Department of Health and Human Services
Office of Inspector General
Office of Audit Services

December 2025 | A-03-22-00002

Essence Healthcare, Inc., Did Not Comply With Federal Requirements for Reporting Direct and Indirect Remunerations for Contract Years 2017 Through 2020

This is a revised version of the report prepared for public release.

REPORT HIGHLIGHTS

December 2025 | A-03-22-00002

Essence Healthcare, Inc., Did Not Comply With Federal Requirements for Reporting Direct and Indirect Remunerations for Contract Years 2017 Through 2020

Why OIG Did This Audit

- CMS contracts with private entities called sponsors that act as payers and insurers to provide prescription drug benefits under Medicare Part D.
- For drugs dispensed to Part D enrollees, Part D prescription drug plan sponsors may receive direct and indirect remuneration (DIR), which consists of rebates, subsidies, or other price concessions that generally decrease the costs that a sponsor incurs for a part D drug. The higher the DIR, the lower the cost of covered drugs.
- This report is part of a series of OIG reports examining Medicare sponsor compliance with requirements related to DIR.

What OIG Found

Essence, a Part D sponsor, incorrectly reported to CMS amounts paid to primary care physician contractors as DIR for contract years 2017 through 2020. Essence incorrectly reported as DIR risk-share payments that were not attributable to Part D drug costs.

- For calendar years 2017 through 2020, Essence incorrectly reported as DIR incentive payments totaling [redacted] that were not attributable to Part D drug cost.
- Another category of risk-share payments, called guarantee payments, also included amounts that were incorrectly reported as DIR. However, we could not determine the amount that should not have been reported as DIR.

By including amounts that were not attributable to drug costs in its reported DIR, Essence lowered its overall DIR, overstated its drug costs, and may have received a higher payment amount from CMS than it should have received.

What OIG Recommends

We made three recommendations, including that Essence request that CMS reopen its 2017 through 2019 DIR reports and refile its 2020 DIR report with the correct amounts. The full recommendations are in the report.

Essence did not agree with our findings and did not address our recommendations.

This is a revised version of the report prepared for public release.

TABLE OF CONTENTS

This is a revised version of the report prepared for public release.

This is a revised version of the report prepared for public release.

INTRODUCTION

WHY WE DID THIS AUDIT

Medicare Part D is an optional program to help Medicare enrollees pay for prescription drugs. For drugs dispensed to Part D enrollees, Part D prescription drug plan sponsors may receive direct and indirect remuneration (DIR), which consists of rebates, subsidies, or other price concessions that decrease the costs that a sponsor incurs for a Part D drug. Part D sponsors may enter into arrangements with entities other than the Centers for Medicare & Medicaid Services (CMS) to share risk related to the cost of drugs. Any gains or losses that the Part D sponsor may experience as a result of these risk-sharing arrangements constitute DIR that must be reported to CMS.

As part of its oversight activities, the Office of Inspector General is conducting audits to determine whether Medicare Part D sponsors complied with Federal requirements for reporting DIR. This audit is the latest in a series of audits of Medicare Part D DIR.

OBJECTIVE

Our objective was to determine whether Essence Healthcare, Inc. (Essence) complied with Federal requirements for reporting DIR for calendar years (CYs) 2017 through 2020.[1]

BACKGROUND

The Medicare Part D Program

Title I of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 amended Title XVIII of the Social Security Act (the Act) by establishing the Medicare Part D prescription drug program. Under Part D, which began January 1, 2006, individuals entitled to benefits under Part A or enrolled in Part B may obtain drug coverage.

To provide prescription drug benefits under Part D, CMS contracts with private entities called Part D sponsors that act as payers and insurers. Sponsors provide a minimum set of prescription benefits, referred to as the basic benefit. For an additional premium, they may also provide supplemental benefits through enhanced alternative coverage. Sponsors may contract with pharmacy benefit managers (PBMs) to manage or administer the drug benefit for the sponsors. CMS pays sponsors for Part D basic benefits through subsidy payments and a final payment determination (the Act §§ 1860D-14 and -15).[2]

[1] This was the most recent data available at the start of our audit.

[2] Final payment determination is CMS's final plan payment based on the costs actually incurred by the Part D sponsor.

This is a revised version of the report prepared for public release.

CMS pays the subsidies prospectively throughout the plan year based in part on information in the sponsors' annual bid. The bid estimates the plan's allowable costs for providing drug benefits and includes the sponsor's anticipated drug costs, taking into consideration DIR.

Direct and Indirect Remuneration

DIR consists of any rebates, subsidies, or other price concessions, from any source (to include manufacturers, pharmacies, or similar entities), that decrease the costs that a sponsor incurs under the Part D plan (42 CFR § 423.308). DIR results from payment arrangements negotiated independent of CMS between Part D sponsors, PBMs, network pharmacies, drug manufacturers, and other parties involved in the administration of the Part D benefit. Manufacturer rebates comprise a significant share of all DIR reported to CMS. Other examples of DIR include incentive payments and risk-sharing arrangements with various parties (including PBMs), and concessions (such as pharmacy fees).

Sponsors report DIR to CMS using the Summary DIR Report (DIR report). This DIR report is divided into multiple columns for reporting various types of DIR. Sponsors must submit a DIR report each contract year for each plan that they offer and must report DIR in accordance with CMS's annual DIR reporting requirements. CMS issues the final Part D DIR reporting requirements after the plan year ends. Although the requirements are generally consistent from year to year, CMS may expand or change the reporting requirements.

Part D allows sponsors to enter into certain types of risk-sharing arrangements in which the sponsor shares the risk with a provider (e.g., pharmacy) or other party involved in the administration or delivery of a Part D benefit. Gains or losses attributable to the cost of Part D covered drugs that sponsors may receive or pay as a result of the risk-sharing arrangements, with entities other than CMS, must be reported. For risk-sharing arrangements that were not solely attributable to Part D drug costs, the sponsor must determine and report as DIR the portions specifically related to Part D drug costs.

After the close of the plan year, CMS calculates the final payment amount for each Part D sponsor by reconciling the prospective payments made to the sponsor to the sponsor's actual allowable costs (42 CFR § 423.343). Total prospective payments include certain CMS subsidy payments and enrollee premiums minus administrative costs. Actual allowable costs are generally the payments that the sponsor makes for covered drugs less reported DIR; the higher the DIR, the lower the cost of covered drugs to the Federal Government.

Essence Healthcare, Inc.

Essence is a Medicare Advantage organization founded by a group of doctors in the Saint Louis, Missouri, area. Essence's Medicare plans offer various services including comprehensive hospital, medical, and prescription drug coverage for enrollees residing in certain counties in Missouri and Illinois.

This is a revised version of the report prepared for public release.

Essence contracted with [redacted] primary care physician groups (PCP contractors) to provide or arrange for certain health care services to eligible individuals under its plans. The contracts were for coordination of all aspects of a plan member's health care, including emergency medical services and referrals to other contracted providers.

HOW WE CONDUCTED THIS AUDIT

We reviewed the risk-share payments and adjustments in Essence's DIR reports, totaling [redacted] We reviewed Essence's contracts with its PBM, as well as Essence's contracts with PCP contractors. We compared and validated the amounts Essence reported as PCP contractors' risk-share amounts in CMS's Health Plan Management System (HPMS)[3] DIR Reports and the amounts from Essence's DIR data.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

The Appendix contains the details of our audit scope and methodology.

FINDING

Essence did not comply with Federal requirements for reporting DIR for CYs 2017 through 2020. For those years, Essence incorrectly reported as risk-sharing arrangements in its DIR reports guarantee and incentive payment amounts that were not attributable to Part D drug costs.[4] Because Essence did not separately identify the amount of the guarantee payment that pertained to each service provided, we could not determine the amount of the guarantee payments that should not have been reported as DIR; however, we determined that Essence reported approximately [redacted] in DIR for incentive payments. Essence correctly reported as DIR approximately [redacted] for incentive payments attributable to Part D drug costs and incorrectly reported approximately [redacted] as incentive payments that were not attributable to Part D drug costs.

[3] HPMS is CMS's full-service website where health and drug plans, plan consultants, third party vendors, and pharmaceutical manufacturers can work with CMS to fulfill the plan enrollment and compliance requirements of the Medicare Advantage and Part D programs.

[4] Guarantee payments and incentive payments were the names of two categories of risk-share payments Essence made to PCP contractors.

Because the payments were not attributable to drug costs and were paid by the sponsor, they lowered Essence's DIR overall.[5] By including amounts that were not attributable to drug costs in its reported DIR, Essence overstated its drug costs, which in turn caused CMS to use the overstated drug costs in its Part D final payment determinations for CYs 2017 through 2020. As a result, Essence may have received an inflated final payment amount.

This overstatement of Part D drug costs occurred because Essence's DIR policies and procedures did not require that it calculate and report only those amounts attributable to Part D drug costs. Essence stated that the costs were properly reportable as DIR because they were paid using surpluses[6] from Part D revenues and expenses. However, Essence used these surpluses, in part, to pay for health services that were not attributable to Part D. Therefore, the costs for those health services were not reportable as DIR.

NOT ALL RISK-SHARE PAYMENTS REPORTED AS DIRECT AND INDIRECT REMUNERATIONS WERE ATTRIBUTABLE TO PART D DRUG COSTS

Federal Requirements

Section 1860D-15(f)(1)(A) of the Act requires Part D sponsors to fully disclose to CMS any information necessary for carrying out Part D's payment provisions, including reinsurance and risk-sharing calculations. Each Part D sponsor is required to report to CMS its drug costs and DIR associated with the Medicare prescription drug benefit, and CMS uses these data to calculate its payments to each Part D sponsor.

For CYs 2017 through 2020, CMS's Final Medicare Part D DIR Reporting Guidance required sponsors to report any gains or losses attributable to drug costs received or paid as a result of permissible risk-sharing arrangements with entities other than CMS. For any payments or adjustments resulting from risk-sharing arrangements not wholly attributable to Part D drug costs, the sponsor was required to determine and report as DIR only the portion attributable to Part D drug costs.

CMS has the authority to reopen and revise initial or reconsidered final Part D payment determinations within specified time periods.[7] The annual Final Medicare Part D DIR Reporting Guidance provided instructions for reporting changes such as refiling a prior year's DIR reports or submitting a request to CMS for reopening final payment.

[5] These payments were included as a negative amount on the DIR report. Since DIR is subtracted from the total drug cost during reconciliation, negative DIR increases total drug cost.

[6] Essence explained that the Part D surplus was calculated as Part D revenue - Part D expenses.

[7] 42 CFR § 423.346.

Essence Incorrectly Reported Guarantee Payments Not Attributable to Part D Drug Costs

Essence incorrectly reported some guarantee payments paid to its PCP contractors as DIR for CYs 2017 through 2020. Some of these guarantee payments were not attributable to Part D drug costs; therefore, the portion that was not attributable to Part D drug costs should not have been reported as DIR.

The guarantee payments were surpluses from a fund that Essence used to pay for certain health services provided to its members (Medicare enrollees) and specified in Essence's contracts with providers. The services provided include [redacted] The fund was made up of a credited share of the monthly revenue Essence received on behalf of its Medicare enrollees.

Specifically, in addition to Part D drug costs, Essence reported as DIR guarantee payments for [redacted] As none of these services were attributable to Part D drug costs, they should not have been reported as DIR.

Because Essence did not separately identify the amount of the guarantee payment that pertained to each service provided, we were unable to determine the portion of the payment amount that was attributable to Part D drug costs and was properly reportable as DIR and the portion that was not attributable to Part D drug costs and should not have been reported as DIR. During our audit period, Essence reported as DIR guarantee payments totaling [redacted]

By including amounts that were not attributable to drug costs in its reported DIR, Essence overstated its drug costs and may have received an inflated Part D final payment amount. This overstatement occurred because Essence's DIR policies and procedures did not require that it calculate and report only those amounts attributable to Part D drug costs. Essence stated that the costs were properly reportable as DIR because they were paid using surpluses from Part D revenues and expenses. Irrespective of the source of the amounts making up the Part D surplus, some of the guarantee payments made from the surplus were not attributable to Part D drug costs and were therefore not reportable as DIR.

Essence Incorrectly Reported Incentive Payments Not Attributable to Part D Drug Costs

Essence incorrectly reported some incentive payments made to its PCP contractors as DIR for CYs 2017 through 2020. Some of these incentive payments were not attributable to Part D drug costs; therefore, the portion that was not attributable to Part D drug costs should not have been reported as DIR.

These incentive payments were quality bonuses Essence paid to [redacted] occurred as measured against certain quality metrics. Essence established these quality metrics to ensure that its Medicare enrollees received quality care and positive health outcomes, to reduce the risk of underutilization, and to support quality improvement programs and initiatives.

Specifically, in addition to costs attributable to drugs, Essence reported as DIR incentive payments [redacted]

During our audit period, Essence reported approximately [redacted] in DIR for incentive payments. Essence correctly reported as DIR approximately [redacted] for incentive payments attributable to Part D drug costs and incorrectly reported approximately [redacted] as incentive payments that were not attributable to Part D drug costs. See the table for more information about the incentive payments incorrectly reported as DIR and the recommended amount to resubmit to reflect only the amount attributable to Part D drug costs.

Table: Reported Incentive Risk-Share Amounts

Year	Incentive Amount Reported as DIR	Incentive Amount Not Attributable to Part D Drug Costs	Incentive Amount Attributable to Part D Drug Costs
2017	[redacted]	[redacted]	[redacted]
2018	[redacted]	[redacted]	[redacted]
2019	[redacted]	[redacted]	[redacted]
2020	[redacted]	[redacted]	[redacted]
Totals	[redacted]	[redacted]	[redacted]

By including amounts that were not attributable to drug costs in its reported DIR, Essence overstated its drug costs and may have received an inflated Part D final payment amount. This overstatement occurred because, despite contract terms that identified the incentive amounts allocable to each of the services, Essence's DIR policies and procedures did not require that it calculate and report only those amounts attributable to Part D drug costs. Essence stated that the costs were properly reportable as DIR because they were paid using surpluses from Part D revenues and expenses. However, some of the costs were not attributable to Part D and were therefore not reportable as DIR.

This is a revised version of the report prepared for public release.

RECOMMENDATIONS

We recommend that Essence Healthcare, Inc.:

- submit to CMS a reopening request for DIR reports for CYs 2017 through 2019:
    - with the correct incentive amounts, including only the portion that relates to Part D drug costs, which total [redacted]), and
    - with only the guarantee payment amounts attributable to Part D drug costs;
- refile the CY 2020 DIR report:
    - with only the [redacted] in incentive payments attributable to Part D drug costs and
    - with only the guarantee payment amount attributable to Part D drug costs; and
- develop written policies and procedures for calculating and reporting on the DIR report only the portion of the risk-share payments attributable to Part D drug costs.

ESSENCE'S COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

In written comments to our draft report, Essence did not agree with our findings and did not address our recommendations. Specifically, Essence stated that our draft report contained "inaccurate factual information" and misapplied regulatory guidance.

We reviewed the entirety of Essence's comments, including additional information that it provided. This additional information consisted of copies of documents previously provided during the audit. Essence stated that it appropriately applied the Part D portion of its risk-sharing arrangements in its DIR reports and provided documentation that it believes supports that statement. In addition, Essence stated that our draft report contained factual errors. Further, Essence stated that our draft report: (1) failed to apply relevant regulatory guidance; (2) contradicts CMS policy and guidance regarding quality metrics; and (3) did not reflect actual provider performance in our calculations associated with the quality bonus finding.

For the reasons stated below, we maintain that our findings and recommendations remain valid. Our report does not contain incorrect information and does not misapply regulatory guidance.

Essence's comments, excluding the additional information that Essence provided, are included as Appendix B.

This is a revised version of the report prepared for public release.

ESSENCE STATED THAT IT APPROPRIATELY APPLIED THE PART D PORTION OF ITS RISK-SHARING ARRANGEMENTS TO DIRECT AND INDIRECT REMUNERATION REPORTING

Essence's Comments

Essence indicated that it appropriately applied the Part D portion of its risk-sharing arrangements to its DIR reports.

Essence stated that it utilizes value-based contracting arrangements in which its network PCP contractors enter into risk-sharing arrangements with Essence. Essence also stated that the risk-sharing arrangements cover both Part C medical and Part D drug revenue and costs. Essence further stated that, for the purpose of DIR reporting, it segregated Part D revenue and expenses and only included the total amount of risk-sharing amounts paid to providers for the Part D portion of their global risk-sharing agreements in DIR reporting.

Office of Inspector General Response

We did not evaluate whether actual contract provisions adhered to Part D rules generally or to DIR guidance, nor did we make any determination about the contracts' compliance with Part D rules or DIR guidance in the body of the report or during the course of the audit. Instead, we reviewed the contracts to understand the intent of and purpose for the payments reported as DIR. For the purpose of our audit, the contracts only served as supporting documentation (along with the other information provided) in determining whether the payments described in the contracts were attributable to Part D drug costs. We concluded that some amount of the guarantee payments may have been attributable to Part D drug costs but, overall, these payments were not solely attributable to Part D drug costs. Simply applying contract terms (i.e., [redacted] for the guarantee payments and [redacted] for the incentive payments, as cited in Essence's response to our draft report) to the Part D surplus did not make the payments for services unrelated to Part D drug costs attributable to the Part D program, and they are not, therefore, reportable as DIR.

Although Essence's reported DIR risk-share amounts, overall, contained some payment amounts attributable to Part D performance measures, the guarantee and incentive performance measure payments specifically were not wholly attributable to Part D. That is, for both the guarantee and incentive amounts, the payments were for measures that were not solely attributable to Part D drug costs.

For example, while Essence reported guarantee payments that were paid from Part D surplus as DIR, the guarantee was paid to PCP contractors for certain health services provided to members (Medicare enrollees) and specified in Essence's contracts with providers. The services provided included [redacted]

This is a revised version of the report prepared for public release.

As summarized in the report body, Essence's contracts stated that the payments would be used for expenses paid relative to health services, not drug costs. While the list of services included drugs, there were no contract provisions indicating that these funds were attributable to Part D drug costs, such as a provision for reimbursement to pharmacies for dispensing Part D drugs.

As another example, for its incentive payments, Essence paid an incentive to [redacted], which would be attributable to Part D drug costs and appropriately reportable in Essence's DIR Report. However, Essence also paid an incentive to [redacted] which was not attributable to drug costs and should not have been included in Essence's DIR Report.

ESSENCE STATED THAT DOCUMENTATION IT PRODUCED SUPPORTS ITS APPLICATION OF ONLY THE PART D PORTION OF ITS RISK-SHARING ARRANGEMENTS TO DIRECT AND INDIRECT REMUNERATION REPORTING

Essence's Comments

Essence described a series of meetings and the information it provided to us on various dates and stated that it produced documentation supporting that it included only the Part D portion of its risk-sharing arrangements to its DIR reporting.

Office of Inspector General Response

During the audit, Essence provided detailed information in response to our requests to support its DIR submissions. We reviewed this information and sought followup clarification when Essence provided new updated information or otherwise provided further explanation of previously provided information. This followup included obtaining and reviewing support for DIR reports that Essence resubmitted throughout our audit. This information supported that Essence calculated its DIR reported amounts by applying a calculation to the Part D surplus. However, the payments were not solely attributable to Part D drug costs and therefore should not be totally reportable as DIR. Accordingly, we used the information provided and specifically related it to the then-current DIR filing to calculate the incentive payment finding amount. We were not able to calculate a comparable amount for the guarantee as the cost information provided did not provide sufficient detail, but guarantee amounts not attributable to Part D costs should not have been included in DIR.

ESSENCE STATED THAT OUR REPORT CONTAINS FACTUAL ERRORS

Essence's Comments

Essence stated that the draft report contained factual errors by indicating that Essence included payments for services other than drugs in its DIR reports, while we were not able to determine the portion of the payment amount attributable to Part D drug costs. Essence stated that we

could not determine the portion attributable to Part D drug costs because there were not any non-Part D expenses included in its DIR report.

Essence also stated that throughout the audit, the audit team contended that Essence's provider contracts must comport with DIR reporting requirements. Essence stated that its calculations of the guarantee and incentive payments complied with DIR reporting requirements and that the contractual provisions for a global risk-sharing arrangement would not and should not specifically call out division of Part D costs and revenues for CMS reporting requirements.

Office of Inspector General Response

Our report did not contain factual errors. As stated above, although Essence's reported DIR risk-share amounts contained some amounts attributable to Part D, the guarantee and incentive payments specifically were not wholly attributable to Part D. That is, for both the guarantee and incentive amounts, the payments were for measures that were not solely attributable to Part D drug costs.

We could not determine the portion attributable to Part D drug costs for the guarantee portion because, as mentioned in our report, Essence did not separately identify the amount of the guarantee payment that pertained to each service provided. Specifically, we were unable to determine the portion of the payment amount that was attributable to Part D drug costs and was properly reportable as DIR and the portion that was not attributable to Part D drug costs and should not have been reported as DIR.

Finally, as stated above, we reviewed the contracts between Essence and its PCP contractors to understand the intent of and purpose for the payments reported as DIR. For the purpose of our audit, the contracts only served as supporting documentation (along with the other information provided) in determining whether the payments described in the contracts were attributable to Part D drug costs.

ESSENCE STATED THAT OUR REPORT FAILS TO APPLY RELEVANT REGULATORY GUIDANCE

Essence's Comments

Essence stated that our draft report failed to apply relevant regulatory guidance. Specifically, Essence stated that the report suggested that value-based contracts with global risk-sharing arrangements are not permitted but that plans must negotiate and document separate Part C medical and Part D drug risk-sharing arrangements. Essence stated that this position is contradictory with guidance issued by CMS. Essence also indicated that we cannot identify any contradictory guidance or regulatory provisions from the Code of Federal Regulations that prohibit global risk-sharing arrangements.

Office of Inspector General Response

For this audit, we applied the relevant regulatory guidance that was in effect during our audit period. Specifically, we used the Final Medicare Part D DIR Reporting Requirements for 2017, dated May 30, 2018; Revised Final Medicare Part D DIR Reporting Requirements for 2018, dated April 30, 2019; Final Medicare Part D DIR Reporting Requirements for 2019, dated April 23, 2020; and Final Medicare Part D DIR Reporting Guidance for 2020, dated May 20, 2021.

We used CMS's Final Medicare Part D DIR Reporting Requirements or Guidance for each contract year, as appropriate. The guidance required sponsors to report any gains or losses attributable to drug costs that the Part D sponsor may receive or pay resulting from risk-sharing arrangements with entities other than CMS and that are permissible under the Part D regulations and applicable laws. For any payments or adjustments resulting from global risk-sharing arrangements, which are wholly attributable to Part D drug costs, the sponsor was required to determine and report as DIR only the portion specifically related to Part D drug costs. In applying this guidance, our report states that the amounts reported on the DIR must be attributable to Part D drug costs and does not state that value-based contracts with global risk-sharing arrangements were not permissible nor that the Part C and D amounts must be negotiated separately.

ESSENCE STATED THAT OUR POSITION REGARDING QUALITY METRICS CONTRADICTS CMS POLICY AND GUIDANCE

Essence's Comments

Essence stated that our position in the draft report regarding quality metrics contradicts CMS policy and guidance. Essence stated that CMS has a history of promoting and aligning provider incentive quality measures with achieving better patient outcomes at lower costs.

Office of Inspector General Response

We did not contradict CMS policy and guidance. Instead, while we determined that some of the risk-sharing arrangements appear to be related to expenses for drug costs, we also determined that there were portions of those risk-sharing payments that were not attributable to Part D drug costs or that were not paid to help cover the costs of Part D drugs. Applying contract terms (i.e., [redacted] for the guarantee payments and [redacted] for the incentive payments, as cited in Essence's response to our draft report) to Part D surpluses did not make these payments attributable to drug costs and they were not, therefore, reportable as DIR.

This is a revised version of the report prepared for public release.

ESSENCE STATED THAT OUR CALCULATIONS ASSOCIATED WITH THE QUALITY BONUS FINDING DID NOT REFLECT ACTUAL PROVIDER PERFORMANCE

Essence's Comments

Essence stated that, even if our position regarding quality bonuses and metrics was correct, it believed we used a proportional division of the quality measures, and our calculations associated with its incentive payments for quality bonuses did not reflect actual provider performance. Essence indicated that its recalculation identified [redacted] in quality bonuses that would not be allowable, compared to the [redacted] reported in the draft report.

Office of Inspector General Response

We used the amounts reported on the 2017 DIR report dated July 27, 2022; 2018 DIR report dated July 28, 2021; 2019 DIR report dated July 27, 2022; and 2020 DIR report dated July 29, 2024, as well as the PCP contractor incentive bonus calculation Essence provided to determine the amount of the incentive bonus that was not attributable to Part D drug costs. Essence's contracts identified how much the PCP contractors would receive for each quality metric met. The contracts also identified the incentive payment bonus calculation.

We followed the contract terms to determine the amount of payment for each incentive quality measure. We did not evaluate provider performance and relied on Essence's determination that the provider met the incentive quality measure. We noted instances in which Essence did not follow its contract terms by applying an incentive payment amount higher than should have been provided based on contract terms. When asked about this, Essence indicated that an Essence official determined that a higher incentive payment should be applied in those cases. We did not use these higher amounts in our calculations because Essence did not provide documentation to support the purpose or justification for the higher payments related to Part D drug costs.

Essence made incentive payments for achieving various performance measures not revolving only around Part D drug costs; these performance measures included payments for [redacted] Essence accounted for these non-Part D drug services in the incentive payments portion of the risk-sharing amount reported in its 2017, 2018, 2019, and 2020 DIR reports.

This is a revised version of the report prepared for public release.

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

We reviewed Essence's DIR reports for CYs 2017 through 2020 (audit period). We reviewed Essence's contracts with its PBM, as well as contracts Essence had with its [redacted] PCP contractors. We reviewed risk-share payments and adjustments totaling [redacted] reported by Essence.

We did not audit the overall internal control structure of Essence or its PBM. Rather we audited only those internal controls related to our objective. We limited our audit to determining whether Essence complied with Federal requirements for reporting risk-share payments in its DIR reports.

We conducted our audit from December 2021 through November 2024.

METHODOLOGY

To accomplish our objective, we:

- reviewed applicable Federal laws, regulations, and guidance pertaining to reporting DIR risk-share payments;
- obtained from CMS's HPMS, Essence's DIR reports for CYs 2017 through 2020, and compared them against the DIR reports provided by Essence for accuracy;
- reviewed Essence's policies and procedures for DIR reporting;
- met with Essence officials to gain an understanding of its DIR reporting process;
- met with Essence's PBM to gain an understanding of its claims and DIR reporting processes;
- reviewed the contracts between Essence and its PBM;
- reviewed contracts with [redacted] drug manufacturers to identify the types of DIR for which Essence contracted;
- reviewed the contracts between Essence and its [redacted] PCP contractors to identify risk-share payment terms; and
- met with Essence officials to discuss the results of the audit.

This is a revised version of the report prepared for public release.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

This is a revised version of the report prepared for public release.

APPENDIX B: ESSENCE'S COMMENTS

April 11, 2025

Essence Healthcare ("Essence") appreciates the opportunity to comment on the Office of Inspector General's ("OIG") draft report regarding review of the Plan's Direct and Indirect Remuneration ("DIR") Reporting for CY 2017 – CY 2020.

Essence Healthcare has high regard for the OIG and the role it plays. We believe its reports carry great weight with ramifications not only for the parties to the audit or investigation but the industry at large. That is why it is so disappointing and concerning that this draft report contains inaccurate factual information and misapplies regulatory guidance.

The Plan is deeply concerned that the inaccurate information conveyed in the draft report contradicts discussions with and documentation Essence provided to OIG during the audit process regarding Essence's global risk-sharing agreements with its providers and its accounting of the Part D portion of the risk-sharing arrangements. OIG's position also conflicts with regulatory guidance from the Centers for Medicare and Medicaid Services ("CMS") for DIR Reporting and policies related to value-based contracting.

Essence appropriately applies the Part D portion of its risk-sharing arrangements to DIR Reporting.

Essence utilizes value-based contracting arrangements in which its network primary care providers enter into risk-sharing with the Plan, legally sharing in a portion of losses or surpluses generated through managing care. Essence's risk-sharing agreements are contracted at the provider group level and are global in nature, covering both Part C medical and Part D drug revenue and costs. The amount of risk-sharing is outlined in the agreement and is calculated as a percentage of managed care savings the provider is able to share with the Plan.

For many Essence provider agreements, and as is common industry practice for risk-sharing agreements with providers, a [redacted] These quality measures are industry-standard and developed by the National Committee on Quality Assurance (NCQA) and Pharmacy Quality Alliance (PQA). For example, a [redacted] but if the provider met certain [redacted] the provider could earn an additional [redacted] earning then [redacted] of the [redacted] Provider groups can earn the additional risk-sharing rate through achieving a combination of NCQA and PQA measures.

For the purpose of DIR Reporting, Essence segregates Part D revenue and expenses and only includes the total amount of risk-sharing amounts paid to providers for the Part D portion of their global risk-sharing agreements in DIR Reporting. For example, if a provider has an [redacted] risk-sharing percentage and total shared savings of [redacted] of which [redacted] is attributed to Part D, the provider is entitled by contract to [redacted] of the total savings or [redacted] but Essence applies the [redacted]

This is a revised version of the report prepared for public release.

risk-sharing to the [redacted] Part D surplus or [redacted] for the purposes of DIR reporting and in accordance with CMS guidance.[1] .

Essence produced documentation supporting its application of only the Part D portion of its risk-sharing arrangements to DIR Reporting.

January 3, 2023, Essence provided initial documentation requests, including the CY 2017-2020 DIR Reports, Plan and PBM operating procedures for DIR, and PBM Fair Market Value (FMV) evaluations of Bona Fide Service Fees. On January 4, 2022, the Plan held a kick-off meeting with the OIG and provided its relevant provider contracts with risk-sharing provisions. On March 24, 2023, Essence met with OIG to discuss the previously submitted documents and answer OIG questions.

On April 21, 2023, the Plan met with OIG and provided an explanation of DIR processes, risk-sharing agreements, and the application of the agreements to DIR; a presentation on quality metrics; an example provider agreement with risk-sharing provisions highlighted supporting the risk sharing calculations; and discussed operating procedures and Plan and PBM review processes for DIR. On May 8, 2023, Essence resent the relevant provider agreements, highlighted again to help OIG personnel locate relevant risk-sharing provisions and supporting the calculations submitted.

On June 23, 2023, Essence provided to OIG a detailed walkthrough of the aggregate and individual accounting for all provider groups. This walkthrough addressed the assessment of the combined global risk-sharing and the Part D portion only. In the presentation, Essence included source documentation such as CMS and PBM reports and other records that tied back to the amounts applied to Part D revenue and expenses. The walkthrough demonstrated that the provider risk-sharing payments Essence included in DIR were limited to those Part D revenue and costs and the associated risk-sharing rate. The Plan met with OIG on July 11, 2023, to discuss the materials provided on June 23rd and answer OIG questions.

On August 1, 2023, the Plan provided a sample quality bonus reconciliation and a narrative explaining physician incentive agreements and the calculations associated with the incentives. The narrative noted that the combined guarantee and quality bonus percentages are applied globally to both Part C and Part D revenues and costs in calculating the ultimate payment to providers; however, for the purposes of reporting DIR and in accordance with CMS DIR guidance, Essence again demonstrated that the DIR reporting only included Part D costs and revenues in its Part D calculations. On August 10, 2023, the Plan provided responses to follow-up questions from OIG regarding documents provided which attempted to explain again the calculations and the inclusion of only Part D costs and revenues. The Plan met with OIG to address responses on August 11, 2023. On August 21, 2023, Essence provided additional responses to OIG questions related to previously provided physician agreements to attempt to explain the risk-sharing arrangement and quality bonus structure.

On November 1, 2023, the Plan provided a reconciliation worksheet reconciling provider payments to DIR amounts and a PBP-level breakdown by provider group. And in February 2024, Essence

[1] CMS, Final Medicare Part D DIR Reporting Guidance for 2023 (March 14, 2024) at 23, DIR #10 – Risk-Sharing Arrangement Payments and Adjustments. ("For any payments or adjustments resulting from global risk-sharing arrangements with other entities—those which do not revolve only around Part D drug costs—the sponsor should determine and report as DIR only the portion specifically related to Part D drug costs.")

provided a breakdown of quality bonus metrics and results by provider group. The Plan met with OIG on February 21, 2024, to discuss the quality bonus metrics and respond to OIG questions.

The Plan has included the materials (with the exception of provider agreements) cited above that were previously provided and presented to OIG for its review of this response. Each file folder contains the material provided to the OIG auditors on the specific reference date. Please treat the supporting documentation as proprietary and confidential.

In the multiple conversations with Essence, including the exit conference on September 9, 2024, OIG acknowledged and agreed that Essence applied only Part D revenue and expenses to DIR Reporting. The OIG objected to the inclusion of Part C and Part D quality measures in determining if the provider group earned the additional risk-sharing rate. In fact, the only item that OIG took issue with was that the additional risk-sharing percentage earned based on quality metrics did not separately calculate Part C and Part D quality metrics, attempting to suggest that somehow the combination of quality metrics in a global capitation arrangement resulted in the inclusion of more than Part D considerations in reporting. As we describe more fully below, assessing both Part C and Part D quality metrics in bonus payment considerations does not mean reporting cannot somehow consider only Part D costs and revenues in DIR reporting.

OIG's draft report contains factual errors.

In its draft report, OIG alleges that risk-sharing amounts Essence included in DIR reporting included amounts not attributable to Part D revenue and expenses. Specifically, OIG states that Essence included "payments for [redacted] in its DIR reporting. But OIG further states they "were unable to determine the portion of the payment amount that was attributable to Part D drug costs."

The reason that OIG could not ascertain the amounts of non-Part D expenses included in DIR Reporting, is simply that there were not any. In the various and detailed walkthroughs with the OIG, Essence presented both the combined global risk-sharing calculations in addition to the segregated Part D portion. See e.g., Essence OIG Audit 2017-2020 DIR Detailed Example 6.23.23.pdf. To support the finding, the OIG Auditors lifted language from the Essence contracts related to Part C and D services. This contractual language is unrelated to the calculation mechanism, however. Our detailed explanation of our calculations clearly demonstrated that the only amount included in the DIR report was that portion of cost and revenue for Part D amounts.

Throughout the audit process, OIG's audit team continued to contend that Essence's provider contracts must comport with DIR Reporting requirements, which is the inverse of the actual regulatory requirement that DIR Reporting must be limited to Part D revenue and expenses, regardless of the terms of a plan's global risk-sharing arrangements.[2] Essence's calculations complied with DIR reporting requirements; the contractual provisions for a global risk-sharing arrangement would not and should not specifically call out division of Part D costs and revenues for CMS reporting requirements.

[2] *See id.*

OIG's draft report fails to apply relevant regulatory guidance.

OIG's draft report suggests that value-based contracts with global risk-sharing are not permitted but rather plans must negotiate and document separate Part C medical and Part D drug risk-sharing agreements. This position is in direct contradiction with CMS' own DIR guidance issued annually to the plans.[3]

In its draft report, OIG fails to cite relevant regulatory guidance relating to DIR Reporting. Annually, CMS releases DIR Reporting Guidance for the prior contract year. It is notable that OIG failed to cite this guidance as it explicitly outlines the appropriateness of global risk-sharing arrangements and the appropriate reporting of the Part D portion of global risk-sharing arrangements. For example, in March 2024, CMS stated: "For any payments or adjustments resulting from global risk-sharing arrangements with other entities—those which do not revolve only around Part D drug costs—the sponsor should determine and report as DIR only the portion specifically related to Part D drug costs."[4]

CMS' DIR guidance clearly anticipates and permits global risk-sharing arrangements and requiring only that the Plan apply only the portion related to Part D costs when reporting DIR in a global risk arrangement. Furthermore, the OIG cannot identify any contradictory guidance or regulatory provision from the Code of Federal Regulations that prohibit global risk sharing arrangements. In utilizing a global-risk sharing arrangement, Essence was required to report only the portion of risk-sharing related to Part D revenue in its DIR reporting. Essence demonstrated to the OIG that only Part D revenues were considered in its DIR reporting calculations.

OIG's position in the draft report regarding quality metrics contradicts CMS policy and guidance.

OIG's draft report takes issue with the Plans inclusion of quality metrics in its risk-sharing agreements. The use of quality incentives to drive quality measures is long supported by CMS policies and statements. CMS has a history of promoting and aligning provider incentives with achieving better patient outcomes at lower costs. For example, in the Proposed Rule for Contract Year 2026[5] in the section on MA and Part D Medical Loss Ratio (MLR) Reporting, CMS proposed requiring Medicare Advantage plans that utilize risk-sharing agreements to tie provider incentives and bonus arrangements to clinical or quality improvement standards in a similar fashion to how Essence has structured its risk-sharing arrangements. Nothing in that proposed guidance requires the quality measures to be solely related medical or drug measures.

Further, regardless of whether the metrics include both medical and drug measures, the risk-sharing amounts reported in the Plan's DIR reflect only Part D revenue and expenses. If a provider achieves additional risk-sharing percentage through quality metrics, the total risk-sharing percentage is still only applied to the relevant provider's Part D revenue and cost. For example, assume a provider agreement has a base risk-sharing rate of [redacted] with the potential to earn an additional [redacted] risk-sharing

[3] *See id.*

[4] *Id.*

[5] Medicare and Medicaid Programs; Contract Year 2026 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, Medicare Cost Plan Program, and Programs for All-Inclusive Care for the Elderly, 89 Fed. Reg. 99340, 99343 (Dec. 10, 2024).

This is a revised version of the report prepared for public release.

for meeting quality metrics (for a total of the risk-sharing percentage of [redacted]. The quality metrics are a mix of Part D and Part C quality measures and assume that the provider achieves the necessary measures to earn all of the [redacted] bonus.

The DIR calculation only applies to the Part D revenue and cost, Essence applies the [redacted] or [redacted] risk-sharing percentage only to Part D for the purpose of DIR Reporting. Continuing the example from above, if the provider achieves [redacted] in total shared savings and the full risk-sharing potential based on quality metrics, then the provider receives [redacted] or [redacted]. However, the DIR reporting does not take into account the total shared savings. Essence applies the risk-sharing percentage to the Part D portion only. In this example, Essence would report [redacted] of the [redacted] in Part D shared savings, or [redacted]. This is consistent with CMS' DIR Reporting Guidance, which states that risk-sharing amounts must only include Part D costs.[6]

OIG calculations associated with its quality bonus finding do not reflect actual provider performance.

We believe that our reporting was correct in the first instance and that no understatement of DIR occurred. However, even if OIG's position is correct, Essence disputes the calculations included in the draft report. In asserting that inclusion of quality metrics in the calculation of Part D risk-sharing inappropriately included Part C costs, OIG took a proportional division of quality measures between Part C and Part D to arrive at an understatement of DIR of [redacted]. However, this flawed calculation fails to recognize actual provider performance where provider may have met all Part D metrics and would be awarded the full quality bonus.

[redacted] Essence recalculated using [redacted] based on the contract. Any remaining risk-sharing percentage not earned through Part D measures was excluded. Based on the Plan's recalculation, the portion considered not Part D by OIG would be [redacted]

	2017	2018	2019	2020	Quality bonus not considered Part D by OIG
Part D quality metrics earned	[redacted]	[redacted]	[redacted]	[redacted]	
Remaining quality bonus not considered Part D by OIG	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
Total quality bonus paid on Part D costs and revenues	[redacted]	[redacted]	[redacted]	[redacted]	

OIG personnel assigned to the audit lacked the necessary expertise.

The audit was initiated by OIG in December 2021. For over **three years**, Essence dedicated extensive resources educating the OIG audit team on DIR reporting and value-based contracting, on the Plan's risk-sharing agreements, as well as foundational provider contracting principles through multiple meetings, responding in writing to OIG's questions, and by responding to other requests for

[6] CMS, Final Medicare Part D DIR Reporting Guidance for 2023 (March 14, 2024) at 23.

This is a revised version of the report prepared for public release.

information, including providing multiple copies of relevant documents. Throughout this process, we noted that the audit team did not appear to retain the information previously shared, appeared to be increasingly confused on how the risk-sharing arrangements operated, and how the Plan isolated Part D revenue and expenses. We believe this contributed to the problems we have outlined above with the draft audit report. Notwithstanding this experience, however, Essence is willing to continue to work with the audit team to review these principles, respond to additional requests for information, and help ensure that OIG issues a final audit report that contains accurate factual information and correctly applies regulatory guidance.

Additionally, the Plan is concerned regarding the haste with which the report was issued following several months of no communication or activity after the exit conference. So rushed was the issuance, after reaching out to the Plan to confirm CEO information, the OIG failed to update its report, acknowledging to Plan staff that there was not sufficient time to edit before issuing the same day.

Given the Plan's concerns outlined above, Essence request OIG to withdraw its draft report or take action to modify and reissue the draft report to accurately reflect Essence's practices and relevant regulatory guidance. In the absence of withdrawal or edits requested, Essence requests OIG update its calculation of non-Part D portion to reflect actual provider performance of Part D quality metrics.

Report Fraud, Waste, and Abuse

OIG Hotline Operations accepts tips and complaints from all sources about potential fraud, waste, abuse, and mismanagement in HHS programs. Hotline tips are incredibly valuable, and we appreciate your efforts to help us stamp out fraud, waste, and abuse.

TIPS.HHS.GOV

Phone: 1-800-447-8477

TTY: 1-800-377-4950

Who Can Report?

Anyone who suspects fraud, waste, and abuse should report their concerns to the OIG Hotline. OIG addresses complaints about misconduct and mismanagement in HHS programs, fraudulent claims submitted to Federal health care programs such as Medicare, abuse or neglect in nursing homes, and many more. Learn more about complaints OIG investigates.

How Does It Help?

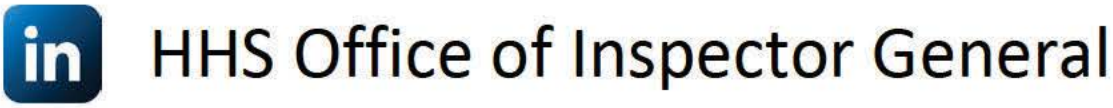
Every complaint helps OIG carry out its mission of overseeing HHS programs and protecting the individuals they serve. By reporting your concerns to the OIG Hotline, you help us safeguard taxpayer dollars and ensure the success of our oversight efforts.

Who Is Protected?

Anyone may request confidentiality. The Privacy Act, the Inspector General Act of 1978, and other applicable laws protect complainants. The Inspector General Act states that the Inspector General shall not disclose the identity of an HHS employee who reports an allegation or provides information without the employee's consent, unless the Inspector General determines that disclosure is unavoidable during the investigation. By law, Federal employees may not take or threaten to take a personnel action because of whistleblowing or the exercise of a lawful appeal, complaint, or grievance right. Non-HHS employees who report allegations may also specifically request confidentiality.

Stay In Touch

Follow HHS-OIG for up to date news and publications.



Subscribe To Our Newsletter

OIG.HHS.GOV

Contact Us

For specific contact information, please visit us online.

U.S. Department of Health and Human Services
Office of Inspector General
Public Affairs
330 Independence Ave., SW
Washington, DC 20201

Email: Public.Affairs@oig.hhs.gov