

# Clover Health

November 29, 2019

Representative Danny Davis  
U.S. House of Representatives  
2159 Rayburn House Office Building  
Washington D.C. 20515

Representative Brad Wenstrup  
U.S. House of Representatives  
2419 Rayburn House Office Building  
Washington D.C. 20515

Representative Terri Sewell  
U.S. House of Representatives  
2201 Rayburn House Office Building  
Washington D.C. 20515

Representative Jodey Arrington  
U.S. House of Representatives  
1029 Longworth House Office Building  
Washington D.C. 20515

Sent via email at: Rural\_Urban@mail.house.gov.

***Re: Rural and Underserved Communities Health Task Force Request For Information***

Dear Representatives Davis, Wenstrup, Sewell, and Arrington:

I am writing on behalf of Clover Health (“Clover”) in response to the Rural and Underserved Communities Health Task Force Request For Information (“RFI”).<sup>1</sup> We believe that technology that delivers real-time information and monitoring, coupled with thoughtful policy initiatives, can result in better health outcomes and access to rural and underserved communities.

As background, Clover is a health care data and technology company offering a Medicare Advantage (“MA”) insurance product. We are dedicated to improving care outcomes and the efficiency of care delivery by enabling primary care providers with real-time access to actionable data on their patients at the point of care. We have developed a proprietary software platform, the Clover Assistant, that (1) aggregates health data from every spectrum of the member’s health care experience, from lab and utilization management requests to specialist visits and customer experience encounters; (2) analyzes that data through machine learning and artificial intelligence while integrating clinical practice insights and plan benefit information (e.g., formulary medications); and then (3) curates the data insights, personalized to each member’s unique conditions or circumstances, to help providers ensure that patients receive the right care at the right time. Our platform helps to raise the level of care of every primary care provider, allowing our business model to expand access and offer wide provider networks, in any part of the country, including the rural and inner-city areas that have been largely skipped over by other MA

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<sup>1</sup> U.S. House Ways and Means Committee, *Rural and Underserved Communities Health Task Force Request for Information*, available at <https://waysandmeans.house.gov/rural-and-underserved-communities-health-task-force-request-information>

plans. We began offering MA plans in 2013, and, to date, have grown to manage over 40,000 beneficiaries - the majority of which are minority - in seven states.

Turning to the RFI, we offer our general recommendations regarding question 2, and can follow-up with more detail in response to each of the questions. Given the rapidly changing advancements in modes of delivery and technology, we support policies wherein health plans have the ability to develop alternative care delivery approaches to support rural and underserved populations.

- The Clover Assistant program provides a tool for primary care physicians (“PCP”) that enhances their ability to provide evidence-based care for Clover patients and to deliver better clinical results. Unlike many other technologies, the Clover Assistant tool is used by PCPs at the point of care. The tool affords a tremendous opportunity to inform PCP decision-making through sharing data insights and recommendations, and thereby partners with PCPs to elevate care delivery.
  - The Clover Assistant enhances our ability to serve low socio-economic status (“SES”) populations because it is designed to raise the level of care of any PCP, no matter where she is located or what resources she has. With the Clover Assistant program, Clover is able to offer plans in under-resourced areas which are often overlooked by sophisticated practice groups and not served by other MA plans.
- Clover also operates a complex care program for our most vulnerable members in need of intensive health care and social services. Our comprehensive program, which has to date enrolled over twelve-hundred members, provides qualifying members with access to a dedicated in-home care team that includes a doctor, medical assistant, and patient-care coordinator. In-home doctor visits are provided as often as needed, combined with a 24/7 nurse support line. Additionally, Clover assists members by scheduling appointments with specialists and arranging for transportation to specialist visits.
  - On average, participants in this program have 9.2 chronic health conditions, compared to 3.3 for the rest of our health plan members. Moreover, over a third of the participants have a major behavioral health condition, including schizophrenia, or schizoaffective, bipolar, or substance abuse disorders.
  - Though the program is not aimed exclusively at individuals with low SES, many of the members in our complex care program are from traditionally underserved populations. Over 65 percent of complex care program members are from underrepresented groups, including those of African-American and Hispanic

heritage. In addition, many are low income, as 20 percent receive additional Medicaid health insurance and nearly 48 percent receive low income subsidy payments from the federal government.

- As a result, program participants have additional access to social workers who help improve access to financial resources, food assistance programs, and behavioral health providers, including psychiatrists and therapists. Overall, the program has significantly reduced hospitalization rates for the participants.
- We support recent efforts to reform MA that support plans in rural and underserved areas and call on Congress to further bolster these efforts.
  - Congress and the Administration have adopted policies to further enable the use of telehealth services in MA. We believe telehealth services effectively support care in lower acuity settings, thus reducing the risk of hospitalizations and complications. Telehealth encounters, however, are not treated on par with face-to-face encounters for purposes of diagnosing chronic conditions and determining disease burdens of patients, factors that are relevant for determining payments to plans under MA. We believe these encounters ought to be treated on the same footing in rural settings given the particular challenges to access to providers in such settings.
  - MA network adequacy conditions also ought to be reconsidered in rural contexts. Currently MA plans must negotiate their own private contracts with providers in order to establish adequate networks of providers in all the areas they serve. This requirement is particularly challenging in rural communities because there are fewer providers to contract with, and often there is a single hospital or health care system that has control over an area. This challenge makes it much harder for MA organizations to offer plans in rural settings. We believe Congress can rectify this situation by requiring all fee for services (“FFS”) providers to accept Medicare-eligible patients in rural areas, regardless of whether an individual is enrolled in MA, and to require MA organizations to charge those MA patients the same in- and out-of-network cost-sharing for seeing those providers. In other words, there ought to be cost parity between in- and out-of-network providers for MA patients in these rural communities. Clover currently offers in- and out-of-network parity for many of its MA plans.

Thank you for your consideration of these critical issues. We are available at your convenience to further discuss our experience and serve as a resource to Committee.

Sincerely,

*Erica Pham*

Erica Pham  
Vice President, Legal and Government Affairs, Deputy General Counsel  
Clover Health