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March 15, 2022

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BY E-MAIL

Russ McCracken, Staff Attorney
Green Mountain Care Board
144 State Street
Montpelier, VT 05602

Re: Responses to reporting requirement follow-up questions

Dear Mr. McCracken:

I write on behalf of Clover Health Partners, LLC ("CHP," and together with its affiliates "Clover") in response to your letter of March 7, 2022 with follow-up questions regarding CHP's FY2022 budget submission. Below please find responses to your questions.

As discussed previously, CHP is a publicly held health care organization dedicated to improving the quality of life for both providers and patients through the use of its unique and proprietary technology and care coordination program. As such, we continue to request that the GMCB hold confidential certain information submitted in response to the Reporting Requirements; The information is exempt from disclosure under 1 V.S.A. § 317(c). We have enclosed two versions of our responses to your supplemental questions: (1) A complete preliminary submission; and (2) A redacted preliminary submission, with confidential responses removed. We note that the complete preliminary submission is provided the GMCB for its deliberation of CHP's requests for confidentiality. In this version, each piece of information for which we seek confidentiality is highlighted in blue, accompanied by a comment bubble identifying the reason for confidentiality.

1. **Does Clover Health plan to continue participation in the new ACO REACH model when it replaces the Direct Contracting Model next year?**

   CHP intends to participate in the Accountable Care Organization Realizing Equity, Access, and Community Health Model ("ACO REACH") in 2023.

2. **Section 1, Question 5b: The question is asking about Clover's executive leadership compensation, not DCE provider participant payments. Please answer the question with this clarification: "does the ACO have any *executive leadership* compensation structure that is tied to reducing the amount paid for patient care?"**

   The compensation of CHP's executive leadership is not tied to reducing the amount that CHP pays for the care of aligned beneficiaries.

3. **When does Clover expect audited financials for 2021 to be available? Can you send them to us when they are available?**

   2021 audited financials for Clover Health Investments, Corp. ("CHIC") are publicly available via the following link:

   https://www.sec.gov/ix?doc=/Archives/edgar/data/1801170/000180117022000015/clov-20211231.htm

4. **Why doesn't Clover Health Partners require a stand-alone audit of its financials?**

   - CHP's Participation Agreement with CMS (attached as Exhibit A to CHP's original submission) does not require a stand-alone audit of CHP financials. Nor, to the best of CHP's knowledge, is a stand-alone audit of CHP's financials required by any other Clover regulator.

   - CHP is fully consolidated into CHIC and is in scope under CHIC's integrated audit

   - We believe CHIC's segment reporting and financial statement line item presentation of the consolidated Balance Sheet and P&L adequately disclose the financial results of CHP.

5. **Given Clover remains hundreds of millions of dollars away from profitability, with operating losses YTD 9/30/2021 at $450 million, how and when does Clover hope to become profitable and sustainable?**

   CHIC has not yet issued to the public any projection of when it or CHP will become profitable and cannot commit to a profitability timeline at this time. As discussed in CHIC's Q4 2021 earnings release, CHIC is implementing a number of initiatives in 2022 aimed at

driving operating efficiencies and improved medical loss ratios in 2022 and 2023, and we expect these initiatives to have a positive impact on CHIC's profitability going forward. See: https://investors.cloverhealth.com/static-files/14744ef0-888f-44a4-af19-bdd290fbe16

6. **Please submit a copy of the CHP beneficiary notification letter for 2022.**

   Please see the document attached hereto as **Exhibit A**.

7. **Network development:**

   a. **How do you plan to grow and expand your consumer base in Vermont in FY2022?**

      For 2022 the only opportunity for CHP to grow its aligned beneficiary population is through voluntary alignment. Should our Participant Provider organization in Vermont elect to participate in voluntary alignment, its patients that are not claims-aligned to CHP will have the opportunity to voluntarily align to the organization.

   b. **Does CHP have any voluntarily aligned beneficiaries in Vermont?**

      Yes

   c. **Do you have plans to expand your network of participant providers in FY2023?**

      We do not currently have any plans to expand our network of Participant Providers in Vermont in FY2023.

8. **In response to question 6 at the bottom of page 6, you say that you currently are only focused on bringing on new Preferred Providers (such as home health) to support existing Participant Providers (a PCP). On Page 7, you state in response to question 3 that you do not intentionally limit the number of providers you work with. Please clarify:**

   CHP does not intentionally exclude or limit the number or type of providers it works with, provided they meet CMS guidelines; CHP does, however, prioritize which providers we actively pursue working with.

   a. **Is there a possibility you might expand the number of PCPs you work with in Vermont in the next five years?**

      Yes.

i. **If you answered yes, please explain how you recruit new providers including contact methods (phone calls, mailings, in-person outreach, etc.) and how you choose which providers to try to recruit or which types of providers you avoid.**

CHP recruits Participant Providers in a number of ways including but not limited to networking, phone calls, email, marketing events and in-person outreach. One key criteria in determining whether to pursue a relationship with a Participant Provider is the Participant Provider's willingness to use the Clover Assistant.

ii. **If you are not looking to expand in the near future in Vermont, please explain why.**

N/A.

9. **When and how will CHP determine any shared savings paid to Vermont providers?**

CHP expects that CMS will determine CHP's PY2021 preliminary shared savings/loss in July of 2022 and CHP's final PY 2021 shared savings/loss in July of 2023. At that time CHP will determine what share, if any, will be paid to Vermont providers.

What are the terms of Clover's contracts with participating and preferred providers regarding earning shared savings? Please explain or cite a specific section of the provider contract.
Please refer to Section 3 of Exhibit A to Exhibit D-2 of CHP's original submission for the contract terms pertaining to shared savings applicable to CHP's Vermont Participant Provider.

Below is a representative example of the shared savings terms applicable to CHP's Vermont Preferred Providers. [Redacted]

10. **You state that your providers do not assume any downside risk, but the ACO assumes "100%" of downside risk. Please clarify, do you share downside risk with payers such as through risk corridors? If yes, please provide details of how you share upside and downside risk with payers.**

No, CHP does not share downside risk with any Vermont providers.

a. Further, please explain how your model incentivizes lower cost, better quality care when the providers are not assuming any downside risk?

CHP does not believe that providers must take on downside risk in order to feel motivated to lower cost and improve quality. We believe that (1) there are many MSSPs over the past decade that have lowered cost and achieved high quality scores without taking on downside risk through better coordination of care; and (2) better care coordination can be achieved in multiple ways, including through use of the Clover Assistant. Our contract with our Vermont Participant Provider requires use of the Clover Assistant. It also requires other care coordination activities.

11. Is your savings model designed to lower utilization trends? If yes, for which provider/service types? Is your savings model designed to lower unit costs? If yes, for which provider/service types?

CHP's model is designed to achieve the program goals of better health, better health care, and lower Medicare per capita costs for aligned beneficiaries. These goals can be achieved by a number of initiatives which include, but are not limited to, reducing unnecessary or inappropriate utilization and reducing the cost of services provided. Reducing unnecessary utilization and improving the cost of care is not limited to any provider/service type.

12. How do you ensure that Clover Assistant will accurately reflect patient morbidity and not make patients appear sicker than they are, which unnecessarily inflates prices and potentially undermines Vermont's all payer model?

The Direct Contracting program has several design elements that are designed to protect against this including: (1) normalizing risk scores; (2) applying a symmetric 3% risk score cap; and(3) applying a Coding Intensity Factor. See Section IV of Appendix B to CHP's Participation Agreement with CMS (attached as Exhibit A to CHP's original submission). Please note also that Clover Assistant does not diagnose patients; it presents providers with available information to assist them in diagnosing patients.

13. How does the ACO support person-directed care?

Our Clover Assistant technology platform surfaces personalized information on patient health risk to physicians caring for patients. In addition, CHP leverages specific Beneficiary Enhancements available under the Direct Contracting program to provide additional care for beneficiaries who wish to receive it. See, for example, Section 10.04 of the

Participation Agreement (Post-Discharge Home Visits Benefit Enhancement) and Section 10.05 (Care Management Home Visits Benefit Enhancement).

14. How does the ACO support appropriate utilization?

CHP provides extra benefits for the sickest patients requiring additional care coordination and management services by leveraging the Benefit Enhancements referenced in response to Question 13. These benefits are intended to improve health outcomes, including by helping avoid adverse health events such as hospital and nursing home stays.

15. How does the ACO support the use of shared care plans?

Our Clover Assistant technology platform is designed to promote data sharing among physicians. For example, diagnosis data from one physician can be surfaced to another physician via the platform. This information surfacing can increase the likelihood of integrated care plans for patients.

16. Does the ACO have evidence to support its Model of Care approach (such as peer reviewed studies or past performance) regarding the measures in the APM agreement?

CHP leverages care management home visits in its Model of Care. House calls for frail elders have been shown to lower hospitalizations and costs per the CMS Independence at Home demonstration as well as by the VA in various studies. Additionally, data from Clover's Medicare Advantage ("MA") business shows that Clover's MA members whose primary care providers ("PCPs") use the Clover Assistant have medical loss ratios that are lower than members whose PCPs do not use the Clover Assistant, and the differential was over 1,000 basis points in 2021.

17. It was noted in CH's response that specialist providers will be contracted to ensure timely access to services to patients, and that house call providers are available to patients (Medical Neighborhood). Has this network of providers come to bear in Vermont?

Home Health and Skilled Nursing Facility Preferred Providers are in place. CHP is still working to develop an in-home care partnership in Vermont.

18. Regarding evidence-based recommendations in CA, what is the nature of the recommendations, procedural or diagnostic?

The Clover Assistant is designed to surface information from the health care ecosystem that we believe may be of use to treating providers as they formulate care plans. This information may help in many cases with both diagnosis and treatment, such as evidence that a patient may have chronic kidney disease based on claims data as well as lab data.

19. What is the data source of the evidence-based recommendations made in Clover Assistant? What is the process for internal review and updates of these recommendations?

Source data for the Clover Assistant includes claims data (including Part D data), as well as lab result data. Using this data, we create mappings and clinical rules based on medications to the diseases they treat in addition to abnormal lab results to associated common conditions. We leverage these mapping for improved diagnosis suggestions based on the aggregate collection of clinical artifacts. Clinical guidelines in the Clover Assistant generally relate to medical society guidelines (e.g., from the American Diabetes Association), which represent standards of care for disease management.

20. What benefit enhancement and beneficiary engagement incentives are CHP participating in? Please resubmit "Appendix B: 2022 Program Arrangements and Elements between ACO and Payer." The benefit enhancement information in the original submission is cut off.

CHP has submitted for approval and been approved to participate in all Benefit Enhancements and all Beneficiary Engagement Incentives. Please find attached hereto as **Exhibit B** a reformatted version of Appendix B to CHP's original submission.

21. How does your business model align with Vermont's Blueprint to Health and the All-Payer Model?

The Clover Assistant is designed to surface information from the health care ecosystem that we believe may be of use to treating providers as they formulate care plans and to promote data sharing among physicians (connecting patients with whole-person care). Clinical guidelines in the Clover Assistant generally relate to medical society guidelines (*e.g.*, from the American Diabetes Association), which represent standards of care for disease management (evidence-based care). The Clover Assistant surfaces personalized information on patient health risk to physicians caring for patients (patient-centered care). Our DCE provides extra benefits for the sickest patients requiring additional care coordination and management services through Benefit Enhancements available under the Direct Contracting

program (*e.g.*, Post-Discharge Home Visits Benefit Enhancement and Care Management Home Visits Benefit Enhancement). These benefits are intended to improve health outcomes, including by helping avoid adverse health events such as hospital and nursing home stays (cost-effective care).

22. Does CHP do any internal or external evaluation of their clinical model? If so, please explain, including what methods will be used, who will conduct the assessment, and how do you define success.

Clover's internal actuarial team evaluates data related to usage of the Clover Assistant and our in-home care management programs. Success may include evidence of reduced medical loss ratio as well as reduced adverse health events (*e.g.*, hospital stays).

23. Some data in CA is provided in real-time such as quality-of-care gaps and lab data is delivered overnight; how frequently is other data, such as claims data and the ADT feed, refreshed in the system?

Claims data is currently updated monthly, and ADT feeds are currently updated daily.

24. In the response to Section 5, Question 2, (page 15) CHP explained that the measures listed in the question were part of the complex care program. How are these measures addressed in patients who are not qualified for the complex care program?

The Clover Assistant is designed to surface common health conditions that a patient may have, such as those in Section 5 Question 2 (e.g. Asthma/COPD, mental health conditions). The Clover Assistant prompts physicians to consider if a patient has these conditions, and to create a treatment plan that can improve patient care and outcomes.

25. Please describe how you work to address racial health inequalities? Please include specific examples or how you implement these policy goals?

CHP as an organization is very focused on issues relating to health equity. For example, we know that racial and ethnic minorities are more likely to be frail and homebound, and provide additional care management services in the home for the sickest patients. We also work to alleviate cost share, as appropriate, for patients receiving these services.

Relatedly, we would like to note that the National Committee for Quality Assurance ("NCQA") recently informed Clover of preliminary evidence of Clover's MA plan's strong performance on a prototype of the MA Health Equity Summary Score ("HESS"), a newly

developed measurement tool for identifying plans that do well at providing high-quality, equitable care to their members, including groups who are disproportionately affected by social risk factors.

26. When are Quality results expected to be reported and posted for 2021 and 2022?

CHP expects CMS to report quality performance results at the same time as it reports shared savings results. We expect CMS to determine CHP's PY2021 preliminary quality performance in July 2022 and CHP's final PY 2021 quality performance in July 2023. For PY2022, we expect that CHP quality performance will be reported in July 2023.

27. The PY1 withhold is set at $7,121,097.09 (5% of benchmark); however, the PY1 measures are pay-for-reporting only, how will this withhold be earned back?

CHP can earn back the withhold by timely reporting on the PY1 measures.

28. Does CHP benchmark measures against other similar entities?

CHP intends to benchmark against other DCEs as well as other CMS value based care programs.

29. Please confirm that your Conflict-of-Interest policy permits Clover's Board of Directors to determine that there is no conflict of interest for individuals who fit the definition of an "interested person."

CHP's Conflict of Interest Policy (attached to CHP's original submission as Exhibit C) permits CHP's Board of Directors to determine that a potential conflict of interest does not constitute a conflict of interest. Please see Section 1.B of the policy.

a. Would Clover consider requiring Board members to find that anyone who qualifies as an "interested person" has a conflict of interest and must either break financial ties with Clover or with the entity that is creating the conflict?

We believe that conflict should be examined on a case-by-case basis by non-conflicted individuals.

b. Why do you believe that Clover's conflict of interest policy should be confidential?

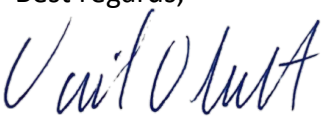
In general, we believe that documents pertaining to the internal processes and policies of CHP should remain confidential unless public disclosure is specifically required by CMS under the Participation Agreement. As the subsidiary of a publicly-traded company, disclosure of internal processes and policies present complicated questions for CHP under federal and state securities laws.

30. Clover is not presently accredited, certified or otherwise recognized by an external review organization. Why is this, and do you plan to seek any type of accreditation?

CHP is a relatively new organization and therefore not accredited/certified by an external review organization outside of CMS. CHP is not currently seeking any other accreditation/certification.

Please do not hesitate to reach out with any additional questions or requests for clarification.

Best regards,



David O. Ault

Enclosures

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

EXHIBIT A

Clover Health Partners

P.O. Box 2093
Jersey City, NJ 07303
1-888-528-0639

<PCP/PRACTICE LOGO>
<PCP/PRACTICE NAME>

<BENEFICIARY FULL NAME>
<ADDRESS1>
<ADDRESS2>
<CITY, STATE ZIP>

REQUIRED ANNUAL NOTICE: NO ACTION NEEDED

Dear <BENEFICIARY FULL NAME>,

We are writing to let you know that your doctor <PCP NAME OR PCP PRACTICE NAME> is part of **Clover Health Partners**, a Medicare Direct Contracting Entity (DCE) participating in a program within Medicare.

Your Medicare benefits have not changed. Your doctor asked Clover Health Partners to help see that you get the right care at the right time. You still have the freedom of choice to go to any doctor, hospital, or other healthcare provider of your choice that accepts Medicare.

A DCE is a group of doctors, hospitals, and other healthcare providers who agree to work together to keep you healthy. All members of **Clover Health Partners** agree to work together to see that you get the right care at the right time. We will help everyone work together to give you better care. We will coordinate your care according to your individual medical needs and treatment choices. We will protect your medical records and privacy. We will work to reduce duplicate tests and duplicate paperwork that cost you time and money. To see a list of the doctors and other groups that work with us, visit our website at: **cloverhealthpartners.com/patients**.

Doctors who are part of a DCE find that they are able to give their patients better quality care. **Your Medicare Benefits have not changed.** You may still go to any doctor, hospital, or other healthcare provider that accepts Medicare. However, because your doctor is now connected with **Clover Health Partners,** some special features may be available to you at no extra cost. For information about any of these features, please ask your doctor or healthcare provider.

Questions?

If you have questions about this letter or the program benefits, please call us at 1-888-528-0639. Or, you may call Medicare at 1-800-MEDICARE (1-800-633-4227; TTY users may call 1-877-486-2048). You can learn more about Medicare Direct Contracting Entities at innovation.cms.gov/innovation-models/direct-contracting-model-options.

We look forward to helping your doctor care for you over the coming year!

Clover Health Partners

EXHIBIT B

Appendix B: 2022 Program Arrangements and Elements between ACO and Payer

ACO	Clover Health Partners, LLC
Year	2022 Budget

Section 3: Questions 2 and 3.

Payer	Direct Contracting Risk Sharing Option	Describe Risk Sharing Arrangement (full risk, shared risk, shared savings, other - please specify)	Indicate Use of Minimum Savings Rate, Minimum Loss Rate or Similar Concept (if any), and Specify Percentage	Specify Percentage of Downside Risk Assumed by the ACO	Specify Cap on Downside Risk Assumed by the ACO (if any)	Specify Cap on Upside Gain for the ACO (if any)	Risk Mitigation Provision in Payer Contract*	Method for Setting Budget Target**	Benfit Enhancements and Beneficiary Engagement Incentives (please list all)	Anticipated Attributed Lives in Vermont	Projected Spending or Payment Associated with Attributed Lives
Medicare	**Global**	**Full Risk**	See Note #1	100%	See Note #1	See Note #1	See Note #1	See the CMS publication titled "Direct Contracting Model Global and Professional Options Financial Companion to Operating Guide Overview: Standard DCE," attached hereto as Exhibit F. Please also refer to Appendix B of the Participation Agreement, attached hereto as Exhibit A.	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	[Redacted]	
TOTAL											

Notes:

**Please describe nature of risk mitigation provision:*

Exclusion or truncation of high-cost outlier individuals (please describe)
Payer-provided reinsurance
Risk adjustment: age/gender, clinical (identify grouper software)

***Please describe method for setting the budget target:*

Trended historical experience
Percentage of premium
Other (please describe)

Note #1: CHP is participating in the Stop-Loss Arrangement available under the Participation Agreement. Please refer to the Participation Agreement, attached hereto as Exhibit A, including pages 171 to 181 for more information. Additionally, CMS has created a mandatory Risk Corridor program that allocates the DCE's Shared Savings and Losses in bands of percentage thresholds, after a deviation of greater than 25.0% of the Performance Year Benchmark. Please refer to Table H on Page 169 of the Participation Agreement for additional information regarding these Risk Corridors.