



Medicaid Reform: Risk-Adjusted Rates Used to Pay Medicaid Reform Health Plans Could Be Used to Pay All Medicaid Capitated Plans

at a glance

As required by state law, the Agency for Health Care Administration has phased in a method that pays Medicaid Reform capitated plans monthly rates that are risk-adjusted to reflect the health status of plans' beneficiaries. With risk-adjusted rates, the agency pays higher rates to plans that serve beneficiaries who are sicker and have greater health care needs than plans that serve healthier beneficiaries. The agency currently uses the Medicaid Rx model which uses pharmacy claims and demographic data to calculate these rates. By 2009, it expects to begin phasing in another model, the CDPS that will rely on diagnostic data from the agency's newly developed encounter data system and may continue using pharmacy data as well.

The advantage of risk-adjusted rates is that they better match capitated plan payments to the health status and costs of each beneficiary. Regardless of whether Medicaid Reform expands beyond the pilot counties, once AHCA gains experience using encounter data to set risk-adjusted rates, the Legislature should consider directing the agency to also use risk-adjusted rates to pay non-Reform capitated plans.

Medicaid Reform

The 2005 Legislature authorized the Agency for Health Care Administration (AHCA) to reform the state Medicaid program with the intent of improving health outcomes of Medicaid beneficiaries and achieving budget predictability.¹ AHCA obtained a federal waiver and legislative approval to implement a managed care pilot program, which began providing services to Medicaid beneficiaries in Broward and Duval counties in September 2006. AHCA expanded the pilot to Baker, Clay, and Nassau counties in September 2007.² AHCA will need legislative approval to expand Medicaid Reform beyond these five counties.³

The major premise of Medicaid Reform is to improve health care services by giving managed care health plans flexibility to better meet the specific needs of Medicaid beneficiaries and to promote competition among these plans. Under Medicaid Reform, health plans can develop customized benefits packages for different beneficiary groups. Medicaid Reform is intended to empower beneficiaries by offering them more managed care options and encouraging them to take an active role in their health care.

¹ Chapter 2005-133, *Laws of Florida*.

² AHCA received approval to implement an 1115 Research and Demonstration Waiver application from the Centers for Medicare and Medicaid Services in October 2005. The Legislature approved implementation of the waiver in December 2005 (Chapter 2005-358, *Laws of Florida*).

³ Chapter 2005-358, *Laws of Florida*, established a goal of statewide implementation by June 2011 in accordance with waiver requirements but requires AHCA to obtain legislative approval to expand implementation beyond the pilot sites.

Medicaid Reform beneficiaries receive detailed information on their health plan choices and assistance from specially trained choice counselors to help them select a Reform plan that best fits their needs. Beneficiaries can earn monetary credits for participating in certain healthy behaviors that they can use to purchase health-related products.

Participation in Medicaid Reform in the pilot counties is mandatory for certain low-income children and families and aged and disabled beneficiaries. These include families who have incomes at or below 23% of the federal poverty level, children who live in families that earn up to 200% of the federal poverty level (depending on the children's ages), and individuals who are age 65 and older or disabled and receive federal Supplemental Security Income.⁴ Other beneficiaries may choose to participate in Medicaid Reform, including children in foster care, individuals with developmental disabilities, and Medicare beneficiaries who are also eligible for Medicaid (dual eligibles).

As required by Chapter 2005-133, *Laws of Florida*, this is one of a series of reports presenting the results of OPPAGA's evaluation of the Medicaid Reform managed care pilot programs. This report reviews how AHCA sets payment rates for Medicaid Reform managed care plans and addresses four questions.

- How does AHCA set Medicaid Reform capitated rates and how does this differ from non-Reform plans?
- Why did AHCA select the risk-adjusting model it currently uses for Medicaid Reform and what model does AHCA plan to use in the future?
- What are Medicaid Reform plans' views regarding Florida's transition to risk-adjusted rates for Medicaid Reform?
- Would it be beneficial for AHCA to use risk-adjusted rates for other Medicaid health plans?

⁴ In 2008, 23% of the federal poverty level is \$4,048 per year for a family of three; 100% of the federal poverty level is \$17,600 for a family of three; and 200% of the federal poverty level for a family of three is \$35,200.

How does AHCA set Medicaid Reform capitated rates and how does this differ from non-Reform plans?

Under Medicaid Reform, AHCA pays capitated health plans a monthly rate that is risk-adjusted based on beneficiary health status and demographic factors.⁵ By risk-adjusting rates, the state pays plans that serve beneficiaries who are sicker and have greater health care needs more than plans that serve healthier beneficiaries. This differs from non-Reform in that AHCA pays non-Reform capitated plans monthly rates that take into account certain demographic factors but are not adjusted based on health status.

AHCA currently pays each Medicaid Reform capitated plan a monthly rate that adjusts for the health status of its beneficiaries using Medicaid Rx. Medicaid Rx is a statistical model that uses prescription drug information to identify medical conditions and uses this information (along with age-gender categories) to predict beneficiary health care costs.^{6,7} To develop Reform capitated rates, AHCA first derives a per member per month base rate for each of four groups defined by eligibility category (children and families or aged and disabled) and service area (AHCA area 4 or 10) using historical expenditure and enrollment data.^{8,9} AHCA adjusts these base rates based on the health status of plan beneficiaries. The Medicaid Rx model predicts beneficiary health status and costs by calculating risk scores based on prescription drug use and age-gender categories

⁵ AHCA currently pays all Reform provider service networks (PSNs) using fee-for-service reimbursement, but also develops risk-adjusted rates for each PSN and periodically reconciles each plan's spending with the amount the plan would have received under risk-adjusted capitated payments. PSNs must begin accepting risk-adjusted capitated payments within three years of joining Reform, which will be September 2009 for the first participating PSNs.

⁶ The Department of Family and Preventive Medicine at the University of California, San Diego developed Florida's Medicaid Rx model using data from California's Medicaid program collected from 1995 through 2004.

⁷ AHCA contracts with Mercer to develop Reform rates using the Medicaid Rx model and will pay \$2.8 million from March 2006 through January 2010 for these services.

⁸ AHCA service area 4 includes Duval and the surrounding rural counties: Baker, Clay, Nassau, Flagler, St. Johns, and Volusia. AHCA service area 10 includes only Broward County.

⁹ AHCA in collaboration with its contractor, Mercer, develops base rates using two years of historical spending for all beneficiaries eligible for managed care (including those enrolled in PSNs and fee-for-service) and divides this total spending by the total months of service for these beneficiaries.

for each beneficiary enrolled in Medicaid for at least 6 months during the 12-month measurement period.^{10, 11} For beneficiaries enrolled for less than six months, AHCA assigns them the plan’s average risk score. AHCA then develops a total risk score for each children and families and aged and disabled plan by averaging the individual risk scores for the beneficiaries enrolled in that plan. To determine a plan’s total capitated payment, AHCA multiplies the original base capitation rate by the average risk score for the plan and the total number of beneficiaries. AHCA updates risk scores monthly, based on each plan’s previous month’s enrollment and reevaluates pharmacy data quarterly to update beneficiaries’ health status and individual risk scores.

The primary advantage of using risk-adjusted rates is that this system enables the state to allocate funding so that plans with beneficiaries who are sicker and have greater health care needs (and are thus more costly to serve) receive higher payments than plans with healthier beneficiaries, while the total cost to the state remains unchanged. Exhibit 1 illustrates how this works for a hypothetical situation involving three plans, each with four beneficiaries. Plan A’s beneficiaries have a higher average risk than Plans B and C. Thus, Plan A would receive a higher per member per month rate (\$216) and its total payment would be higher as well.

In contrast, AHCA pays non-Reform plans capitated rates using a different method which does not take into account beneficiary health status. To establish these rates, AHCA uses historical fee-for-service claims data for specified groups of beneficiaries in each of its 11 service

areas.¹² For each service area AHCA calculates rates for 19 beneficiary groups defined by eligibility type and age-gender category.¹³ For example, AHCA calculates a per member per month rate for male children and families beneficiaries in area 4, age 14-20, and a different rate for female children and families beneficiaries in this same area and age group. However, unlike the risk-adjusted system, AHCA pays all health plans that serve beneficiaries in one of these groups the same rate for all beneficiaries in that group, regardless of their health status. (Appendix A compares Reform and non-Reform rate setting methods.)

**Exhibit 1
Higher Average Beneficiary Risk Scores Result in Higher Payments for Reform Health Plans**

	Risk Scores and Payments for Each Plan ¹		
	Plan A	Plan B	Plan C
First beneficiary in plan	1.18	0.90	0.91
Second beneficiary in plan	0.99	0.98	0.90
Third beneficiary in plan	1.22	1.10	1.03
Fourth beneficiary in plan	0.93	0.94	0.92
Average risk score	1.08	0.98	0.94
Base payment per month	\$200.00	\$200.00	\$200.00
Risk-adjusted rate	216.00	196.00	188.00
Payment for four beneficiaries	864.00	784.00	752.00

¹ Hypothetical amounts, for illustrative purposes only. Source: OPPAGA analysis.

As required by state law, AHCA has phased in the risk-adjusted rate setting process. During the first year of Reform, AHCA based 25% of each plan’s monthly payment on the risk-adjusted rate derived from Medicaid Rx and 75% based on the method it uses to pay non-Reform plans. In the second year, AHCA based 50% of Reform plans’ monthly rates on using Medicaid Rx to adjust for health status.

¹⁰ Medicaid Rx determines each beneficiary’s health status or risk based on the beneficiary’s age, gender, and prescription drug claims. Risk scores can range from <1.0 to 50+, with beneficiaries with higher risk scores predicted to consume more costly services.

¹¹ The measurement period evaluates past pharmacy claims. For example, AHCA based the March 2008 risk scores rates on pharmacy claims from July 2006 through June 2007.

¹² Similar to Reform, AHCA uses the two most recent years of fee-for-service claims data to determine non-Reform rates.

¹³ This method, referred to as a demographic rate setting model, groups beneficiaries into categories that are associated with different costs. AHCA separates groups by gender starting at age 14 for the beneficiaries in the children and families eligibility group. AHCA considers four Medicaid eligibility groups—children and families, aged and disabled who receive SSI but no Medicare, aged and disabled who receive SSI and Medicare Parts A and B, and aged and disabled who receive Medicare Part B only. AHCA calculates rates for defined age-gender categories within these groups. After calculating rates, AHCA applies regional discounts that range from 91% to 100% of the base capitated rate to ensure savings from managed care where there is competition and to encourage managed care in areas that lack competition.

During this same timeframe, as directed by state law, AHCA also has limited the variation of the risk-adjusted rates to 10% below or above the average rate across all plans, creating a range known as a risk corridor.¹⁴ For example, if the average adjusted plan rate is \$200 per member per month and a plan's average risk for its beneficiaries is 1.22, the plan would receive \$220 per member, \$24 less than the \$244 it would have received without the risk corridor adjustment.

Beginning in September 2008, AHCA will base 100% of each plan's capitated rate on the Medicaid Rx model and will no longer use risk corridors. Thus, capitated Reform plans will receive their full adjusted rate based on the risk scores of their enrolled beneficiaries. For the most part, the September 2008 rates for plans will vary from approximately 0.83 (17% below) to 1.27 (27% above) the average rate for children and families beneficiaries, and from 0.74 (26% below) to 1.32 (32% above) the average rate for aged and disabled beneficiaries.¹⁵ These rates vary significantly more than the 10% above and below the average rate that was allowed through the use of risk corridors.

Why did AHCA select the risk-adjusting model it currently uses for Medicaid Reform and what model does AHCA plan to use in the future?

AHCA selected the Medicaid Rx model to set risk-adjusted rates because Reform prescription drug information was readily accessible and up to date. Once encounter data becomes available, AHCA plans to use the CDPS, a diagnosis based model to calculate risk-adjusted rates.¹⁶ It also plans to

test the feasibility of setting these rates using a combined model that uses both diagnostic information and pharmacy claims. Either approach should better predict future costs because they will allow AHCA to better identify beneficiaries most likely to incur high costs.

The Florida Legislature requires AHCA to risk-adjust Reform capitated payments. To fulfill this mandate, AHCA selected the Medicaid Rx model to use while it works with managed care capitated plans to develop an encounter database system. This model was developed specifically for the Medicaid population and uses pharmacy claims to link prescription data to 45 disease categories for adults and 2 additional categories for disabled children that along with demographic information can predict on average from 6% to 15% of beneficiaries' future costs.¹⁷ This is an improvement over the method AHCA uses to set non-Reform capitated rates, which generally predicts only 1-2% of each beneficiary's future costs.¹⁸

AHCA plans to begin using the CDPS diagnostic model once capitated plan encounter data becomes available. This model is expected to better predict beneficiary health care costs than the current Medicaid Rx model since it can predict on average from 7% to 24% of Medicaid beneficiaries' future costs.¹⁹ AHCA also plans to test the feasibility of risk-adjusting capitated rates using both diagnostic and pharmacy information. Using a combined model may predict health care costs better than the CDPS alone.²⁰ Exhibit 2 summarizes AHCA's activities to develop and implement an encounter data system that will be used to support the new model.

¹⁴ Medicaid programs that use risk-adjusted rates sometimes initially limit the range of these rates, creating a "risk corridor" to ensure that managed care plans do not experience too large of an upward or downward shift to revenue. This approach gives Medicaid programs and their capitated plans an opportunity to understand the impact of risk adjusting and to review and refine their risk-adjustment models.

¹⁵ These ranges represent plans that had at least 100 enrollees in September 2008, since smaller plans tend to have even greater variation in risk scores.

¹⁶ The CDPS (Chronic Illness and Disability Payment System) model uses diagnostic information to establish risk and can be used independently or in combination with certain pharmacy claims.

¹⁷ The Medicaid Rx model predicts approximately 15% of future costs for the disabled, 11% of future costs for adults enrolled in the children and families group and 6% of costs for children enrolled in the children and families group.

¹⁸ This is based on research that compares the predictive accuracy of rates developed using only demographic factors compared to approaches that combine demographic and other health status information.

¹⁹ Research indicates the CDPS model predicts approximately 24% of future costs for the disabled, 12% of future costs for adults enrolled in the children and families group and 7% of costs for children enrolled in the children and families group.

²⁰ Initial research indicates that combining diagnostic information with pharmacy claims could, on average, predict approximately 26% of the costs for disabled beneficiaries and approximately 15% and 9% of the costs for adults and children, respectively.

Exhibit 2

AHCA Expects to Have All Encounter Data Needed to Phase in the CDPS Model by 2009

Year	Percentage Premium Risk-Adjusted	Risk-Adjusting Model	Risk Corridors +/-10%	Encounter Data
September 2006	25%	Medicaid Rx	Yes	Collect prescription data (ongoing)
September 2007	50%	Medicaid Rx	Yes	Provide technical assistance (ongoing) Collect and test statewide encounter data
September 2008	100%	Medicaid Rx	No	Collect statewide encounter data using the new fiscal agent Test data on CDPS and/ or combined risk-adjusting model
September 2009	100%	Medicaid Rx	No	Collect statewide encounter data Begin phase-in of CDPS and/or combined risk-adjusting model ¹

¹AHCA will run both the Medicaid Rx and the CDPS models during the phase-in period to ensure that the data from the CDPS or combined model is sufficiently accurate to develop accurate rates.

Source: Agency for Health Care Administration.

What are Medicaid Reform plans' views regarding Florida's transition to risk-adjusted rates for Medicaid Reform?

Reform plan representatives generally support the use of risk-adjusted rates; however, representatives from provider service networks (PSNs) and health maintenance organizations (HMOs) have different opinions on how the state should proceed in using the Medicaid Rx model.²¹ PSN plan officials support AHCA's planned schedule to fully implement risk-adjustment using Medicaid Rx beginning in the fall of 2008. In contrast, HMO officials believe it is important to wait to fully implement risk-adjusted rates until encounter data is available and AHCA begins using the CDPS model or a combined model that includes pharmacy data.

PSN plans favor moving to full implementation of risk-adjusted rates and removing risk corridors. PSN officials indicated that using risk-adjusted rates more appropriately pays health plans that serve sicker beneficiaries and that AHCA should base 100% of capitated plans' payments using Medicaid Rx until encounter data is available. These officials supported using the Medicaid Rx model in the interim because it predicts beneficiary costs better than the method AHCA uses to set rates for non-Reform plans. PSNs also

avored discontinuing the 10% risk corridor limit to premium variation based on average risk because it penalizes plans that serve sicker beneficiaries by limiting payments to these plans.²²

In general, the PSNs expect that it will be relatively straightforward for them to collect encounter data from their providers. Because most of their providers already submit detailed claims to receive payment, PSNs reported that encounter submissions will not be problematic for them and anticipate that valid encounter data will be available to set risk-adjusted rates.

HMO plans do not favor immediate implementation of fully risk-adjusted rates and believe AHCA should continue using risk corridors. While HMO officials also agreed that using risk-adjusted rates is appropriate for setting payments for capitated plans, they did not favor using the Medicaid Rx model to calculate 100% of their payments starting fall 2008, in part because pharmacy data can reflect physician prescribing patterns and not necessarily beneficiary health status.²³ This can occur when plans allow physicians to prescribe drugs for off-label uses or prescribe drugs for diseases and symptoms for which the medical community lacks standard prescribing practices, such as gastro-acid reflux, insomnia, pain, and low-grade infections. Because the Medicaid Rx model may result in

²¹ We contacted all 6 PSNs and 10 HMOs and spoke to or received written responses from representatives from 4 PSNs (ACCESS, Children's Medical Services, NetPASS, and South Florida Community Care Network) and 7 HMOs (AMERIGROUP, Buena Vista, HealthEase, Staywell, Total Health Choice, Universal, and Vista). The remaining plans did not respond to our request for information.

²² Two PSNs also expressed concerns that they may not be able to accept risk under a capitated system, because rates do not adequately cover their costs.

²³ Three HMOs are also concerned about continuing to participate if risk adjusting is combined with rate decreases.

some plans receiving higher payments due to prescribing practices, HMO officials asserted the state should reinstate the use of risk corridors.

HMO officials also reported that it will be difficult for them to collect valid encounter data from providers that they pay using capitated payments. Because many plan providers are not currently required to submit detailed information on each encounter, HMO officials expect that some providers may not be able to submit valid encounter data within the agency's established time frame and this will affect AHCA's ability to use this information to set valid rates. However, HMOs are continuing to work with their providers to improve the quality of encounter data.²⁴

Would it be beneficial for AHCA to use risk-adjusted rates for other Medicaid health plans?

The primary advantage of using risk-adjusted rates is that this system enables the state to better allocate funding so that plans serving beneficiaries who are sicker and have greater health care needs (and are thus, more costly to serve) receive higher payments than plans with healthier beneficiaries. Regardless of whether Medicaid Reform expands beyond the pilot counties, once risk-adjusted rates based on the health status of plan beneficiaries are fully implemented in Reform areas, the Legislature should consider directing AHCA to also use this rate setting model to pay non-Reform plans that accept capitated payments. Risk-adjusted rates are preferable to the method AHCA currently uses to pay non-Reform Medicaid capitated health plans because the system is based on methods that generally predict beneficiary health care costs better than methods that only

²⁴ Plans that pay providers using capitated payments do not routinely receive encounter or diagnosis code information. Plans report it is challenging to ask providers to accurately submit this information and also report they will not have the historical information needed to set rates for several years after the encounter system is operational.

consider demographic information, especially for chronically ill and disabled beneficiaries.²⁵

Medicaid programs in several states successfully use risk-adjusted rates to pay managed care plans. Some of these states have done so since the late 1990s. Maryland began using risk-adjusted rates in 1997, and Colorado and Oregon began in 1998. Eleven other state Medicaid programs currently use or plan to use risk-adjusted rates.²⁶ The federal Medicare program also pays managed care plans using risk-adjusted rates.

Recent changes to Florida law may increase the number of Medicaid beneficiaries enrolled in capitated managed care plans in non-Reform counties.²⁷ With a greater dependence on managed care, it will be important for AHCA to allocate Medicaid funds in a manner that pays plans based on the health status and expected costs to serve their beneficiaries.

Agency Response

In accordance with the provision s. 11.51(5), *Florida Statutes*, a draft of our report was submitted to the Secretary of the Agency for Health Care Administration for her review and response.

The Secretary's written response has been reproduced in Appendix B.

²⁵ Small plans or plans serving specialty populations with highly variable costs will have difficulty accepting any type of capitated payment.

²⁶ A Society of Actuaries 2008 [publication](#) lists the following states: Massachusetts, Michigan, Minnesota, New Jersey, New York, Ohio, Pennsylvania, South Carolina, Tennessee, Utah, and Washington.

²⁷ Chapter 2008-143, *Laws of Florida*, amends s. 409.9122(2), *F.S.*, to change how AHCA assigns beneficiaries to managed care plans. In counties with two or more managed care plans, during reenrollment periods, MediPass participants must choose to remain in MediPass during their 60 day open enrollment period. If they do not make this choice, AHCA will assign them to a managed care plan, and give the beneficiary an additional 90 days to disenroll from that plan. However, implementation of this law, originally expected in October 2008, has been delayed.

 OPPAGA supports the Florida Legislature by providing evaluative research and objective analyses to promote government accountability and the efficient and effective use of public resources. This project was conducted in accordance with applicable evaluation standards. Copies of this report in print or alternate accessible format may be obtained by telephone (850/488-0021), by FAX (850/487-3804), in person, or by mail (OPPAGA Report Production, Claude Pepper Building, Room 312, 111 W. Madison St., Tallahassee, FL 32399-1475). Cover photo by Mark Foley.

Florida Monitor: www.oppaga.state.fl.us

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Gary R. VanLandingham, Ph.D., OPPAGA Director

Appendix A

AHCA Uses Different Methods to Calculate Payment Rates for Reform and Non-Reform Capitated Plans

AHCA pays Medicaid capitated plans a monthly fee to provide all health care services needed by their enrolled beneficiaries. The total payment to all capitated plans is determined by the Medicaid budget. AHCA allocates payments based on the number of beneficiaries enrolled in each plan.

For Medicaid Reform capitated plans, AHCA develops a per member per month base rate using historical expenditure data and demographic factors, develops a risk score for each beneficiary using pharmacy claims and age-gender categories, and averages the risk scores of the beneficiaries enrolled in the plan to determine the plan’s risk-adjusted rate. In contrast, for non-Reform capitated plans, AHCA develops a per member per month base rate using fee-for-service historical expenditure data and demographic factors but does not adjust for beneficiary health status. See Table A-1 for a step by step comparison of these two different methods for developing Medicaid capitated plan payment rates.

**Table A-1
AHCA Uses Different Methods to Calculate Capitated Rates for Medicaid Reform and Non-Reform Capitated Health Care Plans**

	Medicaid Reform Health Plans	Medicaid Non-Reform Health Plans
STEP 1: Select beneficiaries for historical spending analysis	All HMO-eligible beneficiaries enrolled in <ul style="list-style-type: none"> • PSNs • Fee-For-Service 	All HMO-eligible beneficiaries enrolled in <ul style="list-style-type: none"> • PSNs • Fee-For-Service
STEP 2: Separate selected beneficiaries by demographic factors	Selected demographic factors <ul style="list-style-type: none"> • Medicaid eligibility group • Service area 	Selected demographic factors <ul style="list-style-type: none"> • Medicaid eligibility group • Service area • Age-gender group
STEP 3: Calculate base rate for each sub-group	Use two years of historical spending to develop a base rate for each eligibility group and service area.	Use two years of historical spending to develop a base rate for each eligibility group, service area and age-gender group.
STEP 4: Select beneficiaries to receive a risk score	Identify beneficiaries from each sub-group who have been enrolled in Medicaid for any 6 of the 12 months in the measurement period.	
STEP 5: Develop individual risk scores	Develop risk score for each beneficiary enrolled in Medicaid for at least 6 of the 12 months of the measurement period using <ul style="list-style-type: none"> • prior prescription drug claims and • age-gender group. Apply each plan’s average risk score to beneficiaries who have not been in Medicaid for six of the 12 months in the measurement period.	
STEP 6: Total and average the risk scores	Total and average all of the risk scores in each eligibility group and service area (e.g., aged and disabled/Broward) for each plan to determine the plan’s risk score.	
STEP 7: Determine risk-adjusted rates	Multiply the base rate by each plan’s risk score to determine the risk-adjusted per member per month rate	
STEP 8: Total plan payment	Multiply the plan’s risk-adjusted rate by the number of enrolled beneficiaries in each eligibility and service area group.	Multiply the base rate by the number of enrolled beneficiaries in each group.

Source: Agency for Health Care Administration and OPPAGA analysis.

Appendix B



CHARLIE CRIST
GOVERNOR

HOLLY BENSON
SECRETARY

September 26, 2008

Gary R. VanLandingham, Director
Office of Program Policy Analysis and
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Dear Mr. VanLandingham:

Thank you for the opportunity to review the draft report entitled "*Medicaid Reform: Risk Adjusted Rates Used to Pay Medicaid Reform Health Plans Could Be Used to Pay All Medicaid Capitated Plans.*"

The Agency would like to thank OPPAGA for their diligent efforts to understand the risk adjusted rate methodology used in the pilot. As always, we appreciate the opportunity to respond and look forward to working with OPPAGA again in the future.

Sincerely,

A handwritten signature in blue ink, appearing to read "Holly Benson", is written over a series of horizontal blue lines.

Holly Benson
Secretary

HB/co

