RADV-related contexts should be designed, evaluated, and governed to detect inaccuracies in both directions, rather than being optimized exclusively for the identification of potential overpayments.

Assessing AI performance solely based on its ability to identify potential overpayments risks introducing systematic bias into audit processes and undermining confidence in audit integrity. CMS should therefore evaluate AI-supported workflows using balanced performance metrics, including false positive and false negative rates, to ensure that tools are not systematically over-identifying or under-identifying diagnoses. Calibrating AI tools to address both overpayments and underpayments supports accurate payment, strengthens program integrity, and aligns AI use with the underlying objectives of the RADV program.

Recommendation #4: If CMS uses AI tools in RADV audits, BCBSA recommends that CMS establish transparency, validation and auditability requirements to ensure health plans can

meaningfully evaluate and contest AI-assisted audit findings and to ensure that audit determinations accurately reflect the health status and clinical complexity of Medicare Advantage beneficiaries.

Rationale: The use of AI in RADV audits has implications not only for audit process and plan due process, but also for Medicare Advantage beneficiaries whose access to appropriate benefits and care depends on accurate risk adjustment. The use of AI in RADV audits raises important transparency and accountability considerations for maintaining audit integrity and payment accuracy. Unlike traditional audit processes where Plans can trace how a human auditor reached a conclusion by reviewing the same clinical documentation, AI-generated findings may be opaque, making it impossible for Plans to understand why a diagnosis was challenged or determine whether the finding reflects genuine noncompliance or a limitation of the AI tool itself. This opacity undermines both audit integrity and Plans' ability to ensure accurate payments on behalf of beneficiaries.

To preserve audit integrity and due process, CMS should ensure that AI outputs are transparent enough for plans to evaluate and contest. This requires CMS to explain, at a meaningful level, how AI outputs were generated and how they informed audit decisions. At a minimum, CMS should disclose the AI tool's intended use and limitations, the data inputs relied upon, the form of output generated, record-level rationale or citation to supporting documentation where feasible, performance metrics including false positive and false negative rates on a representative RADV-like sample, known failure modes, bias and error monitoring results, the model version used for each audit determination, and sufficient audit trail documentation to support reproducibility and challenge. CMS should also disclose whether and how model performance varies across beneficiary subpopulations with differing levels of clinical complexity.

AI-generated findings must be validated by qualified clinical and coding professionals before informing audit determinations to ensure accuracy and prevent reliance on erroneous outputs. Regular testing is essential to detect and correct systematic bias against certain conditions, providers or populations before such bias affects payment determinations at scale. Of particular concern is whether AI models perform consistently across the diverse patient populations Medicare Advantage plans serve, including beneficiaries with complex, chronic conditions, multiple comorbidities, or disability related documentation patterns that may differ materially from training data derived primarily from less clinically complex cases.

Inconsistent or biased AI performance across beneficiary populations risks distorting risk adjustment outcomes in ways that disadvantage plans serving higher need beneficiaries. Inaccurate audit determinations may discourage appropriate care coordination for beneficiaries with complex conditions and, over time, may affect access to benefits, provider participation, and plan willingness to serve medically complex populations. Ensuring that AI assisted RADV audits accurately capture beneficiary health status is therefore essential not only for audit integrity, but also for protecting beneficiaries and maintaining the stability and equity of the Medicare Advantage program.

CMS should maintain clear documentation, version control and governance processes for AI models used in audits to ensure consistency with current statutory, regulatory and subregulatory guidance governing RADV. CMS should also clarify that the use of AI does not alter existing RADV documentation standards, coding guidelines, or medical record review

criteria, and cannot be used to impose new substantiation expectations absent formal rulemaking.

Plans must retain full rights to review and appeal AI-assisted findings using traditional evidence and clinical documentation. Plans must also be able to reproduce, using the same model version and configuration, any AI outputs that informed the audit determination. Without these safeguards, AI use in RADV audits risks creating a system where payment recovery decisions are based on determinations that Plans cannot understand, verify, or effectively contest, and where beneficiaries with the greatest clinical needs face increased risk of inaccurate payment adjustments that do not reflect their true health status.

Recommendation #5: Before broader implementation of AI tools in RADV audits, BCBSA recommends that CMS conduct comparative validation by subjecting a representative sample of medical records to both traditional coder review and AI-driven coding, comparing results to assess concordance rates and potential bias, and using findings to calibrate AI tools and establish confidence thresholds.

Rationale: Comparative validation against human coder review is important to establish baseline accuracy and identify systematic errors or biases before AI tools influence payment recovery decisions at scale. By reviewing the same records through both traditional and AI-assisted processes, CMS can measure concordance rates, identify categories of discrepancies and detect whether AI tools systematically over-identify or under-identify certain types of coding issues. This validation process allows CMS to refine algorithms, establish appropriate confidence thresholds and determine which types of coding reviews are suitable for AI assistance versus those that require exclusively human review.

Comparative validation should be conducted on a representative sample that reflects variation in record type, care setting, provider type, condition categories, and risk score levels, and results should be reported in a stratified manner rather than in aggregate. CMS should pre-specify acceptance criteria and repeat comparative validation following any material AI model update to address model drift prior to broader implementation. Implementing AI in RADV audits without this comparative validation creates risk of systematic errors that could affect payment accuracy and fairness across the program, with downstream effects on plan operations and the beneficiaries they serve. A phased approach with rigorous validation protects program integrity.

Issue #4: AI Solutions to Improve Hospital Billing

CMS solicits comments on whether AI could be used to increase the efficiency and accuracy of hospital billing.

Recommendation #1: BCBSA recommends CMS consider establishing guardrails for hospitals using AI tools for billing and coding to ensure these tools support accurate billing rather than inappropriate reimbursement increases.

Rationale: AI tools used by hospitals for billing and coding create program integrity considerations that existing oversight frameworks may not adequately address. Ensuring accurate hospital billing protects both program integrity and beneficiaries by preventing systematic overbilling that increases costs across the healthcare system. These tools have the potential to improve efficiency, but they also create risks when they operate without meaningful

human oversight, lack transparency that would enable audit and compliance review or systematically influence billing intensity in ways that are difficult to verify retrospectively. Establishing baseline guardrails would address these considerations while allowing hospitals to realize legitimate efficiency benefits from AI adoption. Such guardrails could include requiring that AI tools function as decision support subject to human validation rather than autonomous coding engines, prohibiting auto-submission of AI-generated codes without qualified professional review, requiring hospitals to maintain documentation explaining what AI tools do and how they influence coding decisions to support audit and investigation processes and establishing specific accountability measures for ambient clinical documentation tools such as maintenance of auditable source records and patient consent requirements. These types of safeguards would help ensure that AI tools are designed and deployed to support coding accuracy and compliance rather than to optimize reimbursement, while preserving hospital accountability for the accuracy and appropriateness of submitted codes regardless of AI involvement.

Recommendation #2: BCBSA recommends that CMS require hospitals using AI tools for billing and coding to implement governance controls and testing requirements aligned with standards being developed by NIST and other standards-setting organizations, including neutral optimization requirements, regular testing to detect inappropriate coding patterns, routine internal audits and formal AI governance processes.

Rationale: Consistent with BCBSA's recommendation above that entities deploying AI tools for MA coding oversight establish internal AI governance programs, technical and governance controls are essential to prevent AI coding tools from systematically driving inappropriate billing increases. Until consensus standards for evaluating AI-assisted coding accuracy are fully developed, requirements should focus on alignment to widely accepted frameworks while establishing baseline governance expectations. Neutral optimization requirements ensure that AI tools do not use reimbursement impact as a feature or objective in their design. Regular testing to detect patterns such as disproportionate increases in high-severity codes or coding shifts not supported by changes in patient acuity allows hospitals to identify and correct problems before they result in systematic overbilling. Routine internal audits comparing AI-assisted coding to historical baselines and peer benchmarks, combined with monitoring for false positives and systematic bias, create accountability mechanisms that support compliance.

Formal AI governance processes, including approval processes for deploying or materially changing AI coding tools, version control and documentation of model updates and training requirements for staff - establish organizational accountability for AI tool deployment and use. Hospitals should maintain audit trails showing original clinical documentation, AI recommendations and final human coding decisions to enable retrospective review. CMS should retain authority to request these materials during audits and require corrective action or tool modification if inappropriate patterns are identified. These controls align with risk-based AI governance frameworks while establishing clear expectations that AI use does not mitigate liability for inaccurate or unsupported coding under existing CMS billing and coding rules, False Claims Act standards and OIG compliance program guidance.

K. Medicaid and CHIP

Issue #1: Improvements to Regulatory Program Integrity Oversight Authority

CMS solicits comments on ways that CMS should better leverage or expand its statutory or regulatory program integrity oversight authority.

Recommendation #1: BCBSA recommends that CMS incentivize states to submit more timely information on provider sanctions and ensure that up-to-date information on exclusions and sanctions is available to managed care organizations (MCOs) in a timely manner.

Rationale: When screening potential and current network providers, MCOs review both state and federal exclusion and sanction data to ensure providers have not been excluded from participation in Medicaid or other government programs. While Medicaid Fraud Control Units (MFCUs) are required to report providers convicted of fraud or abuse to OIG so that those individuals or organizations can be added to the OIG Exclusions List—delays in state reporting create a lag between conviction and list appearance that leaves a window during which excluded providers may remain in managed care networks undetected.

This problem is compounded at the state level. Many states maintain their own Medicaid exclusion lists, but the frequency of list updates and timing of disclosure to contracted managed care plans varies significantly and inconsistently across states. If convicted providers do not appear promptly in the OIG Exclusion list or state exclusion lists due to data lags, those providers may remain in managed care networks and continue to receive reimbursement for potentially fraudulent claims until they do appear in the exclusion list—a gap that directly undermines the integrity of Medicaid managed care payments and exposes beneficiaries to continued care from providers who have been found unfit to participate in the program.. Creating incentives for states to promptly deliver exclusion information to OIG and update and release state exclusion lists on a timely basis will reduce the likelihood that a convicted provider remains in a managed care network and continues to receive Medicaid reimbursement. Incentives could include increased funding for MFCUs or standardized reporting timelines, which would help ensure that OIG and MCOs can identify and remove high-risk providers in a timely manner.

Recommendation #2: BCBSA recommends that CMS update regulations at 42 CFR § 455.23 to explicitly permit MCOs to temporarily suspend payment for providers facing credible allegations of fraud.

Rationale: MCOs play a significant role in identifying potential fraud and reporting it to state agencies and MFCUs. While some states' managed care contracts allow MCOs to suspend payments, MCOs in many states must wait to receive government approval before suspending payments to providers credibly suspected of fraud. As a result, fraudulent activity may continue for several months without corrective action. Allowing MCOs to temporarily suspend payments based on credible fraud allegations without waiting for government review would put a quick stop to fraudulent activity when detected and reduce the volume of unrecoverable losses due to fraud, better protecting taxpayer resources.

Recommendation #3: BCBSA recommends that CMS leverage its existing demonstration authority to test and evaluate Medicaid program integrity models.

Rationale: Little data currently exists on the efficacy of various fraud prevention and identification mechanisms and other program integrity strategies. CMS could consider testing Medicaid program integrity models through its Innovation Center, such as a multi-state, centralized analytics tool that would collect Medicaid claims and encounter data and use

advanced analytics to detect cross-state billing anomalies, coordinated fraud, or unusual provider patterns. By developing, testing, and evaluating program integrity models, CMS could collect data needed to identify highly effective program integrity strategies and better equip states to select the best mechanisms for preventing, identifying and addressing fraud, waste, and abuse in their Medicaid programs.

Recommendation #4: BCBSA recommends that CMS promote alignment in program integrity requirements across states by adding greater specificity to program integrity requirements at 42 CFR Part 438.

Rationale: While 42 CFR Part 438 sets a federal floor for MCO program integrity and accountability, state MCO contracts typically include state- and program-specific provisions in addition to the minimum federally required provisions. For example, states may dictate specific SIU staffing ratios, fraud referral timelines, or provider termination notification requirements. As a result, an MCO operating in multiple states may need to navigate multiple, significantly different compliance environments and operate multiple staffing models and workflows to meet each states' requirements.

These diverging state requirements can consume MCO program integrity resources without necessarily producing better program integrity outcomes. Adding greater specificity to program integrity requirements—including requirements related to reporting and MCO referrals to MFCUS—would create greater alignment in states' program integrity approaches. This, in turn, would allow multi-state MCOs to redirect the time and resources currently spent navigating cross-state administrative variation toward expanding the infrastructure and activities needed to prevent and detect fraud.

Recommendation #5: BCBSA recommends that CMS clarify that Medicaid MCOs have the permissive authority to pend claims when billing patterns demonstrate high correlation with known broker-driven schemes.

Rationale: Medicaid MCOs are well-positioned to identify billing patterns highly correlated with known broker-driven schemes through their SIU analytics and claims review processes. However, MCOs currently lack clear regulatory authority to act on those patterns through prepayment controls. Providing explicit permissive authority to pend claims based on broker-correlated billing patterns would give MCOs a critical and currently absent tool to disrupt these schemes before fraudulent payments accumulate, consistent with MCOs' existing financial incentives and operational capabilities to identify and stop fraud at the point of payment.

Issue #2: Tools or Guidance for States to Enhance Program Integrity

CMS solicits comments on tools or guidance the agency can give to states to enhance program integrity in Medicaid and CHIP managed care and fee-for-service programs.

Recommendation #1: BCBSA recommends that CMS develop standardized predictive analytic models and data validation tools that states can use to identify high-risk providers and improper payments in the Medicaid and CHIP managed care and fee-for-service programs.

Rationale: While CMS currently shares analytics knowledge and training with states, each state typically implements its own analytics approach, leading to variation in risk assessment and detection. By providing standardized predictive models and validation tools, CMS would enable

states to apply consistent analytic standards, improve detection, and reduce the administrative burden that results from building state-specific analytics approaches. CMS could implement these standardized models via rulemaking under 42 CFR Parts 438 and 455.

Recommendation #2: BCBSA recommends that CMS issue implementation guidance to states to support efficient and accurate administration of the Medicaid provisions in PL 119-21.

Rationale: Medicaid provisions of PL 119-21, including community engagement requirements and increased frequency of eligibility redeterminations for the expansion population, will introduce new administrative responsibilities for both states and managed care plans. If states implement these provisions in a cumbersome or burdensome manner, it can increase administrative costs and risk of inaccuracies in eligibility determinations. Consistent, clear federal guidance will be critical to ensuring these provisions are implemented in a manner that is both operationally efficient and accurate. Without such guidance, implementation approaches could vary across states, increasing the risk of administrative inconsistency, eligibility determination errors, and unnecessary burden on states, plans, and enrollees. CMS guidance that promotes a streamlined implementation of these provisions will advance program integrity objectives underlying these provisions while helping ensure individuals meeting eligibility requirements can continue to maintain uninterrupted access to coverage.

Issue #3: State Reporting to CMS to Ensure Fraud is Identified and Resolved

CMS solicits comments on data and information states should report to CMS to ensure that fraud, waste, and abuse is being identified, investigated, and resolved.

Recommendation #1: BCBSA recommends that CMS require states to report MFCU referral and outcome data disaggregated by referral source to distinguish between managed care and fee-for-service sources of referral.

Rationale: MCOs conduct rigorous oversight of their network providers and claims data and make referrals to their state MFCUs when they detect potential fraud. Currently, aggregate MFCU reporting on these referrals does not allow CMS, states, or MCOs to assess whether fraud referrals generated by MCO SIUs are being investigated and acted upon at rates comparable to FFS referrals. Disaggregated reporting would create accountability for MFCU follow-through on the referrals that MCOs make and strengthen the feedback loop between MCO detection activity and government enforcement responses, positioning both MCOs and states to strengthen their fraud deterrence efforts.

Recommendation #2: BCBSA recommends that CMS issue standardized reporting templates and create standardized date-related definitions.

Rationale: Inconsistent reporting templates and definitions of key date fields (e.g., date of discovery, overpayment, investigation open/close) across Medicaid programs can create significant gaps in CMS' ability to aggregate, analyze and act on program integrity data in a timely, accurate manner. Further, when managed care plans operating across multiple states apply different interpretations of these reporting concepts, the resulting data is difficult to reconcile, undermining ability to identify systemic fraud patterns or track bad actors across state lines and deploy enforcement resources where they are most needed. Standardized reporting templates and uniform date-related definitions would ensure that program integrity findings are captured and reported consistently, enabling CMS and its partners to conduct more meaningful cross-state analyses and strengthen fraud prevention and detection efforts.

Recommendation #3: BCBSA recommends that CMS use Medicaid MCO feedback on billing migration and emerging fraud patterns to systematically refine exclusion list criteria, payment suspension thresholds, and analytic triggers over time.

Rationale: Medicaid program integrity tools are most effective when they are regularly updated to reflect real-world fraud patterns as they evolve. Currently, exclusion list criteria, suspension thresholds, and analytic triggers are set administratively without a formal mechanism for incorporating the ground-level intelligence that Medicaid MCOs accumulate through their SIU operations. Creating a structured process for CMS to incorporate MCO feedback into the ongoing refinement of these tools would strengthen the Medicaid program integrity ecosystem and ensure that federal and state enforcement mechanisms keep pace with the increasingly sophisticated schemes that bad actors deploy in response to existing controls.

Issue #4: Publicly Available Information to Promote Transparency

CMS solicits comments on information that should be made publicly available to allow for transparency in Medicaid by states, health plans, and providers.

Recommendation #1: BCBSA recommends that CMS make system-level program integrity metrics publicly available.

Rationale: CMS currently publishes data on enrollment, utilization and improper payments. However, CMS does not currently provide information on program integrity trends. Publishing high-level data—such as multi-state trends in unusual billing and service categories most frequently flagged—will provide actionable insights to MCOs and other program integrity partners, enabling them to anticipate emerging risks and proactively strengthen oversight and prevention efforts.

Issue #5: Support to Prevent Fraud in High-risk Services

CMS solicits comments on how the agency can help states better prevent, and address Medicaid and CHIP fraud, waste, and abuse related to service areas identified as high risk for fraud, such as housing stabilization services, behavioral health services, personal care assistant (PCA) services, and non-emergency medical transportation (NEMT).

Recommendation #1: BCBSA recommends that CMS require staff-level identifiers on claims for applied behavioral analysis (ABA) and other time-based services.

Rationale: Currently, Medicaid ABA claims only show supervising Board-Certified Behavior Analysts (BCBA) National Provider Identification (NPI) numbers and do not include staff-level identifiers (e.g., Registered Behavioral Technician ID). Exclusion of this information from ABA and other time-based service claims prevents states and managed care plans from detecting overlapping services, ghost staff, supervision violations, and impossible hours. By requiring both staff-level and supervisory identifiers, CMS will better equip states and managed care plans to identify and address potentially fraudulent billing patterns in these services.

Recommendation #2: BCBSA recommends that CMS issue national guidance directing states to enforce supervision-ratio and concurrency validation using claim-level data for ABA and other services at high risk of fraud.

Rationale: A common fraud scheme in ABA services involves a licensed supervisor being listed on claims for significantly more sessions than a single person could realistically oversee or being listed as supervising multiple services at the exact same time. Guidance directing states to use claim-level checks and concurrency validation would help flag instances in which a supervisor's name appears on an implausible volume of claims or multiple concurrent claims and allow for appropriate investigation into these claims to identify potential fraud schemes.

Issue #6: Enhancements to the Healthcare Fraud Prevention Partnership

CMS solicits comments on how it can further enhance the Healthcare Fraud Prevention Partnership (HFPP) to strengthen fraud detection within state agencies and law enforcement.

Recommendation #1: BCBSA recommends that CMS consider creating a central dashboard that allows HFPP partners to interactively share and coordinate investigations on high-risk providers in real time.

Rationale: Currently, HFPP partners receive weekly provider alerts, as well as analytic reports and opportunities to attend information-sharing events. However, these notifications are likely retrospective and not designed for real-time collaboration. A structured, interactive dashboard that would enable partners to see cross-payer and cross-state fraud data and patterns as they emerge would be useful as there is no operational workplace currently that would allow for partners to active coordinate investigations, see other partners' actions on the same providers, or track case progress in real time.

L. State-Specific Medicaid and CHIP Questions

Issue #1: Statutory and Regulatory Changes to Strengthen Fraud Reduction in States

CMS solicits comments on statutory or regulatory changes needed to strengthen states' ability to effectively reduce fraud, waste, and abuse in Medicaid and CHIP.

Recommendation #1: BCBSA recommends that CMS issue guidance to clarify how states should balance access to care standards and network adequacy standards with fraud prevention efforts.

Rationale: 42 C.F.R. § 438.68 requires states to develop and enforce network adequacy standards, including quantitative, provider-specific metrics to assess network adequacy among managed care plans. In addition, states must ensure state plan services are available and accessible to managed care enrollees in a timely manner under 42 C.F.R. § 438.206 and MCOs must comply with state-established appointment wait time standards under the 2024 Medicaid Managed Care Access, Finance and Quality final rule. States and managed care plans that take swift, comprehensive action to address provider fraud, waste, and abuse may find themselves unable to meet network adequacy and appointment wait time standards, particularly if fraud, waste or abuse is widespread among a particular provider type. As a result, efforts to eliminate fraud, waste, and abuse may be at odds with efforts to maintain robust provider networks and ensure timely access to care. Guidance to states clarifying how to balance network adequacy and access to care with fraud prevention and elimination—including information on requesting

temporary exemptions from access and adequacy standards due to fraud, waste, and abuse-related provider exclusions—would help ensure that states and MCOs that are effective in preventing and addressing fraud are not unfairly penalized due for impacts on network adequacy or access to care.

Recommendation #2: BCBSA recommends that CMS direct states to exempt MCOs from prompt-payment requirements for claims under investigation for fraud, waste or abuse.

Rationale: Medicaid managed care contracts typically include language dictating a time frame in which an MCO must pay or deny claims that providers submit. While timely claims payment is important for supporting safety net providers and encouraging continued provider participation in Medicaid, these requirements can be at odds with MCO actions to identify and address fraud, waste, and abuse. MCOs that withhold suspicious payments while investigating potential fraud, waste or abuse may face penalties for payment delays. Allowing for an exemption to prompt-pay requirements for claims under investigation for fraud, waste, and abuse would better position MCOs to investigate and address suspicious claims without risk of being deemed non-compliant with contractually required payment timelines.

Issue #2: Changes to Empower States to Pursue Bad Actors and Coordinate Program Integrity Efforts Across Entities

CMS solicits comments on regulatory or administrative changes that could empower states to (a) pursue bad actors; and (b) better coordinate program integrity efforts with the federal government, law enforcement, and other states.

Recommendation #1: BCBSA recommends that CMS issue guidance on best practices for cross-program collaboration.

Rationale: Oversight organizations, such as the U.S. Government Accountability Office and the OIG, have highlighted the importance of stronger coordination and data sharing across states and payers to detect fraud schemes. Additional clarification regarding investigative information sharing and the issuance of best coordination practices from CMS could help states identify new ways in which they can strengthen their collaboration with federal agencies, law enforcement and other states to enhance program integrity.

Issue #3: Use of Federal Database to Move Toward Pre-Pay Review

CMS solicits comments on whether use of federal databases, such as Do Not Pay (DNP), or non-federal databases would provide states with more complete information to move further away from a pay-and chase model and towards pre-pay review.

Recommendation #1: BCBSA recommends that CMS combine information from federal databases, including DNP, with non-federal data sources such as licensure, state program integrity data, and payer data.

Rationale: Federal data can help identify clear eligibility and exclusion issues prior to payment, but on its own may be limited in scope or timeliness. Supplementing federal data with state-specific and non-federal sources such as licensure, program integrity and payer data, would provide a more complete picture of fraud, waste, and abuse risk. Together, these data sources

could support earlier intervention, improve targeting of prepay reviews, and reduce reliance on post-payment recovery.

Issue #4: Best Practices from States

CMS solicits comments on successful strategies states have implemented that others can replicate as best practices.

Recommendation #1: BCBS Plans support proliferation of state efforts to implement stop-payment controls for claims from high-risk providers and facilities, including standardized processes for holding or denying claims pending investigation.

Rationale: Stop-payment controls help Medicaid agencies and their contracted managed care plans quickly halt payments to high-risk providers or providers with recent, suspicious billing activity. By halting payments in this manner, SIUs and MFCUs can investigate potential fraud, waste, and abuse before issuing payments and states can reduce administrative costs of recovering funds paid to unscrupulous providers.

Recommendation #2: BCBSA recommends use of multiple fraud reporting channels and real-time analytics as a best practice for states.

Rationale: Timely reporting and real-time information sharing are critical for enabling states and their Medicaid partners to take swift action to address fraud, waste, and abuse. When states offer multiple channels for reporting potential fraud—including online tools and hotlines—they position managed care plans, providers, and members to make the most timely possible referrals and position the state to take swift action to investigate suspicious activity. Using real-time analytics and dashboards allows states to get information about suspicious activity out to managed care plans as quickly as possible and enable immediate SIU action.

Recommendation #3: BCBSA recommends analysis of aggregated data encompassing fee-for-service, MCOs, limited benefit plans and other delivery models to identify suspicious billing patterns as a best practice for states.

Rationale: Many states operate different delivery models for different benefits or different populations. While some types of claims may be unique to a particular delivery model based on the populations or services it covers, some claims may be shared across models. By conducting analysis of data that captures all Medicaid delivery systems, the state can better identify unusual billing patterns or providers/facilities with suspicious claims and investigate those issues in a timely manner.

Issue #5: Fraud Elimination in Supplemental Payments

CMS solicits comment on how CMS can help states better prevent, identify, and address fraud, waste, and abuse related to supplemental payments (for example, disproportionate share hospital (DSH) payments) or state directed payments.

Recommendation #1: BCBS recommends that CMS issue guidance clearly delineating permissible payment structures, documentation expectations, and monitoring requirements.

Rationale: Managed care plans operating in multiple states frequently encounter inconsistent or contradictory state-level interpretations of what payment arrangements are permissible under

federal Medicaid managed care regulations. Clear guidance on which payment structures are permissible under 41 CFR Part 438 and how permissible structures—such as value-based arrangements between managed care plans and providers—interact with anti-fraud statutes, would help remove ambiguity in existing requirements and better enable managed care plans and states to identify potentially fraudulent supplemental payments. Further, including more detailed guidance on documentation and monitoring expectations would provide a clear federal minimum standard and reduce variation in supplemental payment integrity rigor across managed care programs.

M. Federally Facilitated Exchange (FFE) and State-Based Exchanges (SBEs)

Issue #1: Opportunities to Better Leverage Existing Regulatory Authority

CMS solicits comments on how the agency could better leverage existing regulatory oversight authority and identify areas where additional regulatory authority is needed in both the FFE and SBEs.

Recommendation #1: BCBSA supports revising the Exchanges' failure to reconcile (FTR) process such that Exchanges on the federal platform would conduct the one-year look-back policy beginning in plan year (PY) 2027, with this requirement delayed for state exchanges until PY 2028, as proposed in the 2027 Notice of Benefit and Payment Parameters (NBPP). We recommend all Exchanges provide non-compliant qualified health plan (QHP) enrollees with clear instructions on how to restore their advance premium tax credit (APTC) eligibility both before and after it ends. Exchanges should also notify Qualified Health Plan (QHP) issuers before their members' APTC is terminated.

Rationale: Reinstating the one-year look-back will improve program integrity by ensuring enrollees do not remain in subsidized QHPs they do not realize they have or for which they are ineligible. This policy will only be effective if Exchanges can access Internal Revenue Service (IRS) data confirming compliance with the requirement in a timely manner. In years past when IRS data has lagged, a QHP applicant or enrollee could be determined ineligible for APTC despite having filed and reconciled, causing undue burden for these consumers and potentially preventing or interrupting affordable coverage and care.

In addition, because some consumers do not receive notices or understand their requirement to file and reconcile, particularly low-income consumers without a general filing requirement, clear instructions on how to restore APTC eligibility both before and after it ends will be important for ensuring enrollees can remain covered. Issuers can amplify the message if Exchanges notify them when their enrollees are at risk of losing financial assistance. The federal Marketplace sends helpful outreach files of these enrollees to their QHP issuers, and State Exchanges should be encouraged to do the same.

Recommendation #2: BCBSA supports the federal Marketplace indefinitely generating income data matching issues (DMIs) when trusted data sources indicate consumers' income is below 100% of the federal poverty level (FPL) or when income cannot be verified, as proposed in the 2027 Notice of Benefit and Payment Parameters (NBPP). However we oppose the extension of these income DMI requirements to the State Exchanges. To reduce reliance on manual income

verification more broadly, CMS and states should invest in ways to expand access to trusted electronic data sources.

Rationale: Additional annual income DMIs have the potential to reduce improper enrollments and improper payments in the federal Marketplace which is where they have been especially problematic. However, reinstating the income DMI requirements on State Exchanges would place a disproportionate burden on State Exchanges with relatively low improper enrollment rates, as well as on CMS' oversight of their processes.

Income fluctuations during the year, or enrollees without claims, are not evidence of fraud. It is common for people with insurance to never file a claim, especially among younger enrollees who purchase insurance for emergencies and don't use it for regular health care throughout the year. All Exchange applicants and renewing enrollees are required to estimate their annual income more than a year in advance to qualify for tax credits, and accounting for seasonal income, tips, and multiple sources of income presents real challenges. These natural limitations on the ability of some enrollees to accurately project their income is not evidence of intentional misrepresentation. Tax data demonstrate that the overall accuracy of premium tax credit payments is in fact extremely high.[5,6]

Streamlining the income verification process with more automated, electronic verifications would reduce burdens on all stakeholders. With verification requirements increasing under both the proposed 2027 NBPP and the Working Families Tax Cut (WFTC) legislation, CMS and states should prioritize connecting to more electronic data sources, including current income sources, which can reliably approximate applicants' future income so that manual processes do not overwhelm Exchanges.

Recommendation #3: BCBSA supports prohibiting Exchanges from offering the 150% FPL special enrollment period (SEP) in 2027 and beyond, in alignment with the WFTC legislation, as proposed in the 2027 NBPP.

Rationale: BCBSA agrees that the 150% FPL SEP contributed to the increased improper enrollments in the federal Marketplace. The SEP also increased adverse selection for issuers, particularly in competitive markets where enrollees leveraged the SEP to buy-up to richer benefits or broader networks when their need for health care increased mid-year. This induced issuers to set higher rates for higher-value plans and allowed narrower network, lower-value plans to set lower rates.

When CMS established the 150% FPL SEP during the Public Health Emergency, thousands of low-income enrollees were undergoing Medicaid eligibility redeterminations, many for the first time. The SEP is no longer needed to support this population, especially as SEPs for loss-of-coverage and for advance premium tax credit/cost-sharing reduction (APTC/CSR) eligibility changes remain available for consumers facing regular churn between Medicaid and Exchange coverage. Permanently eliminating this SEP will encourage consumers to enroll for full-year coverage, protecting both consumers and the affordability and stability of the risk pool.

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[5] American Rescue Plan Act: Continued Review of Premium Tax Credit Provisions, Figure 2, Treasury Inspector General for Tax Administration, June 14, 2023. https://www.tigta.gov/sites/default/files/reports/2023-06/202347036fr.pdf

[6] Fiscal Year 2024 Improper Payments Fact Sheet, Nov. 15, 2024

Recommendation #4: BCBSA supports removing the restriction to conduct SEP verification only for the loss-of-minimum-essential-coverage SEP and to require SEP verification for at least 75% of new enrollments on the federal platform, as proposed in the 2027 NBPP. Exchanges, including state-based marketplaces, should allow issuers to pend enrollments and claims for enrollees claiming an address associated with known fraud schemes. In general, Exchanges should be required to consistently provide SEP reason codes on issuer enrollment transactions to allow issuers to identify and target fraud and to more effectively assist enrollees in resolving verification issues.

Rationale: BCBSA appreciates the steps CMS has taken to strengthen program integrity in the federal Marketplace, where unauthorized enrollments perpetuated by unscrupulous agents and brokers have been especially problematic. The stricter oversight of agents and brokers selling through the federal Marketplace, along with new social security number verification requirements, have been particularly helpful in reducing unauthorized enrollments. We agree that the proposed additional SEP verification in the federal Marketplace would help ensure applicants are qualified to enroll outside the open enrollment period. In state-based marketplaces that are experimenting with alternate strategies to prevent fraud, partnering with issuers to pend certain enrollments or claims is something CMS should continue to support.

BCBSA is especially concerned about abuse of the “permanent move” SEP and lack of residency verification in the federal Marketplace. Bad actors (known as “body brokers”) continue to use fraudulent addresses to enroll vulnerable substance use disorder patients into coverage for out-of-state facilities which provide low-quality or non-existent services, some of which have criminal histories. These schemes cause direct harm to vulnerable patients and represent a significant waste of taxpayer dollars.

More broadly, issuers could be a valuable resource in helping both Exchanges and enrollees to identify and combat fraud, verify SEPs, and resolve verification issues if Exchanges consistently provided SEP reason codes on SEP enrollment transactions. Issuers can more rapidly pair suspicious claims activity with fraudulent enrollments when armed with enrolment indicators like SEP reason codes from the Exchanges.

Recommendation #5: BCBSA recommends that CMS delay permitting a state-based Exchange enhanced direct enrollment (SBE-EDE) option until the federal Marketplace’s own EDE platform has robust program integrity controls in place and can demonstrate their effectiveness in preventing or significantly reducing fraudulent and unauthorized enrollments. While BCBSA supports the use of web-based enrollment platforms through direct enrollment application programming interfaces (APIs) to streamline consumer access, it is essential that CMS continues developing and enhancing direct enrollment technology to ensure secure and efficient operations across all exchanges.

Rationale: Plans continue to devote resources to resolving unauthorized enrollments and sober home fraud cases, the majority of which come through the federal EDE platform. While we expect program integrity controls introduced by CMS and Congress this year to reduce fraud in the federal Marketplace, many of those controls have not yet been implemented, so their success is untested. In fact, as recently as last month CMS consulted issuers, agents and brokers on how best to implement identity proofing and other security measures for the federal EDE platform, indicating that CMS is still in the early stages of implementing key EDE program integrity measures and is not yet ready to approve and oversee additional SBE-EDE platforms.

BCBSA has long supported flexibility for states to oversee their own markets and address their unique market dynamics. We also have long supported direct enrollment, with many BCBS Plans investing in related technology and an increasing number of Plans using it to service their members. The technology has made it possible for Plans to assist consumers with eligibility updates, verifications, renewals, and many other post-enrollment activities, all without having to redirect members back through HealthCare.gov's application and plan selection process or to the CMS call center. The main value direct enrollment has provided is not the initial shopping and plan selection, but allowing issuers, agents, and brokers to handle post-enrollment customer service functions more efficiently. We believe Federal and State Exchanges remain best positioned to provide education, comparison, and the initial sale of insurance products and the government subsidies associated with them.

Recommendation #6: BCBSA recommends that CMS facilitate confirmation and provide the necessary enrollment application data to issuers when there is a suspicion that applicants simultaneously have Medicare or Medicaid coverage or are otherwise ineligible for Exchange coverage.

Rationale: Currently, issuers must expend investigative resources to confirm that applicants who are suspected of being ineligible for coverage are in fact ineligible. Facilitation of this information by CMS would save time and resources and would prevent further waste.

Recommendation #7: BCBSA recommends that CMS promote more collaborative fraud intelligence sharing between issuers, states, and the federal government, including between the Center for Program Integrity (CPI) and issuer Special Investigation Units (SIUs).

Rationale: A significant amount of information about fraud schemes is already available to individual states and issuers, but there is currently no mechanism for carriers to request assistance from CMS in researching some elements that are critical to timely and complete investigation, such as the results of pre-enrollment verification (if any) and IP addresses used for enrollments. Having a more formal channel to share intelligence between issuers, states and CMS could help identify similar fraud schemes in other states or impacting other issuers.

Recommendation #8: BCBSA recommends that CMS allow for batch processing of similar cases submitted for policy rescission when multiple cases share similar or identical fact patterns indicating fraud.

Rationale: Submitting information for rescissions is a long and cumbersome process, particularly when multiple requests share similar or identical fact patterns. Allowing batch processing would prevent expending resources on reviewing similar cases separately and would allow for quicker resolution of cases, putting a stop to the fraudulent activity more rapidly. Stopping fraud schemes early would also discourage bad actors from initiating similar schemes in other areas.

Recommendation #9: BCBSA recommends that CMS provide an expedited review process for cases submitted for rescission when enrollees who previously had their policies rescinded re-enroll in the same or similar coverage using the same information that was previously determined to be fraudulent. To reduce these repeated fraudulent enrollments in the first place, Healthcare.gov should have automated checks against fraud systems when enrollees apply.

Rationale: An expedited review process with a less stringent evidentiary standard would save time and resources for issuers and the federal government when dealing with repeat cases of fraud. Issuers should not have to go through the same rescissions process for re-enrollments

using the same fraudulent practices that justified a prior rescission, and when the issuer has documented that the enrollee was properly notified of the rescission and the reasons for it.

BCBSA appreciates the Social Security Number verifications and other up-front checks CMS has added to Healthcare.gov in response to recent fraud through this platform. We believe more can be done before fraudulent enrollments get to issuers where they need to be researched and rescinded through resource-intensive manual processes. CMS data that support fraud and rescission approvals would be a valuable up-front resource in catching and preventing unauthorized and fraudulent enrollments when enrollees apply. As detailed in BCBSA's AI recommendation below, CMS could potentially leverage this data through the use of AI tools. Until CMS is able to stand up these connections to Healthcare.gov and Direct Enrollment applications, flexibility to leverage issuer automated checks could prevent repeat fraud cases from being enrolled in the first place, allowing resources and investigations to be directed at new schemes.

Issue #2: Regulatory Improvements to Strengthen Agent and Broker Oversight

CMS solicits comments on how the agency could improve regulations to strengthen oversight of agents, brokers, web-brokers, and direct enrollment entities.

Recommendation #1: BCBSA supports requiring agents, brokers, and web-brokers to use an HHS-approved and created consumer consent form to meet the eligibility application review requirements and consumer consent documentation requirements, as proposed in the 2027 Notice of Benefit and Payment Parameters (NBPP).

Rationale: Additional CMS oversight of agents and brokers' collection of consumer consent would help to deter fraud and misuse, including unauthorized enrollments. BCBSA continues to support actions from CMS to hold bad actors accountable and protect consumers. The use of a single, consistent consumer consent form avoids unnecessary confusion and makes it clear what is expected of agents, brokers, and web-brokers when working with consumers on their Marketplace applications.

Recommendation #2: BCBSA supports efforts to establish more robust standards of conduct related to the marketing practices of agents, brokers, and web-brokers, as proposed in the 2027 NBPP. We recommend that CMS establish timelines related to the review of potential violations of these standards that consider the relatively short open enrollment period.

Rationale: The proposed changes in regulatory language for § 155.220(j)(3), as proposed in the 2027 NBPP, are reasonable and clear and will be useful in holding bad actors accountable. Unscrupulous marketers have used social-media ads that falsely promise cash cards that can be used for groceries and rent if consumers enroll or switch plans. Under the current timeline and review process as proposed, it seems that an agent, broker, or web-broker acting in bad faith could post misleading material at the start of the open enrollment period and would be able to keep the misleading material up through the end of the open enrollment period before the case is resolved. By this time, the maximum damage has been done.

Additional enforcement actions taken by CMS recently, and those laid out in the 2027 NBPP are welcome and encouraged if they do not inadvertently or unreasonably interfere with a consumer's ability to sign up for coverage in a timely and relatively simple manner.

Recommendation #3: BCBSA recommends that CMS require Exchanges to notify issuers and states when agents, brokers, or web-brokers have in fact violated any standards related to marketing or have committed other misconduct resulting in suspension or termination of their Exchange certification.

Rationale: Timely notification to issuers regarding agents, brokers, and web-brokers who are actively facing penalties for misconduct would allow issuers to ensure that they are no longer doing business with bad actors whom the Exchange has suspended or terminated from assisting with qualified health plan enrollment. Additionally, notification to states of these bad actors would allow states to revoke their licenses and further ensure that these agents, brokers, and web-brokers are not able to cause further harm to consumers.

Recommendation #4: BCBSA recommends CMS continue to prohibit fixed dollar thresholds for binder payments, and to monitor third party premium payments so that agents and brokers are not paying binder payments or subsequent premiums.

Rationale: Enrollees with a premium responsibility should continue to be required to pay a premium to effectuate their coverage. We acknowledge CMS' concerns around agents and brokers potentially paying enrollees' binder payments to effectuate coverage and earn commissions. BCBS Plans have seen increased third-party payment activity in recent months and recommend Exchanges monitor third party premium payments, particularly as these payments do not fall under the exceptions at § 45 CFR 156.1250.

Recommendation #5: BCBSA recommends that CMS establish standard timelines to investigate and, if deemed appropriate, remove agents and brokers from participating with the FFE following notification that a certain NPN is associated with enrollments that have been canceled due to fraud.

Rationale: The perceived significant lag time between when CMS is notified that an NPN is associated with enrollments that have been canceled due to fraud and when that agent or broker is terminated from the FFE allows for agents and brokers acting in bad faith to continue harming consumers. Issuers go through substantial internal processes to create a case for terminating and agent or broker for cause. Without prompt removal of the agent or broker from the FFE, this agent or broker is able to continue inflicting harm by moving on to other issuers who are not yet aware of the misconduct.

Issue #3: Enhancements to HealthCare.gov

CMS solicits comments on how the agency could enhance HealthCare.gov to prevent fraud at the point of enrollment and reduce reliance on post-payment recovery ("pay-and-chase").

Recommendation #1: BCBSA recommends that CMS consider options to require social security numbers (SSNs) or, alternatively, unique "exchange IDs" when individuals are submitting applications for enrollment via Healthcare.gov.

Rationale: Though major progress has been made in securing the Enhanced Direct Enrollment process, with observed reductions in unauthorized enrollments and plan switches, individual enrollments via Healthcare.gov remain vulnerable to fraud and abuse. Issuers are observing sizable batches of enrollments that appear to be fraudulent and in almost all cases the applications do not contain an SSN and are for fully subsidized plans. Significant time and resources from both the federal government and issuers could be saved if these enrollments

were prevented altogether by further safeguards to ensure that those who are submitting applications via Healthcare.gov are acting in good faith.

Recommendation #2: BCBSA recommends that CMS consider allowing Exchanges to place an automatic hold on applications that meet certain criteria indicative of potential fraud for further checks. To ensure that these holds are only used when absolutely necessary, CMS could produce a list of correlated flags, or minimum required application characteristics such as addresses used in multiple applications, that must be met before a hold can be placed.

Rationale: Allowing Exchanges to perform additional checks on applications with suspicious characteristics would allow them to prevent fraudulent enrollments from going into effect in the first place, allowing for time and resources to be saved and focused on serving enrollees acting in good faith.

Issue #4: Use of AI to Address FFE and SBE Fraud, waste, and abuse

CMS solicits comments on how the agency could use advanced technologies, such as AI, to prevent, detect, and address fraud, waste, and abuse in both the FFE and SBEs.

Recommendation: BCBSA recommends that CMS leverage AI tools to strengthen fraud detection and prevention in both the Federally Facilitated Exchange (FFE) and State-Based Exchanges (SBEs) by analyzing enrollment data, claims data, provider behavior and referral patterns to identify potentially fraudulent or abusive activity before payments are made.

Rationale: BCBS Plans have deployed AI tools to support fraud, waste, and abuse prevention, and that experience has demonstrated the meaningful value these tools can deliver in detecting questionable patterns and emerging fraud schemes that would be difficult to identify through manual review alone. The insights gained from Plans' real-world implementation point directly to the opportunity available to CMS: by analyzing enrollment and claims data at scale, AI-driven analytics can help investigators prioritize high-risk cases and intervene earlier in the payment cycle, shifting the paradigm from a post-payment recovery model toward pre-payment fraud prevention.

Certain enrollment fraud schemes are particularly difficult to detect through manual review or single-system oversight because the patterns span multiple data sources, plans and jurisdictions. Identity-based enrollment fraud occurs when individuals misrepresent information during enrollment and are later determined ineligible, resulting in significant expenditures for services that should not have been covered. QHP issuers rely on federal and state exchanges to conduct thorough eligibility verification prior to approving enrollment, yet the volume of rescission requests submitted by QHP issuers indicates that current verification processes are insufficient. AI tools can identify high-risk profiles by detecting reuse of identity across multiple applications, flagging addresses associated with non-residential properties such as churches, schools, shelters, or commercial buildings, and identifying identity patterns across platforms that are not apparent in manual review. Duplicate or concurrent enrollment persists because QHP issuers lack comprehensive visibility into an individual's enrollment history across plans, programs and states. AI can identify individuals appearing in multiple enrollment systems, detect overlapping coverage periods tied to the same identity and flag patterns of repeat duplicate enrollment that are not detectable through single-system reviews. Unauthorized enrollment or plan switching by brokers and agents can be detected through AI analysis of unusually high volumes of enrollments or plan changes, repeated enrollment changes that occur

without typical consumer interaction signals and clustering of consumer complaints, reversals, or corrections tied to specific agents to identify outlier behavior and support earlier intervention. Any AI tools deployed for this purpose should be subject to appropriate governance requirements to guard against false positives that could disrupt legitimate enrollees' access to coverage. CMS should also engage health plans and other stakeholders in the development of AI-driven fraud detection frameworks, leveraging plans' existing data and fraud detection capabilities.

EXHIBIT E

Federal Independent Dispute Resolution (IDR) Process Guidance for Certified IDR Entities

December 2023 Update to March 2023 Guidance

This guidance document is effective upon publication and is consistent with all relevant court cases and guidance **for items and services furnished on or after October 25, 2022 for plan years (in the individual market, policy years) beginning on or after January 1, 2022** by an out-of-network provider subject to the Requirements Related to Surprise Billing; Part II, 86 FR 55980, and Requirements Related to Surprise Billing; Final Rule, 87 FR 52618.

Items and services furnished before October 25, 2022 for plan years (in the individual market, policy years) beginning on or after January 1, 2022 are subject to a different guidance document, issued October 7, 2022 and updated December 15, 2023.

Please visit www.cms.gov/nosurprises for the most current guidance documents related to the Federal IDR Process.

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1. General Information and Background

1.1 Background

Effective January 1, 2022, the No Surprises Act (NSA)[1] prohibits surprise billing in certain circumstances in which surprise billing is common (see Section 1.2 for which items and services are covered). Surprise billing occurs when an individual receives an unexpected bill after obtaining items or services from an out-of-network (OON)[2] provider, facility, or provider of air ambulance services where the individual did not have the opportunity to select a provider, facility, or provider of air ambulance services covered by their health insurance issuer's or plan's network (in-network provider(s)), such as during a medical emergency. In such cases, the individual's health insurance or plan often does not cover the full amount of the OON charges, and the OON provider, facility or provider of air ambulance services then bills the patient for the outstanding amount, which includes OON cost sharing, and sometimes, additional amounts (also known as balance billing). Prior to the NSA, the patient would often be responsible for paying these surprise bills.

The NSA provides Federal protection for patients against surprise bills. In situations covered by the NSA, patients will be required to pay no more than in-network cost-sharing amounts for these services. Health plans, issuers, and Federal Employees Health Benefits (FEHB) Program carriers must pay the OON provider, facility, or provider of air ambulance services an amount in accordance with a state All-Payer Model Agreement under section 1115A of the Social Security Act or specified state law, if applicable. In the absence of an applicable All-Payer Model Agreement or specified state law, the plan must make an initial payment or send a notice of denial of payment[3] within 30 calendar days. If either party believes that the payment amount is not appropriate (either too high or too low), it has 30 business days from the date of initial payment or notice of denial of payment to notify the other party that it would like to negotiate.

Once notified, the parties may enter into a 30-business-day open negotiation period to determine an alternate payment amount. If that open negotiation is unsuccessful, the NSA also provides for a Federal independent dispute resolution process (Federal IDR Process) whereby a certified independent dispute resolution entity (certified IDR entity) will review the specifics of the case and the items or services received and determine the final payment amount. The parties must exhaust the 30-business-day open negotiation period before requesting payment determination through the Federal IDR Process.

On October 7, 2021, the Departments of the Treasury, Labor, and Health and Human Services (collectively, the Departments) and the Office of Personnel Management (OPM) issued interim

[1] Enacted as part of the Consolidated Appropriations Act, 2021 (Pub. L. 116-260).

[2] A provider network is a collection of doctors, other health care providers, hospitals, and facilities that a plan contracts with to provide medical care to its members. These providers are called "network providers" or "in-network providers". A provider or facility that hasn't contracted with the plan is called an "out-of-network (OON) provider" or "OON facility". An OON provider or facility or provider of air ambulance services is also referred to as a nonparticipating provider, facility, or provider or air ambulance services.

[3] Note that a notice of denial of payment is not the same as a denial of coverage as the result of an adverse benefit determination. An adverse benefit determination, if disputed, must be disputed through a plan's or issuer's claims and appeals process, not through the Federal IDR process. See 86 FR at 36901-02.

final rules titled *Requirements Related to Surprise Billing; Part II*,[4] (October 2021 interim final rules) implementing various provisions of the NSA, including the Federal IDR Process for payment determinations. The October 2021 interim final rules are applicable for plan and policy years beginning on or after January 1, 2022, except for the provisions related to IDR entity certification, which are applicable as of October 7, 2021. These interim final rules build on the interim final rules issued on July 13, 2021, *Requirements Related to Surprise Billing; Part I*,[5] (July 2021 interim final rules), which were issued to restrict surprise billing for participants, beneficiaries, and enrollees of group health plans, group and individual health insurance issuers, and FEHB carriers who receive emergency care, non-emergency care from OON providers with respect to patient visits to in-network facilities, and air ambulance services from OON providers. On February 23, 2022, in *Texas Medical Association, et al. v. United States Department of Health and Human Services, et al. (TMA I)*, and July 26, 2022, in *LifeNet, Inc. v. United States Department of Health and Human Services*, the United States District Court for the Eastern District of Texas (the Court) vacated portions of the October 2021 interim final rules related to payment determinations under the Federal IDR process.

In light of the Court's rulings and comments received regarding the October 2021 and July 2021 interim final rules, on August 26, 2022 the Departments issued *Requirements Related to Surprise Billing: Final Rules* (August 2022 final rules).[6] The August 2022 final rules finalize certain disclosure requirements relating to provisions of the July and October 2021 interim final rules. Specifically, these final rules require group health plans, health insurance issuers and FEHB carriers to provide additional information to providers and facilities with the qualifying payment amount (QPA) information that accompanies initial payment or notice of denial of payment in cases when the plan, issuer, or carrier has downcoded the billed claim. Downcoding is defined in the August 2022 final rules to mean the alteration by a or issuer of a service code to another service code, or the alteration, addition, or removal by a plan or issuer of a modifier, if the changed service code or modifier is associated with a lower QPA than the service code or modifier billed by the provider, facility, or provider of air ambulance services. These rules also finalize select provisions under the October 2021 interim final rules to address certain requirements related to the certified IDR entity's consideration of information and written decision when a certified IDR entity makes a payment determination under the Federal IDR Process.

On February 6, 2023, in *Texas Medical Association, et al. v. United States Department of Health and Human Services, et al. (TMA II),* the Court issued a judgment and order vacating certain portions of 45 CFR149.510(c), 26 CFR 54.9816-8(c), and 29 CFR 2590-716-8(c) (implemented by the August 2022 final rules), which are parallel provisions governing the Federal IDR Process applicable to all payment disputes. These provisions relate to the information a certified IDR entity must consider in making a payment determination and the information required to be included in a certified IDR entity's written decision. The Court also vacated the entirety of 45 CFR 149.520(b)(3), 26 CFR 54.9817-2(b)(3), and 29 CFR 2590-717-2(b)(3), which are parallel provisions applicable to

[4] Requirements Related to Surprise Billing; Part II, 86 Fed. Reg. 55980 (October 7, 2021), https://www.govinfo.gov/content/pkg/FR-2021-10-07/pdf/2021-21441.pdf

[5] Requirements Related to Surprise Billing; Part I, Fed. Reg. 36872 (July 13, 2021). https://www.federalregister.gov/documents/2021/07/13/2021-14379/requirements-related-to-surprise-billing-part-i

[6] Requirements Related to Surprise Billing, 87 Fed. Reg. 52618 (August 26, 2022). https://www.federalregister.gov/documents/2022/08/26/2022-18202/requirements-related-to-surprise-billing

air ambulance payment disputes.

On August 3, 2023, the Court issued an opinion and order in *Texas Medical Association, et al. v. United States Department of Health and Human Services, et al.,* Case No. 6:23-cv-59-JDK (*TMA IV*). This order vacated the batching provisions of 45 CFR 149.510(c)(3)(i)(C), 26 CFR 54.9816-8T(c)(3)(i)(C), and 29 CFR 2590.716-8(c)(3)(i)(C), and vacated the $350 per party administrative fee established by the Amendment to the Calendar Year 2023 Fee Guidance for the Federal Independent Dispute Resolution Process Under the No Surprises Act issued on December 23, 2022 (December 2022 fee guidance).

Subsequently, on August 24, 2023, the Court issued an opinion and order in *Texas Medical Association, et al. v. United States Department of Health and Human Services, et al.,* Case No. 6:22-cv-450-JDK (*TMA III*), vacating certain portions of 86 FR 36872, 45 CFR 149.130 and 149.140, 26 CFR 54.9816-6T and 54.9817-1T, 29 CFR 2590.716-6 and 2590.717-1, and 5 CFR 890.114(a), related to the methodology for calculating QPAs. This order also vacated the batching guidance set forth in the August 2022 Technical Guidance for Certified Independent Dispute Resolution (IDR) Entities (August Technical Guidance) that the two service codes (one representing a liftoff code, or base rate, and the other representing a per mileage code) for a single air ambulance transport could not be considered together in a single IDR dispute.

In this document, unless otherwise specified, the generic terms “plan” or “health plan” are used to refer to all such plans, issuers, and FEHB carriers.

1.2 Applicability

The October 2021 interim final rules and August 2022 final rules establish a Federal IDR Process that OON providers, facilities, and providers of air ambulance services and group health plans and health insurance issuers in the group and individual market, as well as FEHB carriers, may use following the end of an unsuccessful open negotiation period to determine the OON rate for certain services. More specifically, in situations where an All-Payer Model Agreement or specified state law does not apply, the Federal IDR Process may be used to determine the OON rate for “qualified IDR items or services,” which include:

- Emergency services;
- Certain nonemergency items and services furnished by OON providers with respect to patient visits to in-network health care facilities; and
- Air ambulance services furnished by OON providers of air ambulance services.

The October 2021 interim final rules and August 2022 final rules generally apply to group health plans and health insurance issuers offering group or individual health insurance coverage (including grandfathered health plans), and FEHB carriers offering a health benefits plan under 5 U.S.C. § 8902, with respect to plan years (in the individual market, policy years) and contract years beginning on or after January 1, 2022.

The August 2022 final rules’ requirements related to the additional information that must be shared about the QPA, payment determination standards for certified IDR entities, written decisions, and reporting standards are applicable with respect to items or services furnished on or after October 25, 2022 for plan or policy years beginning on or after January 1, 2022.

The Federal IDR Process does not apply to items and services furnished by providers, facilities, or providers of air ambulance services for items or services payable by Medicare, Medicaid, the Children's Health Insurance Program, or TRICARE, as each of these programs already has other protections in place against unanticipated medical bills.

The Federal IDR Process also does not apply when a state law or All-Payer Model Agreement establishes a method for determining the final OON payment amount. Specifically, some state laws provide a method for determining the total amount payable by a plan for an item or service furnished by an OON provider, facility, or provider of air ambulance services to a participant, beneficiary, or enrollee, in circumstances covered by the NSA. The NSA refers to such laws as "specified state laws." The NSA also recognizes that a state may establish a method for determining OON payment rates under the terms of an All-Payer Model Agreement under Section 1115A of the Social Security Act. Where an All-Payer Model Agreement or specified state law provides a method for determining the total amount payable for OON items and services, the state process will govern, rather than the Federal IDR Process for determining the OON rate under the NSA.

To learn more about what items and services fall under the Federal IDR Process for each state, see the CAA Enforcement Letters that are posted here: https://www.cms.gov/CCIIO/Programs-and-Initiatives/Other-Insurance-Protections/CAA.

1.3 Purpose

The purpose of this document is to provide guidance to certified IDR entities on various aspects of the Federal IDR Process. This document includes information on how the parties to a payment dispute may initiate the Federal IDR Process and describes the requirements of the Federal IDR Process, including the requirements that certified IDR entities must follow in making a payment determination. This document also includes information related to other aspects of the Federal IDR Process that certified IDR entities must follow, including guidance on confidentiality standards, record-keeping requirements, and the process for revocation of IDR certification, as well as how parties may request an extension of certain time periods for extenuating circumstances. For a detailed overview of the Federal IDR Process, see the visual below, "Federal IDR Process Overview." Additional guidance may be developed in the future to address specific questions or scenarios submitted by certified IDR entities. See Appendix A for the definitions of terms used in this document.

Steps Preceding the Federal IDR Process

TIMELINE	SUMMARY OF STEPS
Start:	A furnished covered item or service results in a charge for emergency items or services from an OON provider or facility, for non-emergency items or services from an OON provider with respect to a patient visit to certain types of in-network facilities, or for air ambulance services from an OON provider of air ambulance services.
Within 30 calendar days	**Initial Payment or Notice of Denial of Payment** Must be sent by the plan, issuer, or carrier no later than ***30 calendar days*** after a bill is transmitted.
30 business days	**Initiation of Open Negotiation Period** An open negotiation period must be initiated within ***30 business days*** beginning on the day the OON provider receives either an initial payment or a notice of denial of payment for the item or service from the plan, issuer, or carrier.
	Open Negotiation Period Parties must exhaust a ***30-business-day*** open negotiation period before either party may initiate the Federal IDR Process.

Federal IDR Process Overview

The Departments may provide extensions to some of these time periods due to extenuating circumstances. See Section 9 for more information.

TIMELINE	SUMMARY OF STEPS
4 business days	**Federal IDR Initiation** Either party can initiate the Federal IDR Process by submitting a Notice of IDR Initiation to the other party and to the Departments within ***4 business days*** after the close of the open negotiation period. The notice must include the initiating party's preferred certified IDR entity.
3-6 business days after initiation	**Selection of Certified IDR Entity** The non-initiating party can accept the initiating party's preferred certified IDR entity or object and propose another certified IDR entity. A lack of response from the non-initiating party **within 3 business days** will be deemed to be acceptance of the initiating party's preferred certified IDR entity. If the parties do not agree on a certified IDR entity, the Departments will randomly select a certified IDR entity on the parties' behalf. If random selection is necessary, the Departments will make the selection no later than ***6 business days*** after IDR initiation. The certified IDR entity may invoice the parties for administrative fees at the time of selection (administrative fees are due from both parties no later than the time of offer submission).
3 business days after contingent selection	**Certified IDR Entity Requirements** Once contingently selected, within ***3 business days***, the certified IDR entity must submit an attestation that it does not have a conflict of interest and determine whether the Federal IDR Process is applicable, thereby finalizing the selection.
10 business days after finalization of selection	**Submission of Offers and Payment of Certified IDR Entity Fee** Parties must submit their offers not later than ***10 business days*** after finalization of selection of the certified IDR entity. Each party must pay the certified IDR entity fee (which the certified IDR entity will hold in a trust or an escrow account), and the administrative fee when submitting its offer (unless the administrative fee has already been paid). If the certified IDR entity fee and administrative fee are not collected from a party, the certified IDR entity will not accept the non-paying party's offer.
30 business days after finalization of selection	**Selection of Offer** A certified IDR entity has ***30 business days*** from the date of finalization of its selection to determine the payment amount and notify the parties and the Departments of its decision. The certified IDR entity must select one of the offers submitted.
30 calendar/ business days after determination	**Payments Between Parties of Determination Amount & Refund of Certified IDR Entity Fee** Any amount due from one party to the other party must be paid not later than ***30 calendar days*** after the determination by the certified IDR entity. The certified IDR entity must refund the prevailing party's certified IDR entity fee within ***30 business days*** after the determination.

2. Overview of Steps Before the Federal IDR Process

2.1 Initial Payment or Notice of Denial of Payment

The provider, facility, or provider of air ambulance services submits a claim for the item(s) or service(s) to the participant's, beneficiary's, or enrollee's plan. The plan processes the claim, and the plan sends an initial payment or notice of denial of payment to the provider, facility, or provider of air ambulance services within 30 calendar days.[7] The initial payment should be an amount that the plan reasonably intends to be payment in full based on the relevant facts and circumstances (including in situations where the plan has determined not to make any payment, if, for example, the individual has not reached the annual deductible), prior to the beginning of any open negotiations or initiation of the Federal IDR Process.

In cases in which the patient cost sharing with respect to an item or service that is subject to the payment dispute is based on the QPA, the plan must include with its initial payment or notice of denial of payment the following information:[8]

- The applicable QPA for each item or service involved (see the definition of QPA in Section 6);
- If the QPA is based on a downcoded service code or modifier, a statement from the plan, issuer or carrier explaining that the service code or modifier billed by the provider, facility, or provider of air ambulance services was downcoded; an explanation of why the claim was downcoded, including a description of which service code or modifiers were altered, added, or removed, if any; and the amount that the QPA would have been had the service code or modifier not been downcoded; [9]
- A statement to certify that the plan has determined that the QPA applies for the purpose of establishing the recognized amount (or, in the case of air ambulance services, for calculating the participant's, beneficiary's, or enrollee's cost sharing), and that each QPA was determined in compliance with applicable rules where the QPA was calculated using a good faith, reasonable interpretation of the applicable statutes and regulations that remain in

[7] The 30-business-day timeline to initiate open negotiations will not begin until an initial payment or notice of denial of payment is made. However, when a plan or issuer issues an initial payment or notice of denial of payment that fails to comply with the disclosure requirements in 26 CFR 54.9816-6T(d)(1) or (2), 26 CFR 54.9816-6(d)(1), 29 CFR 2590.716-6(d)(1) or (2), and 45 CFR 149.140(d)(1) or (2), providers, facilities, or providers of air ambulance services retain the right to initiate the open negotiation period within 30 business days of receiving the initial payment or notice of denial of payment or, alternatively, may request an extension to initiate the Federal IDR process. Parties must remain in compliance with the No Surprises Act and the balance billing provisions and refrain from billing the participant, beneficiary, or enrollee in excess of the applicable cost-sharing permitted under the No Surprises Act unless/until the provider has determined the services are not a covered benefit. FAQs About Affordable Care Act and Consolidated Appropriations Act, 2021 Implementation Part 55, Q17, Q20 (August 19, 2022), available at https://www.cms.gov/files/document/faqs-part-55.pdf . Plans and issuers should also communicate with providers to obtain the information the plan or issuer needs to provide a full and fair review within the 30-calendar-day timeframe to determine whether the services are covered services (and therefore to determine whether the services are subject to the protections of the No Surprises Act), and if covered under the No Surprises Act, to send an initial payment or notice of denial of payment. For more information, refer to FAQs About Affordable Care Act and Consolidated Appropriations Act, 2021 Implementation Part 62 (October 6, 2023), available at https://www.cms.gov/files/document/faqs-part-62.pdf

[8] https://www.cms.gov/files/document/caa-NSA-Issuer-Requirements-Checklist.pdf

[9] These requirements related to downcoding were issued on August 19, 2022, then published in the Federal Register on August 26, 2022, are applicable with respect to items or services provided or furnished on or after October 25, 2022, for plan years (in the individual market, policy years) beginning on or after January 1, 2022.

effect after the *TMA III* decision; [10]

- A statement that if the provider, facility, or provider of air ambulance services, as applicable, wishes to initiate a 30-business-day open negotiation period for purposes of determining the amount of total payment, the provider, facility, or provider of air ambulance services may contact the appropriate person or office to initiate open negotiation, and that if the 30-business-day open negotiation period does not result in an agreement on the total payment for the qualified IDR item(s) or service(s), the provider, or facility, or provider of air ambulance services may initiate the Federal IDR Process within 4 business days after the end of the open negotiation period; and
- Contact information, including a telephone number and email address, for the appropriate person or office to initiate open negotiations for purposes of determining an amount of payment (including cost sharing) for such item or service.[11]

2.2 Initiation of Open Negotiations

The parties must undertake an open negotiation period prior to initiating the Federal IDR Process to determine the OON rate if the item or service is:

- An emergency item or service furnished by an OON provider or facility subject to the NSA, an air ambulance service furnished by an OON provider of air ambulance services, or non-emergency items or services furnished by an OON provider with respect to a patient visit to an in-network facility; and
- Furnished to a covered participant, beneficiary, or enrollee who did not receive notice and/or did not provide adequate consent to waive the balance billing protections with regard to such items and services, pursuant to regulations at 45 CFR 149.410(b) or 149.420(c)-(i), as applicable; and
- Items or services for which the OON rate is not determined by reference to an All-Payer Model Agreement under Section 1115A of the Social Security Act or a specified state law.

Either party may initiate the open negotiation period **within 30 business days** (Monday through Friday, not including Federal holidays), beginning on the day the OON provider, facility, or provider of air ambulance services receives either an initial payment or a notice of denial of payment for the item or service from the plan.

The party initiating the open negotiation must provide **written notice** to the other party of its intent to negotiate, referred to as an **open negotiation notice,**[12] and must include information sufficient to identify the items or services subject to negotiation, including:

- A description of the item(s) or service(s);
- Claim number(s);
- Name of the provider, facility, or provider of air ambulance services, and National Provider Identifier (NPI);

[10] Refer to Frequently Asked Questions (FAQs) About Affordable Care Act and Consolidated Appropriations Act, 2021 Implementation Part 62 (October 6, 2023), https://www.cms.gov/files/document/faqs-part-62.pdf
[11] Certain additional information must be provided in a timely manner upon request from a nonparticipating provider, facility, or provider of air ambulance services. See 26 CFR 54.9816-6T(d)(2), 29 CFR 2590.716-6(d)(2), and 45 CFR 149.140(d)(2).
[12] See "Open Negotiation Period Notice" at: https://www.dol.gov/agencies/ebsa/laws-and-regulations/laws/no-surprises-act

- The date(s) the item(s) or service(s) was/were furnished;
- Corresponding service code(s) for the item(s) or service(s);
- The initial payment amount or notice of denial of payment, as applicable;
- Any offer for the OON rate (including any cost sharing); and
- Contact information of the party sending the open negotiation notice.

To facilitate communication between parties and compliance with this notice requirement, the Departments issued a standard notice that the parties must use to satisfy the open negotiation notice requirement.

The **open negotiation notice** may be sent electronically (such as by email) if:

- The party sending the open negotiation notice has a good faith belief that the electronic method is readily accessible to the other party; and
- Upon request, the notice is provided in paper form and free of charge.

2.3 Commencement of Open Negotiations

The **30-business-day open negotiation** period begins on the day on which the open negotiation notice is first sent by a party.

The requirement for a 30-business-day open negotiation period prior to initiating the Federal IDR Process does not preclude the parties from reaching an agreement in fewer than 30 business days or from continuing to negotiate after 30 business days. However, in the event the parties do not reach an agreement, the parties must still exhaust the 30-business-day open negotiation period before either party may initiate the Federal IDR Process. Parties may continue to negotiate after the open negotiation period has concluded, but if they do, it does not change the timeline for the Federal IDR Process. For example, the Federal IDR Process would still need to be initiated during the 4-business-day period beginning on the 31st business day after the start of the open negotiation period, (or, for claims subject to a 90-calendar-day cooling off period, during the 30-business-day period beginning on the day after the last day of the cooling off period), even if the parties continue to negotiate. As part of open negotiations, the non-initiating party may request that the initiating party provide additional information identifying the claim in dispute (such as a location of service).

If the open negotiation notice is not properly provided to the non-initiating party (and no reasonable measures have been taken to ensure that actual notice has been provided), the Departments may determine that the 30-business-day open negotiation period has not begun. In such a case, any subsequent payment determination from a certified IDR entity may be unenforceable due to the failure of the party sending the open negotiation notice to meet the open negotiation requirement, and the certified IDR entity would retain the certified IDR entity fee of the initiating party. Therefore, the Departments encourage parties submitting open negotiation notices to take steps to confirm that the other party's contact information is correct and confirm receipt by the other party, through approaches such as read receipts, especially where a party does not initially respond to an open negotiation notice. If either party has a concern that the open negotiation process did not occur or that the party was not notified of the open negotiation period, the party will be able to request an extension due to extenuating circumstances from the Departments by emailing the Federal IDR mailbox at FederalIDRQuestions@cms.hhs.gov. While a request for an extension due to extenuating circumstances is under review by the Departments, the Federal IDR Process and all of its timelines continue to apply, so the parties should continue to meet deadlines to the extent

possible, as described in Section 8.

If either party believes that the other party is not in compliance with the balance billing protections it may file a complaint with the No Surprises Help Desk at 1-800-985-3059.

3. Initiating the Federal IDR Process

3.1 Timeframe

If the parties do not reach an agreement on the OON rate by the end of the 30-business-day open negotiation period, either party may initiate the Federal IDR Process by submitting a **Notice of IDR Initiation**[13] to the other party and to the Departments **within 4 business days after the close of the open negotiation period** (in other words, 4 business days beginning on the 31st business day after the start of the open negotiation period) or during the 30-business-day period after the 90-calendar-day cooling off period, if applicable. The initiating party must furnish the Notice of IDR Initiation to the Departments by submitting the notice through the Federal IDR portal at https://www.nsa-idr.cms.gov. [14] A party may not initiate the Federal IDR Process if, with respect to an item or service, the party knows or reasonably should have known that the provider or facility provided proper notice and obtained proper consent from a participant, beneficiary, or enrollee to waive surprise billing protections.[15]

The initiation date of the Federal IDR Process is the date that the Departments receive the Notice of IDR Initiation. The Federal IDR portal will display the date on which the Notice of IDR Initiation has been received by the Departments.

3.2 Delivery of the Notice of IDR Initiation

The **Notice of IDR Initiation form,** which must be sent by the initiating party to the non-initiating party may be filled out and saved through the Federal IDR portal at https://www.nsa-idr.cms.gov and may be sent electronically to the non-initiating party (such as by email) if:

- The initiating party has a good faith belief that the electronic method is readily accessible by the other party; and
- The notice is provided in paper form free of charge upon request.

The **Notice of IDR Initiation** sent to the Departments must be submitted through the Federal IDR portal.

[13] Notice of IDR Initiation. https://www.dol.gov/sites/dolgov/files/ebsa/laws-and-regulations/laws/no-surprises-act/surprise-billing-part-ii- information-collection-documents-attachment-3.pdf.

[14] The Departments established the Federal IDR portal to administer the Federal IDR Process. The Federal IDR portal is available at https://www.nsa-idr.cms.gov and must be used throughout the Federal IDR Process to maximize efficiency and reduce burden. The Federal IDR portal is used to satisfy various functions including provision of notices, Federal IDR initiation, submission of an application to be a certified IDR entity, as well as satisfying reporting requirements.

[15] This is consistent with PHS Act sections 2799B-1(a) and 2799B-2(a), and the implementing regulations at 45 CFR 149.410(b) and 149.420(c)-(i). These sections and regulations state that an OON provider or facility satisfies the notice and consent criteria with respect to items or services furnished by the provider or facility to a participant, beneficiary, or enrollee if the provider or facility fulfills the listed requirements. The OON provider or facility must provide to the participant, beneficiary, or enrollee a written notice and consent form in paper or, as practicable, electronic form, as selected by the individual. The written notice and consent form will be deemed to contain the information required, provided such written notice and consent is in accordance with guidance issued by HHS, and in the form and manner specified in such guidance.

3.3 Notice Content

The **Notice of IDR Initiation** must include the following:

- ✓ Initiating party type (i.e., provider, facility, provider of air ambulance services, issuer, plan, or FEHB carrier);
- ✓ The names and contact information of both parties involved, including:
  - Email addresses;
  - Mailing addresses; and
  - Phone numbers
- ✓ Information sufficient to identify the qualified IDR items or services under dispute, including:
  - A description of qualified item(s) or service(s);
  - Whether item(s) or service(s) are being submitted as a batched (or bundled) dispute;
  - The date(s) the item(s) was/were provided or the date of the service(s);
  - The location where the item(s) or service(s) was/were furnished (including the state or territory);
  - Claim number(s);
  - Any corresponding service and place-of-service codes;
  - The type of qualified IDR item(s) or service(s) (e.g., emergency, post-stabilization, professional);
  - The QPA for each of the item(s) or service(s) involved;
  - The amount of cost sharing allowed; and
  - The amount of initial payment by the plan, where payment was made on the claim(s), ;
- ✓ Information about the group health plan, health insurance issuer, or FEHB carrier involved, including:
  - Name of plan, issuer or FEHB carrier;
  - If a group health plan or FEHB carrier, the plan type (e.g., self-funded or fully insured), FEHB plan code; and
  - Contact information (email addresses, phone numbers and mailing addresses);
- ✓ Information about the provider, facility, or provider of air ambulance services involved, including:
  - Provider or facility name;
  - NPI; and
  - Contact information (email addresses, phone numbers, and mailing addresses);
- ✓ The start date of the open negotiation period;
- ✓ Date of initial payment or notice of denial of payment;
- ✓ The initiating party's preferred certified IDR entity;
- ✓ An attestation that the item(s) or service(s) under dispute is/are qualified IDR item(s) or service(s) within the scope of the Federal IDR Process; and
- ✓ General information describing the Federal IDR Process as specified by the Departments:
  - This general information will help ensure that the non-initiating party is

informed about the process and is familiar with the next steps. This general information should include a description of the scope of the Federal IDR Process and key deadlines in the Federal IDR Process, including the dates to initiate the Federal IDR Process, how to select a certified IDR entity, and the process for selecting an offer.

The Departments issued a standard notice (see Appendix B for Notice of IDR Initiation Template) with the required information that the initiating party must include to satisfy the IDR initiation notice requirement.[16]

4. Federal IDR Process Following Initiation: Selection of the Certified IDR Entity

4.1 Timeframe

The disputing parties in the Federal IDR Process may jointly select the certified IDR entity. The parties must select the certified IDR entity no later than **3 business days** following the date of the IDR initiation. The Departments will provide a list of certified IDR entities on the Federal IDR portal.

In the **Notice of IDR Initiation**, the initiating party will identify its preferred certified IDR entity. The non-initiating party, once in receipt of the **Notice of IDR Initiation**, may agree or object to the selection of the preferred certified IDR entity. Any objection must be raised within the **3-business-day period** for the selection of the certified IDR entity. Otherwise, absent any conflicts of interest, the initiating party's preferred certified IDR entity will be selected.

4.2 Objection to the Initiating Party's Selection of the Certified IDR Entity

If the party in receipt of the **Notice of IDR Initiation** objects to the initiating party's preferred certified IDR entity, that party must notify the initiating party of the objection by submitting a **Certified IDR Entity Selection Response Notice** to the initiating party. The notice provided to the initiating party must propose an alternative certified IDR entity. The initiating party must then agree or object to the alternative certified IDR entity within the same initial **3-business-day period** for the selection of the certified IDR entity.

4.3 Notice of Agreement or Failure to Agree on Selection of Certified IDR Entity

The initiating party must notify the Departments by submitting **the Notice of Certified IDR Entity Selection (or failure to select)** through the Federal IDR portal that both parties agree on a certified IDR entity or, in the alternative, that the parties have not agreed on a certified IDR entity. A notice must be submitted by the initiating party not later than 1 business day after the end of the 3-business-day period for certified IDR entity selection (or in other words, 4 business days after the date of initiation of the Federal IDR Process) through the Federal IDR portal selection process. The Departments will be notified electronically through the certified IDR entity response form submitted through the Federal IDR portal.

[16] See "Notice of IDR Initiation" at: https://www.dol.gov/agencies/ebsa/laws-and-regulations/laws/no-surprises-act.

The **Notice of the Certified IDR Entity Selection** must include:

- The name of the certified IDR entity;
- The certified IDR entity number (unique number assigned to the entity through the Federal IDR portal);
- An attestation by both parties (or by the initiating party if the other party has not responded) that the selected certified IDR entity does not have a conflict of interest with the parties (or party, as applicable), as described in Section 4.6.1. This attestation must be submitted based on a conflicts-of-interest check using information available (or accessible using reasonable means) to the parties (or the initiating party if the other party has not responded) at the time of the selection;
- Signature of a representative of the initiating party, full name, and date;
- Signature of a representative of the non-initiating party, full name, and date (unless the non-initiating party did not respond);
- Written information, including an attestation, regarding the applicability of the Federal IDR Process; and
- Non-initiating party's information regarding the inapplicability of the Federal IDR Process, as necessary.

The **Notice of Failure to Select a Certified IDR Entity** must include:

- Indication that the parties have failed to select a certified IDR entity;
- Written information, including an attestation, regarding the applicability of the Federal IDR process;
- Non-initiating party's information regarding the inapplicability of the Federal IDR Process, as necessary; and
- Signature of a representative of the initiating party, full name, and date.

If the non-initiating party fails to respond to the initiating party's selection of a certified IDR entity, the initiating party's preferred certified IDR entity will be selected, unless that certified IDR entity is ineligible for another reason.

4.4 Instances When the Non-Initiating Party Believes That the Federal IDR Process Does Not Apply

If the non-initiating party believes that the Federal IDR Process is not applicable, the non-initiating party must notify the Departments by submitting the relevant information through the Federal IDR portal as part of the certified IDR entity selection process. This information must be provided no later than **1 business day** after the end of the 3-business-day period for certified IDR entity selection, (the same date that the notice of selection or failure to select a certified IDR entity must be submitted). This notification must include information regarding the Federal IDR Process' inapplicability.

The certified IDR entity must determine whether the Federal IDR Process is applicable. The certified IDR entity must review the information submitted in the **Notice of IDR Initiation** and the notification from the non-initiating party claiming the Federal IDR Process is inapplicable, if one has been submitted, to determine whether the Federal IDR Process applies. If the certified IDR entity determines that the Federal IDR Process does not apply, the certified IDR entity must notify the Departments and the parties within 3 business days of making that determination, as described in Section 4. Further, the Departments will maintain oversight of the applicability of

the Federal IDR Process through their audit authority.

4.5 Failure to Select a Certified IDR Entity: Random Selection by the Departments

When the parties cannot agree on the selection of a certified IDR entity, the Departments will randomly select a certified IDR entity **no later than 6 business days** after the date of initiation of the Federal IDR Process and will notify the parties of the selection.[17] The certified IDR entity selected by the Departments will be the one that charges a fee within the allowed range that can be found here. If there is an insufficient number of certified IDR entities available that charge a fee within the allowed range, the Departments will randomly select a certified IDR entity that has approval to charge a fee outside of that range.

4.6 Certified IDR Entity Responsibilities After Selection

After a certified IDR entity is selected, either by the parties or by the Departments, it must attest to meeting the conflicts of interest requirements as described in Section 4.6.1. The certified IDR entity must also determine whether the Federal IDR Process applies as described in Section 4.

A certified IDR entity:

1) Must attest to being free of conflicts of interest, and
2) Must determine whether the Federal IDR Process applies to the items or services included in the dispute.

See Sections 4.6.1 and 4.6.2 for more details.

4.6.1 Conflicts of Interest

If the selected certified IDR entity cannot attest to meeting the conflicts of interest requirements, it may not participate in the dispute between the parties. In that case, the certified IDR entity must notify the Departments of its inability to attest to meeting the conflicts of interest requirements via the Federal IDR portal. This notification to the Departments must occur within **3 business days** after the contingent selection of the certified IDR entity. If the certified IDR entity attests to having a conflict of interest with one of the parties, the Departments will notify the parties that their selected certified IDR entity cannot participate in their dispute. Once the parties are notified, they will have **3 business days** to select another certified IDR entity, or, when the parties have indicated that they cannot agree on a certified IDR entity, the Departments will randomly select another certified IDR entity, pursuant to Section 4.5.

A certified IDR entity **must not have any conflicts of interest** with respect to either party to a payment determination. Specifically, neither the selected certified IDR entity nor a party to the payment determination can have a material relationship, status, or condition that impacts the ability of the certified IDR entity to make an unbiased and impartial payment determination. Among other things, the **certified IDR entity must not**:

[17] A situation in which the non-initiating party does not object to the preferred certified IDR entity included in the initiating party's Notice of IDR Initiation, and the initiating party submits its preferred certified IDR entity on the Notice of Certified IDR Entity Selection, is not considered a failure to select a certified IDR entity.

- Have personnel, contractors, or subcontractors assigned to a determination who have, a material familial, financial, or professional relationship with a party to the payment determination being disputed. This extends to material relationships with any plan, officer, director, management employee, administrator, fiduciaries, or employees; the health care provider or the health care provider's group or practice association; the provider of air ambulance services or the provider of air ambulance services' group or practice association; or the facility that is a party to the dispute.

In addition, *the certified IDR entity must also ensure that any personnel decisions, such as hiring, compensation, or promotion, are not based on personnel supporting one party or a particular type of party*. Finally, personnel of the certified IDR entity must not have been party to the payment determination being disputed, or an employee or agent of such a party within the one-year period immediately preceding an assignment to a payment determination, similar to the requirements described in 18 U.S.C. §§ 207(b), (c), and (e).[18]

4.6.2 Determining Whether the Federal IDR Process Applies to the Dispute

In addition to checking for and submitting an attestation regarding conflicts of interest, the **certified IDR entity must determine whether the Federal IDR Process applies to the items and services that are the subject of the dispute.**

The Federal IDR process **does not apply** to items and services payable by Medicare, Medicaid, the Children's Health Insurance Program, or TRICARE. The Federal IDR Process also **does not apply** in instances where a specified state law or All-Payer Model Agreement under Section 1115A of the Social Security Act provides a method for determining the total OON amount payable under a group health plan or group or individual health insurance coverage.

The Federal IDR Process **does apply** to non-federal governmental plans, insured and self-insured plans sponsored by private employers, private employee organizations, or both (i.e., self-insured plans governed by Employee Retirement Income Security Act (ERISA)) and/or the Internal Revenue Code) in all states, **except** in cases in which a self-insured plan has opted to subject itself to a specified state law or All-Payer Model Agreement, as permitted under some states' laws. Similarly, in all states, the Federal IDR Process **does apply** to health benefits plans offered through the FEHB Program, where an OPM contract with an FEHB carrier does not provide that a specified state law will apply.

In some states, some items or services provided by OON providers, facilities, or providers of air ambulance services may be subject to the Federal IDR process, while other items and services are subject to a specified state law or All-Payer Model Agreement. For payment disputes regarding OON items or services furnished in these 'bifurcated states,' certified IDR entities are responsible for determining whether or not a dispute is eligible for the Federal IDR process.

[18] 18 U.S.C. § 207 imposes restrictions on former officers, employees, and elected officials of the executive and legislative branches of the government. Specifically, Section 207(b) provides a one-year restriction on aiding and advising, Section 207(c) provides a one-year restriction on certain senior personnel of the executive branch and independent agencies, and Section 207(e) provides restrictions on Members of Congress and officers and employees of the legislative branch.

If the certified IDR entity concludes that the Federal IDR Process does not apply (including to any particular claim under dispute in the case of batched claims), it must notify both the Departments and the parties within **3 business days** of making this determination.

4.7 Treatment of Batched Items or Services

The NSA allows for multiple qualified claims to be considered jointly as part of a batched IDR determination (batching) when certain conditions are met.

A certified IDR entity may consider multiple qualified IDR items or services jointly as part of one IDR payment determination when:

- The qualified IDR items or services are billed by the same provider, group of providers, facility, or provider of air ambulance services, under the same NPI or Taxpayer Identification Number (TIN);
- The payment (or notice of denial of payment) for the qualified IDR items or services would be made by the same group health plan or health insurance issuer or FEHB carrier;
    - **for fully-insured health plans**, this means that qualified IDR items or services can be batched if payment is made by the same issuer even if the qualified IDR items or services relate to claims from different fully-insured group or individual health plan coverage offered by the issuer;
    - **for self-insured group health plans**, qualified IDR items or services can be batched only if payment is made by the same plan, even if the same third-party administrator (TPA) administers multiple self-insured plans;
    - **for FEHB carriers,** qualified IDR items or services can be batched if payment is made by the same FEHB carrier, even if the qualified IDR items or services relate to claims from different FEHB plans offered by the carrier.
- The certified IDR entity determines that the qualified IDR items or services are related to the treatment of a similar condition.[19] The qualified IDR items or services were furnished within the same 30-business-day period and included a 30-business-day open negotiation period that ended within 4 business days of IDR initiation (or are items or services for which the open negotiation period expired during the same 90-calendar-day cooling off period).

  As a result of the *TMA III* order, air ambulance services for a single air ambulance transport, including an air ambulance mileage code and base rate code, may be submitted as a batched dispute, so long as all provisions of the batching regulations are satisfied, in accordance with guidance Nothing in the FAQs about Affordable Care Act and Consolidated Appropriations Act, 2021 Implementation Part 63 or in the *TMA III* opinion and order precludes an air ambulance mileage code or base rate code from being submitted separately as single dispute.[20].

[19] Refer to No Surprises Act (NSA) Independent Dispute Resolution (IDR) Batching and Air Ambulance Policy FAQs (November 28, 2023), available at https://www.cms.gov/files/document/faqs-batching-air-ambulance.pdf.
[20] Refer to FAQs About Affordable Care Act and Consolidated Appropriations Act, 2021 Implementation Part 63 (November 28, 2023), available at https://www.cms.gov/files/document/faqs-part-63.pdf

4.8 Payment of Administrative Fees

If the certified IDR entity attests to having no conflicts of interest, concludes that the Federal IDR Process applies, and the selection of the certified IDR entity is finalized, the **certified IDR entity must collect the administrative fee** from both parties and remit the fee to the Departments. As an operational matter, administrative fees may be invoiced by the certified IDR entity at the time of selection and must be collected by the time of offer submission (see Section 5.4). So long as the administrative fees are collected by the time the offers are submitted (which is also when the certified IDR entity fees must be paid), the certified IDR entity has discretion when to collect the administrative fee.

See Section 10 for additional information on the administrative fee.

5. Payment Determination: Submission of Offers

5.1 Content of Offers

No later than 10 business days after finalization of the selection of the certified IDR entity, each party must submit to the **certified IDR entity**:[21]

- An offer for the OON rate expressed both as a dollar amount and as a percentage of the QPA (see Section 6.2.1);
- For batched qualified IDR items or services, parties must provide offers for each item or service separately. When batched items or services have different QPAs, parties should provide these different QPAs and may provide different offers for these items or services;
- Dispute reference number;
- Organization name;
- Primary and secondary points of contact (including mailing address, phone numbers, and email addresses);
- Any information requested by the certified IDR entity relating to the offer; and
- Additional information, as applicable:
    - Providers and facilities must specify whether the provider practice or organization has fewer than 20 employees, 20 to 50 employees, 51 to 100 employees, 101 to 500 employees, or more than 500 employees;
    - Providers and facilities must also provide information on their practice specialty or type, respectively;
    - Plans must provide the relevant geographic region for purposes of the QPA, and, for group health plans, whether they are fully-insured, or partially or fully self-insured (or an FEHB carrier, if the item or service relates to FEHB coverage);
    - Plans must provide the QPA for the applicable year for the same or similar item or service as the qualified IDR item or service; and
    - Parties may submit any additional information relating to the offer that does not include information on prohibited factors described in Section 6.3 and must do so no later than 10 business days after the finalization of the selection of the certified IDR entity.

[21] Refer to Frequently Asked Questions (FAQs) About Affordable Care Act and Consolidated Appropriations Act, 2021 Implementation Part 62 (October 6, 2023), Q1, available at https://www.cms.gov/files/document/faqs-part-62.pdf

Note: If the QPA is based on a downcoded service code or modifier, either party may submit the information that the plan is required to provide the provider or facility when providing the initial payment or notice of denial of payment based on a downcoded service code, including:

- a statement that the service code or modifier billed by the provider, facility, or provider of air ambulance services was downcoded;
- an explanation of why the claim was downcoded, including a description of which service code was altered, if any, and which modifiers were altered, added, or removed, if any; and
- the amount that would have been the QPA had the service code or modifier not been downcoded.

Downcode – *the alteration by a plan, issuer, or carrier of a service code to another service code, or the alteration, addition, or removal by a plan, issuer, or carrier of a modifier, if the changed code or modifier is associated with a lower QPA than the service code or modifier billed by the provider, facility, or provider of air ambulance services.*

5.2 Submission of Offers to the Certified IDR Entity

After selection, the certified IDR entity must provide instructions to both parties for how to submit offers and any other requested information, as outlined in below and Tables 1 and 2. Final offers of payment and information related to the offer must be submitted through the Federal IDR portal.

5.3 Consequences of Failure to Submit an Offer

If, by the deadline for the parties to submit offers, one party has not submitted an offer utilizing the Federal IDR portal and the Notice of Offer web form the certified IDR entity provided, the certified IDR entity will select the other party's offer as the final payment amount.

5.4 Payment of Certified IDR Entity Fees and Administrative Fees and Consequences of a Failure to Pay the Fees

Each party **must pay the certified IDR entity fee and administrative fee** to the certified IDR entity by the time of the submission of its offer. Therefore, **an offer will not be considered received by the certified IDR entity until the certified IDR entity fee and the administrative fee have been paid.** As described in Section 5.3, **if an offer is not considered received from one party, the certified IDR entity will select the other party's offer as the final payment amount.** See Section 10 for additional information on the certified IDR entity fee and the administrative fee.

6. Payment Determination: Selection of Offer

6.1 Timeframe

Not later than 30 business days after the selection of the certified IDR entity is finalized, the certified IDR entity must select one of the offers submitted by the disputing parties to be the OON rate for the qualified IDR item or service.

Selection of Offer – Baseball-Style Arbitration:

The certified IDR entity must select one of the offers submitted by the disputing parties. The certified IDR entity's determination is legally binding unless there is fraud or evidence of intentional misrepresentation of material facts to the certified IDR entity by any party regarding the claim.

6.2 Factors and Information Certified IDR Entities Must Consider

In determining which offer to select, the certified IDR entity must consider:

The QPA(s) for the applicable year for the qualified IDR item or service; and

Additional information relating to the offers submitted by the parties as described in Section 6.2.3, which does not include information on the prohibited factors described in Section 6.3. This information includes additional information requested by the certified IDR entity from the parties, and all of the information that the parties submit that is consistent with the requirements for non-air ambulance qualified IDR items and services in 26 CFR 54.9816-8(c)(4)(iii)(C), 29 CFR 2590.716-8(c)(4)(iii)(C), or 45 CFR 149.510(c)(4)(iii)(C) (See Table 1); and the requirements for air ambulance qualified items and service in 54.9817-2(b)(2), 29 CFR 2590.717-2(b)(2) and 45 CFR 149.520(b)(2) (See Table 2).

It is <u>not</u> the role of the certified IDR entity to determine whether the QPA has been calculated correctly by the plan, to make determinations of medical necessity, or to review denials of coverage.

6.2.1 Definition of QPA

Generally, the QPA is the ***median of the contracted rates*** recognized by the plan for the same or similar item or service that is provided by a provider in the same or similar specialty or facility of the same or similar facility type and provided in the same geographic region in which the item or service under dispute was furnished, increased for inflation. The plan must calculate the QPA using a good faith, reasonable interpretation of the applicable statutes and regulations that remain in effect after the *TMA III* decision.[22] .

6.2.2 Items Certified IDR Entities Must Consider

Certified IDR Entities Must Consider:

1. QPA(s) for the applicable year for the qualified IDR item or service[23]; and
2. **Other information submitted by a party** as long as it does not contain prohibited factors.

[22] Refer to Frequently Asked Questions (FAQs) About Affordable Care Act and Consolidated Appropriations Act, 2021 Implementation Part 62 (October 6, 2023), available at https://www.cms.gov/files/document/faqs-part-62.pdf.
[23] *Id.*

6.2.3 Additional Information Submitted by a Party

Parties may submit additional information regarding any of the circumstances discussed in Table 1 and Table 2, any information that relates to the offer of either party, or any information requested by the certified IDR entity (that is otherwise not prohibited). The certified IDR entity must consider all information submitted to determine the appropriate OON rate (unless the information relates to a factor that the certified IDR entity is prohibited from considering as described in Section 6.3).

Table 1. Additional Circumstances or Factors for Qualified Non-Air Ambulance Items and Services
1. **The level of training, experience, and quality and outcomes measurements** of the provider or facility that furnished the qualified IDR item or service (such as those endorsed by the consensus-based entity authorized in Section 1890 of the Social Security Act) of the provider or facility that furnished the qualified IDR item or service.
2. **The market share** held by the provider or facility or that of the plan in the geographic region in which the qualified IDR item or service was provided.
3. **The acuity of the participant, beneficiary, or enrollee** receiving the qualified IDR item or service, **or the complexity of furnishing** the qualified IDR item or service to the participant, beneficiary, or enrollee.
4. **The teaching status, case mix, and scope of services** of the facility that furnished the qualified IDR item or service, if applicable.
5. **Demonstration of good faith efforts (or lack thereof) made by the provider or facility or the plan to enter into network agreements** with each other, and, if applicable, **contracted rates** between the provider or facility, as applicable, and the plan during the previous 4 plan years.
6. **Certified IDR entities may request, and disputing parties may provide, additional information relevant to the submitted QPA. Certified IDR entities can consider such information when determining the appropriate payment amount for an item or service**, to the extent such information does not include the prohibited factors identified in 26 CFR 54.9816-8T(c)(4)(v), 29 CFR 2590.716-8(c)(4)(v), and 45 CFR 149.510(c)(4)(v).

Table 2. Additional Circumstances/Factors for Qualified Air Ambulance Items and Services
1. **The quality and outcomes measurements** of the provider of air ambulance services that furnished the services.
2. **The acuity of the condition of the participant, beneficiary, or enrollee** receiving the services, or **the complexity of providing services** to the participant, beneficiary, or enrollee.
3. **The level of training, experience, and quality of medical personnel** that furnished the air ambulance services.
4. **The air ambulance vehicle type, including the clinical capability level of the vehicle**.
5. **The population density of the point of pick-up.**
6. **Demonstration of good faith efforts (or lack thereof) made by the OON provider of air ambulance services or the plan to enter into network agreements, as well as contracted rates** between the provider and the plan during the previous 4 plan years.
7. **Certified IDR entities may request, and disputing parties may provide, additional information relevant to the submitted QPA. Certified IDR entities can consider such information when determining the appropriate payment amount for an item or service**, to the extent such information does not include the prohibited factors identified in 26 CFR 54.9816-8T(c)(4)(v), 29 CFR 2590.716-8(c)(4)(v), and 45 CFR 149.510(c)(4)(v).

6.3 Prohibited Factors

When making a payment determination, the certified IDR entity ***must not*** consider the following factors:

- Usual and customary charges (including payment or reimbursement rates expressed as a proportion of usual and customary charges);
- The amount that would have been billed by the provider, facility, or provider of air ambulance services with respect to the qualified IDR item or service had the provisions of 45 CFR 149.410, 149.420, and 149.440 (as applicable) not applied; or
- The payment or reimbursement rate for items or services furnished by the provider, facility, or provider of air ambulance services payable by a public payor, including under the Medicare program under title XVIII of the Social Security Act; the Medicaid program under title XIX of the Social Security Act; the Children's Health Insurance Program under title XXI of the Social Security Act; the TRICARE program under chapter 55 of title 10, United States Code; chapter 17 of title 38, United States Code; or demonstration projects under Section 1115 of the Social Security Act. This provision also prohibits consideration of payment or reimbursement rates expressed as a proportion of rates payable by public payors.

7. Written Decision

Certified IDR entities have **30 business days** from the date of finalization of their selection to select one of the offers submitted and notify the plan, and the provider, facility, or provider of air ambulance services, as well as the Departments, of the certified IDR entity's payment

determination.

The certified IDR entity must notify the parties and the Departments and must explain its payment determination by submitting a written decision through the Federal IDR portal. The written decision must contain the certified IDR entity's determination of the payment amount and an explanation of the underlying rationale for its determination, including:

- What information the certified IDR entity determined demonstrated that the offer selected as the OON rate is the offer that best represents the value of the qualified IDR item or service.
- The weight given to the QPA and any additional information submitted.

Payment Determination:
Certified IDR entities must select a payment offer **within 30 business days** and notify the plan, provider, facility, or provider of air ambulance services, as well as the Departments. The determination is legally binding unless there is fraud or evidence of intentional misrepresentation of material facts to the certified IDR entity by any party regarding the claim.

7.1 Effect of Determination

After a certified IDR entity makes a payment determination, the following requirements apply:

- **Payment:** The amount due to the prevailing party, which is the party whose offer is selected, must be paid no later than **30 calendar days** after the determination by the certified IDR entity, as follows:

If payment is owed by a plan to the provider, facility, or provider of air ambulance services…	***If the plan is owed a refund…***
The plan will be liable for additional payments when the amount of the offer selected exceeds the sum of any initial payment the plan has paid to the provider, facility, or provider of air ambulance services and any cost sharing paid or owed by the participant, beneficiary, or enrollee.	The provider, facility, or provider of air ambulance services will be liable to the plan when the offer selected by the certified IDR entity is less than the sum of the plan's initial payment and any cost sharing paid by the participant, beneficiary, or enrollee.

NOTE: This determination of the OON rate does not change the participant's, beneficiary's, or enrollee's cost sharing, which is based on the recognized amount, or, in the case of air ambulance services, the lower of the QPA or billed charges.

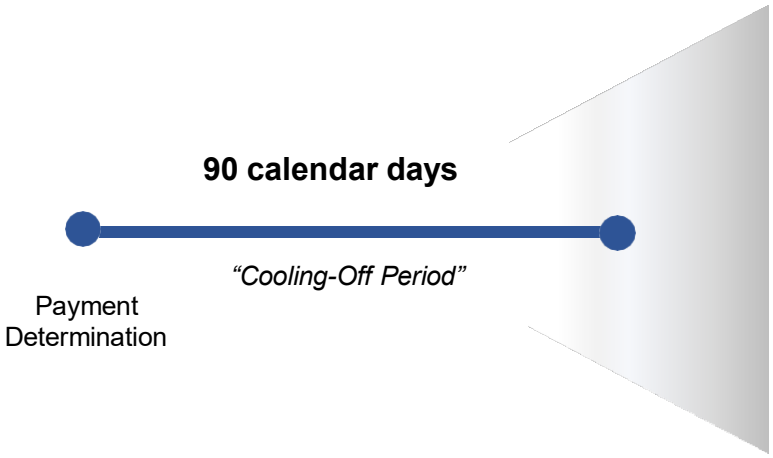
Also note that the non-prevailing party is ultimately responsible for the certified IDR entity fee, which is retained by the certified IDR entity for the services it performed. The certified IDR entity fee that was paid by the prevailing party will be returned to the prevailing party by the certified IDR entity within 30 business days of the certified IDR entity's determination. In the event a resolution is reached outside of the Federal IDR Process through a settlement or withdrawal, the

certified IDR entity must refund each party half of the certified IDR entity fee unless the parties agree otherwise on a method for allocating the applicable fee.

The certified IDR entity must refund the prevailing party the IDR entity fee the prevailing party paid, within 30 business days. In the event neither party is the prevailing party or a resolution is reached outside of the Federal IDR Process, the IDR entity must refund each party half of the certified IDR entity fee unless the parties agree otherwise.

- **Subsequent IDR Requests:** The party that initiated the Federal IDR Process may not submit a subsequent Notice of IDR Initiation involving the same other party with respect to a claim for the same or similar item or service that was the subject of the initial Notice of IDR Initiation during the 90-calendar-day suspension period following the determination, also referred to as a "cooling off" period.

"Cooling Off Period": The 90-calendar-day period following a payment determination when the initiating party cannot submit a subsequent Notice of IDR Initiation involving the same party with respect to a claim for the same or similar item or service that was the subject of the initial Notice of IDR Initiation.

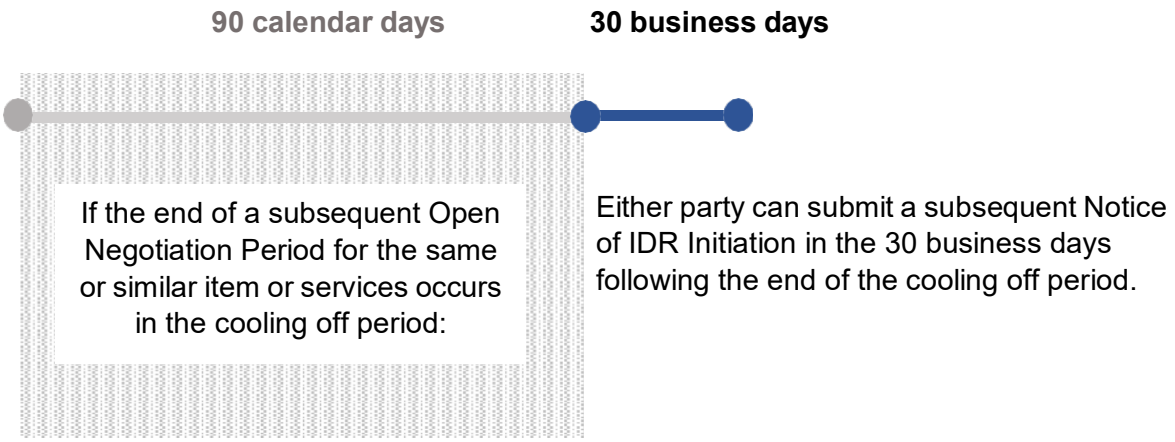


When does the "cooling off period" apply to subsequent IDR initiations? Must meet three criteria:

- ✓ Same parties;
- ✓ Same or similar items or services subject to initial Notice of IDR Initiation; and
- ✓ Payment determination made on the initial Notice of IDR Initiation.

NOTE: A subsequent submission is permitted for the same or similar items or services if the end of the open negotiation period occurs during the 90-calendar-day cooling off period. For these items or services, either party must submit the Notice of IDR Initiation within 30 business days following the end of the cooling off period, as opposed to the standard 4-business-day period following the end of the open negotiation period. The 30-business-day period begins on the day after the last day of the cooling off period.

Subsequent Submissions if the End of the Open Negotiation Period Occurs During the "Cooling Off Period"



8. Extension of Time Periods for Extenuating Circumstances

Certain time periods in the Federal IDR Process may be extended in the case of extenuating circumstances at the Departments' discretion.

- **Time periods for payments CANNOT be extended:** The timing of the payments to the provider, facility, provider of air ambulance services, or plan, as a result of a payment determination or settlement cannot be extended. All other time periods are eligible for an extension at the Departments' discretion.

- **What qualifies as "extenuating circumstances" for an extension:** The Departments may extend time periods if the extension is necessary to address delays due to matters beyond the control of the parties or for good cause. Such an extension may be necessary if, for example, a natural disaster or high dispute volume impedes efforts by the disputing parties to comply with time-period requirements.

- **How to request an extension:** Extensions are provided on a case-by-case basis. Parties may request an extension, and provide applicable attestations, by emailing a **Request for Extension Due to Extenuating Circumstances** to FederalIDRQuestions@cms.hhs.gov, including an explanation about the extenuating circumstances that require an extension and why the extension is needed.

- **When to request an extension:** A request for an extension must be filed as soon as administratively practicable following the event that has resulted in the need for the applicable extension. The request for an extension can be filed either before or after a deadline, and the Departments will consider the request and may grant the extension. However, requesting an extension does not pause or stop the Federal IDR Process, and all of its timelines continue to apply unless and until an extension is granted, so the parties should continue to meet deadlines to the extent possible, until an extension is

granted.

- **Extensions for IDR Entities:** If a certified IDR entity is unable to satisfy certain timing requirements under the Federal IDR Process due to an extenuating circumstance, the certified IDR entity should submit such information to the Departments by emailing the Federal IDR mailbox at FederalIDRQuestions@cms.hhs.gov.

- The Departments may also provide for extensions in guidance, due to extenuating circumstances. Information on these extensions may be found at https://www.dol.gov/agencies/ebsa/laws-and-regulations/laws/no-surprises-act and https://www.cms.gov/nosurprises.

9. Recordkeeping and Reporting Requirements

Six-year recordkeeping requirement: *Certified IDR entities must maintain records of all claims and notices associated with the Federal IDR Process with respect to any payment determination for **6 years**.* These records must be available upon request by the parties to the dispute or a state or Federal agency with oversight authority over a disputing party, except when disclosure is not permitted under state or Federal privacy law.

Mandatory monthly reporting by certified IDR entities: *Certified IDR entities are required to submit data to the Departments on the Federal IDR Process as an ongoing condition of certification.* The Departments will use this information to publish certain aggregated information on a public website as required by the NSA.

The Departments expect that many of these reporting requirements will be captured through the Federal IDR portal, and the Departments do not intend for certified IDR entities to report duplicative information. The Departments will provide additional guidance to certified IDR entities on their specific reporting obligations.

*Each certified IDR entity will be required to report the data in Table 3 within **30 business days** of the close of each month through the Federal IDR portal*.

Table 3: Information to be Reported by Certified IDR Entities on a Monthly Basis

Category of Information	Reporting for Qualified IDR Items and Services That Are Not Air Ambulance Services:	Reporting for Air Ambulance Qualified IDR Services:
QPA versus OON Rate	For each determination issued during the immediately preceding month, the number of times the OON rate payment amount determined or agreed to was higher than the QPA, as specified by items or services.	Same.
Notices of IDR Initiation	Number of Notices submitted to the certified IDR entity during the immediately preceding month. The number of these Notices with respect to which a final determination was made in the immediately preceding month.	Same.
Offers	The amount of the offers submitted by each party expressed as both a dollar amount and as a percentage of the QPA, and whether the offer selected was submitted by the plan, issuer, or FEHB carrier, or provider or facility.	The amount of the offers submitted by each party expressed as both a dollar amount and as a percentage of the QPA, and whether the offer selected by the certified IDR entity to be the out-of-network rate was the offer submitted by the plan, issuer, or carrier (as applicable) or by the provider of air ambulance services.
Size of the Provider Practices and or Facilities; Vehicle Type	In instances where the provider or facility submits the initial Notice of IDR Initiation, specify whether each provider's practice subject to a dispute indicated fewer than 20 employees, 20 to 50 employees, 51 to 100 employees, 101 to 500 employees, or more than 500 employees. For each facility subject to disputes, indicate whether the facility has 50 or fewer employees, 51 to 100 employees, 101-500 employees, or more than 500 employees.	Air ambulance vehicle type, including the clinical capability level of such vehicle (to the extent the parties have provided such information).

Category of Information	Reporting for Qualified IDR Items and Services That Are Not Air Ambulance Services:	Reporting for Air Ambulance Qualified IDR Services:
Items or Services Subject to Determinations	A description of each of the items or services included in the notices of IDR initiation received, including the relevant billing codes (such as Current Procedural Terminology (CPT, Healthcare Common Procedure Coding System (HCPCS), Diagnosis-Related Group (DRG), or National Drug (NDC) Codes).	A description of each air ambulance service included in the notices of IDR initiation received, including the relevant billing and service codes.
Relevant Geographic Region	The relevant geographic region for purposes of the QPA for the items and services.	The point of pick-up (as defined in 42 CFR 414.605) for the services included in such notification.
Offers Submitted by Each Party	For each determination issued during the immediately preceding month, the amount of the offers submitted by each party expressed as both a dollar amount and as a percentage of the QPA, and whether the offer selected was submitted by the plan, or provider or facility.	Same, except whether the offer selected was submitted by the plan, issuer, FEHB carrier, or provider or air ambulance services.
Rationale for Choosing the Selected Offer	For each determination issued during the immediately preceding month, the rationale for the certified IDR entity's selection of offer, including the extent to which a decision relied on criteria other than the QPA.	Same.
Additional Information on the Parties Involved	For each determination issued during the immediately preceding month, the practice specialty and type of each provider or facility, as well as identifying information for each plan, issuer, or FEHB carrier, or provider or facility, such as each party's name and address, as applicable.	Same.
Number of Days Elapsed Between Selection of the Certified IDR Entity	For each determination issued during the immediately preceding month, the number of business days between the selection of the	Same.

Category of Information	Reporting for Qualified IDR Items and Services That Are Not Air Ambulance Services:	Reporting for Air Ambulance Qualified IDR Services:
and the Selection of the Payment Amount by the Certified IDR Entity	certified IDR entity and the selection of the payment amount by the certified IDR entity.	
Number of times During the Month That the Payment Amount Determined Exceeded the QPA Specified by Items or Services	For each determination issued during the immediately preceding month, the number of times the payment amount determined or agreed to was higher than the QPA, as specified by items or services.	Same.
Administrative Fees Collected on Behalf of the Departments	Number of determinations for which the certified IDR entity collected administrative fees from parties during the immediately preceding month.	Same.
Certified IDR Entity Fees	Total amount of fees paid to the certified IDR entity during the immediately preceding month, not including amounts refunded by the certified IDR entity to the prevailing party (or both parties, as in the case of a settlement) or the administrative fees that are collected on behalf of the Departments.	Same.

10. Federal IDR Process Fees

10.1 Administrative Fee

- The administrative fee is based on an estimate of the cost to the Departments to carry out the Federal IDR Process;
- Each party is required to pay an administrative fee;
- Each party pays one administrative fee per single or per batched determination
- Administrative fees may be invoiced by the certified IDR entity at the time of selection and each party must pay the administrative fee by the time of offer submission, but the certified IDR entity has discretion as to when to collect the administrative fee (as long as it is collected by the time the offers are submitted, which is also when the certified IDR entity fees must be paid); and
- The administrative **fees will not be refunded** even if the parties reach an agreement or withdraw the dispute before the certified IDR entity makes a determination.

10.2 Certified IDR Entity Fee

Each party must pay the entire certified IDR entity fee. **The certified IDR entity fee is due when the party submits its offer**.

- As a condition of certification, each certified IDR entity is **required** to submit to the Departments the amount of the certified IDR entity fees it will charge;
- The fees must be within a pre-determined range specified by the Departments, unless otherwise approved by the Departments in writing; and
- A **certified IDR entity must submit a written proposal** to charge a fee beyond the upper or lower limit of the pre-determined range. The Federal IDR portal provides the functionality for certified IDR entities and entities applying to become certified IDR entities to request an alternative fixed fee. The written proposal must include:
    - The alternative fixed fee the IDR entity seeking certification or certified IDR entity believes is appropriate;
    - A description of the circumstances that require an alternative fixed fee; and
    - A description of how the alternative fixed fee will be used to mitigate the effects of these circumstances. Note that the certified IDR entity may not charge a fee that is not within the approved limits unless the certified IDR entity receives written approval from the Departments to charge a fixed fee beyond the upper or lower limits.

The **certified IDR entity must hold the certified IDR entity fees in a trust or escrow account** until the certified IDR entity determines the OON rate, after which point the certified IDR entity must refund to the prevailing party the amount that party submitted for the certified IDR entity fee **within 30 business days**.

The certified IDR entity **retains the non-prevailing party's certified IDR entity fee** as compensation for the certified IDR entity's services. If the parties negotiate an OON rate before a determination is made, or if both parties agree to withdraw a dispute, the certified IDR entity

will return half of each party's payment for the certified IDR entity fee within 30 business days, unless directed otherwise by both parties to distribute the total amount of the refund in different shares.

Collection of Certified IDR Entity Fees:
The certified IDR entity **fee** must be paid by both parties by the time of offer submission.
The certified IDR entity retains the non-prevailing party's certified IDR entity fee as compensation unless the parties settle on an OON rate before a determination or agree to withdraw the dispute.
If the parties settle or withdraw, the certified IDR entity will return half of each party's fee payment, unless directed otherwise by the parties.

10.2.1 Batched Claims, Certified IDR Entity Fee, and Administrative Fee

The certified IDR entity may make different payment determinations for each qualified IDR item or service in a batched claim dispute. In such cases, the party with the fewest determinations in its favor is considered the non-prevailing party and is responsible for paying the certified IDR entity fee. In the event that each party prevails in an equal number of determinations, the certified IDR entity fee will be split evenly between the parties.

The certified IDR entity will collect a single administrative fee from each of the parties for batched claims. The parties should be identified by name and IDR reference number. Each claim should be identified by claim number.

10.2.2 Bundled Payments

A bundled arrangement is an arrangement under which a provider, facility, or provider of air ambulance services bills for multiple items or services under a single service code; or a plan makes an initial payment or notice of denial of payment to a provider, facility, or provider of air ambulance services under a single service code that represents multiple items or services (e.g., a DRG). Bundled payment arrangements are subject to the rules for batched determinations, but the certified IDR entity fee and administrative fee will be the same as for single determinations.

11. Confidentiality Requirements

While conducting the Federal IDR Process, a certified IDR entity will be entrusted with individually identifiable health information (IIHI). The certified IDR entity must comply with the confidentiality requirements applicable to certified IDR entities, including provisions regarding privacy, security, and breach notification under 26 CFR 54.9816-8T(e)(2)(v), 29 CFR 2590.716-8(e)(2)(v), and 45 CFR 149.510(e)(2)(v), and the Independent Dispute Resolution Entity Certification Agreement (the "Agreement"). Failure to comply with these privacy and security measures may result in immediate revocation of an IDR entity's certification and may prevent the IDR entity from future certification and participation in the program, subject to the appeals process.

11.1 Privacy

A certified IDR entity may create, collect, handle, disclose, transmit, access, maintain, store, and/or use IIHI to perform its required duties, when required to do so.

11.2 Security

Certified IDR entities are required to maintain the security of the IIHI they obtain by: ensuring the confidentiality of all IIHI they create, obtain, maintain, store, and transmit; protecting against any reasonably anticipated threats or hazards to the security of this information; protecting against any reasonably anticipated unauthorized uses or disclosures of this information; and ensuring compliance by any of their personnel who have access to IIHI, including their contractors and subcontractors (as applicable).

Certified IDR entities are required to have policies and procedures in place to properly use and disclose IIHI, identify when IIHI should be destroyed or disposed of, properly store and maintain confidentiality of IIHI that is accessed or stored electronically, and identify the steps the certified IDR entities will take in the event of a breach regarding IIHI.

Certified IDR entities must securely destroy or dispose of IIHI in an appropriate and reasonable manner 6 years from either the date of its creation or the first date on which the certified IDR entity had access to it, whichever is earlier. In determining what is appropriate and reasonable, certified IDR entities should assess potential risks to participant, beneficiary, or enrollee privacy, as well as consider such issues as the form, type, and amount of IIHI to be disposed of. In general, shredding, burning, pulping, or pulverizing paper records so that IIHI is rendered unreadable, indecipherable, and otherwise cannot be reconstructed; and, for IIHI contained on electronic media, clearing (using software or hardware products to overwrite media with non-sensitive data), purging (degaussing or exposing the media to a strong magnetic field in order to disrupt the recorded magnetic domains), or destroying the media (disintegration, pulverization, melting, incinerating, or shredding) may be reasonable methods of disposal.

When IIHI is stored by the certified IDR entity, it must periodically review, assess, and modify the security controls implemented to ensure the continued effectiveness of those controls and the protection of IIHI.

Certified IDR entities must develop and utilize secure electronic interfaces when transmitting IIHI electronically, including through data transmission through the Federal IDR portal, and between disputing parties and the certified IDR entity during the Federal IDR Process.

The certified IDR entity must implement and follow policies and procedures for guarding against, detecting, and reporting malicious software; monitoring log-in attempts and reporting discrepancies; creating, changing, and safeguarding passwords; and protecting IIHI from improper alteration or destruction. The certified IDR entity must also implement policies and procedures for the administrative, technical, and physical safeguards for electronic information systems that maintain IIHI to allow access only to those persons or software programs that have been granted access rights.

All confidentiality requirements applicable to certified IDR entities also apply to certified IDR entities' contractors and subcontractors performing any duties related to the Federal IDR

Process with access to IIHI. For example, if a breach rises to the level of requiring notification (as described in Section 11.3), the contractor or subcontractor must notify the certified IDR entity, at the time they determine there is a potential breach, to inform it of the risk assessment results (as described in Section 11.3), and the certified IDR entity must notify the Departments, or OPM if an FEHB Carrier is involved.

The Departments reserve the right to audit certified IDR entity privacy and security protocols to ensure they are operating in compliance with regulatory and contractual requirements.

11.3 Breach Notification

Please refer to the Agreement for detailed instructions, definitions, and legal requirements regarding breaches.

Certified IDR entities must report any actual or suspected breach of unsecured IIHI to the CMS IT Service Desk by telephone (1-800-562-1963 or 410-786-2580) or email at cms_it_service_desk@cms.hhs.gov and must also contact the Information Security and Privacy Group by emailing ACASecurityandPrivacy@cms.hhs.gov within 24 hours of discovery of an actual or suspected breach. Incidents must be reported to the CMS IT Service Desk and the Information Security and Privacy Group by the same means as breaches within 72 hours of from discovery of the actual or suspected incident.[24]

Within five business days of discovery of an actual or suspected breach, the certified IDR entity must conduct a risk assessment to determine whether it is likely or unlikely that the IIHI was compromised based on the nature of the IIHI, the unauthorized person who received (or may have received) it, the acquisition or use of the IIHI, and any steps taken to mitigate the effects of the breach; it must also prepare and submit a written document describing all information relevant to the risk assessment, including a description of the breach, a description of the risk assessment conducted by the certified IDR entity, and the results of the risk assessment. The written risk assessment must be submitted to the Departments (and OPM, if applicable), through the Federal IDR portal; to the CMS IT Service Desk at cms_it_service_desk@cms.hhs.gov; and to the Information Security and Privacy Group at ACASecurityandPrivacy@cms.hhs.gov. If necessary, certified IDR entities may also make a verbal report of the results of its risk assessment to the CMS IT Service Desk by telephone (1-800-562-1963 or 410-786-2580).

If the risk assessment results in a determination that the risk that the IIHI was compromised is greater than 'low,' the certified IDR entity must provide notification of the breach without unreasonable delay, and in no case later than 60 calendar days after the discovery of the breach, to the Departments (and OPM, if applicable); the plan, as applicable; the provider, facility, or provider of air ambulance services, as applicable; and each individual whose unsecured IIHI has been, or is reasonably believed to have been, subject to the breach.

[24] "Breach" of IIHI is defined in 26 CFR 54.9816-8T(a)(2)(ii), 29 CFR 2590.716-8(a)(2)(ii), and 45 CFR 149.510(a)(2)(ii). "Security incident" or "incident" has the meaning contained in OMB Memoranda M 17-12 (January 3, 2017) and means an occurrence that, in relation to a certified IDR Entity's information technology system that stores and maintains unsecured IIHI: (1) actually or imminently jeopardizes, without lawful authority, the integrity, confidentiality, or availability of information or the information system; or (2) constitutes a violation or imminent threat of violation of law, security policies, security procedures, or acceptable use policies.

12. Revocation of Certification

The Departments may revoke certification if it is determined that the certified IDR entity:

1. Has a pattern or practice of noncompliance with the requirements applicable to certified IDR entities under the Federal IDR Process;
2. Is operating in a manner that hinders the efficient and effective administration of the Federal IDR Process;
3. No longer meets the applicable standards for certification, including having violated the confidentiality provisions set forth in Section 11;
4. Has committed or participated in fraudulent or abusive activities, including submission of false or fraudulent data to the Departments;
5. Lacks the financial viability to provide arbitration under the Federal IDR Process;
6. Has failed to comply with requests from the Departments made as part of an audit, including failing to submit all records of the certified IDR entity that pertain to its activities within the Federal IDR Process; and
7. Is otherwise no longer fit or qualified to make determinations.

The Departments will issue a written notice of revocation to the certified IDR entity within **10 business days** of the Departments' decision. To appeal the notice of revocation, the certified IDR entity must submit a request for appeal to the Departments within **30 business days** of the date of the notice. During this time period, the Departments will not issue a final notice of revocation, and a certified IDR entity may continue to work on previously assigned determinations but will not be permitted to accept new determinations.

12.1 Procedures after Final Revocation for Incomplete Determinations

Upon notice of final revocation, the IDR entity shall not be considered a certified IDR entity and therefore shall not be eligible to accept payment determinations under the Federal IDR Process. Moreover, the IDR entity must cease conducting any ongoing payment determinations (if applicable), which will be reassigned to an appropriate certified IDR entity by the Departments. The IDR entity must agree to these terms as part of entering into the Agreement.

12.2 Certified IDR Entity Administrative Fees for Incomplete Determinations

In the event the previously certified IDR entity has any remaining ongoing payment determinations at the time of revocation of its certification, the IDR entity must also refund to the parties all previously paid certified IDR entity fees and any administrative fees related to ongoing payment determinations. The parties shall pay the certified IDR entity and administrative fees to the appropriate reassigned certified IDR entity selected by the Departments.

Appendix A – Definitions

(1) "***Batched items or services***" means multiple qualified IDR items or services that are considered jointly as part of one payment determination by a certified IDR entity for purposes of the Federal IDR Process. In order for a qualified IDR item or service to be included in a batched item or service, the qualified IDR item or service must meet the criteria set forth in 26 CFR 54.9816-8T(c)(3) (i)(A), (B) and (D), 29 CFR 2590.716-8(c)(3) (i)(A), (B) and (D), 45 CFR 149.510(c)(3) (i)(A), (B) and (D) and comply with the statutory requirements that the items and services be related to the treatment of a similar condition.[25]

(2) ***"Bundled arrangement"*** means an arrangement under which a provider, facility, or provider of air ambulance services bills for multiple items or services under a single service code; or a plan, issuer or carrier makes an initial payment or notice of denial of payment to a provider, facility, or provider of air ambulance services under a single service code that represents multiple items or services (e.g., a DRG).

(3) "***Certified IDR entity***" means an entity responsible for conducting determinations under 26 CFR 54.9816-8T(c) and 54.9816-8(c), 29 CFR 2590.716-8(c), and 45 CFR 149.510(c) that meets the certification criteria specified in 26 CFR 54.9816-8T(e), 29 CFR 2590.716-8(e), and 45 CFR149.510(e) and that has been certified by the Departments.

(4) "***Conflict of interest"*** means, with respect to either party to a payment determination or a certified IDR entity, a material relationship, status, or condition of the party or certified IDR entity that impacts the ability of a certified IDR entity to make an unbiased and impartial payment determination. For purposes of this definition, a conflict of interest exists when a certified IDR entity is:
(A) A group health plan; a health insurance issuer offering group health insurance coverage, individual health insurance coverage, or short-term, limited-duration insurance; a carrier offering a health benefits plan under 5 U.S.C. 8902; or a provider, a facility or a provider of air ambulance services;
(B) An affiliate or a subsidiary of any type of organization specified in (4)(A) immediately above;
(C) An affiliate or subsidiary of a professional or trade association representing any types of organizations specified in (4)(A) above.
(D) A certified IDR entity that has or that has any personnel, contractors, or subcontractors assigned to a determination who have, a material familial, financial, or professional relationship with a party to the payment determination being disputed, or with any officer, director, or management employee of the plan, issuer, or carrier offering a health benefits plan under 5 U.S.C. 8902; the plan (or coverage) administrator, plan (or coverage) fiduciaries, or plan, issuer, or carrier employees; the health care provider, the health care provider's group or practice association; the provider of air ambulance services, the provider of air ambulance services' group or practice association, or the facility that is a party to the dispute.

[25] Refer to FAQs About Affordable Care Act and Consolidated Appropriations Act, 2021 Implementation Part 63 (November 28, 2023), available at https://www.cms.gov/files/document/faqs-part-63.pdf

(5) ***"Downcode"*** means the alteration by a plan issuer, or carrier of a service code to another service code or the alteration, addition, or removal by a plan, issuer, or carrier of a modifier, if such a change is associated with a lower QPA than the service code or modifier billed by the provider, facility, or provider of air ambulance services.

(6) "***Health care facility (facility)***" means, in the context of non-emergency services, each of the following: (1) a hospital (as defined in Section 1861(e) of the Social Security Act); (2) a hospital outpatient department; (3) a critical access hospital (as defined in Section 1861(mm)(1) of the Social Security Act); or (4) an ambulatory surgical center described in Section 1833(i)(1)(A) of the Social Security Act.

(7) "***Individually identifiable health information (IIHI)***" means any information, including demographic data, that relates to the past, present, or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual; and that identifies the individual; or with respect to which there is a reasonable basis to believe the information can be used to identify the individual.

(8) "***Material familial relationship***" means any relationship as a spouse, domestic partner, child, parent, sibling, spouse's or domestic partner's parent, spouse's or domestic partner's sibling, spouse's or domestic partner's child, child's parent, child's spouse or domestic partner, or sibling's spouse or domestic partner.

(9) "***Material financial relationship***" means any financial interest of more than five percent of total annual revenue or total annual income of a certified IDR entity or an officer, director, or manager thereof, or of a reviewer or reviewing physician employed or engaged by a certified IDR entity to conduct or participate in any review in the Federal IDR Process. The terms annual revenue and annual income do not include mediation fees received by mediators who are also arbitrators, provided that the mediator acts in the capacity of a mediator and does not represent a party in the mediation.

(10) "***Material professional relationship***" means any physician-patient relationship, any partnership or employment relationship, any shareholder or similar ownership interest in a professional corporation, partnership, or other similar entity; or any independent contractor arrangement that constitutes a material financial relationship with any expert used by the certified IDR entity or any officer or director of the certified IDR entity.

(11) "***Physician or health care provider (provider)***" means a physician or other health care provider who is acting within the scope of practice of that provider's license or certification under applicable State law, but does not include a provider of air ambulance services.

(12) "***Qualified IDR item or service***" means an item or service that is either an emergency service from an OON provider or facility, a non-emergency item or service furnished by an OON provider with respect to a patient visit to an in-network health care facility as defined by the NSA, or air ambulance services furnished by an OON provider of air ambulance services, for which the provider or facility (as applicable) or provider of air ambulance services or plan, issuer, or carrier submits a valid Notice of IDR Initiation. For the notification

to be valid, the open negotiation period must have lapsed without agreement on the payment amount.

(13) ***"Qualifying Payment Amount (QPA)"*** generally means the median of the contracted rates recognized by the plan, issuer or carrier for the same or similar item or service that is provided by a provider in the same or similar specialty or facility of the same or similar facility type and provided in the same geographic region in which the item or service under dispute was furnished, increased by inflation.[26]

(14) ***"Recognized amount"*** means: (1) an amount determined by reference to an applicable All-Payer Model Agreement under section 1115A of the Social Security Act; (2) if there is no applicable All-Payer Model Agreement, an amount determined by reference to a specified state law; or (3) if there is no applicable All-Payer Model Agreement or specified state law, the lesser of the amount billed by the provider or facility or the QPA.

(15) "***Service code***" means the code that identifies and describes an item or service using the Current Procedural Terminology (CPT), Healthcare Common Procedure Coding System (HCPCS), or Diagnosis-Related Group (DRG) codes.

[26] The methodology for calculating the QPA for group health plans subject to Department of Labor rules is found at 29 CFR 2590.716-6. The corresponding methodology for group and individual health insurance markets and for nonfederal governmental group health plans subject to the jurisdiction of HHS is found at 42 CFR 149.140. The corresponding methodology for group health plans subject to the jurisdiction of the Department of the Treasury is found at 26 CFR 54.9816-6T. For more information on QPA calculation see Frequently Asked Questions (FAQs) About Affordable Care Act and Consolidated Appropriations Act, 2021 Implementation Part 62 (October 6, 2023), available at https://www.cms.gov/files/document/faqs-part-62.pdf

Appendix B – Process Steps Summary and Associated Notices

All standard notice templates related to surprise billing can be found on the Department of Labor website.

PROCESS STEPS SUMMARY Before the Federal IDR Process:	STANDARD FEDERAL IDR NOTICE
1. **Covered item or service results in:** an OON charge for furnishing emergency items or services from an OON provider or facility, an OON provider charge for items/services at an in-network facility (without notice and consent), or an OON charge for air ambulance services.	None
2. **Initial payment or notice of denial of payment:** Must be sent by the plan or issuer no later than *30 calendar days* after a bill is submitted. The notice must include information on the QPA, certification that the QPA applies and was determined in compliance with the relevant rules and statutes,[27] a statement that the provider or facility may contact the appropriate person or office to initiate open negotiation, and contact information, including a telephone number, and email address, for the appropriate person or office to initiate open negotiations. In addition, if the QPA is based on a downcoded service code or modifier, the plan must include a statement explaining that the service code or modifier billed by the provider, facility, or provider or air ambulance services was downcoded; an explanation of why the claim was downcoded, including a description of which service code or modifiers were altered, added, or removed, if any; and the amount that would have been the QPA had the service code or modifier not been downcoded. Parties must remain in compliance with the No Surprises Act and the balance billing provisions and refrain from billing the participant, beneficiary, and enrollee in excess of the applicable cost-sharing permitted under the No Surprises Act unless/until the provider has determined the services are not a covered benefit.	None
3. **Open negotiation period:** Parties must exhaust a *30-business-day* open negotiation period before either party may initiate the Federal IDR Process. This period must be initiated within *30 business days* beginning on the day the OON provider receives either an initial payment or a notice of denial of payment for the item or service from the plan. The open negotiation period begins on the day on which the open negotiation notice is first sent by a party. The party initiating open negotiation should use 1 Open Negotiation Notice per each out-of-network item or service, unless a plan made an initial payment as a bundled payment (or specifies that a denial of payment is made on a bundled payment basis) or the initiating party intends to batch all the items or services included in the notice, as permitted under the interim final rules as part of the Federal IDR process.	Open Negotiation Notice
Federal IDR Process:	

[27] Refer to Frequently Asked Questions (FAQs) About Affordable Care Act and Consolidated Appropriations Act, 2021 Implementation Part 62 (October 6, 2023), available at https://www.cms.gov/files/document/faqs-part-62.pdf.

4. **IDR initiation:** Either party can initiate the Federal IDR Process by submitting a Notice of IDR Initiation to the other party and to the Departments within *4 business days* after the close of the open negotiation period (or within 30 business days after a cooling off period, if applicable). The 4 business-day period begins on the 31st business day after the start of the open negotiation period. For claims subject to a 90-calendar-day cooling off period, parties can initiate the Federal IDR process during the 30-business-day period beginning on the day after the last day of the cooling off period. The notice must include the initiating party's preferred certified IDR entity.	Notice of IDR Initiation

PROCESS STEPS SUMMARY Before the Federal IDR Process:	STANDARD FEDERAL IDR NOTICE
5. **Selection of certified IDR entity:** Once the Federal IDR Process is initiated: - *Within 3 business days:* If the non-initiating party does not object to the initiating party's preferred certified IDR entity (included in the Notice of IDR initiation), selection defaults to the initiating party's preferred certified IDR entity unless there is a conflict of interest. If the non-initiating party objects, it must provide an alternative certified IDR entity to the initiating party. - *Within the next business day following the 3-business-day selection period:* The initiating party must submit a Notice of Certified IDR Entity Selection indicating agreement (or, if the parties do not agree on a certified IDR Entity, failure to select a certified IDR entity). Also, if the non-initiating party believes that the Federal IDR Process is not applicable, it must notify the Departments via the Federal IDR portal in the same timeframe. - *Within 6 business days from IDR initiation:* If the parties cannot agree on the selection of a certified IDR entity, the Departments will randomly select a certified IDR entity. Administrative fees may be invoiced by the certified IDR entity at the time the parties select the certified IDR entity and must be collected by the certified IDR entity from the parties by the time the parties submit their offers. If the administrative fee is not collected from a party, the certified IDR entity will not accept the non-paying party's offer. The administrative fee amount will be established by the Departments, available here. The certified IDR entity must follow the process for remitting the administrative fees to HHS each month according to HHS guidance.	Notice of Certified IDR Entity Selection (or Failure to Select)*
6. **Certified IDR Entity requirements:** Following preliminary selection, the certified IDR entity must: - *Attest to having no conflicts of interest:* The certified IDR entity must attest to meeting the requirements of the conflicts of interest rules or notify the Departments of an inability to meet those requirements within *3 business days* of being selected as the certified IDR entity. - *Determine whether the Federal IDR Process applies:* The certified IDR entity must notify both the Departments and the parties within *3 business days* of being selected as the certified IDR entity if it determines that the Federal IDR Process does not apply.	None
7. **Submission of offers:** Parties must submit their offers not later than *10 business days* after certified IDR entity selection is finalized.	Federal IDR Notice of Offer
8. **Payment of Certified IDR Entity fees:** Certified IDR entity fees are collected by the certified IDR entity upon submission of the offers.	None

PROCESS STEPS SUMMARY Before the Federal IDR Process:	STANDARD FEDERAL IDR NOTICE
9. **Continuing negotiations:** The parties may continue to negotiate after initiation of the Federal IDR Process and may reach an agreement before a certified IDR entity makes a determination. If the parties agree to a payment amount after providing the Notice of IDR Initiation, the initiating party must submit a notification to the Departments and the certified IDR entity through the Federal IDR portal or by contacting the selected certified IDR entity, as soon as possible, but not later than *3 business days* after the date of the agreement.	Federal Independent Dispute Resolution (IDR) Process: Notice of Agreement Data Elements
10. **Selection of offer:** A certified IDR entity has *30 business days* from the date its selection was finalized to select one of the offers submitted and notify the parties, as well as the Departments, of its decision.	Certified IDR Entity's Payment Determination
11. **Extenuating circumstances:** The parties may request extensions, granted at the Departments' discretion, to the time periods above (except timelines related to payments) in cases of extenuating circumstances such as matters beyond the control of the parties or for good cause.	Request for Extension due to Extenuating Circumstances
12. **Payment:** Any amount due from one party to the other party must be paid not later than *30 calendar days* after the determination by the certified IDR entity. The certified IDR entity must refund the certified IDR entity fee to the applicable party(ies) within *30 business* days after the determination.	None

*Indicates that a standard Federal notice has not been developed for this step, however, required communication is expected to take place through the Federal IDR portal or directly with the selected certified IDR Entity

Appendix C– Resources

Notices:

- Paperwork Reduction Act (PRA) notices and information collection requirements for the Federal Independent Dispute Resolution Process (Download Notices and Information Requirements)
- Standard notice & consent forms for nonparticipating providers & emergency facilities regarding consumer consent to waive surprise billing protections (Download Surprise Billing Protection Form) (PDF)
- Model disclosure notice on patient protections against surprise billing for providers, facilities, health plans, issuers and carriers (Download Patient Rights & Protections Against Surprise Medical Bills) (PDF)
- Rules and Fact Sheets
- Federal IDR Portal

Please see https://www.cms.gov/nosurprises/policies-and-resources/overview-of-rules-fact-sheets for information on the applicable fees.

Independent Dispute Resolution Timeline for Claims

Where to go for help

CMS.Gov/NoSurprises

No Surprises Help Desk: 1-800-985-3059

Department of Health & Human Services
200 Independence Ave S.W.
Washington D.C. 20201
Toll Free Call Center: 1-877-696-6775
www.hhs.gov

Department of Labor
200 Constitution Ave N.W.
Washington, DC 20210
1-866-4-USA-DOL / 1-866-487-2365
www.dol.gov

Department of the Treasury
1500 Pennsylvania Ave N.W.
Washington, D.C. 20220
General Information: (202) 622-2000
www.treasury.gov

Federal Independent Dispute Resolution (IDR) Process
Guidance for Certified IDR Entities

December 2023 Update to March 2023 Guidance

EXHIBIT F

Supplemental Background on Federal Independent Dispute Resolution Public Use Files
January 1, 2025 – June 30, 2025

The No Surprises Act (NSA) and its implementing regulations[1] establish a Federal Independent Dispute Resolution (IDR) process that out-of-network (OON) providers, facilities, and providers of air ambulance services, and group health plans, health insurance issuers offering group and individual health insurance coverage, and Federal Employees Health Benefits (FEHB) Program carriers (collectively, disputing parties) may use to determine the OON rate for qualified IDR items or services after an unsuccessful open negotiation period. The Departments of Health and Human Services, Labor, and the Treasury (the Departments) launched the Federal IDR portal on April 15, 2022, to facilitate this process. The No Surprises Act requires the Departments to publish on a public website certain information about the Federal IDR process.[2]

To promote transparency in the implementation of the Federal IDR process, the Departments provided several status updates as well as initial reports for calendar quarters in 2022.[3,4] The Departments began publishing the quarterly IDR public use file (PUF) and supplemental tables for 2023. Data are currently available for calendar years 2023 and 2024.[5] The Departments are now releasing the IDR PUF and supplemental tables for the first and second calendar quarters of 2025.

The IDR PUF includes detailed information for each payment determination, including payment determination outcomes and offer amounts. In addition to the IDR PUF, the Departments are publishing supplemental tables with summary information including the number of payment disputes initiated, closed, and the reasons for closure. The information in the IDR PUF and supplemental tables is intended to promote Federal IDR process transparency and provide required information to the public.

Similar to the last six months of 2024, the first six months of 2025 were characterized by an increasingly large volume of disputes submitted through the Federal IDR portal, continuing complexity in determining whether disputes were eligible for the Federal IDR process, and substantial improvement in throughput and dispute closures. Certified IDR entities continued their efforts to scale up their operations to contend with the large volume of disputes, making substantially more payment determinations in the first six months of 2025 compared to the last six months of 2024. Since the first quarter of 2024, certified IDR entities have progressively increased the number of payment determinations made each calendar quarter. Additionally, since July 2024 certified IDR entities have

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[1] Requirements Related to Surprise Billing; Part I, 86 FR 36872 (July 13, 2021), https://www.federalregister.gov/documents/2021/07/13/2021-14379/requirements-related-to-surprise-billing-part-i; Requirements Related to Surprise Billing; Part II, 86 FR 55980 (October 7, 2021), https://www.federalregister.gov/documents/2021/10/07/2021-21441/requirements-related-to-surprise-billing- part-ii; and Requirements Related to Surprise Billing, 87 FR 52618 (August 26, 2022), https://www.federalregister.gov/documents/2022/08/26/2022-18202/requirements-related-to-surprise-billing.

[2] *See* Code section 9816(c)(7), ERISA section 716(c)(7), and PHS Act section 2799A-1(c)(7).

[3] *See* Federal Independent Dispute Resolution Process Status Update (April 27, 2023), available at https://www.cms.gov/files/document/federal-idr-processstatus-update-april-2023.pdf; Federal Independent Dispute Resolution Process Status Update (Aug. 19, 2022), available at: https://www.cms.gov/files/document/federal-idr-process-status-update-august-2022.pdf; and Amendment to the Calendar Year 2023 Fee Guidance for the Federal Independent Dispute Resolution Process Under the No Surprises Act: Change in Administrative Fee (Dec. 23, 2022), available at: https://www.cms.gov/cciio/resources/regulations- and-guidance/downloads/amended-cy2023-fee-guidance-federal-independent-dispute-resolution-process- nsa.pdf.

[4] *See* Initial Report on the Federal Independent Dispute Resolution (IDR) Process, April 15 – September 30, 2022, available at: https://www.cms.gov/files/document/initial-report-idr-april-15-september-30-2022.pdf; and Partial Report on the Independent Dispute Resolution (IDR Process, October 1 – December 31, 2022, available at: https://www.cms.gov/files/document/partial-report-idr-process-octoberdecember-2022.pdf.

[5] *See* Independent Dispute Resolution Reports, available at: https://www.cms.gov/nosurprises/policies-and-resources/reports.

closed more disputes than have been initiated, quarter over quarter. Certified IDR entities have not only kept pace with rising dispute volume but also are steadily working through disputes initiated in prior months.[6]

High Volume of Disputes

Between January 1, 2025, and June 30, 2025, disputing parties initiated 1,186,812 disputes through the Federal IDR portal, 39% more than the last six months of 2024 (853,374 disputes). Providers or their representatives initiated the majority of disputes (81%) in the first six months of 2025, but health care facilities or their representatives initiated a higher share of disputes (19%) in the first six months of 2025, compared to the last six months of 2024 (13%). Similar to the last six months of 2024, the majority of disputes were initiated by a limited number of initiating parties or their representatives. The top ten initiating parties represented approximately 69% of all disputes initiated in the first six months of 2025, similar to the last six months of 2024 (71%). Many of the top initiating parties are (or are represented by) large practice management companies, medical practices, or revenue cycle management companies representing hundreds of individual practices, providers, or facilities. The top three initiating parties (HaloMD, Team Health, and SCP Health) represent thousands of clinicians across multiple states and accounted for approximately 44% of all disputes initiated in the first six months of 2025.

Certified IDR entity operations have successfully addressed the rising volume of disputes. Certified IDR entities closed 1,349,343 disputes in the first six months of 2025, approximately a 48% increase compared to the number of disputes closed in the last six months of 2024 (911,088 disputes). Certified IDR entities closed 14% more disputes in the first six months of 2025 (1,349,343) than were initiated in that time period (1,186,812), outpacing the high dispute initiation volume while significantly reducing the backlog from prior months. Dispute closures include payment determinations, ineligibility determinations, withdrawn disputes, parties reaching a settlement, and closures for administrative reasons (e.g., neither party paid required fees).

Certified IDR entities rendered 1,082,247 payment determinations in the first six months of 2025, approximately a 55% increase from the last six months of 2024 (698,968 determinations). Batched disputes accounted for approximately 31% (335,442) of all payment determinations rendered by certified IDR entities in the first six months of 2025, an increase compared to the last six months of 2024 (27%).

During the first six months of 2025, approximately 37% (401,484) of payment determinations were rendered by certified IDR entities within 30 business days, an increase compared to 29% (203,480) in the last six months of 2024.[7, 8] In the first six months of 2025 approximately 67% (729,870) of payment

[6] For more information on the Departments' efforts to resolve capacity issues and clear the IDR backlog, please see https://www.cms.gov/files/document/fact-sheet-clearing-independent-dispute-resolution-backlog.pdf.

[7] According to statutory timelines, disputes should typically be resolved 39 days from initiation. Certified IDR entity preliminary selection can take up to 6 days (with random assignment), and then final selection (certified IDR entity attesting to no conflict of interest) takes up to 3 days. If a certified IDR entity attests yes to conflict of interest, the dispute is reassigned to a different certified IDR entity, which can take an additional 3 days to attest to no conflict of interest. The 30-business day timeline to resolve a dispute begins at certified IDR entity final selection.

[8] Beginning in 2025, the length of time to make a determination in the Federal IDR PUF represents the number of business days from the date a dispute was initiated until the date the determination was sent to parties and the dispute was closed. For the 2023 and 2024 Federal IDR PUFs, the length of time to make a determination represented the number of business days from the date a dispute was assigned to a certified IDR entity until the date the determination was sent to parties and the dispute was closed. There can be a difference of up to six days from the date a dispute was initiated to the date the dispute was assigned to a certified IDR entity. For more information on the length of time to make determinations, please see the Federal

determinations were rendered by certified IDR entities within 60 business days, a significant increase from 49% (324,356) in the last six months of 2024.[9] Since the second quarter of 2024, the share of disputes for which a payment determination was made within 30 business days has increased each calendar quarter. Certified IDR entities continue to improve the efficiency of dispute processing, decreasing the median number of business days to render payment determinations over time.

Dispute Eligibility

The primary cause of dispute processing delays continues to be the complexity of determining whether disputes are eligible for the Federal IDR process. For all disputes, the certified IDR entity must confirm dispute eligibility before the dispute can proceed. These reviews involve complex eligibility determinations that require certified IDR entities to expend considerable time and resources. Non-initiating parties challenged the eligibility of 40% of initiated disputes in the first six months of 2025 (476,117 of 1,186,812), a slight decrease from 43% in the last six months of 2024.

Eligibility reviews conducted by certified IDR entities are processed more quickly when both disputing parties provide all the required information at initiation. To that end, the Departments added data elements to the dispute initiation and IDR entity selection response web forms and directed the parties to attach documents supporting or contesting eligibility during dispute initiation, to ensure certified IDR entities have all necessary information to determine eligibility earlier in the process.[10] The Departments have also added eligibility screeners to the dispute initiation form, including a duplicate dispute validation.[11] The Departments have also published technical assistance to help disputing parties and certified IDR entities better determine eligibility and resolve disputes more expeditiously.[12, 13, 14]

Process improvements and increased disputing party familiarity with eligibility requirements have likely contributed to a decline in the percentage of disputes found ineligible, from 69% in the first six months of 2022 to 20% in the last six months of 2024 and 17% in the first six months of 2025.The high volume of disputes and the complexity of making eligibility determinations remained a challenge throughout the first half of 2025.

The Departments have proposed additional policy and operational improvements through proposed rulemaking that, if finalized, would improve the process for determining the eligibility of disputes and

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IDR PUF Data Disclaimer – User Agreement and Federal IDR PUF Data Dictionary, available at: https://www.cms.gov/nosurprises/policies-and-resources/reports.

[9] *Id.*

[10] See recent changes to the IDR web forms to streamline operations and enhance the quality of data used to determine dispute eligibility, such as health plan type: https://www.cms.gov/nosurprises/noticese https://www.cms.gov/nosurprises/notices

[11] See recent changes to the IDR web forms to screen out duplicate disputes: https://www.cms.gov/nosurprises/noticese https://www.cms.gov/nosurprises/notices

[12] Federal Independent Dispute Resolution Process Guidance for Disputing Parties (Updated December 2023), available at: https://www.cms.gov/files/document/federal-independent-dispute-resolution-guidance-disputing-parties.pdf.

[13] Federal Independent Dispute Resolution (IDR) Process Guidance for Certified IDR Entities (August 2022), available at: https://www.cms.gov/files/document/ta-certified-independent-dispute-resolution-entities-august-2022.pdf.

[14] See No Surprises Act Independent Dispute Resolution (IDR) Batching and Air Ambulance Policy Frequently Asked Questions (Nov. 2023), available at: https://www.cms.gov/files/document/faqs-batching-air-ambulance.pdf; FAQs about Affordable Care Act and Consolidated Appropriations Act, 2023 Implementation Part 63 (Nov. 2023), available at: https://www.cms.gov/files/document/faqs-part-63.pdf; FAQs about Consolidated Appropriations Act, 2021 Implementation Part 62 (Oct. 2023), available at: https://www.cms.gov/files/document/faqs-part-62.pdf; and the August 2023 IDR Administrative Fees FAQs (Aug. 2023), available at: https://www.cms.gov/files/document/idr-admin-fees-faqs-081123-508.pdf-0.

ultimately increase the speed with which certified IDR entities render payment determinations.[15]

Results of Payment Determinations

Certified IDR entities rendered payment determinations in 1,082,247 disputes from January 1 through June 30, 2025. Emergency department services made up the greatest share (45%) of payment determinations, and radiology services made up 19% of payment determinations. Providers, facilities, or air ambulance providers were the prevailing party in approximately 88% of payment determinations made in the first six months of 2025. Health plans and issuers were the prevailing parties in approximately 12% of payment determinations.

The proportion of payment determinations resulting in default decisions in the first six months of 2025 held stable at 22%, consistent with the last six months of 2024 (22%).[16] The share of default decisions in favor of providers, facilities, and providers of air ambulance services increased in the first six months of 2025 (91%) compared to the last six months of 2024 (87%), while their non-default decision win rate increased slightly between the first six months of 2025 (87%) and the last six months of 2024 (85%). The overall win rate for providers, facilities, and providers of air ambulance services increased by 3% for the first six months of 2025 (88%) as compared to the last six months of 2024 (85%).

The prevailing offer was higher than the qualifying payment amount (QPA) in approximately 88% of payment determinations made in the first six months of 2025.[17] The amount of the prevailing offers relative to the QPA varied by specialty and by the cost of the service. The supplemental tables released with this report detail the median prevailing offer amount relative to the QPA, stratified by specialty and cost band of service. The Departments note that low-dollar items and services had higher prevailing offers expressed as a percentage of the QPA, partly because a small dollar difference translates into a large percentage difference.

Given that providers, facilities, or providers of air ambulance services prevailed in the majority (88%) of payment determinations during this period, the median prevailing offer is often the offer from the provider, facility, or provider of air ambulance services. While health plans and issuers often benchmarked their offers to the QPA, providers, facilities, and air ambulance service providers often benchmarked their offers to past OON payment amounts with the disputing plan or issuers and past in-network rates with either the disputing plan or issuer, or with a different plan or issuer in the same state.

Conclusion

The first six months of 2025 were characterized by a large volume of dispute initiations, continued complexity in determining dispute eligibility, and substantial increases in the number of payment determinations made and disputes closed by certified IDR entities. The Departments and certified IDR entities continued to implement changes to enhance the overall efficiency of the Federal IDR process and manage dispute volume. Certified IDR entities have achieved remarkable improvements in throughput and processing speed over time and are now resolving more disputes than are initiated each

[15] Federal Independent Dispute Resolution Operations, 88 FR 75744 (November 3, 2023), https://www.federalregister.gov/documents/2023/11/03/2023-23716/federal-independent-dispute-resolution- operations.

[16] If one party failed to submit an offer or pay their fees, and the other party submitted an offer and paid their fees, the certified IDR entity must rule in favor of the party that submitted an offer and paid their fees. Please refer to Section 5.4 of Federal IDR Process Guidance for Certified IDR Entities, available at: https://www.cms.gov/cciio/resources/regulations-and-guidance/downloads/federal-independent-dispute- resolution-process-guidance-for-certified-idr-entities.pdf.

[17] This figure was calculated by dividing the number of payment determinations made in the last six months of 2023 where the prevailing offer was greater than the QPA by the number of payment determinations made in the last six months of 2023 where both the prevailing offer and QPA were reported.

quarter. The Departments have proposed additional policy and operational improvements that, if finalized, would further improve the process for determining the eligibility of disputes and ultimately continue to increase the speed at which certified IDR entities render payment determinations.

The Departments are committed to helping certified IDR entities and disputing parties resolve disputes as expeditiously as possible and to promoting efficiency and transparency in the Federal IDR process.

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