DEPARTMENT OF HEALTH & HUMAN SERVICES OFFICE OF THE SECRETARY
Assistant Secretary for Legislation
Washington, DC 20201

April 29, 2024

The Honorable Kamala D. Harris
Vice President
President
United States Senate
Washington, DC 20510

Dear Madam Vice President:

I am respectfully submitting the enclosed report, *Annual Report to Congress: Qualifying Payment Amount Audits,* which is required under section 2799A-1(a)(2)(A)(iii) of the Public Health Service Act.

Section 2799A-1(a)(2)(A)(iii) of the Public Health Service Act states that, "Beginning for 2022, the Secretary shall annually submit to Congress a report on the number of plans and issuers with respect to which audits were conducted during such year pursuant to this subparagraph." This annual report has been prepared by the Centers for Medicare & Medicaid Services (CMS) within the Department of Health and Human Services. This report includes:

- A summary of the general purpose of the qualifying payment amount and the annual reporting requirements;
- A summary of CMS's qualifying payment amount audit process;
- An overview of current CMS Qualifying Payment Amount Audits through December 31, 2023.

I hope you find this information helpful. I am also sending this report to the Speaker of the House of Representatives. Please do not hesitate to contact me at 202-690-7627 if you have questions or concerns.

Sincerely,

Melanie Anne Egorin, Ph.D.
Assistant Secretary for Legislation

Enclosure

DEPARTMENT OF HEALTH & HUMAN SERVICES OFFICE OF THE SECRETARY
Assistant Secretary for Legislation
Washington, DC 20201

April 29, 2024

The Honorable Mike Johnson
Speaker
U.S. House of Representatives
Washington, DC 20515

Dear Speaker Johnson:

I am respectfully submitting the enclosed report, *Annual Report to Congress: Qualifying Payment Amount Audits,* which is required under section 2799A-1(a)(2)(A)(iii) of the Public Health Service Act.

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Sincerely,

Melanie Anne Egorin, Ph.D.
Assistant Secretary for Legislation

Enclosure

U.S. Department of Health and Human Services

Centers for Medicare & Medicaid Services

Report to Congress:

2022 and 2023 Qualifying Payment Amount Audits

April 2024

2022 and 2023 Report to Congress: Qualifying Payment Amount Audits

1. Audit Requirement and Annual Report Requirement

The No Surprises Act was enacted as title I of Division BB of the Consolidated Appropriations Act, 2021.[1] Section 2799A-1(a)(2)(A) of the Public Health Service Act, as added by the No Surprises Act (NSA), requires the Secretary of Health and Human Services (Secretary) to conduct audits to ensure that group health plans and health insurance issuers offering group or individual health insurance coverage are in compliance with the requirements related to calculation of the qualifying payment amount (QPA).

The QPA is generally the median of the contracted rates recognized by the plan or issuer on January 31, 2019, 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 geographic region in which the item or service is furnished, increased for inflation. The QPA is often used to determine patient cost sharing for items and services covered by the NSA.[2] It is also one factor, among others, that certified independent dispute resolution (IDR) entities consider when making a payment determination under the Federal IDR process.

The Secretary is required to conduct audits each year (beginning with 2022) of a sample of claims data from not more than 25 plans and issuers. The Secretary may also audit any plan or issuer if the Secretary has received a complaint or other information about such plan or coverage that involves the compliance with the QPA requirements.[3] The Centers for Medicare & Medicaid Services (CMS), part of the Department of Health and Human Services, conducts audits on behalf of the Secretary. Beginning in 2022, the Secretary is required to submit annually to Congress a report on the number of plans and issuers with respect to which audits were conducted during such year.[4] This report covers both 2022 and 2023 and includes information through December 31, 2023.

2. Summary of CMS Audit Process

The QPA Audit (Audit) follows the Market Conduct Examinations processes outlined in regulations at 45 CFR 149.140(f) and 150.313. The Audits assess whether plans and issuers are in compliance with the requirement of applying a QPA, and whether the QPA applied satisfies the definition of the QPA.[5] The Audits also review whether plans and issuers are in compliance with the disclosure requirements regarding calculation of the QPA.[6]

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[1] Pub. L. 116-260 (Dec. 27, 2020).
[2] For non-air-ambulance items and services, the QPA is used unless the item or service is furnished in a state that has a specified state law in effect with respect to the group health plan or health insurance issuer, or in a state that has an All-Payer Model Agreement under section 1115A of the Social Security Act. For air-ambulance services, the QPA is used unless the billed amount for such services is less than the QPA.
[3] 42 U.S.C. § 300gg-111(a)(2)(A)(ii).
[4] 42 U.S.C. § 300gg-111(a)(2)(A)(iii).
[5] 42 U.S.C. § 300gg-111(a)(2)(A)(i)(I) – (II).
[6] 45 C.F.R. § 149.110(b)(3)(iv)(A), 45 C.F.R. § 149.120(c)(3), and 45 C.F.R. § 149.130(b)(4)(i).

The Audit is an in-depth investigation that requires a large volume of documents to be provided by the plan or issuer and reviewed by CMS, and therefore takes a significant amount of time. During the Audit, CMS requests key information from the plan or issuer necessary to determine the plan's or issuer's compliance with applicable QPA requirements. This information includes, but is not limited to, a comprehensive list of all insurance markets in which the plan or issuer offers coverage; a narrative describing the plan's or issuer's QPA calculation methodology; all claims handling manuals, internal bulletins and guidelines issued by the plan or issuer with respect to the processing and payment of claims; claims data relating to claims for which there was a requirement to apply a QPA; QPA calculation data; and claim samples and related claim processing documents. CMS reviews the information submitted by the plan or issuer for compliance with NSA requirements. CMS provides feedback of any violations to plans and issuers and findings in the final report to the plan or issuer and ensures corrective actions have been implemented and completed before the Audit is completed. CMS may impose civil monetary penalties based on any finding of noncompliance. CMS's processes for imposing civil monetary penalties are outlined in 45 CFR Part 150.

3. Current CMS Audits

Since June 10, 2022, CMS has initiated a total of 23 Audits of plans and issuers subject to CMS's enforcement authority.[7] We expect to have the results of our first Audit in the first half of 2024 and will publish additional Audit reports as the Audits are completed.

On August 24, 2023, the United States District Court for the Eastern District of Texas (district 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 (E.D. Tex.) (*TMA III*) vacating certain provisions of the July 2021 interim final rules[8] that implemented the QPA calculation methodology, cost-sharing calculation provisions, and disclosure requirements subject to these Audits, as well as certain portions of several NSA guidance documents issued by the Departments clarifying these legal standards. The district court in *TMA III* held that several provisions of the regulations and guidance are unlawful and vacated and remanded them for further consideration. Of relevance to the Audits, the district court vacated a number of provisions related to the QPA methodology, including the inclusion of contracted rates for items and services "regardless of the number of claims paid at that contracted rate"; the use of contracted rates of all self-insured group health plans administered by the same entity; rules governing calculation of the QPA for providers "in the same or similar specialty"; the exclusion of bonus, incentive, and risk-sharing payments; and the exclusion of single case agreements.[9] As

[7] CMS has enforcement authority over non-federal governmental plans (such as state and local government employee plans) and over issuers in states that are failing to substantially enforce the QPA requirements. CMS currently is responsible for enforcement of the QPA requirements under the NSA with respect to issuers in the following states: Alabama; Arizona; Arkansas; Colorado (for air ambulance services only); Connecticut (for air ambulance services only); Delaware (for air ambulance services only); Florida (when claim is not subject to state law); Hawaii; Illinois (when the claim is not subject to state law); Indiana; Louisiana; Massachusetts (for air ambulance services only); Missouri (for air ambulance services only); New Hampshire (except for services with respect to emergency, pathology, radiology and anesthesiology providers at in-network facilities in the state); Oklahoma; Rhode Island; Tennessee; Texas (for air ambulance services only); Virginia (for emergency services rendered in a freestanding emergency room, post-stabilization services, and air ambulance services only); and Wyoming.

[8] 86 FR 36872 (July 13, 2021).

[9] On October 20, 2023, the government appealed the decision in *TMA III* to United States Court of Appeals for the Fifth Circuit. Brief for Appellants, Texas Medical Association et al. v. United States Department of Health and Human Services et al., Case No. 6:22-cv-450-JDK (Jan. 12, 2024).

a result, CMS is in the process of reassessing audit findings for audits initiated before August 24, 2023, in light of the district court's decision.[10]

Given the time and resource-intensive nature of Audits, as well as litigation related to the methodology for calculation of the QPA established through rulemaking, none of the Audits initiated for 2022 and 2023 have concluded as of December 31, 2023. This report therefore discloses the number of open Audits and provides general information on the Audit process. Future Reports to Congress will include information regarding the final Audit reports, and all final Audits reports will be publicly posted on a CMS website.[11]

[10] Following the district court decision in *TMA III*, plans and issuers are expected to calculate QPAs using a good faith, reasonable interpretation of the applicable statutes and regulations that remain in effect after the *TMA III* decision. Additionally, CMS will use enforcement discretion under the relevant No Surprises Act provisions for any plan or issuer that uses a QPA calculated in accordance with the methodology under the July 2021 interim final rules and guidance in effect immediately before the decision in *TMA III* for items and services furnished before May 1, 2024. This exercise of enforcement discretion applies to QPAs for purposes of patient cost sharing, providing required disclosures with an initial payment or notice of denial of payment, and providing required disclosures and submissions under the Federal IDR process. FAQs About Consolidated Appropriations Act, 2021 Implementation Part 62, Q1, October 6, 2023 https://www.cms.gov/files/document/faqs-part-62.pdf.

[11] https://www.cms.gov/marketplace/private-health-insurance/consumer-protections-enforcement.