

Report: Federal Qualifying Payment Amount Audit of
CareSource (IN) – HIOS ID #54192
State of Indiana as of May 18, 2026

Audit Report: 2023 – QPA – 10

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I. Scope of Audit

The Center for Consumer Information and Insurance Oversight (CCIIO) conducted a Qualifying Payment Amount (QPA) Audit (Audit) of CareSource of Indiana (Issuer) pursuant to sections 2723(b) and 2799A-1(a)(2)(A) of the Public Health Service Act (PHS Act) and implementing regulations 45 CFR §§ 149.140(f) and 150.313.

The Audit Period was for items and services furnished between January 1, 2022, through May 31, 2023. The purpose of the Audit was to assess the Issuer's compliance with certain Federal requirements under sections 2799A-1(a), 2799A-1(b), and 2799A-2(a) of the PHS Act and implementing regulations:

- 45 CFR § 149.110 – Preventing Surprise Medical Bills for Emergency Services;
- 45 CFR § 149.120 – Preventing Surprise Medical Bills for Non-Emergency Services Performed by Nonparticipating Providers at Certain Participating Facilities;
- 45 CFR § 149.130 – Preventing Surprise Medical Bills for Air Ambulance Services; and
- 45 CFR § 149.140 – Methodology for Calculating Qualifying Payment Amount.

During this Audit, CCIIO requested claim records, data, and documents pertaining to the calculation of QPAs for emergency services, applicable non-emergency services, and air ambulance services subject to the surprise billing provisions of the No Surprises Act (referred to in this report as “No Surprises Act-eligible” claims or services). CCIIO also requested Issuer-generated documents, including:

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

This report is by exception. Therefore, the only areas indicated in the report are areas where findings were noted. Any additional practices, procedures, and files subject to review during the Audit are omitted from this report if no findings are indicated. Some non-compliant

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practices may not have been discovered or noted in this report. Failure to identify or address business practices that do not comply with Federal statutes and regulations or those of other applicable jurisdictions does not constitute acceptance of such practices.

The audit and testing methodologies followed standards established by the National Association of Insurance Commissioners (NAIC)¹ and procedures developed by CCIIO.

The Audit's scope was limited to (i) QPA calculations and (ii) QPA disclosures for No Surprises Act-eligible claims and was conducted pursuant to CMS's authority under sections 2723(b) and 2799A-1(a)(2)(A) of the PHS Act and as outlined in CMS's letter to Indiana regarding enforcement of the provisions of the Consolidated Appropriations Act, 2021.² Accordingly, CCIIO requested and received from the Issuer QPA calculation data and claims which are summarized in the tables below:

QPA calculation data:

Total Number of Usual and Customary Rates ³	Contracted Rates
952	0 ⁴

All No Surprises Act-eligible claims:

Claim Type	Population	Sample Size	Usual and Customary Rates ⁵
Emergency	20,002	50	774
Non-Emergency	24,547	35	106
Air Ambulance	53	21	72

¹ Market Regulation Handbook Examination Standards Summary 2022.

<https://content.naic.org/sites/default/files/publication-mes-hb-market-handbook-examination.pdf>

² Center for Consumer Information & Insurance Oversight, CAA Enforcement Letter to Indiana (as of Dec. 15, 2021), available at <https://www.cms.gov/ccio/programs-and-initiatives/other-insurance-protections/caa-enforcement-letters-indiana.pdf>.

³ The QPA calculation data provided for the Audit contained Usual and Customary Rates that were utilized by the Issuer for out-of-network services in lieu of contracted rates to determine a QPA.

⁴ The Issuer did not produce its contracted rates and instead produced its Usual and Customary Rate records.

⁵ The QPA calculation data provided for the Audit contained Usual and Customary Rates that were utilized by the Issuer for out-of-network services in lieu of contracted rates to determine a QPA.

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Since the commencement of this Audit, 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 regulations and guidance regarding calculation of the QPA. On October 30, 2024, the United States Court of Appeals for the Fifth Circuit (Fifth Circuit) issued an opinion and order in TMA III. The Fifth Circuit reversed the district court's holding that vacated challenged provisions related to the methodology for calculating the QPA; affirmed the district court's vacatur of certain deadline provisions; and affirmed the district court's holding as to the requirements regarding disclosure of information about the QPA. After the Fifth Circuit opinion and order, TMA requested rehearing en banc. On May 30, 2025, the Fifth Circuit vacated the entire panel opinion and granted TMA's request for rehearing en banc.⁶ TMA III remains under litigation as of the date of this report. This report describes the Issuer's compliance with applicable regulations and guidance as modified by the district court in TMA III.⁷

⁶ *Tex. Med. Ass'n, et al. v. U.S. Dep't of Health & Human Servs., et al.*, Case No. 23-40605 (5th Cir. May 30, 2025)

⁷ FAQ About Consolidated Appropriations Act, 2021 Implementation Part 73 (Apr. 1, 2026), available at <https://www.cms.gov/files/document/faqs-part-73.pdf>

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II. Issuer Profile

CareSource of Indiana is an insurance company licensed by the Indiana Department of Insurance to sell health insurance in Indiana and is subject to regulation by the State of Indiana as well as CCIIO. CareSource offers fully insured group health insurance coverage, as well as related programs and services.

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III. Executive Summary

CCIIO conducted an Audit to assess the Issuer's compliance with select provisions of the following requirements under Title XXVII of the PHS Act:

- Section 2799A-1(a) – Preventing Surprise Medical Bills; Coverage of Emergency Services and Qualifying Payment Amount;
- Section 2799A-1(b) – Preventing Surprise Medical Bills; Coverage of Non-Emergency Services Performed by Nonparticipating Providers at Certain Participating Facilities;
- Section 2799A-2(a) – Ending Surprise Air Ambulance Bills;
- 45 CFR § 149.110 – Preventing Surprise Medical Bills for Emergency Services;
- 45 CFR § 149.120 – Preventing Surprise Medical Bills for Non-Emergency Services Performed by Nonparticipating Providers at Certain Participating Facilities;
- 45 CFR § 149.130 – Preventing Surprise Medical Bills for Air Ambulance Services; and
- 45 CFR § 149.140 – Methodology for Calculating Qualifying Payment Amount.

The Audit, for items and services furnished during the period from January 1, 2022, through May 31, 2023, included the review and analysis of claim records, data, and documents pertaining to the calculation of QPAs for No Surprises Act-eligible claims. CCIIO also requested Issuer-generated documents, including: a comprehensive list of all insurance markets in which the Issuer offers coverage; a narrative describing the Issuer's QPA calculation methodology; all claims handling manuals, internal bulletins and guidelines issued by the Issuer with respect to the processing and payment of claims; claims data relating to emergency services, non-emergency services, and air ambulance services for which there was a requirement to apply a QPA; QPA calculation data; and claim samples and related claim processing documents.

This report is by exception. Therefore, the only areas indicated in the report are areas where findings were noted. Any additional practices, procedures, and files subject to review during the Audit are omitted from this report if no findings are indicated. Please note: TMA III remains under litigation as of the date of this report. This report describes the Issuer's

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compliance with applicable regulations and guidance as modified by the district court in TMA III.

In summary, findings, along with completed and/or additional required corrective actions, were identified regarding the following Federal requirements:

Finding 1	
Summary	Failing to provide the required No Surprises Act notices and disclosures (referred to as QPA disclosures) with the initial payment or notice of denial of payment in writing, in paper or electronic form, with initial payments or notices of denial of payment for No Surprises Act-eligible claims.
Citation	45 CFR § 149.140(d)(1)(i), (iii) – (v)
Completed Corrective Action	Prior to December 2023, the Issuer provided QPA disclosures that were minimal and not compliant. In December 2023, the Issuer revised its standard QPA disclosure language included on its provider explanation of payment (EOP).

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Finding 1	Additional Required Corrective Action
Additional Required Corrective Action for Finding 1	Conduct a self-audit of all No Surprises Act-eligible claims from December 1, 2023, through the date of the final report, to identify any claims for which the Issuer failed to provide the required QPA disclosures with an initial payment or notice of denial of payment. Conduct a thorough review of the claim system requirements to ensure that all QPA disclosures are provided for all No Surprises Act-eligible claims with the initial payment or the notice of denial of payment. Determine the policy and/or procedural cause(s) for failing to provide the required QPA disclosures. Implement changes necessary to ensure that QPA disclosures are provided for future claims. Within 30 calendar days of the date of the final report, provide documentation to CCIIO containing the results from the self-audit and provide the identified policy and/or procedural cause(s) for failing to provide the QPA disclosures, along with the steps taken to remediate the failure. The self-audit results must contain the claim numbers and dates of service. The response should include a narrative description

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Finding 1	Additional Required Corrective Action
	of the steps the Issuer has taken or intends to take, along with the timeline for completion, to ensure that it is in compliance with the requirements of 45 CFR § 149.140(d)(1)(i), (iii) – (v).

Finding 2	
Summary	Failing to provide certain information about the QPA in a timely manner upon request of the provider or facility.
Citation	45 CFR § 149.140(d)(2)(i) – (ii)
Completed Corrective Action	In November 2023, the Issuer updated the language contained in its Provider Dispute & Open Negotiation Responses.

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Finding 2	Additional Required Corrective Action
Additional Required Corrective Action for Finding 2	Conduct a self-audit of all No Surprises Act-eligible claims from November 1, 2023, through the date of the final report, to identify any claims for which the Issuer failed to provide certain information about the QPA in a timely manner upon request of providers, facilities, and providers of air ambulance services. Conduct a thorough review of the claim system requirements and determine the policy and/or procedural cause(s) for failing to provide certain information about the QPA in a timely manner upon request of providers, facilities, and providers of air ambulance services. Implement changes necessary to ensure that requested information is provided for future claims as needed. Within 30 calendar days of the date of the final report, provide documentation to CCIIO containing the results from the self-audit and provide the identified policy and/or procedural cause(s) for failing to provide the certain information about the QPA in a timely manner upon request of providers, facilities, and providers of air ambulance services, along with the steps taken to remediate the failure. The self-audit results must contain the claim numbers, dates of service, QPA requests from providers, facilities, and providers of air ambulance services, and the Issuer's responses to providers, facilities, and

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Finding 2	Additional Required Corrective Action
	providers of air ambulance services. The response should include a narrative description of the steps the Issuer has taken or intends to take, along with the timeline for completion, to ensure that it is in compliance with the requirements of 45 CFR § 149.140(d)(2)(i) – (ii).

Finding 3	
Summary	Failing to calculate the QPA using the Issuer's contracted rates and instead using the Usual and Customary Rate.
Citation	45 CFR § 149.140(b)(1)
Completed Corrective Action	In November 2023, the Issuer implemented a corrective action plan to recalculate the QPA for all No Surprises Act-eligible claims.

Finding 3	Additional Required Corrective Action
Additional Required Corrective Action for Finding 3	Conduct a self-audit of all No Surprises Act-eligible claims from January 1, 2022, through the date of the final report, to identify claims for which the reported QPA (based on the Usual and Customary Rate) was higher than the QPA calculated according to applicable statutes and regulations (based on the Issuer's contracted rates). For those claims, refund to the consumer excess cost sharing paid. For claims for which the reported QPA was lower than the QPA calculated according to applicable statutes and regulations, no action is required or recommended. For guidance on QPA calculations and federal exercises of enforcement discretion related to TMA III, see FAQ about Consolidated Appropriations Act, 2021 Part 73.⁸ Within 30 calendar days of the date of the final report, provide documentation to CCIIO containing the results from the self-audit and evidence that any excess cost-sharing amounts have been refunded to consumers. The results must contain the claim numbers, dates of

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⁸ FAQ About Consolidated Appropriations Act, 2021 Implementation Part 73 (Apr. 1, 2026), available at <https://www.cms.gov/files/document/faqs-part-73.pdf>.

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Finding 3	Additional Required Corrective Action
	service, original and corrected QPAs, as well as original and corrected cost-sharing, and amounts and dates of refund of cost-sharing differential payments to consumers. The response should include a narrative description of the steps the Issuer has taken or intends to take, if any, along with the timeline for completion, to ensure that it is in compliance with the requirements of 45 CFR § 149.140(b)(1). Pursuant to 45 CFR § 149.140(b)(2)(iii), QPAs are required to be calculated using the contracted rates for each item or service, including contracted rates where payments are not made on a fee-for-service basis (such as bundled or capitation payments).

Additional details regarding these findings are in the Audit Results section of this report.

The Audit identified practices that did not comply with Federal requirements applicable during the Audit Period. CCIIO strongly recommends that the Issuer apply the required corrective actions outlined in this Audit Report to and share the corrective actions with all of its affiliates, regardless of situs or regulatory jurisdiction for No Surprises Act-eligible claims. Additionally, the Issuer may be subject to future audits.

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IV. Audit Results

A. QPA Disclosure Requirements Findings

Violation of 45 CFR § 149.140(d)(1)(i), (iii) – (v), and (d)(2)(i) – (ii).

CCIIO identified two findings of these provisions in the following instances:

Finding 1 – Failing to provide QPA disclosures with an initial payment or notice of denial of payment for No Surprises Act-eligible services.

Plans and issuers must make required disclosures about the QPA with an initial payment or initial notice of denial of payment. This information must be provided in writing, either on paper or electronically, to a nonparticipating provider, facility, or provider of air ambulance services, as applicable, when the QPA serves as the recognized amount (or, for air ambulance services, the amount on which cost-sharing is based). The Issuer failed to provide QPA disclosures in violation of 45 CFR § 149.140(d)(1). This violation appeared in 106 sampled claims, totaling 735 QPAs.⁹

CCIIO requested 106 No Surprises Act-eligible claim samples. Of these, CCIIO identified 735 occurrences in which the Issuer failed to provide certain required QPA disclosures. The Issuer's standard QPA disclosure language included on its provider explanation of payment (EOP) to providers, facilities, and providers of air ambulance services was minimal and not compliant with 45 CFR § 149.140(d)(1). Specifically, the Issuer failed to provide the following disclosures:

- The QPA for each item or service involved: 45 CFR § 149.140(d)(1)(i).
- Certification that the QPA applies for purposes of the recognized amount (or, in the case of air ambulance services, for calculating the participant's, beneficiary's, or enrollee's cost sharing): 45 CFR § 149.140(d)(1)(iii)(A).
- Certification that each QPA shared with the provider or facility was determined in compliance with 45 CFR § 149.140: 45 CFR § 149.140(d)(1)(iii)(B).
- A statement regarding the option of the 30-day open negotiation period and a statement that the provider may initiate the Independent Dispute Resolution (IDR)

⁹ The number of QPAs cited in Finding 1 is lower than the total QPAs due to the Issuer disclosing a single QPA for bundled payments or DRGs. This single QPA is used as the QPA for all services included within the bundle or under the DRG. Note: Pursuant to 45 CFR § 149.140(b)(2)(iii), QPAs are required to be calculated using the contracted rates for each item or service, including payments that are not made on a fee-for-service basis (such as bundled or capitation payments).

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process within 4 days after the end of open negotiation period: 45 CFR § 149.140(d)(1)(iv).

- Contact information, including a phone number and email address, for the appropriate person or office to initiate open negotiations: 45 CFR § 149.140(d)(1)(v).

The Issuer agreed with this finding in Criticism¹⁰ #1 on June 20, 2024, and provided the following response:

CareSource concurs with this criticism and recognizes that the claim sample review period of Jan 2022-May 2023 was a learning opportunity regarding the implementation of NSA QPA disclosure requirements. We don't believe this was unique to our health plan considering the additional guidance and clarity published for stakeholders after Jan 2022 by the regulatory bodies which was greatly appreciated by all the plans. We believe we have successfully resolved this criticism through the enhancements to the verbiage in our Explanation of Payment (EOP) issued to providers for initial payment or notice of payment denial. These updates were completed in December 2023. See attached updated EOP, specifically within the "No Surprises Act / Balance Billing" section, that includes the additional statement: *Claims paid in accordance with this act are notated in the claim detail above with Remark Code N830. CareSource's Qualified Payment Amounts (QPA) for these services are as follows (with accompanying QPA rates listed)*

See attached updated EOP, specifically within the "No Surprises Act / Balance Billing" section, that includes the additional statements: *If you wish to initiate the open negotiation period for purposes of determining the amount of total payment, please do so within 30 business days from the date of initial payment or notice of denial of payment, by emailing an Open Negotiation Notice from No Surprises Act | U.S. Department of Labor (dol.gov) to CareSource's Grievance and Appeals department at MarketplaceIDR@caresource.com. If the 30-day open negotiation period does not result in an agreement on the total payment for the qualified IDR item(s) or service(s), you may initiate the Federal IDR process within 4 days after the end of the open negotiation period. Please visit our website <https://www.caresource.com/providers/provider-portal/appeals> for more information. For additional questions or concerns you can contact Provider Services at 1-866-286-9949.*

¹⁰ Criticisms are used during the audit to communicate potential findings of violation of federal requirements. Plans and issuers have the ability to provide additional information to demonstrate compliance with the federal requirements or agree with the violation finding.

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Completed Corrective Action for Finding 1:

Prior to December 2023, the Issuer provided QPA disclosures that were minimal and not compliant with regulation. In December 2023, the Issuer revised its standard QPA disclosure language included on its provider EOP to state the following:

- “Claims paid in accordance with this act are notated in the claim detail above with Remark Code N830. CareSource’s Qualified Payment Amounts (QPA) for these services are as follows (with accompanying QPA rates listed)”
- “If you wish to initiate the open negotiation period for purposes of determining the amount of total payment, please do so within 30 business days from the date of initial payment or notice of denial of payment, by emailing an Open Negotiation Notice from No Surprises Act | U.S. Department of Labor (dol.gov) to CareSource’s Grievance and Appeals department at MarketplaceIDR@caresource.com. If the 30-day open negotiation period does not result in an agreement on the total payment for the qualified IDR item(s) or service(s), you may initiate the Federal IDR process within 4 days after the end of the open negotiation period. Please visit our website <https://www.caresource.com/providers/provider-portal/appeals> for more information. For additional questions or concerns you can contact Provider Services at 1-866-286-9949.”

Additional Required Corrective Action for Finding 1:

Based on CMS review of the completed corrective actions for Finding 1, the Issuer has not included following disclosures:

- Certification that the QPA applies for purposes of the recognized amount (or, in the case of air ambulance services, for calculating the participant's, beneficiary's, or enrollee's cost sharing): 45 CFR § 149.140(d)(1)(iii)(A).
- Certification that each QPA shared with the provider or facility was determined in compliance with this section: 45 CFR § 149.140(d)(1)(iii)(B).

Conduct a self-audit of all No Surprises Act-eligible claims from December 1, 2023, through the date of the final report, to identify any claims for which the Issuer failed to provide the required QPA disclosures with an initial payment or notice of denial of payment. Conduct a thorough review of the claim system requirements to ensure that all QPA disclosures are provided for all No Surprises Act-eligible claims with the initial payment or the notice of denial of payment. Determine the policy and/or procedural cause(s) for failing to provide the required QPA disclosures. Implement changes necessary to ensure that QPAs are provided for future claims.

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Within 30 calendar days of the date of the final report, provide documentation to CCIIO containing the results from the self-audit and provide the identified policy and/or procedural cause(s) for failing to provide the QPA disclosures, along with the steps taken to remediate the failure. The results must contain the claim numbers and dates of service. The response should include a narrative description of the steps the Issuer has taken or intends to take, along with the timeline for completion, to ensure that it is in compliance with the requirements of 45 CFR § 149.140(d)(1)(i), (iii) – (v).

Issuer Response:

CareSource acknowledges the findings regarding our failure to provide the required Qualified Payment Amount (QPA) disclosures at the time of payment or denial, as mandated by the No Surprises Act (NSA). We understand the importance of complying with these regulations and are committed to addressing the issues identified in the audit.

To address the root cause of the failure to provide the required QPA disclosures, we implemented a corrective action plan (CAP) which was completed on 12/1/2023. This plan outlined the steps we took to rectify the issues and prevent future occurrences.

In response to the corrective actions outlined by the Centers for Consumer Information and Insurance Oversight (CCIIO), CareSource will conduct a self-audit of NSA eligible claims from December 1, 2023, to the date of the final report within 30 days of receipt of the final report. This audit will identify any claims that did not meet the QPA disclosure requirements as a result of CareSource's remediation plan which was completed at that time. We will document the results, including claim numbers and dates of service (DOS), to ensure clarity and accountability.

CCIIO concurs with the Issuer's position.

Finding 2 – Failing to provide certain information about the QPA in a timely manner upon request of the provider or facility.

Plans and issuers are required to provide certain information about the QPA in a timely manner upon request of providers, facilities, and providers of air ambulance services. Specifically, plans and issuers must provide certain information regarding the basis for QPA calculations and, if the plan or issuer used an eligible database to determine the QPA, information to identify the database used.

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CCIIO requested 106 No Surprises Act-eligible claim samples. Of these, CCIIO identified five claim samples for which a provider, as part of its request to initiate the open negotiation process, requested specific information regarding the basis for calculating the QPAs for claim's billed services.

CCIIO requested a copy of the Issuer's response to the provider's request and further clarification about the Issuer's response to providers, facilities, and providers of air ambulance services requesting QPA information. The Issuer produced a form letter which it sends to providers referencing a "claim dispute request." The Issuer's response to providers, however, failed to provide the requested QPA information as required.

The Issuer "did not object" to this finding in Criticism #2 on June 28, 2024, and provided the following response:

CareSource does not object with this criticism. While CareSource does not believe this issue was unique to our plan particularly given the additional clarifying guidance published for stakeholders after January 2022, CareSource has diligently worked to take corrective action. We have successfully resolved this criticism through the enhancements to the verbiage in our Provider Dispute & Open Negotiation Responses. These updates were completed in November 2023. See attached examples of our responses to request for information required in 45 CFR § 149.140(d)(2)(i) & 45 CFR § 149.140(d)(2)(ii)

Completed Corrective Action for Finding 2:

In November 2023, the Issuer updated the language contained in its Provider Dispute & Open Negotiation Responses.

Additional Required Corrective Action for Finding 2:

Conduct a self-audit of all No Surprises Act-eligible claims from November 1, 2023, through the date of the final report, to identify any claims for which the Issuer failed to provide certain information about the QPA in a timely manner upon request of providers, facilities, and providers of air ambulance services. Conduct a thorough review of the claim system requirements and determine the policy and/or procedural cause(s) for failing to provide certain information about the QPA in a timely manner upon request of providers, facilities, and providers of air ambulance services. Implement changes necessary to ensure that requested information is provided for future claims as needed.

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Within 30 calendar days of the date of the final report, provide documentation to CCIIO containing the results from the self-audit and provide the identified policy and/or procedural cause(s) for failing to provide certain information about the QPA in a timely manner upon request of providers, facilities, and providers of air ambulance services, along with the steps taken to remediate the failure. The results must contain the claim numbers, dates of service, QPA requests from providers, facilities, and providers of air ambulance services, and the Issuer's responses to providers, facilities, and providers of air ambulance services. The response should include a narrative description of the steps the Issuer has taken or intends to take, along with the timeline for completion, to ensure that it is in compliance with the requirements of 45 CFR § 149.140(d)(2)(i) – (ii).

Issuer Response:

CareSource acknowledges the findings regarding our failure to provide certain information about the Qualified Payment Amount (QPA) in a timely manner upon request from providers or facilities. We understand the significance of this requirement and are committed to addressing the issues identified in the audit.

In response to the corrective actions outlined by the Centers for Consumer Information and Insurance Oversight (CCIIO), CareSource will conduct a self-audit of NSA eligible claims from November 1, 2023, to the date of the final report. This self-audit will identify any claims for which we failed to provide certain information about the QPA in a timely manner when it was requested by providers, facilities, and providers of air ambulance services. We will document the results, including relevant claim numbers and dates of service (DOS), to ensure transparency.

We will also perform a thorough review of our claim system requirements to ensure that the necessary information about the QPA is provided promptly upon request. This review will help us identify any gaps in our processes and ensure compliance with regulatory standards.

To determine the root cause of the failure to provide the required information in a timely manner, we will implement a corrective action plan (CAP). This plan will detail the steps we will take to address the identified issues and prevent future occurrences.

CareSource is committed to completing all additional corrective actions as directed by CCIIO within 30 days upon receipt of the final report. We will provide a comprehensive response that includes the results of our self-audit, findings

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regarding the root cause of the failure, and specifics of our corrective action plan, including a timeline for implementation as appropriate.

CCIIO concurs with the Issuer's position.

B. QPA Calculation Methodology Requirements Findings

Violation of 45 CFR § 149.140(b)(1).

CCIIO identified one finding of this provision in the following instances:

Finding 3 – Failing to calculate the QPA using the Issuer's contracted rates and instead using the Usual and Customary Rate.

CCIIO reviewed the Issuer's policies and procedures for calculating QPAs as well as the Issuer's list of QPAs for No Surprises Act-eligible services during the Audit period. CCIIO determined that the Issuer did not properly calculate QPAs as required in 45 CFR § 149.140(b)(1). This violation appeared in 106 sampled claims, totaling 952 QPAs.¹¹

In general, the QPA is calculated following the methodology outlined in regulation. This includes, among other things, the requirement to calculate the median contracted rate by using all unique contracted rates, selecting the median (or in the case of an even number, the average of the middle two contracted rates), and applying the percentage increase to the median of the contracted rates. For items and services furnished in 2022, an issuer must determine if it has "sufficient information" to calculate a median contracted rate based on its 2019 contracted rates. Pursuant to 45 CFR § 149.140(a)(15)(i), sufficient information means that an issuer has at least three (3) contracted rates (meeting regulatory criteria) on January 31, 2019, to calculate the median of the contracted rates for 2022 QPAs. The regulations do not allow an issuer to use the Usual and Customary Rate (UCR),¹² claims experience, or other methodologies not otherwise proscribed in the regulations to determine the median contracted rate or QPA.

In item #2 of CCIIO's letter initiating this Examination (Call Letter), CCIIO requested a step-by-step narrative describing the Issuer's QPA calculation methodology demonstrating compliance. In response, the Issuer produced *Item2.Indiana – QPA*

¹¹ Pursuant to 45 CFR § 149.140(b)(2)(iii), QPAs are required to be calculated using the contracted rates for each item or service, including contracted rates where payments are not made on a fee-for-service basis (such as bundled or capitation payments).

¹² While similar, the UCR is different than the QPA. The UCR is not standardized in regulations and issuers have various ways of determining UCR.

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Calculation Documentation as of 6.14.2023, which suggested that it did not calculate QPAs as required and instead used its UCR in lieu of contracted rates to determine the QPA.

CCIIO sought clarification (RFI #1) regarding the Issuer's QPA calculation methodology. In response, the Issuer produced *Item2.CareSource (IN) – RFI #1* which stated:

Contract rates for 2020 were used for the basis of the calculation provided and not using 2019 rates. ... To this degree, the initial calculation seen used prior Greater of Three ER¹³ regulation logic which based the median in network rate on prior year actuals.

The Issuer later confirmed (*CareSource Response RFI 13 Final*) that the QPA calculation data produced for the Audit “included the Usual & Customary rates which was utilized to represent our QPA rate.”

CCIIO concludes that the Issuer's practices were not compliant with QPA calculation requirements under 45 CFR § 149.140(b)(1).

The Issuer agreed with this finding in Criticism #3 on September 25, 2024, and provided the following response:

CareSource concurs with this criticism noted above.

CareSource began our No Surprise Act implementation work in April 2021, at which time CareSource implemented utilizing our Usual & Customary out-of-network rate to fulfil the Qualified Payment Amount (QPA) requirement. We believed at the time this was sufficient to use a calculated Usual & Customary Rate (UCR) as the initial payment amount based on state regulations IC § 27-1-45-8 and IN HB1004, as the ‘rate or amount of compensation established by the covered individual's network plan’ as our QPA rate.

In late December 2021, CMS decided that Indiana's laws did not qualify as a “specified state law” to fulfill all of the NSA requirements. Due to the late release of CMS decision, and the fact that recalculating the QPA would have negative impact to member cost share after the start of the 2022 year, CareSource made the business decision to continue with the use of our (UCR) initial payment amount as to not negatively impact member cost share.

¹³ Greatest of Three Rule uses the UCR as one of its criteria. See 29 CFR. § 2590.715-2719A(b)(3)(i).

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As a result of this audit and full review of all CMS guidance issued 2022 and hereafter, CareSource identified the gap in updating our QPA calculation methodology, and has conducted an internal review of CMS guidance with CareSource Compliance, Legal and Operations teams and completed the following remediation:

- We secured a consultant resource with subject matter expertise in claim normalization / re-pricing / FFS equivalency creation who assisted in revalidating and implementing our methodology used to calculate the median-in-network rate and all other components of the QPA process.
- Built programmable / operational definitions for the set of in scope services (procedure codes, etc.)
- Built programmable / operational definitions for the levels of aggregation required (urban, rural, facility vs professional, etc.)
- Constructed our universe of in-network claims for the set of in scope services and applicable markets
- Applied trend for CPI-U inflation along with all other regulatory specifications.
- Prepared final materials:
 - (1) QPA rates for all applicable categories,
 - (2) a "configuration companion" document with specifications for implementation,
 - (3) draft standard operating procedure for ongoing maintenance and suggestions for monitoring and oversight and validation.

See attached documents that represent the output of our remediation work:

- RFI#11 response QPA Rates
- Finalized Process Flow for QPA
- QPA Process Narrative

Completed Corrective Action for Finding 3:

In response to this finding, the Issuer implemented a corrective action plan to calculate the QPA for all No Surprises Act-eligible claims. This action was completed on 11/13/2024.

Additional Required Corrective Action for Finding 3:

Conduct a self-audit of all No Surprises Act-eligible claims from January 1, 2022, through the date of the final report, to identify claims for which the reported QPA (based

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on the Usual and Customary Rate) was higher than the QPA calculated according to applicable statutes and regulations (calculated using the Issuer's contracted rates). For those claims, refund to the consumer any excess cost sharing paid. For claims for which the reported QPA was lower than the QPA calculated according to applicable statutes and regulations, no action is required or recommended. For guidance on QPA calculations and federal exercises of enforcement discretion related to TMA III, see FAQ about Consolidated Appropriations Act, 2021 Implementation Part 73.¹⁴

Within 30 calendar days of the date of the final report, provide documentation to CCIIO containing the results from the self-audit and evidence that any excess cost-sharing amounts have been refunded to consumers. The results must contain the claim numbers, dates of service, original and corrected QPAs, as well as original and corrected cost-sharing, and amounts and dates of refund of cost-sharing differential payments to consumers. The response should include a narrative description of the steps the Issuer has taken or intends to take, if any, along with the timeline for completion, to ensure that it is in compliance with the requirements of 45 CFR § 149.140(b)(1). Pursuant to 45 CFR § 149.140(b)(2)(iii), QPAs are required to be calculated using the contracted rates for each item or service, including contracted rates where payments are not made on a fee-for-service basis (such as bundled or capitation payments).

Issuer Response:

CareSource acknowledges the finding regarding our prior methodology for calculating the Qualified Payment Amount (QPA). Initially, when implementing the No Surprises Act (NSA) in April 2021, we utilized the Usual & Customary (U&C) out-of-network rate to fulfill the QPA requirement, believing this approach to be compliant with applicable state regulations. However, in late December 2021, the Centers for Medicare & Medicaid Services (CMS) determined that Indiana's laws did not meet the criteria for a "specified state law" under the NSA, which highlighted a gap in our QPA calculation methodology.

In response to this finding, CareSource has taken significant steps to address the issue. We have engaged a consultant with expertise in claim normalization and fee-for-service equivalency to assist us in revalidating and implementing our methodology for calculating the median in-network rate. Additionally, we have developed operation definitions for in-scope services and established the necessary levels of aggregation for accurate QPA calculations.

¹⁴ FAQ About Consolidated Appropriations Act, 2021 Part 73 (Apr. 1, 2026), available at <https://www.cms.gov/files/document/faqs-part-73.pdf>.

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To address the root cause of the failure to provide the required QPA disclosures, we implemented a corrective action plan (CAP) which was completed on 11/13/2024. This plan outlined the steps we took to rectify the issues and prevent future occurrences.

1. **QPA Recalculation:** We recalculated the QPA rate back to the baseline year of 2019 based on current CMS guidance for median rate development and categorization. Rates were implemented in CareSource systems on 10/2/2024.
2. **Reprocess Claims:** Claims were reprocessed with updated rate structure and appropriate cost share adjustments back to 10/2/2022, according to CareSource policy and our contract with OMPP for dates of service two years prior to implementation.
3. **Recurring Review:** Beginning January 2025, a full annual rate review process was implemented and a No Surprises Act Optimization team to improve monitoring of post pay negotiation and arbitration outcomes.

To comply with the corrective actions outlined by the Centers for Consumer Information and Insurance Oversight (CCIIO), CareSource will complete the following steps:

1. **Self-Audit:** We will conduct a self-audit of NSA-eligible claims from October 2, 2022, to the date of the final report. This audit will identify claims for which the QPA based on U&C was higher than the actual QPA based on our contracted rates that were not [remediated] as part of the corrective action. We will document the results, including relevant claim numbers and dates of service (DOS).

CareSource is committed to completing all additional corrective actions as directed by CCIIO within 30 days upon receipt of the final report. We will provide a detailed response that includes the results of our self-audit and findings.

CCIIO concurs with the Issuer's position.

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V. Closing

QPA Disclosure Requirements Findings: A sample of 106 emergency service, non-emergency service, and air ambulance service claims were reviewed as part of this Audit. From these claims, there were two findings with 740 occurrences.

- The Issuer failed to provide QPA disclosures with initial payments or notices of denial of payment for No Surprises Act-eligible services. There were 735 occurrences.
- The Issuer failed to provide certain information about the QPA in a timely manner upon request of the provider or facility. There were five occurrences.

QPA Calculation Methodology Requirements Findings: A sample of 106 emergency service, non-emergency service, and air ambulance service claims and methodologies were reviewed as part of this Audit. From these claims, there was one finding with 952 occurrences.

- The Issuer failed to calculate the QPA using the Issuer's contracted rates and instead used the Usual and Customary Rate. There were 952 occurrences.

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VI. Audit Report Submission

The courtesy and cooperation extended by the officers and employees of the Issuer during the course of the Audit are hereby acknowledged.

JEFFREY C. WU -S Digitally signed by JEFFREY C. WU
Date: 2026.05.14 18:05:39 -0400

Jeff Wu
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Center for Consumer Information and Insurance Oversight
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In addition, the following individuals participated in this Audit and in the preparation of this report:

Center for Consumer Information and Insurance Oversight

- Michael Rosen-Kahnowitz, MPP
- Darshell Sheppard

Examination Resources, LLC

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