IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF PENNSYLVANIA

UNITEDHEALTHCARE OF PENNSYLVANIA, INC. d/b/a UNITEDHEALTHCARE COMMUNITY PLAN, *Plaintiff*, vs. NORTHSTAR ANESTHESIA OF PENNSYLVANIA, LLC, *Defendant*.	Case No. 25-cv-07187-MAK

PLAINTIFF'S OPPOSITION TO DEFENDANT'S MOTION TO DISMISS

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Through its Motion to Dismiss, Defendant NorthStar Anesthesia of Pennsylvania, LLC ("NorthStar") brazenly asks this Court to immunize providers from liability when they abuse the No Surprises Act ("NSA") Independent Dispute Resolution ("IDR") process and engage in fraudulent misconduct. UnitedHealthcare of Pennsylvania, Inc. d/b/a UnitedHealthcare Community Plan ("United") respectfully submits that this Court should deny NorthStar's Motion.

NorthStar acknowledges that Medicaid and Medicare claims are ineligible for the IDR process under the NSA. Yet NorthStar argues that the IDR process should serve as the exclusive forum for resolving disputes involving Medicaid and Medicare claims that are not subject to that process. NorthStar contends that the "onus" is on health plans to prove the ineligibility of Medicaid and Medicare claims ***after*** providers fraudulently initiate the IDR process. *Memorandum in Support of Defendant's Motion to Dismiss* [ECF No. 26-1] ("Mot.") at 4-5. But health plans are immediately required to pay a ***nonrefundable*** administrative fee when a provider initiates the IDR process and before any eligibility challenge will be entertained by the independent dispute resolution entity ("IDRE"). And IDREs side overwhelmingly in favor of providers because they receive their fee payments only when they determine (correctly or incorrectly) that claims are eligible for the IDR process. Under NorthStar's theory, providers are free to flood the IDR process with hundreds of thousands of indisputably ineligible claims while health plans bear the burden of proving ineligibility after having been forced to pay the nonrefundable fees.

No case better exemplifies the absurdity of NorthStar's position than the matter presently before this Court. Indeed, NorthStar admits, or cannot dispute, the Complaint's core facts:

- NorthStar provided services to a patient covered under a United Medicaid plan. *Declaration of Michelle Balthazor in Support of Defendant NorthStar Anesthesia of Pennsylvania, LLC's Motion to Dismiss* [ECF No. 26-2] ("Balthazor Decl.") ¶¶ 20-21.

- NorthStar does not dispute that it received United's Provider Remittance Advice ("PRA") or that the PRA explicitly stated that the patient had "PA Medicaid."[1] *See generally* Mot. But NorthStar apparently chose not to review it. NorthStar argues that its billing vendor, Arietis, used an electronic 835 data file, "instead of the hard copy PRA," to summarize United's payment on the claim, even though the 835 file is "not readable by a human." *Id.* at 7 n.3; Balthazor Decl. ¶¶ 14-15. NorthStar knew that Arietis's 835 summaries historically omitted fields that showed "whether the processed claim relates to a commercial, Medicaid or MA plan." Mot. at 7. In other words, NorthStar could have, but did not, read United's PRA to see that the patient had "PA Medicaid."
- NorthStar (which boasts that it is "committed to providing . . . quality services in compliance with the laws and regulations that apply to us"[2]) presented the claim to its agent, HaloMD LLC, for IDR submission. Mot. at 7. "On March 3, 2025, HaloMD initiated the open negotiation phase of the IDR process for NorthStar." *Id.* at 8. "On March 7, 2025, United told HaloMD the dispute was ineligible" and referred HaloMD to the "PRA for additional information." *Id.*
- Again, NorthStar and HaloMD (which brags that its "proprietary platform adapts to evolving regulations and ensures filings are handled with accuracy and compliance"[3]) ignored the

[1] To make matters worse, although not known to United at the time the complaint was drafted, NorthStar now admits that it received a face sheet from the facility at which it treated the patient with the patient's Medicaid information. Mot. at 7. NorthStar did not review the face sheet. Instead, NorthStar's billing vendor, Arietis Health (which employs "extensive healthcare expertise" and "sophisticated technology" to "deliver consistently stellar results," *see* Ex. 4, https://www.arietishealth.com/), used the information on the face sheet to populate a claim for submission to United. Mot. at 7; Balthazor Decl. ¶¶ 9-10. In doing so, Arietis inexplicably "selected a United commercial plan" instead of the Medicaid plan reflected on the face sheet provided by the facility. Mot. at 7.

[2] *See* Ex. 3, https://northstaranesthesia.com/compliance-and-safety/.

[3] *See* Ex. 2, https://halomd.com/.

PRA. Instead, on April 15, 2025, "HaloMD escalated the dispute to the IDRE," EdiPhy Advisors, and submitted a formal attestation certifying that "the item(s) and/or service(s) at issue are qualified item(s) and/or service(s) within the scope of the Federal IDR process." Mot. at 8-9 and Ex. E at NSTAR_000017; Balthazor Decl. ¶ 26.

- United immediately "submitted an objection to the eligibility of the dispute," but NorthStar "submitted a brief and a persuasive argument in its favor" that resulted in the IDRE awarding NorthStar $7,075 on the ineligible Medicaid claim. Mot. at 8 and Ex. F at NSTAR_000020.

In short, NorthStar admits that the patient's status as a Medicaid member, and the fact that the Medicaid claim was at all times ineligible for the IDR process, were easily ascertainable from the facility face sheet and the PRA. NorthStar simply did not bother to review them. NorthStar somehow claims that it only "first came to appreciate that the IDR award was ineligible after investigating" the allegations in United's Complaint. Mot. at 9. Again, in the world according to NorthStar, "honest mistakes" like these are to be expected.

NorthStar's narrative must be rejected. United has sufficiently pled that NorthStar did not make an honest mistake. The Court need look no further than the fact that NorthStar sought (and ultimately obtained an award for) $7,075 on the ineligible Medicaid claim at issue—$5,634 more than the amount allowed under Pennsylvania's Medicaid regulations and $625 more than NorthStar originally billed for the claim. It is obvious this was not an "honest mistake." This was an intentional, fraudulent act designed to saddle United with nonrefundable administrative costs and the burden of proving what NorthStar and its agents already knew (that the Medicaid claim was ineligible for the IDR process) and to secure a windfall payment to which NorthStar was not entitled. Remarkably, even after United objected to eligibility with the IDRE and made reference to the PRA that NorthStar now admits shows clearly that this is an ineligible claim that never

should have been submitted to the IDR process in the first place, NorthStar doubled down on its fraud by submitting "a brief and a persuasive argument in its favor" that resulted in the IDRE awarding NorthStar $7,075 on the ineligible Medicaid claim. Mot. at 8.

Contrary to NorthStar's narrative, this is not a rare occurrence; it is part of NorthStar's business strategy for weaponizing the NSA. NorthStar admits that it made at least three more false attestations that Medicare or Medicaid claims were eligible for the IDR process. *Id.* at 9-10; Balthazor Decl. ¶ 35.[4] And though the American Society of Anesthesiologists ("ASA"), filing as amicus curiae, attempts to buttress NorthStar's narrative, the data it provides reveals the true nature and scope of the problem: nearly one in four IDR disputes have been found ineligible since the IDR process began. *Amicus Curiae Brief of the American Society of Anesthesiologists in Support of NorthStar Anesthesia* [ECF No. 32] ("Amicus") at 4. Nearly 900,000 claims cannot all be "honest mistakes." Rather, they reflect providers' widespread use of a strategy that emphasizes volume over accuracy, putting the "onus" on health plans to force adherence with the law. Simply put, submitting high volumes of claims, including ineligible ones, is a profitable strategy with no risk to providers—one that already added $5 billion to overall health system costs. Compl. ¶ 49.

United respectfully requests that the Court deny NorthStar's motion to dismiss because each of its procedural objections fail.

First, United has adequately pled fraud. NorthStar's arguments, if accepted, would immunize any provider who weaponizes the NSA against health plans by fraudulently attesting to IDR eligibility. NorthStar contends that United cannot show "justifiable reliance" because United knew NorthStar's attestation was false. It simultaneously argues that United cannot show

[4] United has identified additional ineligible claims, beyond the three admitted to by NorthStar, that were improperly submitted to the IDR process by NorthStar and believes that discovery will reveal significant issues with NorthStar's claim submission process.

"proximate causation" because it was the IDRE, and not NorthStar, who issued the award. Both of these arguments are unavailing. Congress did not enact the NSA with the intention of conferring blanket immunity on bad actors; indeed, the NSA expressly contemplates that fraud claims may arise from the IDR process.

Second, this Court has subject-matter jurisdiction because United's claims necessarily raise substantial, disputed questions of federal law: whether submitting a false attestation of NSA IDR eligibility constitutes actionable fraud and whether awards issued on ineligible claims are binding. These are pure questions of statutory interpretation with implications far beyond this case.

Third, United's claims are not moot. NorthStar's purported "corrective actions," initiated only *after* litigation began, fall far short of the relief United seeks. NorthStar has merely requested—not obtained—reopening of the award. United's IDRE payment has not been refunded by NorthStar or the IDRE, and United will never recover its nonrefundable administrative fee absent relief from this Court. Further, despite identifying other instances in which it submitted similar ineligible Medicaid and Medicare claims, NorthStar has taken no action to address the systemic failures that led it to submit a false attestation of eligibility in this instance and in others. Under the voluntary cessation doctrine, NorthStar's unilateral and impermanent policy changes (made only *after* being sued) do not strip this Court of its authority to decide the conduct's legality.

Finally, this Court—not CMS—is the proper forum. It is undisputed that the Medicaid claim at issue here is not, ***and never was***, subject to the NSA's IDR process. The notion that United is limited to an inapplicable administrative process is absurd. NorthStar engaged in a flagrant abuse of the NSA IDR process, which is exactly the sort of behavior that calls for judicial review. This Court, not CMS, can adjudicate fraud claims and award the injunctive relief United seeks. United has no obligation to wait indefinitely for administrative action that may never come.

FACTUAL BACKGROUND

The facts here are simple: NorthStar, through its agent HaloMD, knowingly submitted a formal attestation—in violation of federal law—falsely certifying eligibility of a Medicaid claim for the federal IDR process despite having received explicit written notice that the claim was ineligible.[5] *See* pp. 2-3, *supra*. When NorthStar submitted the ineligible claim, United was then forced to participate in the IDR process or risk a default determination. On April 16, 2025—the day after NorthStar initiated the IDR dispute—United attested through the IDR portal that the claim was "not eligible for IDR under the NSA because this Member is enrolled in a Medicare, Medicaid, Children's Health Insurance Program, or TRICARE plan," and attached the PRA as evidence. Compl. ¶¶ 73-74. The PRA, which was first sent to NorthStar after it billed United for the care at issue, expressly stated that the patient was a Medicaid member and warned that "[b]illing or balance billing UnitedHealthcare Community Plan Medicaid members is prohibited." *Id.* ¶¶ 61-63. The PRA left no room for doubt. It was unequivocal evidence of the patient's Medicaid status, provided to NorthStar at the first opportunity and every opportunity thereafter. On May 2, 2025, United sent a letter directly to the IDRE, reiterating that the claim was "not eligible" for IDR adjudication "because this Member is enrolled in . . . Medicaid." *Id.* ¶ 75.

[5] The amicus argues that ineligible claims like the one at issue here are submitted to the IDR process through "miscommunication or a lack of communication between the disputing parties" or a "lack of clarity" as to whether the claim at issue is a Medicare or Medicaid claim. Amicus at 4 (quoting Federal Independent Dispute Resolution Operations, 88 Fed. Reg. 75744, 75753-54 (Nov. 3, 2023)). This characterization cannot be squared with the facts of this case. Here, United provided clear, unambiguous notice to NorthStar that the claim was ineligible, including a PRA expressly stating that the patient was covered by "PA Medicaid," yet NorthStar pressed forward anyway with a false attestation of eligibility. When providers receive explicit notice of ineligibility and proceed regardless, they are not victims of "miscommunication." Moreover, the notion that providers cannot determine whether a patient is enrolled in Medicaid—when their entire revenue process depends on determining a patient's insurance status—strains credulity.

But NorthStar, through its agent, persisted in pursuing that claim through the IDR process despite United's repeated explanation that the claim was ineligible. NorthStar ultimately succeeded in obtaining a $7,075 windfall award from the IDRE, on a claim for which NorthStar was actually entitled to only $1,440.72 under Pennsylvania's Medicaid fee schedule. *Id.* ¶ 90.

Despite United's repeated, documented objections, including the unambiguous PRA, the IDRE credited NorthStar's false attestation and ruled in its favor, finding that United "did not submit any other persuasive argument." Mot. at 8 and Ex. F at NSTAR_000018-20; Balthazor Decl. ¶ 27. On June 26, 2025, after the IDRE's erroneous ruling, United emailed the IDRE notifying it again that the dispute was "not eligible for the NSA process due to this member's plan being a Medicaid plan," and informing the IDRE that United had submitted a complaint to CMS regarding the improper award. Mot. at 9 and Ex. G at NSTAR_000023; Balthazor Decl. ¶ 28. To date, United has heard nothing from the IDRE or CMS regarding the email and administrative complaint it sent nine months ago. The IDRE's failure to recognize clear documentary evidence of Medicaid status and CMS's failure to address United's complaint underscore the systemic vulnerabilities that NorthStar is exploiting.

ARGUMENT

I. UNITED HAS ADEQUATELY PLED FRAUD UNDER RULE 9(B)

United has pled all elements of common-law fraud. The fundamental facts are undisputed: NorthStar, through its agent HaloMD, made a false attestation that a Medicaid claim was eligible for IDR, even after United provided clear evidence that the claim was ineligible.[6] Mot. at 6, 8 and Exs. C, E. Once NorthStar initiated the IDR process, United was immediately and automatically obligated to pay a nonrefundable administrative fee to CMS. Had NorthStar not initiated the IDR

[6] NorthStar goes on to admit that it has made at least three more false attestations that Medicare or Medicaid claims were eligible for IDR. Balthazor Decl. ¶ 35.

process, United would not have had to pay the administrative fee. Upon receiving notice that NorthStar had improperly initiated the IDR process, United immediately objected to eligibility. Mot. at 8. But NorthStar doubled down on its fraud and "submitted a brief and a persuasive argument in its favor" that resulted in the IDRE overruling United's objection and awarding NorthStar $7,075 on the ineligible Medicaid claim. *Id.* This undisputed sequence of events establishes the foundation for United's fraud claim: NorthStar made a knowingly or recklessly false statement regarding a material fact (IDR eligibility) and submitted that attestation to the IDRE with the intent that it be relied upon, it was relied upon, and United suffered harm as a direct result. United's Complaint adequately alleges both justifiable reliance and proximate causation.

A. United's Reliance Was Compelled by the IDR Framework

NorthStar argues that United cannot establish fraud because it knew that NorthStar's attestation of eligibility was false from the moment it was made. NorthStar's argument, if accepted, would immunize all providers who submit fraudulent eligibility attestations through the IDR process and create an illogical paradigm: if an insurer recognizes the fraud and alerts the IDRE (as United did here), NorthStar contends the insurer cannot establish "justifiable reliance" because the insurer knew the attestation was false. Mot. at 12. But if the insurer fails to alert the IDRE and the fraud goes undetected, the insurer would be faulted for causing its own harm. *See id.* at 14; *infra* § I.C. Under NorthStar's theory, there is no path to a fraud claim. Object and you lose on reliance; stay silent and you lose on causation. *See* Mot. at 12, 14. This Catch-22 would bar any fraud claim arising from the IDR process, no matter how egregious the provider's misconduct. Congress did not design such a framework. Setting aside that the claim at issue was ***never*** eligible for the IDR process (whether United objected or not), the NSA itself and CMS's Technical Assistance guidance recognize that IDR disputes are binding only "in the absence of a fraudulent claim or evidence of misrepresentation of facts." 42 U.S.C. § 300gg-111(c)(5)(E)(i)(I);

Ex. 1, *Federal Independent Dispute Resolution (IDR) Technical Assistance for Certified IDR Entities and Disputing Parties*, Centers for Medicare & Medicaid Services (June 2025), https://www.cms.gov/files/document/idr-ta-errors-after-dispute-closure.pdf ("Technical Assistance") at 1 n.1.[7] Thus, the NSA expressly contemplates that fraud claims may arise from the IDR process and that fraudulently procured awards are not entitled to binding effect. If Congress intended that fraud claims could never arise from the IDR process, it and CMS would not have expressly exempted them in both the NSA and its guidance on IDR determinations.

Moreover, justifiable reliance is a factual issue rarely suitable for resolution on a motion to dismiss. *Behr v. Fed. Home Loan Mortg. Corp.*, 2015 WL 5123656, at *7 (W.D. Pa. July 29, 2015); *Dilworth v. Metro. Life Ins. Co.*, 418 F.3d 345, 354 (3d Cir. 2005) (reliance "is generally a question of fact"). Here, NorthStar's false attestation deprived United of the very interest that the reliance element is designed to protect: its decisional autonomy. The wrong of fraud is fundamentally "an interference with [the injured party's] interest in being able to make . . . decisions in certain settings free of misinformation generated by others." John C.P. Goldberg, Anthony J. Sebok & Benjamin C. Zipursky, *The Place of Reliance in Fraud*, 48 Ariz. L. Rev. 1001, 1002–03 (2006). Once NorthStar (through its agent HaloMD) submitted the false attestation, United had no choice but to pay the nonrefundable administrative fee and participate in the IDR process; otherwise, it risked default. Compl. ¶ 110. And once the IDRE issued its determination, United was ostensibly bound by the outcome (at least until a court determines that the award was procured by fraud). Mot. at 5 ("Under the NSA, the determination of an IDRE is 'binding upon the parties involved.'" (quoting 42 U.S.C. § 300gg-111(c)(5)(E)(i)(I))). That is

[7] This Court can consider the Technical Guidance because it is "incorporated by reference in the complaint." *See* Compl. ¶ 96 n.51; *Wax v. Trs. of Univ. of Pa.*, 799 F. Supp. 3d 422, 429 (E.D. Pa. 2025).

precisely why United seeks a declaration that fraudulently obtained awards on ineligible claims are not binding. The fact that the award is ostensibly binding, compelling United to either pay or sue, is what makes NorthStar's fraud actionable, not what defeats United's claim. United's only recourse was to bring this action challenging NorthStar's fraud.

United's knowledge that NorthStar's attestation was false did not negate its reliance. United objected to eligibility at every stage of the IDR process: during open negotiation, through the IDR portal, by letter to the IDRE, and by complaint to CMS. *See supra* Factual Background. Despite United's objections, the IDRE credited NorthStar's attestation, its brief, and its "persuasive argument in its favor," and ruled in NorthStar's favor. *See* Mot. at 8 and Ex. F at NSTAR_000018-20. United's objections did not (and could not) prevent it from being subject to the IDRE's determination. The IDR framework thus compelled United's reliance on NorthStar's attestation, regardless of whether United disputed it.

These facts distinguish United's claim from cases like *Angino v. Branch Banking & Trust Co.*, 2020 WL 1082591 (M.D. Pa. Mar. 4, 2020), *aff'd*, 855 F. App'x 96 (3d Cir. 2021). In *Angino*, the plaintiffs could have contested the alleged fraud through available judicial procedures. *Id.* at *2. Here, United had no such opportunity. The IDR process is not a judicial proceeding. There is no discovery, no evidentiary hearing, and no neutral factfinder empowered to reject a fraudulent attestation. It is baseball-style arbitration that is, by letter and spirit of the NSA, wholly inapplicable to Medicaid and Medicare claims. Yet United was trapped by NorthStar's false attestation, and none of its litany of objections could or did change that.

B. United Has Established Proximate Causation

NorthStar, by its own admission, is the proximate cause of United's harm. When a defendant's fraudulent conduct is a "substantial factor" in causing harm to the plaintiff, the defendant's conduct is a proximate cause of the plaintiff's harm. *Kilbride Invs. Ltd. v. Cushman*

& Wakefield of Pa., Inc., 294 F. Supp. 3d 369, 381 (E.D. Pa. 2018) (noting that a "concurring cause" does not absolve a defendant of liability, and the "substantial factor need not be the only factor responsible for bringing about the alleged harm").[8] NorthStar concedes its billing practices caused the fraudulent statement. *See* Mot. at 6 ("NorthStar believes its unique revenue cycle process contributed to the outcome before the IDRE."). NorthStar's "unique revenue cycle process" involves NorthStar outsourcing claims processing to third-party vendors, deliberately structuring its operations so that it apparently never reviews a patient's insurance card or United's PRA, and relying on data summaries that it knew omitted critical eligibility information showing whether claims related to Medicaid. *Id.* at 7-8; Balthazor Decl. ¶¶ 8-10. NorthStar built a system designed to maximize IDR submissions while minimizing its own accountability.

United was plainly "within the foreseeable class of persons who would be injured" by NorthStar's fraudulent conduct. *Woodward v. Dietrich*, 548 A.2d 301, 310 (Pa. Super. Ct. 1988) (defendant's actions proximately cause harm where defendant "had reason to expect" plaintiff would rely on misrepresentation and plaintiff is "within the foreseeable class of persons who would be injured"). NorthStar's fraud aimed to secure payment from United on an ineligible claim. Compl. ¶¶ 110, 112. The IDRE's failure to detect the fraud does not break the causal chain. *Woodward*, 548 A.2d at 316 (intermediate party's failure to detect fraud would not "absolve [defendant] from liability"). It was not only entirely foreseeable that the IDRE would credit NorthStar's attestation; that was the entire point. As the amicus observes, IDREs are overwhelmed with submissions. Amicus at 4. The IDREs lack the resources to scrutinize every attestation.

[8] NorthStar's citation to *City of Phila. v. Beretta* is inapt because it is factually dissimilar to this case and involved public nuisance and negligence claims. *City of Phila. v. Beretta U.S.A. Corp.*, 277 F.3d 415, 419 (3d Cir. 2002) (dismissing public nuisance and negligence claims concerning guns "fall[ing] into the hands of criminals and children," not fraud).

Providers like NorthStar know that submitting high volumes of claims is a profitable strategy because some ineligible claims—like the one at issue here—will inevitably escape detection. The very purpose of NorthStar's attestation was to induce the IDRE to exercise jurisdiction and rule in NorthStar's favor. That is what happened. And as noted above, once NorthStar initiated the IDR process, United was forced to immediately pay the nonrefundable administrative fee that it will never recover absent relief from this Court. Again, NorthStar knew this would happen.

C. NorthStar's Challenges to United's Fraud Claim Are Internally Contradictory

NorthStar's fraud challenges are self-defeating: it faults United both for objecting to the fraud and for not objecting forcefully enough. Mot. at 12, 14. These arguments cannot logically coexist. On the one hand, NorthStar argues that United's participation in the IDR process—repeatedly notifying the IDRE that the claim was ineligible—negates United's justifiable reliance. *Id.* at 12. On the other hand, NorthStar argues that United was the proximate cause of its own harm both because United (1) failed to submit sufficient evidence to the IDRE and (2) "chose to forego . . . multiple administrative and judicial avenues in the IDR process for resolving disagreements." *Id.* at 14. NorthStar cannot have it both ways: United cannot be faulted for objecting too vigorously (thereby negating reliance) while simultaneously being faulted for not objecting vigorously enough (thereby causing its own harm). Not only does this internally contradictory argument defeat itself, but it is entirely unsupported by the facts.

United submitted clear, unambiguous evidence that the claim involved a Medicaid patient, *e.g.*, the PRA explicitly stated "PA Medicaid." Compl. ¶¶ 62-63. The IDRE's failure to credit this evidence does not transform NorthStar's fraudulent attestation into a legitimate submission. Mot. at 8 and Ex. F at NSTAR_000020. Rather, it further emphasizes the centrality of NorthStar's fraudulent attestation of eligibility, which was the only basis for initiation of the dispute and which the IDRE relied upon in wrongly finding against United.

After the IDRE issued the improper award, United submitted a complaint to CMS. Ex. G at NSTAR_000023. NorthStar argues United should have pursued other administrative remedies but conspicuously stops short of asserting that United was required to exhaust the Technical Assistance process before filing suit. Mot. at 14, 18-20. This is telling. The Technical Assistance guidance is exactly that—guidance. It carries no force of law and imposes no exhaustion requirement.[9] Neither the NSA nor CMS regulations mandate that a party pursue the Technical Assistance process before seeking judicial relief for fraud. United was not required to pursue—and is not required to await the outcome of—the Technical Assistance process before bringing this fraud claim (which is a good thing, since United has not received anything from CMS or the IDRE in response to the administrative complaint it lodged nine months ago).

II. THE COURT HAS SUBJECT-MATTER JURISDICTION BECAUSE UNITED'S CLAIMS NECESSARILY RAISE SUBSTANTIAL QUESTIONS OF FEDERAL LAW

This Court has subject-matter jurisdiction because United's claims necessarily raise substantial, disputed questions of federal law. Under 28 U.S.C. § 1331, federal courts have jurisdiction over state-law claims, like United's fraud claim, when the "vindication of a right under state law . . . necessarily turn[s] on some construction of federal law." *Manning v. Merrill Lynch Pierce Fenner & Smith, Inc.*, 772 F.3d 158, 163 (3d Cir. 2014) (quoting *Franchise Tax Bd. of State of Cal. v. Constr. Laborers Vacation Tr. for S. Cal.*, 463 U.S. 1, 9 (1983)). Specifically, "federal jurisdiction over a state law claim will lie if a federal issue is: (1) necessarily raised, (2) actually disputed, (3) substantial, and (4) capable of resolution in federal court without disrupting the federal-state balance approved by Congress." *Gunn v. Minton*, 568 U.S. 251, 258 (2013) (applying

[9] Ex. 1 at 1.

Grable & Sons Metal Prods., Inc. v. Darue Eng'g & Mfg., 545 U.S. 308, 314 (2005)). United's fraud claim satisfies all four prongs of the *Grable* test.

First, resolution of United's claims necessarily requires the construction of the NSA. The central disputed questions are legal, not factual: (1) whether falsely attesting that a Medicaid claim is eligible for IDR constitutes fraud; (2) whether IDR awards issued on ineligible claims—and thus exceeded the IDRE's jurisdiction—are binding on the parties; and (3) whether the NSA's administrative remedies preclude, or must be exhausted before pursuing, judicial relief for fraud. NorthStar disputes each of these propositions. *See* Mot. at 1 ("Congress designed and CMS implemented the IDR process knowing that disagreements about eligibility do not equate to fraud . . . ."); *id.* at 5 ("[T]he determination of an IDRE is 'binding upon the parties involved.'"); *id.* at 14 ("Congress and CMS created multiple administrative and judicial avenues in the IDR process for resolving disagreements . . . ."). These are pure questions of statutory interpretation with controlling significance in future cases, not fact-bound inquiries specific to this dispute.

Second, the federal law issues in this case are actually disputed. NorthStar argues that there is no federal-question jurisdiction because the parties agree that managed Medicaid claims are ineligible for IDR. *Id.* at 15. But that concession does not eliminate the disputed federal questions. Under *Grable*, jurisdiction exists over a state-law claim requiring construction of a federal statute when "the meaning of the federal statute is actually in dispute." 545 U.S. at 315. Here, the parties sharply dispute the legal consequences that flow from submitting an ineligible claim to IDR.

It is true that "[t]he meaning of the NSA is undisputed between the parties" on the narrow question of "whether disputes involving managed Medicaid claims are eligible for IDR under the NSA." Mot. at 15. But that agreement does not resolve the case; rather, it is merely the predicate for the disputed questions. The parties dispute whether submitting an ineligible claim with a false

attestation constitutes actionable fraud or merely an "error" to be resolved administratively. *Compare* Compl. ¶ 109 ("NorthStar submitted the IDR notice of initiation in the dispute with full knowledge of, or at the very least with reckless disregard to, the falsity of this attestation."), *with* Mot. at 1 ("[D]isagreements about eligibility do not equate to fraud . . . ."). The parties dispute whether IDR awards that exceeded the IDRE's jurisdiction are void or remain binding. *Compare* Compl. ¶¶ 104, 115 (awards on ineligible claims are non-binding and not payable), *with* Mot. at 5 ("[T]he determination of an IDRE is 'binding upon the parties involved.'"). And the parties dispute whether United must pursue administrative remedies before seeking judicial relief for fraud. *Compare* Compl. ¶ 96 (administrative process is "objectively insufficient"), *with* Mot. at 14 (United should have pursued "multiple administrative and judicial avenues in the IDR process"). Each of these questions requires construction of the NSA.

NorthStar's caselaw is distinguishable. For example, in *MHA LLC v. HealthFirst, Inc.*, 629 F. App'x 409 (3d Cir. 2015), the parties did not disagree about the requirements of the federal Medicare statute at issue—only factual questions about whether the defendant "wrongly denied claims as untimely, and/or ignored or refused to process them." *Id.* at 411, 414. Here, the parties dispute the requirements of the NSA and the effects of an improper IDR determination. *See* Compl. ¶¶ 104, 109.[10]

Third, the federal law issues here are substantial. One factor demonstrating substantiality "is if the issue presents a 'nearly "pure issue of law," one "that could be settled once and for all . . . ."'" *Ali v. DLG Dev. Corp.*, 283 F. Supp. 3d 347, 355 (E.D. Pa. 2017) (quoting *Empire*

[10] Similarly, in *Pennsylvania v. Tap Pharmaceutical Products, Inc.*, 415 F. Supp. 2d 516, 524-25 (E.D. Pa. 2005), the court found that construing the meaning of a federal law was not required to resolve the dispute. In *Hoffnagle v. Conn. Water Co.*, 2024 WL 4443699, at *2 (D. Conn. Sept. 25, 2024), the court observed that the claims could "be litigated entirely without reference to" the relevant federal statute.

Healthchoice Assurance, Inc. v. McVeigh, 547 U.S. 677, 700 (2006)). A ruling on whether false eligibility attestations constitute actionable fraud, and whether an IDR award entered in the absence of jurisdiction is binding, will inform how similarly situated parties navigate the IDR system. These questions are "significant to the federal system as a whole," and thus "substantial" enough to justify federal-question jurisdiction under *Grable*. *See Gunn*, 568 U.S. at 264.

NorthStar claims that the issue is not "substantial" because the Court's "determinations are situation-specific ones that turn on an investigation of the facts." Mot. at 16. But, as NorthStar concedes, the central factual question—whether or not the claim NorthStar falsely attested was eligible for the IDR process was, in fact, eligible—is not disputed. *Id.* NorthStar relies on *Benjamin v. JBS S.A.*, 516 F. Supp. 3d 463 (E.D. Pa. 2021), to support its contention that the matter here turns on factual issues. But *Benjamin* concerned a negligence and intentional tort action arising from an alleged wrongful death in connection with COVID-19. There, the essential issues were pure questions of fact connected to whether the employer in fact knew COVID-19 was present in the workplace. *Id.* at 471. Here, the core *factual* questions are undisputed: the claim NorthStar submitted to the IDR process was ineligible for that process. The substantial question arises out of the *legal significance* of those facts and whether NorthStar's action amounts to fraud. *Compare* Compl. ¶ 109 ("NorthStar submitted the IDR notice of initiation in the dispute with full knowledge of, or at the very least with reckless disregard to, the falsity of this attestation."), *with* Mot. at 1 ("[D]isagreements about eligibility do not equate to fraud . . . .").

Fourth, United's claims may be resolved without disrupting the federal-state balance approved by Congress. NorthStar does not raise an argument on this point; but, exercising jurisdiction here would not upset the balance because it would not shift a large number of cases to federal court that would otherwise be decided in state court. Once this Court rules on whether

false eligibility attestations constitute actionable fraud, and whether an ineligible IDR award entered in the absence of jurisdiction is binding, subsequent cases can be adjudicated in state court. *See, e.g.*, *Harrison v. Health Network Lab'ys. Ltd. P'ship*, 2017 WL 75787, at *3 (E.D. Pa. Jan. 9, 2017) ("[T]his Court's exercise of federal jurisdiction under the facts of this particular Whistleblower Act case will not upset the balance of federal and state responsibilities because the vast majority of Whistleblower cases will still be decided in state court.").

III. UNITED'S CLAIMS ARE NOT MOOT

United's claims are not moot because (1) United has not received complete relief; (2) there is an ongoing risk of recurrence; and (3) the voluntary cessation exception precludes a finding of mootness. A defendant arguing claims have become moot through its own purportedly voluntary action takes on the burden of demonstrating mootness. *Friends of the Earth, Inc. v. Laidlaw Env't Servs. (TOC), Inc.*, 528 U.S. 167, 189 (2000). NorthStar cannot meet this burden.

A. United Has Not Received Complete Relief

Mootness requires that the defendant provide all the relief that the plaintiff could recover through litigation. *See Road-Con, Inc. v. City of Phila.*, 120 F.4th 346, 356 (3d Cir. 2024). United has not received such relief for at least three reasons.

First, NorthStar has merely requested a reopening of the IDRE's award. It has been over two months since that request was made, and there is no indication it has been granted (indeed, it has been nine months since United's complaint to CMS and email to the IDRE, and no action has been taken). A pending administrative request does not constitute complete relief. *Walter v. Se. Pa. Transp. Auth.*, 2007 WL 966227, at *8 (E.D. Pa. Mar. 28, 2007) (holding that future mootness "is not the equivalent of stating that at this moment those claims are moot").

Second, and critically, none of NorthStar's corrective actions address United's nonrefundable administrative fee. NorthStar argues that the $115 fee cannot constitute damages

because United paid it before the alleged fraud and would have owed it as a prevailing party. Mot. at 17 n.6. This is factually incorrect. United paid the fee only after NorthStar initiated the IDR process and falsely attested to eligibility. United would not have incurred this fee at all had NorthStar not submitted the ineligible claim to IDR. The fee is a direct consequence of NorthStar's fraudulent submission because United was forced to participate in an IDR proceeding that should never have occurred. That United might have recovered the fee had it prevailed in a separate, legitimate IDR dispute is irrelevant; this was not a legitimate dispute, and NorthStar's fraud is the reason United incurred the cost. Because United seeks damages, its claims cannot be moot. *See CMR D.N. Corp. v. City of Phila.*, 703 F.3d 612, 622 (3d Cir. 2013) ("Claims for damages are retrospective in nature—they compensate for past harm. By definition, then, such claims 'cannot be moot.'" (quoting *Lippoldt v. Cole*, 468 F.3d 1204, 1217 (10th Cir. 2006))).

Third, NorthStar's alleged corrective actions do not provide the declaratory and injunctive relief United seeks. Rather, its actions address only limited aspects of NorthStar's revenue cycle process which contributed to its false submissions but do nothing to eliminate the structural vulnerabilities that enabled this fraud. NorthStar has identified a single insufficiently detailed document template, the 835 summary, and instructed its third-party processor to "initiate[] the process of modifying" that template. Mot. at 10. Troublingly, however, NorthStar continues to rely on these same vendors—Arietis and HaloMD—whose processes enabled the fraud. And, even more critically, even under NorthStar's own version of events, HaloMD received United's explicit notice of ineligibility on March 7, 2025, yet proceeded to submit the false attestation on April 15, 2025. *Id.* at 8 and Exs. C, E; Balthazor Decl. ¶¶ 24, 26. Though NorthStar acknowledges that the ineligible claim here is not the only one HaloMD has submitted for IDR on its behalf, NorthStar has taken no corrective action with respect to this agency relationship.

B. United Faces Ongoing Risk of Recurrence and the Voluntary Cessation Doctrine Applies

NorthStar has not met its burden of demonstrating that "the alleged violation has ceased, and there is no reasonable expectation that it will recur." *Providence Pediatric Med. Daycare Inc. v. Alaigh*, 672 F. App'x 172, 175 (3d Cir. 2016). And, even if it had, under the voluntary cessation doctrine, "a defendant's voluntary cessation of a challenged practice does not deprive a federal court of its power to determine the legality of the practice." *Friends of the Earth*, 528 U.S. at 189. The defendant must show "it is absolutely clear the allegedly wrongful behavior could not reasonably be expected to recur." *Id.* at 189-90. NorthStar cannot meet this burden.

First, NorthStar's corrective actions were unilateral and reversible. *See Hartnett v. Pa. State Educ. Ass'n*, 963 F.3d 301, 307 (3d Cir. 2020) (focusing "on whether the defendant made that change unilaterally and so may 'return to [its] old ways' later on" (quoting *Friends of the Earth*, 528 U.S. at 189)). Nothing prevents NorthStar from changing its policies were this case to be dismissed. *Second*, NorthStar acknowledged ineligibility "only . . . in response to this litigation, which weighs against mootness." *Fields v. Speaker of Pa. House of Representatives*, 936 F.3d 142, 161 (3d Cir. 2019); *see United States v. Virgin Islands*, 363 F.3d 276, 285 (3d Cir. 2004). *Third*, NorthStar concedes a history of violative conduct and itself points to at least three other ineligible IDR submissions in 2025 alone. Balthazor Decl. ¶ 35. Such a pattern is relevant to recurrence. *Del. Audubon Soc., Inc. v. Sec'y of U.S. Dep't of Interior*, 612 F. Supp. 2d 442, 448 (D. Del. 2009). *Fourth*, NorthStar's policy changes do not guarantee nonrecurrence. NorthStar characterizes its false submissions as erroneous, not volitional, yet points to no case holding that general policies are sufficient to demonstrate that the at-issue harm will not recur. Indeed, several of the cases NorthStar cites involve conduct made unlawful only by subsequent judicial clarification. *See Hartnett*, 963 F.3d at 306-07; *Clark v. Governor of N.J.*, 53 F.4th 769, 775,

780-81 (3d Cir. 2022). United requests exactly the relief that guaranteed nonrecurrence in those cases: a declaration that the complained-of conduct is unlawful.

IV. THIS COURT IS THE PROPER FORUM FOR UNITED'S CLAIMS

This Court—not CMS—is the appropriate forum to resolve United's claims. The Medicaid claim at issue is not, and never was, subject to the NSA's IDR process. Nevertheless, NorthStar argues that this action should be dismissed because CMS somehow has "primary jurisdiction" over United's claim. But the Third Circuit has made clear that primary jurisdiction referrals are disfavored because "[f]ederal courts have a 'virtually unflagging obligation . . . to exercise the jurisdiction given them.'" *Baykeeper v. NL Indus., Inc.*, 660 F.3d 686, 691 (3d Cir. 2011) (quoting *Colo. River Water Conservation Dist. v. United States*, 424 U.S. 800, 817 (1976)). "Abstention, therefore, is the exception rather than the rule." *Id.* The party invoking primary jurisdiction "bears the burden of demonstrating its application," and "[c]ourts should refrain from reflexively applying the doctrine simply because litigation touches on an area within the expertise of an agency." *In re Budeprion XL Mktg. & Sales Litig.*, 2010 WL 2135625, at *13-15 (E.D. Pa. May 26, 2010).

Four factors generally determine whether primary jurisdiction applies: "(1) [w]hether the question at issue is within the conventional experience of judges or whether it involves technical or policy considerations within the agency's particular field of expertise; (2) whether the question at issue is particularly within the agency's discretion; (3) whether there exists a substantial danger of inconsistent rulings; and (4) whether a prior application to the agency has been made." *Baykeeper*, 660 F.3d at 691. None of the *Baykeeper* factors favor deferral here.

First, the issues here are within the conventional experience of judges. NorthStar contends that IDR eligibility is a "technical issue" requiring agency expertise. Mot. at 19. It is not. Determining whether the claim at issue was eligible for IDR requires only two straightforward determinations: (1) whether Medicaid claims are eligible for the NSA's IDR process (they are not),

and (2) whether this patient was a Medicaid patient (she was). The NSA and CMS regulations are explicit: "[t]he Federal IDR process ***does not apply to items and services payable by Medicare, Medicaid,*** the Children's Health Insurance Program, or TRICARE." Compl. ¶ 20 n.5 (emphasis added). The patient's insurance card displayed a Medicaid identification number, and United's PRA was printed on UnitedHealthcare Community Plan letterhead and explicitly noted that NorthStar had made a claim against a "PA Medicaid" plan. *Id.* ¶¶ 56, 62. By contrast, NorthStar's cited cases involve complex factual questions. *United States v. W. Pac. R.R. Co.*, 352 U.S. 59 (1956) (whether steel casing with napalm is an "incendiary bomb"); *Ferrare v. IDT Energy, Inc.*, 2015 WL 3622883 (E.D. Pa. June 10, 2015) (regulatory and market factors for electricity pricing).

Second, the question at issue is not particularly within CMS's discretion. As already noted, Medicaid and Medicare claims are not eligible for the NSA's IDR process. And although CMS administers the IDR process for eligible commercial insurance claims, neither the NSA nor CMS regulations charge CMS with adjudicating common-law fraud claims. *Cf. Baykeeper*, 660 F.3d at 691-92 ("[N]either the RCRA nor the CWA charges [the agency] with enforcing those particular statutes . . . . Accordingly, this matter is not *particularly* within the discretion of [the agency]."). For all of these reasons, United's common-law fraud claims are cognizable ***only*** in this court.

Third, there is no risk of inconsistent rulings. To the extent CMS investigates, its administrative investigations address compliance with IDR procedures, not common-law fraud. The two proceedings address different questions and provide different remedies.

Fourth, a prior application was made but remains unresolved. While United submitted an administrative complaint to CMS, this factor does not compel referral where the other factors weigh against it. *See Baykeeper*, 660 F.3d at 692 ("[T]his single factor cannot outweigh the others that disfavor abstention on primary jurisdiction grounds" where the agency "last spoke on the

issue" years earlier "and no action has been taken since."). Here, CMS has not acted on United's complaint, and there is no indication when—or whether—it ever will.[11]

NorthStar's and the amicus's overarching narrative—that the IDR system is broken and that these are all "honest mistakes" resulting from complexity—does not justify deferral to CMS. At the motion to dismiss stage, the Court cannot assume, as NorthStar asks, that eligibility determinations are so inherently complex that providers cannot be expected to identify Medicaid patients. In fact, identifying Medicaid patients is straightforward and something providers must do in the ordinary course of their business. NorthStar's and the amicus's complexity narrative invites the Court to credit one inference—innocent error—while ignoring an equally plausible inference supported by the data: that providers are intentionally overwhelming IDREs with ineligible claims, intending that ineligibility goes unnoticed. More than 20% of all closed IDR disputes involve ineligible claims. Compl. ¶ 50. NorthStar and its affiliated entities initiated 6,214 NSA IDR disputes against United in the first ten months of 2025—up from just 115 disputes in December 2024. *Id.* ¶ 5. This flood of claims is inconsistent with a good-faith effort to submit only eligible disputes; it is entirely consistent with a strategy of overwhelming IDREs and

[11] The amicus cites *Guardian Flight, L.L.C. v. Health Care Service Corp.*, 140 F.4th 271 (5th Cir. 2025), for the proposition that the NSA does not create a private right of action. But *Guardian Flight* addressed whether providers could sue to enforce IDR awards and not whether insurers can bring common-law fraud claims. The Fifth Circuit's reasoning supports United's position: the court noted that "[t]he NSA expressly bars judicial review of IDR awards," 42 U.S.C. § 300gg-111(c)(5)(E)(i)(II), but this bar applies only to review of the merits of an award—not to fraud claims challenging the validity of a proceeding that should never have occurred. Indeed, the Technical Assistance guidance expressly contemplates that IDR determinations are binding only in the absence of "a claim of fraud or misrepresentation of facts." Ex. 1 at 1 n.1. Congress and CMS understood that fraud claims would arise from the IDR process and deliberately preserved judicial remedies for them.

collecting windfall awards when ineligibility goes undetected. On a motion to dismiss, the Court must draw inferences in United's favor. *See Bell Atl. Corp. v. Twombly*, 550 U.S. 544, 556 (2007).

The amicus warns that fraud claims will undermine the administrative system created by Congress. The opposite is true. Permitting providers to submit false attestations without consequence undermines the IDR process by rewarding bad actors and penalizing insurers who play by the rules. The IDR system's integrity depends on truthful attestations; otherwise, IDR becomes a vehicle for unlawfully extracting windfall payments rather than a mechanism for fair dispute resolution.

NorthStar's implicit suggestion that United should wait for Congress or CMS to "fix" the IDR system is equally unavailing. United has no obligation to endure ongoing, systemic fraud while awaiting legislative or regulatory reform of indefinite timing. CMS has produced no results on United's administrative complaint filed over nine months ago, and NorthStar's own request to withdraw the dispute has been pending for over two months without action. *See* Exs. G, H. The Technical Assistance is insufficient to address the scale of fraud in the IDR system. Compl. ¶ 96. NorthStar's arguments for judicial abstention ask the Court to reward providers who continue to game the system with impunity while insurers wait indefinitely for administrative action that may never come. Only judicial deterrence can prevent continued abuse of the IDR process.

CONCLUSION

For the foregoing reasons, United respectfully requests that this Court deny NorthStar's Motion to Dismiss.

Date: March 27, 2026

Respectfully submitted:
/s/ *Jordan Hughes*

Jordan Hughes (PA Bar No. 330649)
LATHAM & WATKINS LLP
555 Eleventh Street, NW
Suite 1000

Washington, D.C. 20004
Telephone: (202) 637-2200
Email: jordan.hughes@lw.com

David C. Tolley (admitted pro hac vice)
William J. Trach (admitted pro hac vice)
U. Gwyn Williams (admitted pro hac vice)
LATHAM & WATKINS LLP
200 Clarendon Street
Boston, MA 02116
Telephone: (617) 948-6000
Email: david.tolley@lw.com
william.trach@lw.com
gwyn.williams@lw.com

CERTIFICATE OF SERVICE

I hereby certify that on March 27, 2026, I electronically filed the foregoing Opposition to Defendant's Motion to Dismiss and a proposed order with the Clerk of Court using the CM/ECF system, which will automatically send email notification to all counsel of record.

Dated: March 27, 2026

/s/ Jordan Hughes
Jordan Hughes

EXHIBIT 1

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 2

PageVault

Document title:	Home - HaloMD
Capture URL:	https://halomd.com/
Page loaded at (UTC):	Fri, 27 Mar 2026 18:38:19 GMT
Capture timestamp (UTC):	Fri, 27 Mar 2026 18:41:14 GMT
Capture tool:	10.80.0
Collection server IP:	54.145.42.72
Browser engine:	Mozilla/5.0 (X11; Linux x86_64) AppleWebKit/537.36 (KHTML, like Gecko) Chrome/144.0.7559.236 Safari/537.36
Operating system:	Linux (Node 24.14.0)
PDF length:	4
Capture ID:	tqK5Uyn89u7FiVA5m8qBaD
Display Name:	m.dean.guevara

Experts in Independent Dispute Resolution (IDR)

Utilizing No Surprises Act (NSA) and State Balance-Billing Laws

Request A Demo

A Pioneering Force

With an exclusive focus on **Independent Dispute Resolution (IDR)**, HaloMD supports t**housands of healthcare providers across the country**. Our work reinforces financial sustainability in specialties most affected by out-of-network disputes, ensuring communities can rely on consistent access to critical healthcare services.

Request a Demo

Industry Leading Results

88%+
Industry-Leading Win Rate

5x+
Increase Over Initial QPA

20,000+
Providers Supported

40
Days in IDR Process

Industry-Leading Win Rate

Increase Over Initial QPA

Providers Supported

Days in IDR Process

The HALOMD® Advantage: Navigating IDR with Precision and Power

HaloMD manages **Independent Dispute Resolution (IDR)** at scale. With exclusive focus on the **No Surprises Act** and **state balance-billing laws**, our proprietary platform adapts to evolving regulations and ensures filings are handled with accuracy and compliance. Every dispute is managed with transparency and consistency—helping providers strengthen financial stability and preserve access to care for patients.

HaloMD's platform expertly navigates the complexity of IDR with a seamless, data-driven approach. Here's how it works:

Initial Claim Submission

Offer Analysis

Data-Driven Strategy

Documentation Preparation

Submission to IDRE

Expert Negotiation

Resolution

Ongoing Reporting

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EXHIBIT 3

PageVault

Document title:	NorthStar's Compliance Program
Capture URL:	https://northstaranesthesia.com/compliance-and-safety/
Page loaded at (UTC):	Fri, 27 Mar 2026 18:42:33 GMT
Capture timestamp (UTC):	Fri, 27 Mar 2026 18:44:00 GMT
Capture tool:	10.80.0
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Operating system:	Linux (Node 24.14.0)
PDF length:	2
Capture ID:	ghPy3txeob2hhQRF8cS9mw
Display Name:	m.dean.guevara

NorthStar's Compliance Program

NorthStar is committed to providing quality care to our patients and we are equally committed to providing those quality services in compliance with the laws and regulations that apply to us. To further our commitment we have established a Compliance Program, overseen by NorthStar's Chief Compliance Officer.

The purpose of our Compliance Program is to prevent and detect violations of state and federal laws and regulations. Our Compliance Program was developed to be consistent with the Office of Inspector General's Compliance Program Guidance and the federal Sentencing Guidelines for Organizations.

If you have a question regarding our Compliance Program, please contact our Compliance Team at Compliance@northstaranesthesia.com.

Confidential reports may be made to our Compliance Action Line hosted by EthicsPoint.

EXHIBIT 4

PageVault

Document title:	Arietis Health | Healthcare Revenue Cycle Management
Capture URL:	https://www.arietishealth.com/
Page loaded at (UTC):	Fri, 27 Mar 2026 18:44:22 GMT
Capture timestamp (UTC):	Fri, 27 Mar 2026 18:44:54 GMT
Capture tool:	10.80.0
Collection server IP:	54.145.42.72
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Operating system:	Linux (Node 24.14.0)
PDF length:	7
Capture ID:	1fzPtd5dqxsPdsGoCuGwi5
Display Name:	m.dean.guevara

Arietis Health

Your Revenue Cycle Partner for Stellar Results

Powered by technology and focused on patients, our solutions transform your healthcare revenue cycle into a well-oiled machine.

We hold ourselves accountable to deliver consistently stellar results.

We do this through our world-class team, our sophisticated technology, and our personlized focus on patients and clients.

Our Story

Our Approach

Personalized Service Driven by Patient-centricity, Innovative Technology, and Proven Processes

Our Solutions

Patient-focused and

Our offerings are never one-size fits all. We meet your organization where it is to optimize revenue, improve

Our Solutions

Patient-focused and Tech Powered Revenue Cycle Solutions

Our offerings are never one-size fits all. We meet your organization where it is to optimize revenue, improve security, ensure compliance, and enhance business excellence. Each healthcare billing solution prioritizes patient experience. Our services span medical specialties and billing platforms.

End-To-End Revenue Cycle Management (RCM)

Our end-to-end healthcare revenue cycle solutions are powered by exceptional technology and a patient-centered team. We help our clients maximize revenue and enhance patient experience.

Customized Solutions

Leverage our suite of stellar, a la carte RCM solutions for medical practices, ranging from coding only and AR management, to worker's compensation and auto claim management and advisory services.

Learn More

Our Priority

Serving You and Your Patients with Precision

Healthcare RCM is critically important in keeping people and businesses healthy. We approach RCM differently by prioritizing people and focusing on the fundamentals when solving your most complex RCM challenges. Our sophisticated technology and culture empower our team to care for your patients. The result: improved patient experience and exceptional results for your organization.

Exceptional RCM Results

We transform revenue cycles into well-oiled machines, and our partners choose us because

Exceptional RCM Results

We transform revenue cycles into well-oiled machines, and our partners choose us because we continually deliver.

0	4%	4%
charts coded annually	claims submitted electronically	clean claim rate

Our Team

Inspired Humans, Healthcare Revenue Cycle Experts

We believe the not-so-secret ingredients to exceptional RCM results are outstanding people, innovative technology, and a positive, collaborative work environment. Our company is unique in the healthcare revenue cycle management space because we actively seek out service-oriented team members who care about patients. Are you looking for an inspiring new role with an encouraging team? Learn more about our exceptional culture and the way we support our people.

Explore Careers in the U.S.

Explore Careers in India

"I love being part of the Arietis team because of the dynamic creative environment. This is a group of passionate, creative, and dedicated people that are reshaping the way RCM is viewed. "

Allyson Cohan, Director of Revenue Integrity and Compliance

creative environment. This is a group of passionate, creative, and dedicated people that are reshaping the way RCM is viewed. "

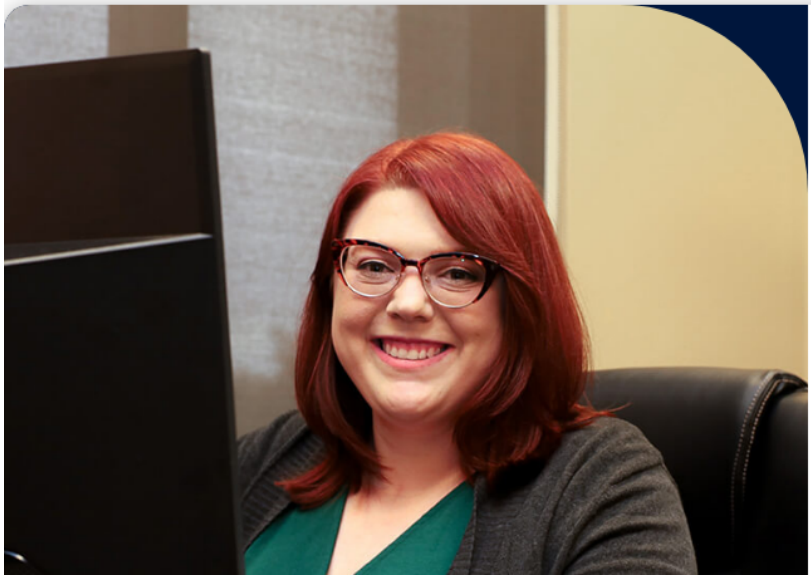
Allyson Cohan, Director of Revenue Integrity and Compliance

Consistently Stellar Performance

We Improve Key Revenue Cycle Metrics, Every Time

Whatever your RCM needs, our tech-powered solutions and personalized focus help cut costs, streamline processes, and identify sources of coding errors and denials to optimize future collections. We dig in to pinpoint core issues in your revenue cycle and put processes in place to increase cash flow and reduce lost revenue.

Our partners experience:

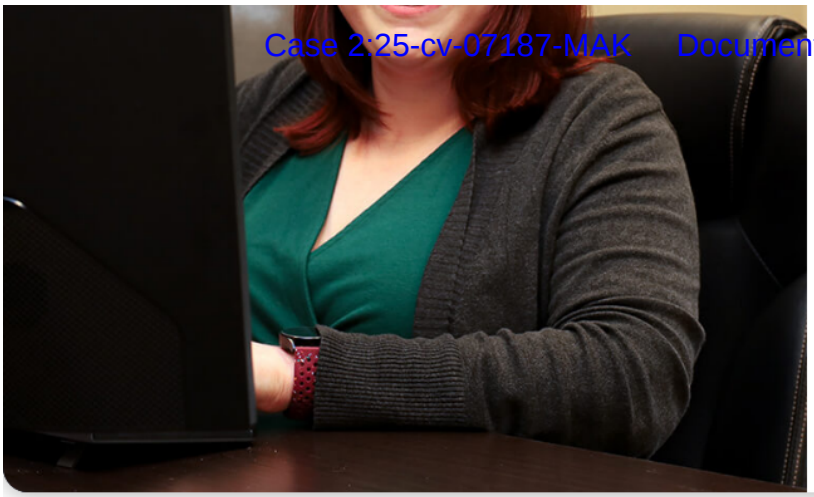


Why Arietis Health

Our Team Personalizes Proven Processes to Transform your RCM

Our partners appreciate our extensive healthcare expertise, sophisticated technology, and our focus on patients. Choose Arietis for:

- Exceptional technology and data analytics
- Guaranteed increase in collections and



Our partners appreciate our extensive healthcare expertise, sophisticated technology, and our focus on patients. Choose Arietis for:

- Exceptional technology and data analytics
- 100% transparency and real-time access to your data
- Agnostic solutions for any specialty
- Guaranteed increase in collections and reduction in denials
- RCM solutions customized to fit the unique nuances of your organization

"Arietis has a creative team. They are truly a partner working to optimize collections. They are not just executing; they think about the way they can change their approach to continually improve collections."

Adam Spiegel, CEO
NorthStar Anesthesia

LOOKING FOR AN RCM PARTNER WHO AIMS HIGHER?

We help our partners streamline their revenue cycle so they can focus more on patient care. Connect with us to learn more about how we are reimagining RCM.

Contact Us

Arietis Health

COMPANY

About
Our Leadership
Why Partner with Arietis

LOCATIONS

FORT MYERS – ARIETIS HQ
13500 Powers Court
Suite 230
Fort Myers, FL 33912

RECENT AWARDS

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Arietis Health

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Privacy Policy
Commitment to Compliance
Arietis Health Trust Center

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Why Partner with Arietis
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OFFERINGS
End-to-End RCM and Specialized Solutions

CAREERS
U.S. Careers
India Careers

LOCATIONS

FORT MYERS – ARIETIS HQ
13500 Powers Court
Suite 230
Fort Myers, FL 33912

INDIA
Arietis Healthtech International Private Ltd.
8th Floor, Tower-A, Knowledge Boulevard
Sector-62, Noida, Uttar Pradesh – 201309

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