



DEPARTMENT OF HEALTH & HUMAN SERVICES

OFFICE OF THE SECRETARY

Assistant Secretary for Legislation
Washington, DC 20201

August 14, 2025

The Honorable JD Vance
President
United States Senate
Washington, DC 20510

Dear 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;
- The number of open CMS Qualifying Payment Amount Audits;
- An overview of final CMS Qualifying Payment Amount Audits through December 31, 2024.

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,

A handwritten signature in black ink, reading "Gary Andres", is positioned above the printed name and title.

Gary Andres
Assistant Secretary for Legislation

Enclosure



DEPARTMENT OF HEALTH & HUMAN SERVICES

OFFICE OF THE SECRETARY

August 14, 2025

Assistant Secretary for Legislation
Washington, DC 20201

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

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U.S. Department of Health and Human Services

Centers for Medicare & Medicaid Services

Report to Congress:

2024 Qualifying Payment Amount Audits

AUGUST 2025

2024 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 (PHS Act), as added by the No Surprises Act, 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 is 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 No Surprises Act.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 Qualifying Payment Amount Audits (QPA 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 U.S. Department of Health and Human Services (HHS), 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 QPA Audits were conducted during such year.⁴ This report covers the period from January 1, 2024, through December 31, 2024. This report details the number of open QPA Audits, summarizes the results of QPA Audits closed in 2024, and provides general information on the QPA Audit process conducted by CMS. Future reports to Congress will include information regarding the final QPA Audit reports closed during the reporting year, and all final QPA Audits reports will be publicly posted on a CMS website. As of the date of this report, the first QPA Audit has already been posted online.⁵

¹ Pub. L. 116-260 (Dec. 27, 2020).

² For emergency and non-emergency items and services subject to the surprise billing provisions of the No Surprises Act, the lesser of the billed amount or the QPA is used to calculate patient cost sharing, 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 and the item or service, or in a state that has an All-Payer Model Agreement under section 1115A of the Social Security Act, in which case the state law or All-Payer Model Agreement determines patient cost sharing. For air ambulance services subject to the surprise billing provisions of the No Surprises Act, the lesser of the QPA or the billed amount for such services is used to determine patient cost sharing.

³ 42 U.S.C. § 300gg-111(a)(2)(A)(ii). PHS Act section 2799A-1(a)(2)(A)(ii).

⁴ 42 U.S.C. § 300gg-111(a)(2)(A)(iii). PHS Act section 2799A-1(a)(2)(A)(iii).

⁵ Qualifying Payment Amount Audits available online: <https://www.cms.gov/marketplace/private-health-insurance/consumer-protections-enforcement>.

2. Summary of CMS Audit Process

The process used by CMS to conduct a QPA Audit follows the market conduct examinations process outlined in regulations at 45 CFR §§149.140(f) and 150.313. The QPA Audits assess whether plans and issuers are in compliance with the requirement of applying a QPA, and whether the QPA applied satisfies the applicable definition of the QPA.⁶ The QPA Audits also review for compliance with the requirements regarding disclosure of information about the QPA.⁷

CMS conducts QPA Audits of non-federal governmental plans (non-federal plans) in all States to verify compliance with applicable PHS Act requirements, including: the QPA calculation methodology, prompt payment or denial of a claim, and related disclosure requirements under the No Surprises Act. CMS also conducts QPA Audits of health insurance issuers (issuers) in states in which it has enforcement authority.⁸ To date, CMS has selected non-federal plans and issuers for QPA Audits based on complaints received from providers and facilities alleging that the plan's or issuer's QPAs are inaccurate.

The QPA Audit is an in-depth investigation that requires a large volume of documents to be provided by the non-federal plan or issuer and reviewed by CMS, and therefore takes a significant amount of time and resources. During the QPA Audit, CMS requests key information from the non-federal plan or issuer necessary to determine their 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 their QPA calculation methodology; all claims handling manuals, internal bulletins and guidelines issued by the non-federal plan or issuer with respect to the processing and payment of claims subject to the No Surprises Act; 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 submitted information for compliance with applicable No Surprises Act requirements. In addition, CMS and the non-federal plan or issuer subject to the audit have recurring bi-weekly meetings throughout the QPA Audit process.

If findings of violations are confirmed, CMS may take various enforcement actions, including but not limited to requiring the non-federal plan or issuer take corrective actions to address violations noted in the final QPA Audit report. CMS provides an explanation regarding any findings to non-federal plans and issuers in the final report to the non-federal plan or issuer and

⁶ 42 U.S.C. § 300gg-111(a)(2)(A)(i)(I) – (II). PHS Act section 2799A-1(a)(2)(A)(i)(I) – (II).

⁷ 45 C.F.R. §§ 149.110(b)(3)(iv)(A), 149.120(c)(3), 149.130(b)(4)(i), and 149.140(d).

⁸ CMS has enforcement authority 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 No Surprises Act 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.

ensures corrective actions have been implemented and completed before the QPA Audit is completed. Corrective actions may include conducting self-audits to determine if any other members were affected by the violation, re-adjudicating claims in compliance with No Surprises Act requirements, updating internal policies and procedures to avoid future violations, and conducting member outreach and education. For example, if the QPA reported by the plan or issuer is higher than it should have been, if calculated correctly, the non-federal plan or issuer is directed to refund the member any excess cost sharing paid. If applicable, in the final QPA Audit report, CMS strongly recommends that the issuer share with and apply the corrective actions outlined in the QPA Audit Report to all of its affiliates, regardless of situs or regulatory jurisdiction for No Surprises Act-eligible claims.

CMS may also pursue further enforcement action, as warranted, including requiring additional corrective action to correct noncompliance, and/or assessing civil money penalties under section 2723(b) of the PHS Act and its implementing regulations at 45 CFR Part 150, Subpart C and as otherwise consistent with law.

3. Current CMS QPA Audits

In 2024, CMS initiated two QPA Audits of non-federal plans and issuers subject to CMS's enforcement authority. Since June 10, 2022, CMS has initiated a total of 25 QPA Audits of non-federal plans and issuers subject to CMS's enforcement authority. The first QPA Audit results are posted online, and we will publish additional QPA Audit reports as they are completed.⁹

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,¹⁰ which implemented the QPA calculation methodology, cost-sharing calculation provisions, and disclosure requirements subject to these QPA Audits, as well as certain portions of several No Surprises Act guidance documents issued by the Departments of Labor, HHS, and the Treasury (collectively, 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 QPA 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.¹¹

⁹ Qualifying Payment Amount Audits available online: <https://www.cms.gov/marketplace/private-health-insurance/consumer-protections-enforcement>.

¹⁰ 86 FR 36872 (July 13, 2021).

¹¹ 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).

On October 6, 2023, the Departments, along with the Office of Personnel Management (OPM), issued FAQs about Consolidated Appropriations Act, 2021 Implementation Part 62 (FAQs Part 62),¹² acknowledging the impact of the district court’s decision in *TMA III* on QPAs and the significant resources and challenges associated with recalculating QPAs in accordance with the applicable statutes and regulations that remained in effect after the decision. The FAQs stated that the Departments and OPM would exercise their enforcement discretion under the relevant No Surprises Act provisions for any plan or issuer, or party to a payment dispute in the Federal IDR process, that uses a QPA calculated in accordance with the methodology under the July 2021 interim final rules and guidance in effect immediately before the district court’s decision in *TMA III* (the 2021 methodology), for items and services furnished before May 1, 2024 (the first day of the calendar month that was 6 months after the issuance of FAQs Part 62).

The Departments and OPM subsequently issued FAQs about Consolidated Appropriations Act, 2021 Implementation Part 67 (FAQs Part 67)¹³ on May 1, 2024, extending this enforcement relief period for an additional 6 months, that is, for items and services furnished before November 1, 2024.

On October 30, 2024, the United States Court of Appeals for the Fifth Circuit (Fifth Circuit) issued an opinion and order in *TMA III*.¹⁴ The Fifth Circuit reversed the district court’s vacatur of certain challenged 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 exclusion of single case agreements, and the exclusion of bonus, incentive, and risk-sharing payments. The Fifth Circuit affirmed the district court’s vacatur of certain deadline provisions and the district court’s decision upholding the requirements regarding disclosure of information about the QPA.¹⁵ On December 16, 2024, the plaintiffs in *TMA III* filed a petition for rehearing *en banc*.

On January 14, 2025, the Departments and OPM issued FAQs about Consolidated Appropriations Act, 2021 Implementation Part 69 (FAQs Part 69).¹⁶ FAQs Part 69 extend the enforcement relief for QPAs calculated in accordance with the 2021 methodology, for items and services furnished before August 1, 2025. FAQs Part 69 also explain that plans and issuers may rely on any QPAs that have been calculated using a good faith, reasonable interpretation of the applicable statutes and regulations that remained in effect following the district court’s decision

¹² See FAQs about Affordable Care Act and Consolidated Appropriations Act, 2021 Implementation Part 62 (Oct. 6, 2023), available at <https://www.dol.gov/agencies/ebsa/about-ebsa/our-activities/resource-center/faqs/aca-part-62> and <https://www.cms.gov/files/document/faqs-part-62.pdf>.

¹³ See FAQs about Affordable Care Act and Consolidated Appropriations Act, 2021 Implementation Part 67 (May 1, 2024), available at <https://www.dol.gov/agencies/ebsa/about-ebsa/our-activities/resource-center/faqs/aca-part-67> and <https://www.cms.gov/files/document/faqs-part-67.pdf>.

¹⁴ *Tex. Med. Ass’n, et al. v. U.S. Dep’t of Health & Human Servs., et al.*, Case No. 23-40605 (5th Cir. Oct. 30, 2024).

¹⁵ On December 16, 2024, the plaintiffs in *TMA III* filed a petition for rehearing *en banc*, which was granted on May 30, 2025. As a result, the district court’s decision from August 24, 2023 is binding pending the Fifth Circuit’s *en banc* decision.

¹⁶ See FAQs about Affordable Care Act and Consolidated Appropriations Act, 2021 Implementation Part 69 (Jan. 14, 2025), available at <https://www.dol.gov/agencies/ebsa/about-ebsa/our-activities/resource-center/faqs/acapart-69> and <https://www.cms.gov/files/document/faqs-part-69.pdf>.

and before the Fifth Circuit's decision in *TMA III*, for items or services furnished before August 1, 2025.

On May 30, 2025, the Fifth Circuit granted the plaintiff's rehearing *en banc*, and vacated the Fifth Circuit's October 30, 2024, panel opinion. As a result, the aforementioned district court's decision from August 24, 2023, continues to bind the Departments pending the Fifth Circuit's *en banc* decision.

On July 30, 2025, the Departments and OPM issued FAQs about Consolidated Appropriations Act, 2021 Implementation Part 71 (FAQs Part 71).¹⁷ FAQs Part 71 provide guidance on the QPA methodology and related disclosures under the No Surprises Act, in light of the May 30, 2025 order of the U.S. Court of Appeals for the Fifth Circuit granting rehearing *en banc* and vacating the Fifth Circuit's October 30, 2024, panel opinion in *TMA III*. FAQs Part 71 also extends the enforcement relief outlined in FAQs Part 69 for QPAs calculated in accordance with the 2021 methodology, for items and services furnished before February 1, 2026. As explained in FAQs Part 71, once the Fifth Circuit's *en banc* decision in *TMA III* is released, the Departments and OPM will evaluate whether it is necessary to provide additional enforcement relief. The Departments and OPM do not currently expect any such additional enforcement relief would extend beyond August 1, 2026, but will reassess the status of QPA recalculations and provide additional guidance as appropriate.

Given the time and resource-intensive nature of QPA Audits, as well as litigation related to the methodology for calculation of the QPA established through rulemaking, one QPA Audit was concluded during calendar year 2024.

Summary of QPA Audit Closed in 2024

Aetna Health – Texas¹⁸

CMS conducted a QPA Audit of Aetna Health Inc. (Aetna-TX) for air ambulance service QPA calculations made and claims for air ambulance services furnished by a nonparticipating provider of air ambulance services from January 1, 2022, through June 10, 2022. The purpose of the QPA Audit was to assess Aetna-TX's compliance with federal requirements under section 2799A-2(a) and (c)(2) (which cross references section 2799A-1(a)(3)(E)), and implementing regulations 45 C.F.R. §§ 149.130 and 149.140. The QPA Audit's scope was limited to air ambulance service QPA calculations and air ambulance service claims subject to the No Surprises Act, and the QPA Audit was conducted pursuant to CMS's authority as outlined in CMS's letter to Texas regarding enforcement of the provisions of the Consolidated Appropriations Act, 2021.¹⁹

The QPA Audit included the review and analysis of air ambulance service claim records, data, and documents pertaining to the calculation of QPAs. CMS also requested Aetna-TX-generated

¹⁷ See FAQs about Consolidated Appropriations Act, 2021 and Affordable Care Act Implementation Part 71 (July 30, 2025), available at <https://www.dol.gov/sites/dolgov/files/ebsa/about-ebsa/our-activities/resource-center/faqs/aca-part-71.pdf> and <https://www.cms.gov/files/document/faqs-part-71.pdf>.

¹⁸ See Final Report: Federal Qualifying Payment Amount Audit of Aetna Health Inc.: <https://www.cms.gov/files/document/qpa-final-report-aetna-tx.pdf>.

¹⁹ Center for Consumer Information & Insurance Oversight, CAA Enforcement Letter to Texas (as of Jan. 25, 2022), available at <https://www.cms.gov/files/document/caa-enforcement-letters-texas.pdf>.

documents, including: a comprehensive list of all insurance markets in which Aetna-TX offers coverage; a narrative describing the Aetna-TX's QPA calculation methodology; all claims handling manuals, internal bulletins and guidelines issued by Aetna-TX with respect to the processing and payment of claims; claims data relating to air ambulance services for which there was a requirement to apply a QPA; QPA calculation data; air ambulance provider contracts; and claim samples and related claim processing documents.

Findings were identified regarding the following federal requirements:

- Aetna-TX failed to properly calculate the QPA by using claim paid amounts instead of contracted rates, and counting each claim as its own contracted rate, even when the claims were for the same amounts for the same item or service and to the same provider of air ambulance services, in violation of 45 C.F.R. §§ 149.140(b)(1) and (c)(1)(i).
 - Corrective Action: Aetna-TX correctly recalculated the five QPAs during the QPA Audit. After the QPA Audit, Aetna-TX conducted the required self-audit of QPA calculations for air ambulance claims for the period of January 1, 2022, through May 30, 2024, and submitted the results of its self-audit to CMS. Aetna-TX's self-audit was comprised of 89 unique claims. No additional QPA calculation errors were identified.
- Aetna-TX failed to provide a statement that the provider may initiate the IDR process within four days after the end of open negotiation period, in violation of 45 C.F.R. § 149.140(d)(1)(iv).
 - Corrective Action: Aetna-TX implemented a system enhancement on December 8, 2023, to update the disclosure language regarding the four-day period in which the provider or facility may initiate the IDR process with a compliant statement. Aetna-TX conducted a self-audit of air ambulance claims for the period of January 1, 2022, through May 5, 2024, to identify claims for which disclosures provided with the initial payment or notice of denial of payment contained the non-compliant IDR disclosure language. The self-audit results identified 58 claims, prior to the system enhancement, in which the incorrect disclosure was sent with an initial payment or notice of denial of payment.
- Aetna-TX failed to share the QPA in a remittance advice sent with an initial payment or in a notice of denial of payment, in violation of 45 C.F.R. § 149.140(d)(1)(i).
 - Corrective Action: Aetna-TX implemented a system enhancement which included adding a QPA field to disclosures provided with initial payments and notices of denial of payment for items and services for which the QPA requirement applies, reprocessed the one claim identified during the QPA Audit that failed to include the QPA, and shared the QPA with the nonparticipating provider of air ambulance services. Aetna-TX also conducted a self-audit of air ambulance claims for the period of January 1, 2022, through May 5, 2024. The self-audit identified 89 unique claims, prior to the system enhancement, in which the QPA requirement applied and disclosures without the added QPA field were sent.