STATE OF VERMONT
GREEN MOUNTAIN CARE BOARD

In re: MVP Health Plan, Inc. 2025 Individual Market Rate Filing	))))	GMCB-005-23rr SERFF No. MVPH-134081032
In re: MVP Health Plan, Inc 2025 Small Group Market Rate Filing	))))	GMCB-006-23rr SERFF No.: MVPH-134081005

Dear Mr. Karnedy,

The Green Mountain Care Board hereby requests that MVP Health Plan, Inc. (MVP) provide the following information to assist with the Board's review of the above-referenced filings. Please provide responses to all questions by July 12, 2024.

1. Provide MVP's Supplemental Health Care Exhibit and Annual Statement Key Pages for 2023.

2. For the most recent year for which data are available (please specify), provide the dollar value of payments and the percentages of payments made by MVP under each alternative payment model category below across MVP's individual and small group plans and identify the relevant program or payment arrangement(s).

(YEAR)			
HCP-LAN Category	**Program or Payment Arrangement(s)**	**$ value**	**% of total**
Category 1: FFS-No link to Quality and Value			
1: FFS-No link to Quality & Value			
Category 2: FFS-Link to Quality and Value			
2A: Foundational payments for infrastructure & operations			
2B: Pay for reporting			
2C: Pay for performance			
Category 3: APMs Built on FFS Architecture			
3A: APMs with shared savings			
3B: APMs with shared savings and downside risk			
3N: Risk based payments NOT linked to quality			

Category 4: Population-Based Payment			
4A: Condition-specific population-based payment			
CU4B: Comprehensive population-based payment			
4B with reconciliation to FFS and ultimate accountability for TCOC			
4B with NO reconciliation to FFS			
4C: Integrated finance & delivery system			
4N: Capitated payments NOT linked to quality			

3. Using the most recent calendar year of complete data for the populations covered by these filings, compare MVP's average payment to primary care providers to MVP's average payment to non-primary care providers. Please use NESCSO definition 2 (Defined PCPs, All Services) and NESCSO definition 4 (Defined PCPs, Selected OB/GYN Services) for this analysis and include non-claims-based payments as applicable.[1] *See* New England States Consortium Systems Organization, *The New England States' All-Payer Report on Primary Care Payments* (Dec. 22, 2020), https://nescso.org/wp-content/uploads/2021/02/NESCSO-New-England-States-All-Payer-Report-on-Primary-Care-Payments-2020-12-22.pdf.

4. The Board's 2024 QHP order required MVP to "report back to the GMCB describing the rates awarded to Board-regulated and non-Board-regulated entities and explaining how MVP considered and utilized affordability, access, and quality in negotiating rates." In response to this requirement, MVP submitted a PowerPoint presentation on April 12, 2024. Please reproduce slide two of this presentation, clarify what the table reflects, and provide comparable data for non-Board regulated entities. Please also explain how MVP considered affordability, access, and quality in negotiating provider reimbursement rates.

5. RAND recently released Round 5 of its Hospital Price Transparency Study. *See* RAND, Hospital Price Transparency Study Round 5, https://www.rand.org/health-care/projects/hospital-pricing/round5.html. The data shows Vermont being above the national benchmark on several metrics, such as outpatient facility plus physician price and total facility plus physician price. The accompanying research report also shows that Vermont had the highest State-Level Hospital-Administered Commercial Drug Price Relative to ASP of any state. *See* Christopher M. Waley, Rose Kerber, Daniel Wang, Aaron Kofner, and Brian Briscombe, Prices Paid to Hospitals by Private Health Plans: Findings from Round 5 of an Employer-Led Transparency Initiative, 22. Describe how MVP interprets these findings and whether they are consistent with or vary from any similar analyses or studies MVP has done or accessed. Describe how MVP can leverage information in this study.

[1] Please note that this is not a request for the percentage of total claims expenditures attributable to primary care. If MVP wishes to provide this analysis too, it would be welcome.

6. Explain in detail how charge increases get applied within the categories of inpatient, outpatient, and physician services. Is it completely up to the hospital? Is it a matter that is or can be negotiated? Has MVP observed any patterns or trends related to how charge increases are applied at the service level?

Sincerely,

s/ *Michael Barber*
Michael Barber
General Counsel, Green Mountain Care Board
(802) 828-1741
michael.barber@vermont.gov