STATE OF VERMONT
GREEN MOUNTAIN CARE BOARD

FY22 ACCOUNTABLE CARE ORGANIZATION BUDGET ORDER

In re:	Clover Health Partners, LLC)	
	Fiscal Year 2022)	
	)	Docket No. 21-002-A

INTRODUCTION

The Green Mountain Care Board (GMCB or Board) is charged with reviewing, modifying, and approving the budgets of accountable care organizations (ACOs). 18 V.S.A. § 9382(b). Fiscal Year 2022 (FY22) is the fifth year that ACO budgets are subject to Board review. Below, we describe the relevant legal framework, outline the criteria that the Board considered during its review, and present specific Findings and Conclusions in support of our Order approving an FY22 budget for Clover Health Partners, LLC (CHP).

LEGAL FRAMEWORK

Under the ACO oversight statute, the Board's review of ACO budgets differs depending on whether an ACO has more or less than 10,000 attributed lives in Vermont. 18 V.S.A. § 9382(b)(1)-(2). For ACOs with fewer than 10,000 attributed lives, the Board may consider the factors set out in 18 V.S.A. § 9382(b)(1) "as the Board deems appropriate to a specific ACO's size and scope." 18 V.S.A. § 9382(b)(2). The statutory factors that the Board may – but is not required – to consider in reviewing the budget of an ACO with fewer than 10,000 lives generally fall into the following categories:

- Historic and future expenditures and the effects of care models on utilization, including the provision of innovative services;
- The ACO's efforts to strengthen and provide resources to primary care, address social determinants of health and the impacts of childhood trauma, integrate community providers, improve care coordination, and reduce duplication of services in partnership with the Blueprint for Health;
- Health resource allocation priorities;
- Transparency of the ACO's costs;
- Effects of Medicaid reimbursement on other payers;
- Solvency and ability to assume financial risk;
- Administrative costs;
- The character, competence, fiscal responsibility and soundness of the ACO and its leaders; and
- The Office of the Health Care Advocate's (HCA) feedback and public comment.

See 18 V.S.A. § 9382(b)(1). The Board must therefore consider the size and scope of an ACO with less than 10,000 lives when reviewing its budget. Based on its consideration of the size and scope of CHP's operations in Vermont, the Board's review focused on 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;
- 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.

The Board's budget review must also consider any benchmarks established by Rule by the Board and 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. *See* GMCB Rule 5.000, § 5.405(c).

The ACO oversight statute and GMCB Rule 5.000 state that the Board will review, modify, and approve ACO budgets. *See* 18 V.S.A. § 9382(b), GMCB Rule 5.000, § 5.405(c).

Under statute, the Board's annual ACO budget review is separate from the Board's role in certifying ACOs. Certification is required for an ACO in Vermont to be "eligible to receive payments from Medicaid or commercial insurance through any payment reform program or initiative, including an all-payer model." *See* 18 V.S.A. § 9382(a).

FY22 REVIEW PROCESS

The review process for CHP FY22 budget is reflected in the following timeline:

10.20.21: The Board issued FY22 Medicare Only Non-Certified ACO budget guidance and reporting requirements.
12.31.21: CHP submitted its proposed FY22 budget to the Board.
03.07.22: Board staff and HCA requested additional information from CHP regarding its proposed FY22 budget.
03.15.22: CHP responded to March 7, 2022 questions from Board staff and HCA.
03.16.22: Board staff presented their analysis and preliminary recommendations regarding CHP's proposed FY22 budget.
03.23.22: Board staff presented additional analysis and updated recommendations regarding CHP's proposed FY22 budget, and Board voted to approve CHP's FY22 budget on the terms and subject to the conditions described in this Order.

The written materials from this process are posted on the Board's website[1] and video recordings of the meetings are available from Onion River Community Access (ORCA) Media.[2]

FINDINGS

Overview

1. Clover Health Partners, LLC ("CHP") is a Delaware limited liability company. CHP is an indirect, wholly owned subsidiary of Clover Health Investments, Corp. ("Clover Health"), which is a publicly traded company. *See* CHP Budget Submission, 1.

2. CHP is participating in the Direct Contracting Model for Medicare payments, which is run by the Centers for Medicare and Medicaid Services (CMS). *See* CHP Budget Submission, 24. Within the Direct Contracting Model, CHP participates in the Global Risk Sharing Option. *See id*.

3. CHP anticipates approximately 1,800 aligned Medicare beneficiaries for FY22 in Vermont, with one primary care office (comprised of 20 providers) as CHP's only Participating Provider in the state. *See* CHP Budget Submission, 23. CHP's network includes five preferred providers throughout the state. *See* Staff Analysis, 19.

4. CHP operates in numerous states in addition to its presence in Vermont. *See* CHP Budget Submission, 1.

5. CHP leadership presented to the GMCB at a public meeting on June 23, 2021 regarding CHP's business model and operations in Vermont. *See* Clover Health Partners Presentation (June 23, 2021), 1.

Direct Contracting Model

[1] Written budget materials are available at https://gmcboard.vermont.gov/aco-oversight/2022. Board presentations are available at https://gmcboard.vermont.gov/board/meeting-information/2021-meetings.
[2] https://www.orcamedia.net/series/green-mountain-care-board.

6. The CMS Direct Contracting Model started in 2021 and will run until the end of 2022, at which point it will be replaced with a new CMS model called ACO REACH. *See* Staff Analysis, 8.

7. The Medicare Direct Contracting (DC) Model brings more Medicare payments from FFS into value-based payment arrangements through two voluntary risk sharing options. *See* Staff Analysis, 8. Beneficiaries aligned to DCEs are still in Traditional Medicare, and retain access to the entire Traditional Medicare network. *See* Staff Analysis, 9. Alignment to a DCE does not affect out-of-pocket costs and premiums and does not affect use of supplemental insurance (Medigap). *See id*.

8. Direct Contracting Entities, like CHP, enter into a Participation Agreement with CMS that sets out the terms and conditions of the Direct Contracting Model. *See generally*, Clover Budget Submission, 25-330. The Participation Agreement includes certain rights for attributed beneficiaries, including notification, freedom of choice, and rights to opt out of data sharing. *See* Clover Budget Submission, 50-51, 85-86. The Participation Agreement also requires CHP to publicly report certain information, including the amount of any shared savings and shared losses for each year. *See* Clover Budget Submission, 111.

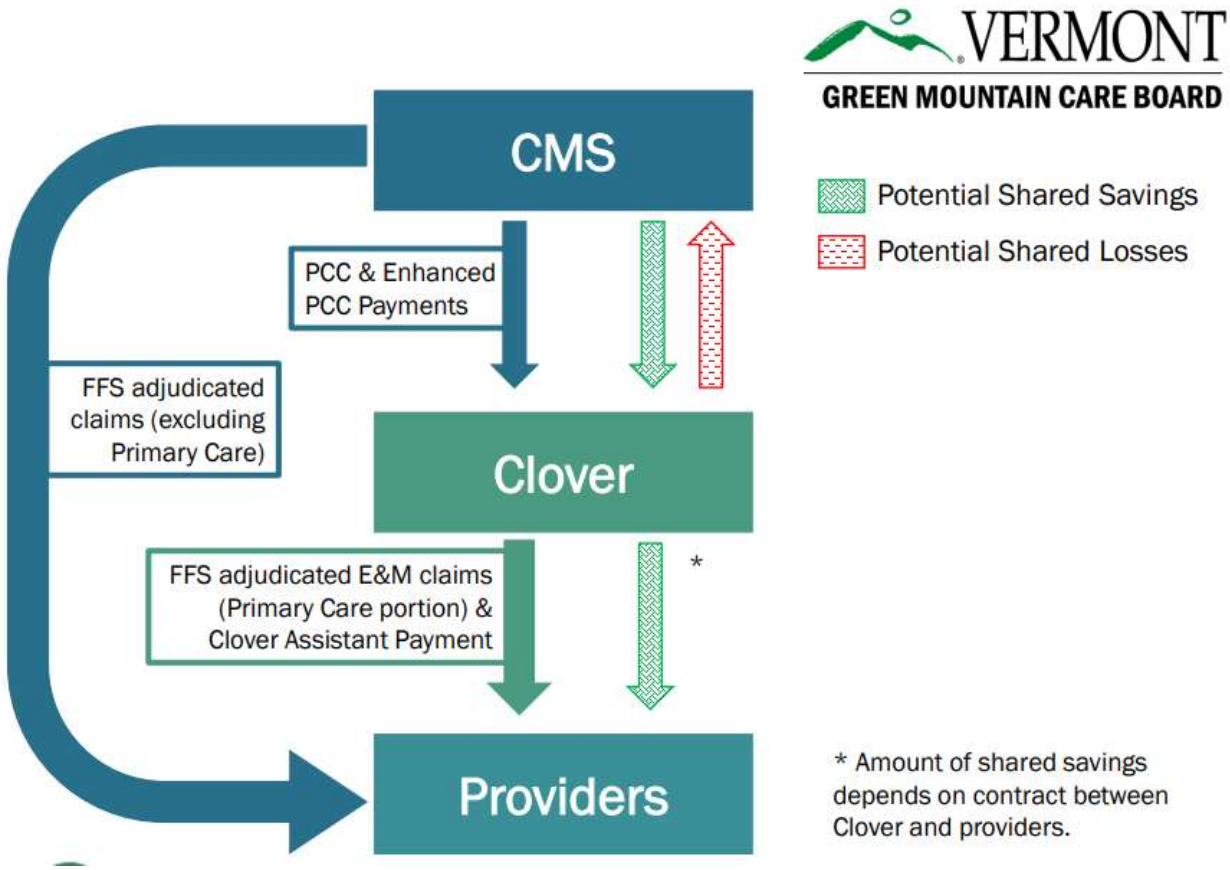
Integration with Vermont All-Payer Model Initiative

9. Participants in the Direct Contracting Model cannot participate in the Medicare Shared Savings Program or other Medicare shared savings initiatives, which means those participants could not participate in Vermont's Medicare ACO Initiative. *See* Staff Analysis, 11.

Payer Program and Risk Model

10. Medicare is the only payer that CHP participates with. *See* Staff Analysis, 21. Risk and payment options are for all of CHP's aligned beneficiaries (both in and outside of Vermont), and the specific requirements for attribution, which can be claims-based or voluntary, as well as the other parameters for participation in the model are set in CHP's Participation Agreement with CMS. *See id*.

11. Direct Contracting is essentially a fee for service model, with CMS adjudicating claims and paying providers on a fee for service basis. *See* Staff Analysis, 21. There is potential for shared savings or shared loss, which would be paid between CMS and CHP. *See id*. CHP pays providers a fixed payment per visit for using CHP's Clover Assistant point of care tool. *See id*; *see also* CHP Budget Submission, 10-11. The flow of payments is outlined below:



Staff Analysis, 22.

12. Risk corridors are set by CMS under the Direct Contracting Model. *See* CHP Budget Submission, 7-8. CHP has the potential to earn shared savings or to be liable for shared loss under its Participation Agreement. *See id*.

13. CHP elected to participate in the Global risk sharing option in the Direct Contracting Model, which has the highlighted risk corridors set out below:

	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%

See Participation Agreement, Table H: Risk Corridors, p. 182 (highlighting added). .

14. CHP does not share any potential downside risk with Vermont providers. *See* Letter from David Ault (March 15, 2022), 4.

15. The total cost of care benchmark is set by CMS for entities participating in the Direct Contracting Model. *See* CHP Budget Submission, 99. The total cost of care benchmark is set prospectively and covers all Medicare Part A and Part B expenditures. *See* Staff Analysis, 26.

16. Final financial settlement for both 2021 and 2022 will be made available by CMS in July, 2023. *See* Staff Analysis, 27.

Financials (Revenues and Expenses)

17. CHP does not have separate, stand-alone audited financials; CHP's financials are fully consolidated with its parent company, Clover Health Investments Corp., which reports its financials publicly in its annual and quarterly reports filed with the Securities and Exchange Commission. *See* CHP Budget Submission, 9; *see also* Letter from David Ault (March 15, 2022), 2.

18. Administrative expenses of CHP are not paid for by Vermont providers or Vermont aligned beneficiaries. *See* Staff Analysis, 29.

Litigation

19. CHP's parent entity has received subpoenas from the U.S. Securities and Exchange Commission since February 2021, and is subject to an ongoing inquiry by the U.S. Attorney's Office for the Eastern District of Pennsylvania that Clover states is relating to, among other things, certain of our arrangements with providers participating in Clover's network and programs, and the Clover Assistant. *See* Clover Health Investments, Corp. Form 10-K for Fiscal Year ended December 31, 2021, Item 3. CHP's parent entity is also subject to shareholder derivative lawsuits and disputes with healthcare providers related to reimbursement under the parent entity's Medicare Advantage plans. *See id* at Note 21 – Legal Actions.

Public Comments

20. The Board received two public comments, a comment from CHP, and comments from the Office of the Health Care Advocate in connection with its review of CHP's FY22 budget. *See* Final Staff Recommendations (March 23, 2022), 2. The Board reviewed and considered all public comments.

CONCLUSIONS

Under the ACO oversight statute, 18 V.S.A. § 9382, the GMCB's regulatory role for an ACO, like CHP, that only participates with Medicare payments is not to approve or deny the

ACO's operation in Vermont. The GMCB's role, instead, is to approve or modify a proposed budget for the ACO for each year that the ACO elects to operate in Vermont. CHP bears the burden of justifying its proposed FY22 budget. Rule 5.000, § 5.405(a). In deciding whether to approve or modify the budget, the Board the Board may consider as many of the criteria of 18 V.S.A. § 9382(b) as the Board deems appropriate to a specific ACO's size and scope. In light of CHP's limited size in Vermont, with only approximately 1,800 aligned beneficiaries, and the parameters for CHP's operations established by CMS, the Board focused its review on the factors set out in the Legal Framework. *See* Findings, ¶¶ 3, 8.

Medicare beneficiaries that are aligned to CHP remain enrolled in traditional Medicare, and they are not restricted from the traditional Medicare network that they would have access to if they were not aligned to CHP. *See* Findings, ¶ 7. The terms and conditions of the payer program arrangement are set by CMS, and the GMCB is not tasked with approving or modifying those terms. *See* Findings, ¶ 8.

CHP is a new entrant in Vermont, so we conclude that it is appropriate to focus on collecting information about CHP's performance for FY22 – with a focus on shared savings and loss and available quality metrics to help establish a baseline of performance for CHP's operations in Vermont. We recognize that the aligned beneficiary population in Vermont is small, and so any reporting will be done in a way that ensures patient confidentiality is protected. The Direct Contracting Model is also a new CMS model, but will be short lived and is slated for replacement at the end of FY22. *See* Findings, ¶ 7. CMS's replacement model, ACO REACH, will start at the start of FY23 and is expected to make changes to governance and other programmatic requirements that the Board will review as the model's terms are finalized. *See* Findings, ¶ 6. We have concerns about reported inquiries into CHP's parent entity by the U.S. Securities and Exchange and Department of Justice, and so we require CHP to provide updates regarding any investigations and litigation.

ORDER

Based on our Findings and Conclusions above, and pursuant to 18 V.S.A. § 9382, we hereby approve CHP's FY22 budget as submitted and subject to the conditions set forth below:

1. Clover Health shall provide to GMCB its shared savings, with the proportion attributable to Vermont providers and the actual amount paid out to Vermont providers (participant and preferred). Clover shall provide preliminary shared savings results for 2021 in July 2022 and final results for 2021 and 2022 in July 2023, or in each case within 14 days after CMS publicly releases results.

2. Clover Health shall provide to GMCB its quality reporting, segmented for Vermont if possible, with appropriate restrictions to protect patient confidentiality. Clover shall provide preliminary quality results for 2021 in July 2022 and final results for 2021 and 2022 in July 2023, or in each case within 14 days after CMS publicly releases results.

3. Clover Health shall provide to GMCB audited financials for Clover Health that include CHP's balance sheet and statement of operations contributions, and submit a standalone

audit for CHP, in each case to the extent required by CMS or if filed or required to be filed with the Securities and Exchange Commission.

4. Clover Health shall provide 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.

GENERAL

5. After notice and an opportunity to be heard, the GMCB may make such further orders as are necessary to carry out the purposes of this Order and 18 V.S.A. § 9382.

So ordered.

Dated: July 13, 2022 at Montpelier, Vermont

s/ Kevin Mullin, Chair)
)
s/ Jessica Holmes) GREEN MOUNTAIN
) CARE BOARD
s/ Robin Lunge) OF VERMONT
)
s/ Thom Walsh)

Board Member Pelham, dissenting.

s/ Tom Pelham)

Filed: July 13, 2022

Attest: */s/ Jean Stetter*
Green Mountain Care Board
Administrative Services Director

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