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GREEN MOUNTAIN CARE BOARD

ACO Oversight
FY 2022 Budget Review
Clover Health Partners

Staff Analysis and Recommendations

March 16, 2022

Agenda for Today

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1. GMCB Authority and Criteria
2. Background and Overview
3. FY22 ACO Budget Review
4. Staff Recommendations
5. Board Questions/Discussion
6. Public Comment
7. Next Steps

ACO Oversight Statute/Rule

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- Oversight of Accountable Care Organizations (18 V.S.A. § 9382 and Rule 5.000)
  - **Certification:** Not applicable to ACO that does not receive payments from Medicaid or commercial insurance through any payment reform program or initiative. 18 V.S.A. § 9382(a)
  - **Budget:** Annually review and approve or modify ACO budget. 18 V.S.A. § 9382(b). Statute distinguishes between ACOs with greater or fewer than 10,000 attributed lives in Vermont.

ACO Oversight Statute/Rule (cont'd)

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- What is the Board approving?
  - Certification is not required under 18 V.S.A. § 9382(a)
  - Under 18 V.S.A. § 9382(b)(2) and Rule 5.405, GMCB shall review and approve or modify an ACO's budget.
    - Guidance approved by the Board in October last year for Medicare-only ACOs with fewer than 10,000 attributed lives
  - Scope of Board's jurisdiction
- Reporting obligations under Rule 5.501
- Procedural history
  - Clover Health's request for a waiver of the budget review process was denied by the Board in June, 2021.
  - Staff developed guidance for Medicare-only ACOs with fewer than 10,000 attributed lives in Vermont, approved by Board in October, 2021.
  - Clover Health's budget submitted 12/31/21.

Budget Review Process

18 V.S.A. § 9382(b)(2) and Rule 5.405(c)

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In deciding whether to approve or modify the proposed budget of an ACO projected to have fewer than 10,000 attributed lives in Vermont during the next Budget Year, the Board will take into consideration:

1. any benchmarks established under section 5.402 of this Rule;
2. those criteria listed in 18 V.S.A. § 9382(b)(1) ***that the Board deems appropriate to the ACO's size and scope***;
3. the elements of the ACO's Payer-specific programs and any applicable requirements of 18 V.S.A. § 9551 or the Vermont All-Payer Accountable Care Organization Model Agreement between the State of Vermont and CMS; and
4. any other issues at the discretion of the Board.

Factors from 18 V.S.A. § 9382(b)(1)

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- Staff recommend Board consider the following factors from 18 V.S.A. § 9382(b)(1):
  - information regarding utilization of the health care services delivered by health care providers participating in the ACO and the effects of care models on appropriate utilization, including the provision of innovative services;
  - the character, competence, fiscal responsibility, and soundness of the ACO and its principals;
  - any reports from professional review organizations;
  - the ACO's efforts to prevent duplication of high-quality services being provided efficiently and effectively by existing community-based providers in the same geographic area, as well as its integration of efforts with the Blueprint for Health and its regional care collaboratives;

18 V.S.A. § 9382(b)(1)

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- public comment on all aspects of the ACO's costs and use and on the ACO's proposed budget;
- information gathered from meetings with the ACO to review and discuss its proposed budget for the forthcoming fiscal year;
- information on the ACO's administrative costs, as defined by the Board;
- the extent to which the ACO makes its costs transparent and easy to understand so that patients are aware of the costs of the health care services they receive; and
- the extent to which the ACO provides resources to primary care practices to ensure that care coordination and community services, such as mental health and substance use disorder counseling that are provided by community health teams, are available to patients without imposing unreasonable burdens on primary care providers or on ACO member organizations.

High-Level Overview

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- **What:** The Medicare Direct Contracting (DC) Model brings more Medicare payments from FFS into value-based payment arrangements through two voluntary risk sharing options
  - Model runs from 2021-2022 (transition to ACO REACH Model in 2023)
  - Risk model: Direct Contracting Entity (DCE) bears full upside/downside risk; higher risk than other ACO arrangements
- **Who:** Agreement between CMS, Direct Contracting Entities (DCEs), and providers who contract with DCEs
- **Clover Health Partners (CHP):** A multi-state DCE that has contracted with Vermont providers
  - Clover agrees to be accountable for the cost and quality for aligned beneficiaries
  - Providers have access to Clover Assistant, a point of care tool offering clinical support and other capabilities.

How does the DC Model impact Medicare beneficiaries' costs and care?

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- Beneficiaries aligned to DCEs are still in Traditional Medicare:
  - Access to the entire Traditional Medicare network
  - Alignment to DCE does not affect out-of-pocket costs and premiums
  - Does not affect use of supplemental insurance (Medigap)
- DCE Attributed Beneficiary Rights in DCE Participation Agreement:
  - Beneficiary Notifications (Section 5.05)
  - Beneficiary Freedom of Choice (Section 5.07)
  - Rights to Opt Out of Data Sharing (Section 6.04)
- Through DCE providers, beneficiaries may have access to additional benefits:
  - Coordinated care between DCE Participating Providers (Primary Care) and Preferred Providers (e.g. home health), option to go outside DCE network
  - Access to benefit enhancements [*see slide 34 for Clover-specific benefits]*

Public Reporting and Transparency

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The DCE shall report the following organizational information on a publicly accessible website maintained by the DCE.

A. Name and location of the DCE;

B. Primary contact information for the DCE;

C. Identification of all DC Participant Providers and Preferred Providers;

D. Identification of all joint ventures between or among the DCE and any of its DC Participant Providers and Preferred Providers;

E. Identification of the DCE's key clinical and administrative leaders and the name of any company by which they are employed; and

F. Identification of members of the DCE's governing body and the name of any entity by which they are employed.

G. Shared Savings and Shared Losses information, including:
   1. The amount of any Shared Savings or Shared Losses for any Performance Year;
   2. The proportion of Shared Savings invested in infrastructure, redesigned care processes, and other resources necessary to improve outcomes and reduce Medicare costs for Beneficiaries; and
   3. The proportion of Shared Savings distributed to DC Participant Providers and Preferred Providers.

H. The DCE's performance on the quality measures described in Section 9.02.

Source: CMS GPDC Model Participation Agreement available with Clover's budget submission at https://gmcboard.vermont.gov/sites/gmcb/files/documents/2022%20Clover%20Health%20ACO%20Submission.pdf

Integration with VT APM initiative

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- DC Model participants cannot participate in the Medicare Shared Savings Program or other Medicare shared savings initiatives.
  - Participants cannot also participate in Vermont Medicare ACO Initiative
- Staff analysis determined that CHP's program in Vermont is unlikely to qualify for APM scale.

High-Level Overview – ACO REACH

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- Direct Contracting Model sunsets at the end of 2022
- Redesigned to new ACO REACH Model starting January 1, 2023
  - ACO REACH: Realizing Equity, Access, and Community Health
- DCEs that wish to transition to ACO REACH must be in good standing and be compliant with all requirements of the new model by January 1, 2023, to continue participation
- ACO REACH participation agreement expected later in 2022

High-Level Overview – ACO REACH

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New ACO Reach Requirements

- **ACO Governance:** change from 25% to 75% governing board voting rights held by participant providers; Beneficiary and consumer advocates must each hold voting rights.
- **Health Equity:** ACOs develop a Health Equity Plan and collect beneficiary-reported demographic and social needs data; Introduction of health equity benchmark adjustment and new benefit enhancements.
- **Changes to Benchmarking:** including changes to the "Risk Score Growth Cap" to further mitigate potential inappropriate risk score gains.
- **Additional Monitoring and Compliance:**
  - Assess annually whether beneficiaries are being shifted into or out of MA.
  - Examine ACO's risk score growth to identify inappropriate coding practices.
  - Increase use of data analytics to monitor use of services over time and compared to a reference population to assess changes in beneficiaries' access to care, including stinting on care.
  - Audit annually REACH ACO contracts with providers to learn more about their downstream arrangements and identify any concerns.

Comparison Chart: https://innovation.cms.gov/media/document/gpdc-aco-reach-comparison

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FY22 ACO BUDGET REVIEW

Clover Health Partners, submitted December 31, 2021

Public Comment
Themes

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- Past Public Comments:
  - In June 2021, the Board accepted public comment on a request from CHP that the Board waive the review and approval of CHP's annual budget. Commenters generally opposed waiving the budget review.
  - On June 30, 2021, the Board unanimously voted to deny CHP's waiver request.
- Current Public Comment Period:
  - The Board opened a public comment period for comments ahead of today's staff analysis.
  - No public comment received as of Friday, March 11, 2022
- Thank you to the HCA for working with the GMCB to submit questions to Clover
- Public comment period continues until Board vote

Key Areas Of Review – Guidance

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Sec. 1: ACO Information

Sec. 2: Provider Network

Sec. 3: Payer Program

Sec. 4: Budget and Finances

Sec. 5: Care Model

Sec. 6: VT All-Payer Model Alignment

ACO Information

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- Clover Health Partners is a Direct Contracting Entity that has been operating in Vermont since April 2021 under the DC Model Participation Agreement with CMS.
  - Materials available at: https://gmcboard.vermont.gov/aco-oversight/clover-health-partners
- Introduction to Clover June 23 and June 30, 2021
- Pending/ongoing litigation
  - Shareholder litigation
  - Ongoing DOJ and SEC investigations, as noted in staff presentation from June 2021.
- **Recommendation:** Clover Health provides to GMCB semi-annual updates on any material pending legal actions taken against the ACO or its affiliates, or against any members of the ACO's executive leadership team or Board of Directors related to their duties, and any such actions known to be contemplated by government authorities.

Provider Network

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- Network providers:
  - Participant – *primary care providers who can align beneficiaries*
  - Preferred – *specialists and ancillary facilities to improve care management, quality, cost of care*
- Provider list due to CMS in September for following year

Clover's 2022 Provider Network in Vermont

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HSA	Facility Name	Category	Provider Class	Count
Burlington	Evergreen Family Health Group	PCP	Participating Provider	20
Rutland	Rutland Healthcare and Rehabilitation Center	SNF	Preferred Provider	N/A
Newport	Bel Aire Center	SNF	Preferred Provider	N/A
Brattleboro	Forefront Telecare Inc	SNF	Preferred Provider	N/A
St. Albans	Saint Albans Healthcare and Rehabilitation Center	SNF	Preferred Provider	N/A
Rutland	Mountain View Center Genesis Healthcare	SNF	Preferred Provider	N/A

Sources:
- CHP's FY22 budget submission and at https://www.cloverhealthpartners.com/en/about-us.
- DAIL, Division of Licensing and Protection, Nursing Homes by County at https://dlp.vermont.gov/sites/dlp/files/documents/nh_list_by_county.pdf.

Provider Network - Recommendations

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- No staff recommendations for FY22
  - Network development questions are included in the annual Budget Guidance
  - Provider contract reported to GMCB and CMS

Payer Program

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- Medicare only
  - Parameters are set by the DC Participation Agreement with CMS
  - Risk and payment option selections are for entire DCE (not by state/provider)
- Attribution
  - Claims-based alignment
  - Voluntary alignment

Funds Flow

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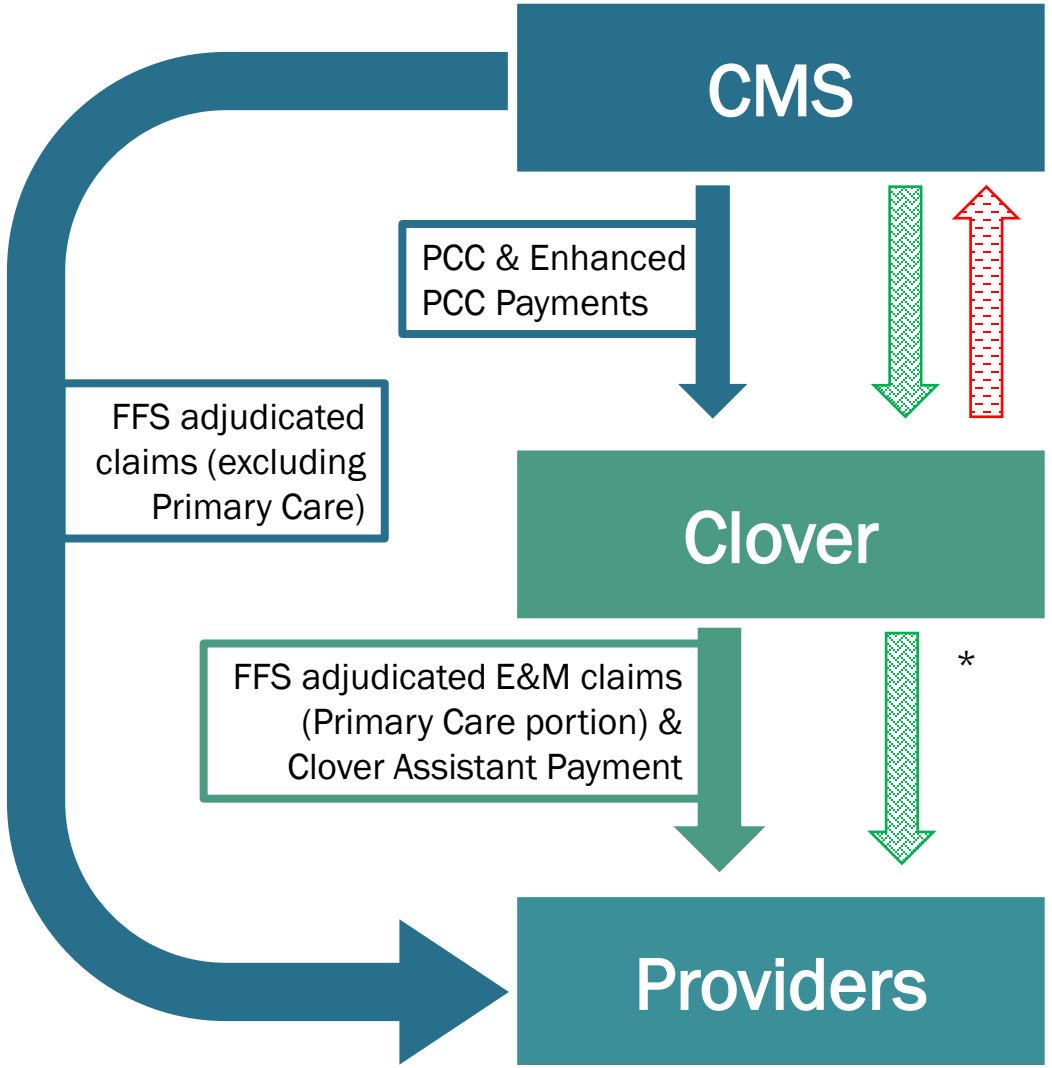
Key Takeaways

- This is still a Fee For Service (FFS) Model, with CMS paying for most care via FFS.
- There is a quality element through potential SS/SL (quality withhold).
- Providers receive payment for using Clover Assistant, a point of care tool offering clinical support and other capabilities.



Potential Shared Savings

Potential Shared Losses

* Amount of shared savings depends on contract between Clover and providers.

Risk Model

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- **Upside/downside model**
  - DCE has potential for both shared savings and shared losses
- **Wide risk corridors compared to other ACO arrangements in Vermont**
  - DCE bears 100% risk at <25% PY benchmark
  - Savings/loss rate decreases at >25% (4 risk bands)
  - Participant/preferred providers bear no risk
- **DCE collects any shared savings and pays any losses**
  - Shared savings may be paid to providers; providers are not responsible for losses

Risk Corridors

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- The risk corridors are automatically set under the CMS agreement
- Clover has selected the Global Risk Sharing Option (highlighted in table below)
- If spending is within 25% of benchmark, SS/SL rate is 100%. If spending is more/less than 25% of benchmark, SS/SL rate decreases.

	Risk Sharing Option			
	Global (Full Risk)		Professional (Partial Risk)	
Risk Band	% of Performance Year Benchmark	Savings/Losses Rate	% of Performance Year Benchmark	Savings/Losses Rate
Corridor 1	Less than 25%	100%	Less than 5%	50%
Corridor 2	25% to 35%	50%	5% to 10%	35%
Corridor 3	35% to 50%	25%	10% to 15%	15%
Corridor 4	More than 50%	10%	More than 15%	5%

Risk Model

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- Options for risk model defined under the DC agreement. Clover selected:

CMS DCE Program:	Risk Options	Capitation Payment Mechanism	Risk Corridor	Risk Mitigation
	Global: 100% SS Professional: 50% SS	Primary Care Capitation or Total Care Capitation	automatically set under agreement	Optional Stop Loss
Clover's Selections:	Global Automatic 2% discount on benchmark	Primary Care Capitation	Four Risk Bands Mitigate SS/SL if actual PY expenditures are far lower/higher than benchmark	Stop Loss

Total Cost of Care Benchmark

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- Like the Vermont Medicare ACO Model, total spending is compared to a performance year "benchmark" (expected total cost of care) which is adjusted for population risk score, among other factors.
  - ~1,800 aligned beneficiaries (minimal change from 2021)
  - Prospectively set benchmark covering all Part A and B Medicare expenditures
  - CMS is continuing to address concerns about increased coding intensity through modifications in the ACO REACH Model

Shared Savings/Losses

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- Results to date
  - Clover Health has not yet issued to the public any projection of CHP's anticipated 2022 Shared Savings/Loss and/or financial performance, other than to note that it expects its Direct Contracting Margin, which represents the ratio of net medical claims incurred for its Direct Contracting segment to Direct Contracting revenue, to improve in 2022 versus 2021 levels. (FY22 CHP Budget Submission, p. 11)
  - Clover Health's Direct Contracting Margin reported in 2021 Earnings Releases was 103.0% in Q4, 102.4% in Q3, and 111.8% in Q2.
- If CHP earns shared savings, VT providers are potentially eligible to receive a share
- Final financial settlement for both 2021 and 2022 to be reported in July 2023
  - 2021: ~19 months after end of PY1 (preliminary in July 2022)
  - 2022: ~7 months after end of PY2

Payer Program - Recommendations

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- **Recommendation:** Clover Health provides to GMCB its shared savings, segmented for VT.
- **Key points:**
  - Payer program arrangements are set by Medicare in the Participation Agreement
  - Participation Agreement was reported to GMCB
  - There are new requirements in the ACO REACH Model around governance, health equity, and additional monitoring and compliance

Financials

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- What is there to know?
  - Company (Clover Health Investments & subsidiaries) growing fast
    - Unaudited FY2021 total revenues grew 119% over prior year-end, up t o$1.47B
    - Growth driven by direct contracting revenues from Q2-Q4 and as of year-end accounted for 45% of FY21 revenues. Direct contracting revenues not reported in Q1
    - Expenses grew by 175% over prior year-end, up to $2.1B, driven by net medical claims incurred (up 163%); Sal. & Benefits (up 266%); G&A (up 54%)
    - Loss on operations eroded from -$92.7million, to -$637million
    - Net margin eroded from -$137million, to -$587.7million
    - B/S: Assets up 256%; Liab. down 5%; total stockholders' equity up from -$617million to $539million
    - Accumulated deficit $1.61B as of FYE2021
- Reviewed SEC filing
  - Does not include auditor notes and is at the consolidated level.
    - This makes it difficult to see Clover Health Partners contribution to the overall financial condition and understand material/subsequent events
- Admin costs: not borne by Vermont providers

Financials - Recommendations

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- **Recommendation:** Collect audited financials indicating CHP's balance sheet, and statement of operations contributions; submit a standalone audit for CHP if available.

Model of Care: Review Criteria

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- Strengthen primary care
- Support appropriate utilization
- Integrate with community-based providers and the Blueprint for Health
- Prevent duplication of services

18 V.S.A. § 9382 b(1):(A)(F)(G)(H)(P)

Model Review Criteria

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Strengthen Primary Care

- Flat payment for use of Clover Assistant per visit; possible shared savings payments
- Point-of-care quality gap alerts; feedback on quality measure achievement
- Evidence-based care recommendations

Support Appropriate Utilization

- Evidence-based care recommendations
- Complex Care Program
- Admission, Discharge, Transfer (ADT) Alerts
- Care coordination services available
- Telehealth module
- Benefit Enhancements and Engagement Incentives

Integrate with Community Providers and Prevent Duplication of Services

- Network of Preferred Providers
- Referral capabilities within Clover Assistant
- ADT Alerts
- Care coordination services available
- Socioeconomic, Pharmacy, and Lab data
- Medication reconciliation prompts
- Clinical data sharing capabilities

Clover Assistant

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- Proprietary point of care technology platform
- Financial incentives to use Clover Assistant via fixed, flat payment per office visit.
- Capabilities:
  - Connected to Vermont's Health Information Exchange
  - 3 years of Medicare claims data
  - Lab data delivered overnight from Quest and LabCorps
- Population Health support:
  - Real-time prompting of quality-of-care gaps to participant providers
  - Quality measure feedback
  - Socioeconomic data
  - Care coordination and referral services

Benefit Enhancements and Beneficiary Engagement Incentives

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- 3-Day SNF Rule Waiver Benefit Enhancement ("BE")
- Telehealth BE
- Post- Discharge Home Visits BE
- Care Management Home Visits BE
- Home Health Homebound Waiver BE
- Concurrent Care for Beneficiaries that Elect Medicare Hospice BE
- Part B Cost-Sharing Support Beneficiary Engagement Incentive ("BEI")
- Chronic Disease Management Reward BEI

Quality Measures

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Domain	Measure Title	Method of Data Submission	Pay for Performance Phase for FY22
Care Coordination/ Patient Safety	Risk-Standardized, All Condition Readmission*	Claims	Reporting and Performance
	All-Cause Unplanned Admissions for Patients with Multiple Chronic Conditions*	Claims	Reporting and Performance
	Timely Follow-Up After Acute Exacerbations of Chronic Conditions	Claims	Reporting
Patient/Caregiver Experience	CAHPS*	Survey	Reporting

CMS shall use the DCE's performance on each of the quality measures to calculate the DCE's total quality score according to a methodology determined by CMS.
CMS shall use the DCE's quality scores in determining the DCE's Performance Year Benchmark.

*Aligned with APM Quality Measures

Care Model - Recommendations

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- **Recommendation:** Clover Health provides to GMCB its quality reporting, segmented for VT but with appropriate restrictions to protect patient confidentiality.

Recommendations:

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- Approve Clover Health Partners FY22 budget as submitted subject to the following conditions:
  - Clover Health provides to GMCB its shared savings, segmented for VT.
  - Clover Health provides to GMCB its quality reporting, segmented for VT but with appropriate restrictions to protect patient confidentiality.
  - Collect audited financials indicating CHP's balance sheet, and statement of operations contributions; submit a standalone audit for CHP if available.
  - Clover Health provides to GMCB semi-annual updates on any material pending legal actions taken against the ACO or its affiliates, or against any members of the ACO's executive leadership team or Board of Directors related to their duties, and any such actions known to be contemplated by government authorities.

Next Steps

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- Board Questions/Discussion
- Public Comment
- Potential Vote – March 23

Acronym List

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- ACO—Accountable Care Organization
- APM—All-Payer Model
- CHP – Clover Health Partners, LLC
- CMS—Centers for Medicare & Medicaid Services
- FFS—Fee-for-Service
- FY – Fiscal Year
- GMCB—Green Mountain Care Board
- HCA—Health Care Advocate
- HSA—Health Service Area
- PCP—Primary Care Provider
- PMPM—Per-Member Per-Month
- PY—Performance Year
- SNF—Skilled Nursing Facility
- SS/SL—Shared Savings/Shared Losses
- TCOC—Total Cost of Care