MVP HEALTH CARE
625 State Street, PO Box 2207
Schenectady, NY 12301-2207
mvphealthcare.com

June 25, 2021

Michael Barber
General Counsel
Green Mountain Care Board

Re: MVP Health Plan, Inc. GMCB-007-21rr
2022 Individual Market Rate Filing SERFF No. MVPH-132824950

MVP Health Plan, Inc. GMCB-008-21rr
2022 Small Group Market Rate Filing SERFF No. MVPH-132824927

Dear Mr. Barber:

This letter is in response to your correspondence received 06/07/21 regarding the above-mentioned rate filing. The responses to your questions are provided below.

1. For each filing, specify the percentage of the proposed premium (not premium increase) and the projected PMPM claims expenditures associated with spending at hospitals under the budget review jurisdiction of the Green Mountain Care Board, broken down by inpatient, outpatient, and physician services.

Response: Please see the following tables for the individual and small group filing, respectively.

MVPHP Individual Rate Filing		
Service Category	**Percentage of Proposed Premium at GMCB Facilities**	**Projected PMPM Claim Expenditures at GMCB Facilities**
Inpatient	10.72%	$73.78
Outpatient	30.04%	$206.69
Physician	5.94%	$40.90
Total	**46.71%**	**$321.36**

MVPHP Small Group Rate Filing		
Service Category	**Percentage of Proposed Premium at GMCB Facilities**	**Projected PMPM Claim Expenditures at GMCB Facilities**
Inpatient	11.39%	$68.18
Outpatient	25.94%	$155.29
Physician	6.03%	$36.08
Total	**43.36%**	**$259.54**

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2. For each filing, calculate how MVPHP's pricing trend assumptions, medical trend assumptions, and proposed average rate increase would be impacted if the company had assumed that the Green Mountain Care Board will approve the same hospital budget increases later this year as it approved in 2019.

Response: Please see the following tables for the individual and small group filing, respectively.

MVPVP Individual Rate Filing		
	Proposed Rate Increase Under Projected Hospital Budget	**Proposed Rate Increase Under Hospital Budget from 2019**
Allowed Medical Trend	5.8%	5.3%
Paid Medical Trend	6.4%	5.8%
Total Trend	7.6%	7.1%
Average Rate Increase	17.0%	15.7%

MVPVP Small Group Rate Filing		
	Proposed Rate Increase Under Projected Hospital Budget	**Proposed Rate Increase Under Hospital Budget from 2019**
Allowed Medical Trend	5.8%	5.4%
Paid Medical Trend	6.7%	6.2%
Total Trend	8.1%	7.6%
Average Rate Increase	5.0%	3.8%

3. Explain how MVPHP expects the Transparency in Coverage final rule and the Hospital Price Transparency final rule to impact insurer/provider contracting, if at all.

Response:
This response was prepared by MVP's contracting team.

Transparency in Coverage
Inpatient claims are typically paid on a DRG basis. DRG pricing requires calculation based on all patient diagnoses during a stay as well as calculated severity of illness, length of stay, cost, etc. These factors can only be determined after the fact and, therefore, any up-front pricing information would be highly speculative and would require in-depth knowledge of a highly complicated calculation.

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Most hospitals in Vermont are paid on a line-item discount off charges methodology for outpatient claims. Pre-service pricing estimates could only be made accurately if a health plan knew in advance every service and supply that a hospital would bill during a given encounter. This would be unlikely and, therefore, also highly speculative.

The Transparency in Coverage final rule has the potential to pressure health plans and hospitals to reconsider their payment methodologies - which would be a very significant undertaking on both ends - in order to provide more accurate pre-service pricing.

Hospital Price Transparency

Hospital Price Transparency has the potential to affect MVP's contracting with its network hospitals to the extent that the consumer awareness it creates will likely pressure hospitals to rationalize and make shifts within their chargemasters. A hospital may need to stay competitive, for example, with its ambulatory surgery pricing by lowering those rates in exchange for increasing rates on other services (i.e., lab, imaging). This may result in significant cost shifts for MVP. If a hospital has historically focused on inflating prices on high volume services, any significant cost shifting within its chargemaster has the potential to negatively affect MVP's claims expenditure for its Vermont members.

4. For the most recent year for which data are available, specify the percentages of payments made by MVPHP under each APM category below across its individual and small group plans. The categories below are described in more detail in the Health Care Payment Learning & Action Network's Alternative Payment Model Framework Final White Paper dated January 12, 2016, available at https://hcp-lan.org/workproducts/apmwhitepaper.pdf and are the subject of issuer reporting in the QIS Implementation Plan and Progress Report Form, OMB 0938-1286.

Category 1 – Fee for Service – No Link to Quality & Value	71%
Category 2 – Fee for Service – Link to Quality & Value	0%
Category 3 – APMs Built on Fee for Service Architecture	
• APMs with Upside Gainsharing	29%
• APMs with Upside Gainsharing/Downside Risk	0 %
Category 4 – Population-based Payment	
• Condition-Specific Population-Based Payment	0 %
• Comprehensive Population-Based Payment	0 %

Response: Please see the table above for the percent of claims paid under each category.

5. Describe in detail MVPHP's efforts and plans to increase the use of higher-value payment approaches and its efforts and plans to implement fixed prospective payments within its ACO program in Vermont.

Response: This response was prepared by MVP's contracting team. MVP continues to engage in a total cost of care shared savings arrangement with OneCare VT in 2021 for our Commercial Individual and Small Group lines of business. Both parties continue discuss the exploration of potential future pathways that will benefit consumers that are designed to improve population health, member satisfaction and cost efficiency through the reduction of

low value care through further alignment of payment models (e.g. down-side risk, capitation, etc.)

6. Explain how MVPHP defines and measures low value care and whether it has estimated the amount of low value care provided in Vermont.

Response: This response was prepared by MVP's clinical team. MVP Health Care focuses on low value care and its implications for value, cost and quality, which we define as care that:

- Exposes patients to iatrogenic (doctor-caused) harm and/or increased unnecessary downstream utilization;
- Imposes unnecessary out of pocket costs; and/or
- Leads to lost time, lost productivity, and increased stress for the consumer.

Thoughtfully addressing low value care requires education to members that "more care" is not equal to "good care." As well, close partnering with providers who champion a focus on low value care reduction is essential. Fundamentally, those provider partnerships embedded in value based provider arrangements with downside risk, alternative payment methods, and capitation models are the best positioned to target successful reduction of low value care.

7. Explain MVPHP's rationale for classifying antidepressants and antipsychotic/antimanic agents as preventive and explain whether MVPHP anticipates a decrease in claims costs associated with better management of associated conditions.

Response: This response was prepared by MVP's clinical team. MVP reviewed claims data and the definition of preventive drugs. Based upon other drug categories being categorized as preventive, antidepressants and antipsychotics medications were added as of 1/1/20. Preliminary data has shown increased medication compliance after adding to the preventive drug list, but more time is needed to evaluate full financial impact due to 2020 not being a typical year.

8. Explain how the surgery center adjustments reflected in the outpatient trend table on page 1 of the documents submitted on May 24, 2021 and titled "CONFIDENTIAL_Support for LE Individual Objection #2_SERFF.pdf" and "CONFIDENTIAL_Support for LE Small Objection #2_SERFF" were calculated.

Response: This adjustment was calculated by assuming a shift in outpatient surgery services from hospitals to the Green Mountain Surgery Center. 2019 claims data was used and as the starting point of this analysis. MVP assumed that 8.7% of eligible outpatient surgery services would shift from hospitals to the Green Mountain Surgery Center. Based on the analysis done in Question 5 of the 2020 VT rate filings post hearing questions from the Green Mountain Care Board, the services at the GMSC will be a reduction in cost of -40.4% as compared to the same services in a hospital setting. This results in a decrease of -0.15% in outpatient trend.

9. Specify the number of members directly enrolled in MVPHP plans and describe in detail the efforts MVPHP has made to date and will make prior to open enrollment to inform these individuals of the subsidies that may be available to them if they purchase a qualified health plan through Vermont Health Connect.
    a. At the hearing, please be prepared to explain how many directly enrolled members have enrolled

through Vermont Health Connect for the 2021 plan year.

Response: This response was prepared by MVP's marketing and communications team. MVP Health Care® (MVP) has been working collaboratively with Vermont Health Connect to develop communication plans and to outreach Vermonters regarding the increased subsidies available through the American Rescue Plan Act (ARPA). MVP currently has 2,391 members directly enrolled in MVPHP plans, and MVP has contacted all of the subscribers associated with these members.

In April 2021, MVP mailed an informational letter and flyer to 865 Vermont Individual subscribers enrolled directly with MVP in Platinum, Gold, and Bronze plans to explain the ARPA provision and how eligible members could take advantage of increased subsidies.

Additionally, in May 2021, MVP mailed an informational letter and flyer to 37 direct subscribers enrolled in base Silver plans, and approximately 500 subscribers enrolled in Silver Reflective plans.

Beginning in early June, MVP also updated our online Shop for a Plan tool to reflect ARPA subsidy eligibility changes, added a website banner calling out the change, and began running organic social media campaigns targeted to Vermont geographies to advertise the new subsidy availability per ARPA.

MVP continues to meet weekly with Vermont Health Connect representatives on ARPA-specific communications and is discussing the possibility of a secondary mailing via postcard or an email outreach to direct MVP Individual members later this summer prior to Open Enrollment.

10. We understand that carriers will take over premium billing in 2022. On a PMPM basis, quantify the administrative costs associated with this function that are included in the proposed rates.

Response: This response was prepared by MVP's financial planning team. Please see below for a PMPM breakdown of billing related costs. These figures represent MVP's total cost for these breakouts, not the incremental cost year over year.

- Individual
    - Billing related costs (i.e. print postage and staff): $1.73
    - Treasury related costs (i.e. credit card and other banking fees) $4.88

- Small Group
    - Billing related costs (i.e. print postage and staff): $0.33
    - Treasury related costs (i.e. credit card and other banking fees) $0.60

11. For each of the past five years, specify the percentage of claims MVPHP has recovered through its Special Investigations Unit (fraud, waste, and abuse program) for the plans under review, explain whether there are any national benchmarks for such recoveries, and explain how MVPHP monitors or evaluates the effectiveness of this program.

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Response: This response was prepared by MVP's SIU team. In each of the last 5 years, recoveries for Vermont membership has accounted for less than 1% of claim adjustments resulting from SIU actions. These recoveries are in line with expectations based on the smaller ratio of Vermont to New York membership, where roughly 7% of members are from the state of Vermont.

Each year the SIU creates a Fraud, Waste, and Abuse Prevention plan, which evaluates industry schemes and organizational risk, to establish the areas that the SIU will focus on in the coming year. These risk areas are analyzed and pursued at the issue level and would affect all MVP membership. MVP evaluates the effectiveness of its fraud, waste, and abuse program each November when a comparison is conducted between the Fraud, Waste and Abuse Prevention plan and SIU activities. The FWA Prevention Plan is reviewed, approved and effectiveness evaluated each year by the Corporate Compliance Committee.

12. For each Vermont general/community hospital and for Dartmouth-Hitchcock, the ratio of MVPHP's inpatient reimbursement to Medicare's inpatient reimbursement, standardized by MS-DRG relative weights, and the ratio of MVPHP's outpatient reimbursement to Medicare's outpatient reimbursement, standardized by APC relative weights (in a similar format as MVPHP provided last year in response to question 15 of the Board's post-hearing questions).

Response: [redacted]

If you have any questions or require any additional information, please contact me at cpontiff@mvphealthcare.com.

Sincerely,

Christopher Pontiff, ASA
Leader, Actuarial
MVP Health Care