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March 11, 2021

**VIA EMAIL: MICHAEL.BARBER@VERMONT.GOV**

Michael Barber
General Counsel
Green Mountain Care Board
144 State Street
Montpelier, VT 005602

Re: Waiver Request for CMS Direct Contracting Entity

Dear Mr. Barber:

I am writing on behalf of my client, Clover Health Partners, LLC (Clover Health), a health care organization that will be participating as a Direct Contracting Entity (DCE) in the Centers for Medicare & Medicaid Services' (CMS) new Direct Contracting Model (Direct Contracting or the Model). Through our previous discussions, you confirmed that Clover Health – a DCE only operating as a Medicare accountable care organization (ACO) – does not require certification by the Green Mountain Care Board (GMCB) as an ACO in Vermont but that certain other state statutes and rules may apply. Pursuant to this correspondence, Clover Health requests to waiver of GMCB Rule 5.400 and 5.500, pursuant to Rule 5.601.

***Clover Health Partners, LLC***

CMS accepted Clover Health as a participant in the Model beginning with its start on April 1, 2021. Clover Health anticipates operating as a DCE in several states, including Vermont. As an organization dedicated to improving the quality of life for both providers and patients, Direct Contracting will be a valuable platform for Clover Health to expand the reach of the high-value care it already provides through its Medicare Advantage plans to over 57,000 patients across seven states. At this time, Clover Health anticipates alignment of around 3,000 Medicare beneficiaries in Vermont through the Model.

***Background on CMS's Direct Contracting Model***

Medicare ACOs provide an alternative payment method intended to promote better care for individuals, better health for populations, and lower growth in expenditures for the Medicare fee-for-service (FFS) population. CMS currently operates a number of federal initiatives designed to support organizations with experience operating as ACOs or in similar arrangements in providing more coordinated care to Medicare beneficiaries at a lower cost to Medicare. Two such programs are (1) the Next Generation ACO Model (NGACO) and (2) the Medicare Shared Savings Program (MSSP). Both programs test the impact of different payment arrangements to achieve the goals of providing better care to Medicare beneficiaries and reducing costs for the Medicare FFS program.

Direct Contracting is CMS's newest alternative payment model and builds upon the experience and successes of NGACO. The Model is scheduled to begin its first performance year in April 2021 and operate for six years (through 2026).

Direct Contracting rebrands ACOs as DCEs. They differ from ACOs only in name, not function. Each DCE will be responsible for providing care under Medicare Parts A and B to a specified group of beneficiaries. A Medicare beneficiary (1) will be aligned with a DCE if that beneficiary received the plurality of his or her care during a two-year window from the DCE participants; or (2) can voluntarily align with the DCE. A standard DCE must maintain an aligned population of at least 5,000 Medicare beneficiaries. It is important to note that Medicare beneficiaries remain Medicare FFS beneficiaries, are not required to receive care from the ACO's providers and are free to choose any Medicare provider they wish.

Consistent with NGACO, DCEs are accountable to CMS for the cost and quality outcomes of the aligned beneficiaries. To determine whether the cost and quality outcomes are attained, CMS will prospectively set a benchmark using expenditure, quality, and risk score data available prior to the start of each performance year.

Direct Contracting offers a Global Population-Based Payment (PBP) track (where 100% of savings or losses accrue to the DCE) and a Professional PBP track (where 50% of savings or losses accrue to the DCE). The risk arrangement applies to the difference between actual expenditures and the discounted benchmark. CMS will apply risk corridors at the aggregate savings/losses level for each DCE. Following each performance year, CMS will determine whether a DCE has any savings/losses by comparing actual FFS Medicare expenditures against a final performance year benchmark.

The Model's Global PBP track includes a choice of either Total Care Capitation (TCC) or Primary Care Capitation (PCC). Under TCC, a DCE's providers will continue to submit all claims for aligned Medicare beneficiaries to CMS as they currently do. Once submitted, CMS will "zero out" all claims for which it has made capitated payments to the DCE. CMS will make a monthly capitated payment to the DCE based on expected expenditures for its aligned beneficiaries and, in turn, the DCE will be responsible for making payments to its providers. Under PCC, CMS will

only zero out claims for primary care services provided by the DCE's providers, with remaining claims paid directly to the providers.

DCEs will also be subject to comprehensive and stringent oversight protocols. As described in the Model's Request for Applications (RFA) and draft Participation Agreement, which are enclosed with this letter, DCEs are subject to record keeping and reporting, public disclosure, audits, among other oversight activities. Moreover, DCEs must demonstrate solvency and financial stability as well as experience in population health management and care coordination.

***Clover Health's Direct Contracting Operations***

*1. Physical Address, Mailing Address, and Website Address*

Clover Health Partners, LLC
30 Montgomery St. 15th Floor
Jersey City, NJ 07302

Website: cloverhealthpartners.com
Username: clover
Password for Website: clover2021
[Please Note: Website is password protected until such time as Clover Health is permitted to publicly announce its participation in the Model. All Participant and Preferred Providers are given the password to access the website.]

*2. Organization Type*

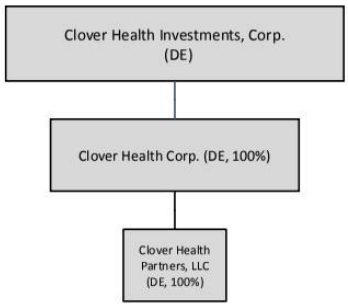
Clover Health is a network of individual physician practices, Independent Physician Associations (IPAs), and ACOs – all under contract with the DCE to participate in the Model.

*3. Date and State of Incorporation*

Delaware; December 23, 2020

*4. Organizational Chart*

**Clover**




*5. The executive summary required by the CMS Request for Applications, Question 6 under Background Information.*

[Note: The text provided below is the text provided to CMS in response to Question #6. Please note – the contracting entity that will be the DCE has changed since submission of the response. It is no longer Principium Health – but rather Clover Health. Further, certain of the numbers articulated in this text have been updated since the response was submitted to CMS. See Question #6 below for updated numbers.]

Clover's DCE, Principium Health (referred herein also as Clover or Clover Health DCE), is a professionally managed, physician-led integrated network comprising acute and sub-acute facilities, primary care and specialist providers, and a variety of medical suppliers that have aligned to be accountable for the delivery of higher quality and more efficient care delivered at a lower cost. Our DCE positions its participant providers to take on higher levels of accountability to effectively manage utilization and the health of populations. Our DCE is applying for participation as a Standard DCE taking on Global Risk. Our key differentiator is our technology platform, Clover Assistant (CA), which will be used by all Participant Providers at the point-of-care to deliver evidence-based care management and care coordination to DCE-aligned beneficiaries to improve outcomes. CA is currently used by over 1,500 providers across Clover's MA network.

Professional Management: Clover's DCE is managed by healthcare professionals with demonstrated experience and success with outcomes-based arrangements, including but not limited to Medicare Advantage, Pioneer ACO, Independence at Home and Medicare Shared Savings Program. Our executives and lead staff have a proven track record for responsible clinical, financial, management, health information technology (HIT), and quality of care improvement functions.

Physician Leadership: Clover's DCE physician leadership has a robust communication strategy across the network and its partners and has established clear goals and objectives for both network participant and preferred physicians which will encourage dialogue and partnership formation as the strategy is implemented. Physician leaders will actively participate in DCE governance and provide leadership to committees formed to achieve DCE objectives.

Participation Criteria: Clover's DCE Participant and Preferred Providers have all signed a detailed participation agreement which clearly outlines the expectations and requirements for participation. Participant and Preferred Providers must adhere to program guidelines including:

- Adoption of CA information technology at the point-of-care
- Integration of their electronic medical record (EMR) with CA
- Utilizing the DCE Network population health management website to access cost and quality performance
- Compliance with clinical protocols and care pathways
- Allowing the DCE to identify and co-manage Complex Care beneficiaries

Performance Improvement: Clover's DCE will engage its participant and preferred providers in determining how quality is defined and measured and allow them to take an active role in care redesign and protocol development to increase quality, more effectively manage costs, reduce variation and eliminate unnecessary waste. DCE management will clearly define baseline performance and identify areas where the network can improve quality and operational efficiencies. Performance improvement initiatives will include:

- Variance and cost reduction — Improving operational efficiencies
- Clinical efficiency — Reducing avoidable, unproductive and duplicative services
- Care redesign — Ensuring treatment in the most optimal setting by the right provider
- System optimization — Shifting focus to preventive care and population health
- Patient experience — Objective and meaningful comparisons between providers

Information Technology: Clover Assistant (CA) will serve as the backbone of Clover's DCE information technology and will be utilized at the point-of-care by Participant and Preferred Providers to ensure that the network is able to achieve the value of enhanced coordination between providers following evidence-based guidelines. To ingrain information technology utilization into the culture, not only is CA's adoption and use a participation requirement, but this is also reinforced through minimum usage standards and performance incentive dollars.

CA is critical to improving coordination and connectivity between providers of care and will fully integrate CMS claims data, provider electronic health record (EHR) clinical data and DCE risk stratification and registry data. CA interfaces with multiple data sources to provide valuable data at the point-of-care to more effectively manage utilization, improve outcomes and patient satisfaction.

Provider Composition:

- Specialists in the following specialties: Allergy, Cardiology, Chiropractic, Dermatology, Endocrinology, Ear-Nose-Throat, Gastroenterology, Home Health, Hospice and Palliative

Care, Nephrology, Neurology, Gynecology, Oncology, Ophthalmology, Optometry, Pain, Podiatry, Psychiatry, Psychologist, Pulmonology, Rheumatology, Urology
- Critical Access Hospitals, Federal Qualified Health Centers, Rural Health Clinics, Short-term acute care hospitals, Skilled Nursing Facilities

*6. The other states Clover Health plans to operate in as a DCE for performance year 1 of the Model and the overall number of aligned Medicare beneficiaries Clover Health expects to have.*

- Arizona
- Georgia
- Kansas
- New Jersey
- New York
- Pennsylvania
- Texas

Clover Health will be operating in the following states in performance year 1 (April 2021) and will start with approximately 77,000 claims aligned beneficiaries. The numbers submitted to CMS in Clover Health's original application were estimates based on Participant Provider contracting pipeline at the time of submission. Those estimates included both claims-aligned and voluntarily-aligned beneficiary estimates based on historical claims data. The addition of Clover Health's Vermont Participant Provider was made after the submission of Clover Health's original application to CMS.

*7. Clover Health's Participant Providers and Preferred Providers in Vermont*

| | |
|---|---|
| A. Provider Location (and Name) | Evergreen Family Health<br>28 Park Ave, Williston, VT 05495 |
| B. Services Provided | Primary Care |
| C. Participant Type | Participant |
| D. Shared Savings (Yes/No) | Will be eligible for shared savings when a Participant Provider shared savings program is developed. This program is expected to be developed in Performance Year 1. |
| E. Shared Losses (Yes/No) | No |
| F. Clover admin or expense contribution (Yes/No) | No |
| G. Payment arrangement | Clover to pay provider (i) full Medicare FFS rates for Medicare Part A/B services provided to aligned beneficiaries; and (ii) a fee for each aligned beneficiary encounter where the Clover Assistant is used by the provider at the point of care. |

*8. Total number of Participant Providers and Preferred Providers in the first performance year of the Model*

- Approximately 989 Participant Providers
- Approximately 848 Preferred Providers

*9. Clover Health's risk track selection*

- Global Risk, Standard DCE

*10. Clover Health's capitation payment election for the 2021 performance year*

- Primary Care Capitation with Advanced Payment Option

*11. Clover Health's care model and the role of the Vermont providers in the Model*

For its Medicare Advantage business, Clover Health has historically used telephonic nurse care managers and social workers to coordinate care for patients. These teams have coordinated services in tandem with primary care providers, including:

- Access to home health services
- Prescriptions for durable medical equipment - Introduction to hospice providers
- Pharmacy assistance
- Finding a PCP or specialist
- Scheduling provider appointments
- Accessing free or low-cost transportation
- Completing financial assistance applications - Accessing free or low-cost meal options
- Utility and housing assistance

The DCE will similarly leverage telephonic nurse care managers and social workers to coordinate care for patients. The DCE will also use Clover Assistant (CA) to promote care coordination and care transitions throughout care episodes by:

- Alerting Participant Providers about hospital and post-acute care admissions and discharges
- Leveraging CA's telehealth module to stimulate care coordination and care
- Sharing information from Medicare Part A, B, and D claims through CA
- Sharing hospital discharge information

When care is transferred between providers, the DCE will facilitate timely information sharing:

- For transfer of providers within the DCE, the accepting DCE provider will immediately have access to the same data in CA that was formerly available to the transferring provider
- For transfer to providers external to the DCE, we can prepare and send the beneficiary's Medicare claims information to another provider or entity

The DCE has extensive health plan IT capabilities, software development capabilities, and CRM capabilities via Salesforce HealthCloud. The DCE also leverages the management of multiple clinical information data streams via a backend vendor, CareEvolution, who is very familiar with and already deploys CMS claims data exchanges for ACOs.

CA will also surface to DCE Participant Providers available specialists within the beneficiary catchment area. These specialists will be contracted to ensure timely access to services. For members who would benefit from in-home rather than office-based care, DCE Participant Providers will have the ability to make referral through CA to house call providers.

Clover Health will provide population health reporting to Participant Providers, providing feedback on quality measures, including real-time prompting in CA of quality of care gaps requiring closure, as well as beneficiaries requiring expedited outpatient visits. The DCE will also promote high quality medication management and coordination for its beneficiaries in the following ways:

- Surfacing Part D claims in CA
- Using Part A and B claims to provide evidence-based recommendations to improve management within CA
- Prompting providers in CA to reconcile medications following inpatient stays
- Prompting Participant Providers to extend fill periods for chronically used medications from 30 days to 90 days to increase adherence

Clover Health's Vermont provider will participate as Participant Provider. This provider will provide primary care to Medicare beneficiaries utilizing CA to promote care coordination and care transitions throughout care episodes – all in accordance with the care model described above.

***Medicare/Federal and Vermont ACO Requirements***

*Rule 5.400 (Review of ACO Budgets and Payer Programs)*

GMCB Rule 5.400 sets out numerous requirements centered around an ACO's budget and related ability to successfully perform its duties in coordinating the provision of high value care to patients. Specifically, the GMCB requires its participation in – and approval of – an ACO's annual budget. ACOs must also annually provide documentation on its governance structure, financial operations, and care coordination activities. These requirements are, in large part, duplicative of the obligations placed on DCEs by CMS.

In order to be accepted as a DCE in the Model, CMS required Clover Health to submit an application demonstrating its ability to meet all of the model requirements, from both a financial and operational perspective. CMS reviewed Clover Health's business model and reviewed the organization's prior experience in risk-based and outcomes-based agreements. Clover Health demonstrated its ability to fund its DCE activity, including a plan for how it would support a program that drives better health, better health care, and lower costs. Clover Health

showed how it will compensate its contracted providers and improve the care for its aligned beneficiaries. A copy of Clover Health's application is enclosed with this letter.

*Rule 5.500 (Monitoring and Enforcement)*
GMCB Rule 5.500 requires ACO to maintain ACO records and report to the GMCB on quality of care, ACO care coordination activities, and financial performance. ACOs must also report ACO information on a public website. The rule allows the GMCB to monitor ACO activity and to take remedial actions against an ACO for failure to meet the requirements of GMCB rules.

Pursuant to the Participation Agreement with CMS, a DCE must comply with nearly identical – if not more stringent – monitoring and enforcement requirements. A DCE must maintain all records of its operations (including financial and quality records) and make them available to CMS and other Federal agencies. Compliance for DCEs begins with preparation of a compliance plan that must be reviewed approved by CMS. CMS audits DCEs for compliance with all provisions of the Participation Agreement, which include receiving documentation directly from providers and interviewing providers and beneficiaries. Moreover, DCEs and their providers are subject to ongoing program integrity review by CMS's Office of Program Integrity, the HHS Office of the Inspector General, and the U.S. Department of Justine. DCEs are also required to maintain a public website that includes contact information for DCE executives as well as reports on the DCE's performance on financial and quality metrics. DCEs also agree to strict enforcement by CMS, which ranges from warning letters and corrective action plans to termination of participation in the Model.

***Request for Waiver of Certain Vermont Statutes and Rules***

Clover Health is operating solely as a Medicare ACO (as defined by 18 V.S.A § 9571 and Rule 5.103) under the rules of Direct Contracting and, therefore, is not required to be licensed as an ACO by the GMCB under 18 V.S.A. § 9382(a) ("In order to be eligible to receive payments from Medicaid or commercial insurance through any payment reform program or initiative, including an all-payer model, each accountable care organization shall obtain and maintain certification from the Green Mountain Care Board."). However, certain other state statutes and rules may apply to ACOs and the Vermont legislature has granted the GMCB discretion to deem such provisions satisfied.

For purposes of Clover Health's participation as a DCE in Direct Contracting, Clover Health requests the GMCB waive the following requirements pursuant to Rule 5.601:

- Rule 5.400: Review of ACO Budgets and Payer Programs
- Rule 5.500: Monitoring and Enforcement

Waiver of these requirements is appropriate and necessary under Rule 5.601, which provides that:

> In order to prevent unnecessary hardship or delay, in order to prevent injustice, or for other good cause, the Board may waive the application of any provision of

> this Rule upon such conditions as it may require, unless precluded by the Rule itself or by statute. Any waiver granted by the Board shall be issued in writing and shall specify the grounds upon which it is based.

Clover Health will satisfy equivalent – if not more stringent – standards by virtue of its execution of a Participation Agreement with CMS, binding it to the requirements of the Model. As described above and detailed in the enclosed copies of the RFA and Participation Agreement, Clover Health and its providers have been, and will continue to be, subject to review, monitoring, and enforcement of its structure and governance, budgets and finances, care coordination and benefit enhancement activities, beneficiary/patient protection activities, and record keeping, reporting and transparency.

The requirements set forth in the GMCB rules: (1) are largely duplicative of the obligations placed on DCEs by CMS; and (2) are not tailored to – or relevant to – a Medicare ACO that is operating in the context of a Federal Medicare initiative run by CMS. It is of no surprise that requirements duplicative of CMS requirements because the GMCB rules arose around the implementation of the Vermont's All-Payer Model – a model that was based on NGACO (in fact, for the first year of the Vermont All-Payer Model, the Vermont ACO was a participating ACO in NGACO). As the Direct Contracting requirements are built upon the NGACO, a DCE's compliance with model's Participation Agreement – with CMS as the enforcing body – ensures that DCEs meet the standards demanded by the GMCB. Accordingly, requiring a DCE to separately meet the requirements of GMCB Rules 5.400 and 5.500 would place unnecessary burden on the DCE, taking additional resources away from the DCE - - resources that could be better used to implement the DCE's care model for the benefit of Vermont's beneficiaries.

***Alternative Temporary Non-Enforcement Position***

Clover Health recognizes that it is the first ACO to operate in Vermont (aside from the state's own all-payer ACO). To that end, the GMCB has not yet had the opportunity to develop protocols and guidance for ACOs seeing to operate in Vermont. For instance, we understand that documents referenced the GMCB's rules, such as the "Annual Budget and Review Manual." For ACOs participating in Medicare regulated initiatives that do not require certification, the GMCB will also need to distinguish between those requirements that ensure the ACO will be able to meet its obligations to its patients and providers and those requirements that place undue burden on the ACOs. For these ACOs, the GMCB could consider taking a non-enforcement position with respect to its Rule 5.000 requirements while it considers these issues. At such time that the GMCB determines any requirements are reasonable and necessary, it could then notify any Medicare ACOs operating in Vermont of the obligation to comply with those requirements. Clover Health would be happy to engage in ongoing dialogue with the GMCB to assist in this process.

***Request of Confidentiality***

Pursuant to GMCB Rule 5.106, Clover Health requests that that the GMCB hold in confidence the information contained in this letter and any additional information submitted by Clover Health in support of the waiver request. This information describes non-public financial information for the company, company trade secrets, and other proprietary information.

***Conclusion***

For the reasons described above, Clover Health requests that the GMCB waive Rule 5.400 and 5.500 with respect to the ACO's participation in Direct Contracting. Alternatively, Clover Health asks the GMCB to take a temporary non-enforcement position on these rules. We appreciate your time and consideration of this request and stand ready to provide any additional information you may find helpful in reviewing this request.

Very truly yours,

David O. Ault

Enclosures

cc:

Office of the Health Care Advocate (hca@vtlegalaid.org)