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

July 27, 2021

Michael Barber
Green Mountain Care Board
144 State Street
Montpelier, VT 05602

Re: MVP Health Plan, Inc.
2022 Individual Market Rate Filing
SERFF Tracking #: MVPH-132824950, GMCB Docket #: GMCB-007-21rr

MVP Health Plan, Inc.
2022 Small Group Market Rate Filing
SERFF Tracking #: MVPH-132824927, GMCB Docket #: GMCB-008-21rr

Dear Mr. Barber:

This letter is in response to your correspondence received 07/22/21 regarding the above-mentioned rate filings. The responses to your questions are provided below.

1. Do MVP's 2021 rates include funding to pay for the company's assumption of billing functions from Vermont Health Connect in 2022? If so, quantify the amount of funding included on a total and PMPM basis.

Response: The assumed project costs (i.e. 2021 Budget) related to the implementation efforts needed to assume the billing function, was initially estimated at $250k ($0.56 PMPM). Current forecasts project this number to be higher, some of which may occur in 2022. The work identified expanded from our initial scope based on more detailed discussions with the State of VT on their requirements. In addition, we will likely work on streamlining / automate these new internal processes after putting in production the basic functionality needed for go live in December (2021) - hence requiring additional expense in 2022.

2. Explain how the DFR Order at Exhibit 29 impacts MVP's $1.89 PMPM adjustment for telehealth utilization.

Response: MVP's proposed rate filing assumed $1.89 PMPM cost increase due to increased utilization attributable to telehealth. Based on the payment policy MVP is strongly considering along with DFR's guidance, this figure is revised down to $0.47 PMPM which is a reduction of $1.42 PMPM.

3. In his testimony, Mr. Lombardo mentioned analyses that MVP has done to understand how members at various income levels will be impacted by the proposed rates after accounting for subsidies. Please describe the analyses that were done and provide the results.

Response: Based on MVP's modeling of premium subsidies under ARPA comparing 2021 approved rates to 2022 proposed rates, policyholders purchasing the benchmark plan will be unaffected by the proposed rate increases up to approximately 750% of the federal poverty limit ($95,700 in annual income for a single person household). See the attached PDF for a summary of premium impact by income level.

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4. Mr. Lombardo testified that MVP projects being 8% to 10% behind its target for 2021 for its Vermont individual and small group business. What are MVP's expected gains or losses and contributions to reserve for these plans for 2021 and for the two-year period 2020-2021?

Response: MVP is projecting 2021 losses will largely offset our 2020 gains. Overall, MVP is projecting 2020 + 2021 VT Exchange operations to generate approximately $2.5M in income which is a contribution to reserve margin of 0.5% over the two-year time period.

5. Explain how the initiative that was discussed in executive session will benefit members in the individual and small group markets and how the initiative is expected to impact claim costs in these markets. Provide support for any expected impacts to claims costs.

[redacted]

6. Explain whether MVP's surplus is allocated by state for purposes of assessing its surplus as a percentage of premium or whether surplus as a percentage of premium is determined based on total surplus and premium.

Response: MVP calculates the surplus as outlined by the requirements as a percent of premium and the surplus is separately tracked in the ledger.

7. For the individual and small group block of business, provide MVP's assumed admin PMPM (from the May filing), budgeted admin PMPM (from the February budgeting process), and actual PMPM (from the SHCE) for 2018, 2019, and 2020.

Response: Please see the table below that shows the requested admin PMPM's.

VT Small Group and Individual Market Administrative Cost Comparison 2018-2020

Year	Assumed Admin from Filing	Budgeted Admin PMPM	Actual PMPM
2018	$38.10	$39.35	$40.72
2019	$39.80	$38.29	$39.86
2020	$42.00	$39.66	$34.40

8. On page 6 of Exhibit 8, MVP states that in each of the past five years, recoveries for its Vermont membership accounted for less than 1% of total claim adjustments resulting from SIU actions. Please specify the actual percentages

for each of the past five years and explain why these results are "in line with expectations" when, as the response acknowledges, approximately 7% of members are now from Vermont.

Response: Response will be provided by Friday, July 30, 2021.

9. Is MVP's SIU delivering a positive return on investment for Vermont ratepayers?

Response: Response will be provided by Friday, July 30, 2021.

10. Please follow up on MVP's response to Question 5 in Exhibit 8 and describe any efforts the company has made to implement fixed prospective payments and any plans the company has to implement fixed prospective payments.

Response: One of MVP's top strategic priorities is the investment in alternate payment model programs. MVP has been engaged in alternate payment models including: pay-for-performance, shared savings, risk sharing, bundles and primary care capitation with network providers for the past several years, aligning with Federal, VT and NYS roadmaps.

The following are some of the fixed compensation paradigms that MVP has built to offer capitation to PCPs:

- Primary care capitation accompanied by a shared savings program.
- Performance based primary care capitation with capitation increased for quality, efficiency, access, and member satisfaction. This model could be accompanied by a shared savings model.

The primary care capitation model has been implemented for almost a decade with many providers in NY. Now the performance-based capitation model is being rolled out to eligible providers in Eastern NY at this time and expansion to additional MVP service areas is being planned.

As stated in MVP's response to Question 5 in Exhibit 8, 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 to 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.)

The COVID-19 crisis initially led to a pause with respect to these glidepath discussions and in 2021 MVP and our network providers are reimagining planned arrangements including careful consideration of the impact of the abnormal utilization patterns due to COVID used to baseline new APM models. MVP remains committed to continuing to explore a path from shared savings to a longer-term risk model including the option of fixed prospective payments with OneCare VT.

11. Would MVP consider using fixed prospective payments for non-hospital providers? If so, which ones? If not, why not?

Response: MVP's alternate payment model (APM) programs are designed to reward providers for delivering high quality appropriate care to our members to improve their health outcomes while controlling the overall cost of care. As stated in response to question 10, MVP is actively pursuing roll-out of the performance-based PCP capitation model in NY and would be willing to explore expansion of that model to VT providers. Longer term, MVP believes that

introducing a performance based primary care capitation model designed to elevate the member experience by addressing immediate access needs – moving beyond the traditional face to face visits to alternatives such as telemedicine (where bandwidth allows) and telephonic and asynchronous communication – to improve member satisfaction will be most effective. Capitated payments under this model would provide a consistent and predictable revenue stream to primary care providers in the MVP network. Capitation allows primary care practices to apply segmented, team-based care that is still nuanced for the population and provided by teams that include doctors, nurses, medical assistants, care managers, behavioral health providers, pharmacists, and clerks. This type of team-based care is well documented to improve outcomes for patients.

As an agent of innovation and change, MVP is committed to continuously evaluating how to develop and enhance existing care delivery models to meet member needs, with an emphasis on expanding access, developing new provider models and solutions, and empowering our members. MVP welcomes exploration and collaboration with key providers in our service area that will enhance the member experience, where new models (including fixed prospective payments) would align provider interests, incentives, and payments to deliver patient-centered care. The caveat is that a key consideration once new models are conceptually defined is both provider and payer implementation and operational readiness requires thoughtful evaluation and planning.

12. At page 11 of his pre-filed testimony (Ex. 16), Mr. Lombardo states that Case Managers "ensure that members have access to information to support the selection of providers and facilities that will move members into systems in which standards of care are utilized effectively and will provide cost-effective outcomes." At page 4 of Exhibit 8, in answer to a question about low value care, MVP describes "close partnering with providers who champion a focus on low value care reduction" as "essential." What specific metrics does MVP use to distinguish providers and facilities that provide cost effective care or that champion low value care reduction from those that do not? Once identified, what specific, concrete actions does MVP take to steer members away from providers and facilities identified as either not cost effective or low value care centers (be sure to address frequency and intensity of those actions)? What steps, if any does MVP take to sever relationships with such providers?

Response: MVP's focus on reducing low value care initially began with an assessment of inappropriate lab utilization. In 2020, we implemented claims edits to ensure that certain lab services are covered only when billed with an appropriate, medically necessary diagnosis to support that test. In most cases, this aligns with efforts that NYS Medicaid and CMS have introduced. In all cases, this effort aligns tightly with current clinical practice guidelines from trusted professional societies.

As we have expanded our efforts and in order to more objectively track and target low value care being provided to our members, we built a Low Value Care Dashboard comprised of measures directly based upon guidelines from nationally recognized sources such as the National Quality Forum (NQF) and the United States Preventive Service Task Force (USPSTF).

The categories of measures included in the MVP Health Care Low Value Care Dashboard includes the following:

- Cancer Screening
- Diagnostic and Preventive Testing
- Preoperative Testing
- Imaging

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- Cardiovascular Testing and Procedures
- Other Surgery

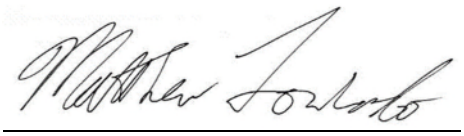
Although currently still in development, the dashboard will eventually produce a detailed data extract functionality for each measure, thus allowing the user to drill down based on geography and provider groups. The specific actions that will be taken as a result of the findings from the dashboard remain in discussion but will likely fall into strategic clinically targeted programs with the highest outlier providers, leveraging education, partnership and alternative payment methods to influence provider ordering behavior.

13. When did MVP last put its pharmacy benefits manager (PBM) contact out to bid? When is MVP's current PBM contract set to expire?

Response: MVP last put it PBM out to bid in late 2019 into 2020 for a January 1st, 2021 effective date. The current PBM contract expires 12/31/2023 with other provisions.

If you have any questions, please contact me at mlombardo@mvphealthcare.com.

Sincerely,



Matthew Lombardo, FSA, MAAA
Senior Leader, Actuarial Services
MVP Health Care, Inc.

Member Premium Net of APTC - VT Approved 2021 vs Proposed 2022										
FPL (One person Household)	< 200%	200%	250%	300%	400%	401%	500%	600%	750%	1000%
Annual Income (One Person Household)	< $25,760	$25,760	$31,900	$38,280	$51,040	$51,168	$63,800	$76,560	$95,700	$127,600
2022 Proposed Rates	$0	$43	$107	$193	$365	$366	$456	$547	$684	$777
2021 Approved Rates (ARPA Subsidies Assumed)	$0	$43	$107	$193	$365	$366	$456	$547	$669	$669
Difference in Member Premium Cost	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**($15)**	**($108)**