# Successful Implementation in the Public Sector: Lessons Learned from Florida's Medicaid Reform Program

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In 2006, the state of Florida's Medicaid program began implementing a pilot reform program in 5 counties, 2 of them being the state's largest counties. In addition to transitioning Medicaid beneficiaries from traditional fee-for-service Medicaid to managed care plans, the reform sought to empower beneficiaries to take control of their health through several innovative programs. Implementation of the reform was challenging because of the large number of beneficiaries in transition, the number of providers participating in the Medicaid program, the large number of health plans that elected to participate in the reform, the large advocacy community, and a short time frame given for implementation. This case study of the Florida Medicaid Reform experience illustrates how public agencies can implement change to the Medicaid program. Findings and conclusions offer the public health community a better understanding of the resources and processes required for implementing similar reforms and programs in the future.

**KEY WORDS: administrative reform, medicaid, medicaid waiver, policy implementation**

Medicaid offers an insurance option for more than 60 million poor Americans who otherwise would not have health benefits.[1] The program, which is jointly funded by the federal and state governments, is facing significant economic pressures. In 2009, Medicaid spending growth was about 7.9%, which was the highest in 6 years.[2] In addition, despite having coverage, individuals in the Medicaid program demonstrate poorer health status than their wealthier counterparts.[3] Concern about spending growth has lead a number of states to implement reforms aimed at slowing the rate of growth in Medicaid expenditures. Because of the relative poor health of Medicaid beneficiaries, reform activities often include preventative initiatives including incentive programs for healthy behaviors and disease management programs.

In July 2006, the state of Florida's Medicaid program began implementing a pilot reform program in 2 of the state's largest counties. In addition to transitioning Medicaid beneficiaries from traditional fee-for-service Medicaid to managed care plans, the reform sought to empower beneficiaries to take control of their health through several innovative programs.[1] The actual implementation of the initiative proved challenging because of the large number of beneficiaries who would transition, the number of providers participating in the Medicaid program, the large number of health plans that elected to participate in the reform, and a short time frame given for implementation. By using the Florida Medicaid Reform experience as a case study of how a public agency can implement change to the Medicaid program, we offer the public health community a better understanding of the resources and processes required for implementing similar reforms and programs in the future.

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## Policy Implementation

*The successful implementation of an administrative reform* can be defined in 2 ways: (1) consequences of program action or (2) the extent to which the designer's plans are fulfilled.[4] Because it will take several years to collect the data necessary to determine whether Florida's Reform achieves its intended consequences, we will be defining implementation as the extent to which the designer's plans are completed. In this case, the designer's plans include transitioning Medicaid beneficiaries to managed care, and implementing the Choice Counseling, Opt-Out, and Enhanced Benefits Rewards (EBR) programs.

Policy researchers have identified numerous organizational factors associated with successful implementation. However, no formula or specific combination of factors has been identified that can accurately predict the success of an implementation. Depending on the context, the level of ambiguity, and the level of conflict, different factors are related to successful implementation.[5] We have identified 5 factors that will be critical to successful Reform implementation. Based on the implementation literature, the presence (or absence) of these 5 factors will help explain the relative success of the implementation described in this research.

### Goal consensus

In a policy implementation, goal consensus is necessary for success, particularly when the actors responsible for implementation are separate organizations that are not the authors of the policy reform.[6] Organizations have their own goals that are not necessarily aligned with the policy goals. Congruence of these goals is vital for a successful implementation, and this congruence is more difficult when policy goals or organizational systems are complicated and complex.[7]

### Flexibility

When a policy implementation involves multiple actors at various locations, flexibility is an important determinant of success. The ability to change and make adjustments for local implementers eases the implementation process.[8]

### Cultural change

Organizations involved in implementing policies often come with unique organizational cultures.[6] These cultures can cause resistance to change, and they influence the implementation strategies selected. If a policy's implementation brings about programmatic change, this can change the culture of an organization.[9] Unless participating organizations are willing to adjust their cultures, implementation can be challenged.

### Resources

Implementation success depends on the use of appropriate resources.[5] The type and scale of resources needed for implementation can be determined on the basis of the institutional factors of the organizations responsible for the policy change and on the level of resource interdependence of the organizations participating in the implementation.[4,10] Over time, the content and success of a reform will evolve with the type and scale of required implementation resources.[4]

### Leadership

Policy implementations involving multiple organizations often fail because leadership is ineffective in making structural and cultural changes needed for success and in facilitating cooperation and collaboration among participating parties.[11] This failure has been demonstrated in studies of failed welfare policy implementations.[12,13] Inability to clearly articulate the purposes of the policy change and the goals of implementation may result in failure.[12] Leadership is also charged with navigating the external environment during an implementation process.

## Florida's Medicaid Reform

In October 2005, Florida's Agency for Health Care Administration (AHCA) was formally approved for an 1115 research and demonstration waiver by the US Department of Health and Human Service's Centers for Medicare and Medicaid Services. In December 2005, the legislature authorized the design and implementation of the reforms as set forth in the waiver application. The implementation of this reform began in July 2006, and the transition of Medicaid beneficiaries into managed care organizations began on September 1, 2006. Florida's Medicaid Reform was initially implemented in 2 of the state's largest and most geographically and demographically diverse counties: Duval and Broward. In its second year, implementation was scheduled for 3 rural counties: Baker, Clay, and Nassau. These counties were selected as pilot areas because they are largely representative of all counties in the state of Florida. If Reform is considered successful in the 5 pilot counties, the legislature can approve expansion into the remaining 62 counties. Approximately 6 months passed from the date of legislative approval for Reform to the

beginning of implementation, which is a very aggressive timeline for a policy change of this magnitude.[1]

In the context of Florida's Medicaid Reform, we will specifically view the achievement of the following milestones as implementation. First, implementation means the movement of Medicaid beneficiaries to a managed care plan. This includes (*a*) identifying and contracting with managed care plans, (*b*) publicizing and making beneficiaries aware of the changes, (*c*) facilitating beneficiaries' choice of plan, and (*d*) ensuring that they receive care. The implementation of the Choice Counseling program is a key component of the transition to managed care. Secondly, implementation means ensuring the presence and monitoring of disease management and other prevention programs for chronic diseases within participating managed care plans. Thirdly, implementation means putting the Opt-Out and EBR programs in place.

### *Transitioning to managed care*

All Medicaid beneficiaries in the pilot counties were to be transitioned from fee-for-service Medicaid into managed care options. Encouraging decisions in selecting a managed care plan is one mechanism through which Reform intended to empower beneficiaries. Market competition for enrollees was to be encouraged by allowing plans to have a certain amount of flexibility in benefit design. Although all participating plans had to offer a basic level of benefits, Reform allowed plans to add additional benefits such as adult dental care or an over-the-counter drug benefit. Beneficiaries were then expected to select a plan, using Choice Counseling, with the benefit design that best met their needs.

### *Disease management and prevention*

The transition to managed care was intended to emphasize preventative care. Agency for Health Care Administration mandated that participating managed care plans were to design and implement disease management programs in 5 areas: (1) human immunodeficiency virus/AIDS, (2) congestive heart failure, (3) diabetes, (4) asthma, and (5) hypertension. Through Medicaid Reform, AHCA also intended to work with the managed care plans to monitor and improve quality. Beginning in January 2007, managed care plans were required to begin collecting data on new quality measures to be reported to AHCA on an annual basis. Quality metrics were selected on the basis of nationally accepted quality measures and state-specific interests. These measures will be used to track plan performance improvement and identify areas where improvement is needed.[1]

### *Opt-Out program*

Another mechanism built into Florida's Medicaid Reform to facilitate beneficiary choice is the Opt-Out program. This program assists Medicaid-eligible beneficiaries in purchasing health insurance through their employers if they so desire. The structure of the Opt-Out program would allow for a family to seek employer-sponsored health insurance using a Medicaid premium. For example, this would allow for an entire family to receive coverage when before this option, only a child might have coverage.[14]

### *EBR program*

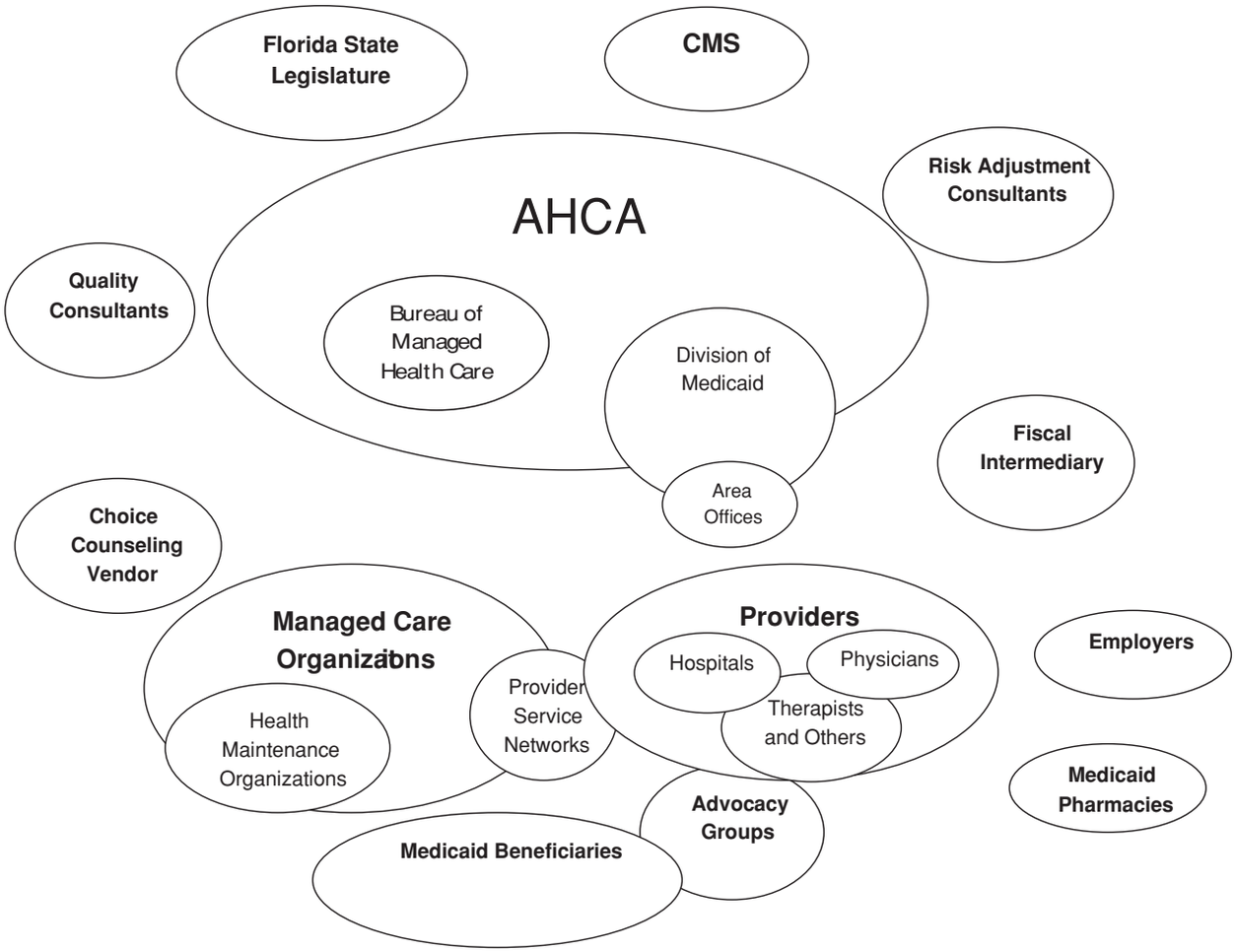
The EBR program was created to incentivize beneficiaries to participate in healthy behaviors. Managed care plans report beneficiary behavior on a monthly basis, and beneficiaries receive credits to an account that can be used to purchase health-related items from approved retail pharmacies. Both active and passive healthy behaviors are included on the list of qualifying activities. For example, a beneficiary might receive credits for going to a primary care appointment (a passive behavior) and they might receive credits for beginning a smoking cessation program (an active behavior). Preventive care is emphasized in the behaviors incentivized by the EBR program. Participants receive credits for prevention and wellness visits, childhood immunizations, mammograms, Papanicolaou tests, colorectal screenings, disease management, weight loss, and smoking cessation programs. The lists of items on which enrollees can spend their credits are also health related and include vitamins, diapers, and over-the-counter medications, among other items.[14]

### *Organizations and stakeholders involved in implementation*

At the center of Reform is AHCA, the state agency responsible for the Medicaid program. Two of the units within AHCA that are working on Reform include the Bureau of Managed Health Care (under the Division of Health Quality Assurance) and the Division of Medicaid. The Division of Medicaid also has area offices across the state, including in each of the pilot counties. The nature of the reform involved AHCA contracting with nongovernmental Medicaid managed care organizations to manage and coordinate the care of Medicaid beneficiaries. Agency for Health Care Administration also had to cultivate a relationship with beneficiary employers to launch the Opt-Out program, and they had to work with providers and pharmacies to implement the EBR program.

A variety of organizations not directly involved in the operation of Reform were also integral, adding

**FIGURE ● Organizations Involved in Medicaid Reform Implementation**




to the complexity of the implementation. These organizations included the Florida state legislature, the governor's office, and the Centers for Medicare and Medicaid Services, which provide oversight to the Medicaid program. In addition, there are various consulting groups, which provided ad hoc services such as the calculation of risk-adjustment rates, the development of beneficiary outreach materials, and assistance with quality initiatives. The agency contracted with a fiscal intermediary, an organization that provides Choice Counseling services, and a university to conduct the program's evaluation. Figure 1 provides a visual interpretation of these organizations.

As noted earlier, AHCA contracted with health plans to provide services to enrollees. Some plans are national companies, whereas some are purely Florida-based organizations formed specifically for Reform. Some are for-profit entities, and some are not-for-profit entities. Some focus purely on public payers such as Medicaid, and some cover a commercial market, too. Some plans are aligned with either physician groups or hospitals, whereas others are more traditional managed care organizations. Finally, some plans are fully capitated, whereas others are fee-for-service entities. In the first year of Reform, approximately 16 managed care organizations of various types participated.

Health care providers are also critical to Reform implementation. Physicians, hospitals, and other health care providers must negotiate contracts with participating health plans. In addition, they need to be informed on aspects of each plan and the EBR program. Safety net providers often serve the Medicaid population, and therefore, they have a vested interest in any reforms or changes to the program. Two of the primary hospital safety net providers, one in Broward County and one in Duval County, elected to create provider service networks (PSNs) to serve the Medicaid population in the Reform counties as managed care organizations. Physician groups serving primarily the Medicaid population, including a large pediatric practice, also chose to create PSNs to ensure seamless service to their patients in the Reform counties.

Medicaid beneficiaries are the most important group of stakeholders involved in this implementation process. The care of these individuals will be affected by Reform; therefore, communicating with this group and soliciting feedback are of major importance. Agency for Health Care Administration intended for beneficiaries to become empowered with regard to their health, and they hoped to engage beneficiaries in making a choice with regards to their managed care plans. Keeping this group informed on upcoming changes with the Medicaid program is a critical success factor for Reform implementation.[1,14] Advocacy organizations were extremely vocal in ensuring that the needs of beneficiaries were addressed throughout the implementation process.

## Methods

Our analysis had 2 goals: (1) to track the progress of Reform implementation in its first year using verifiable metrics and (2) to distill the thoughts of stakeholders on the Reform progress and identify important lessons learned through the implementation process. Using the information gleaned from this analysis, we can confirm the presence (or absence) of the 5 factors necessary for a successful policy implementation on the basis of the policy literature: (1) goal consensus, (2) flexibility, (3) cultural change, (4) resources, and (5) leadership.

### Process of identifying themes

Semistructured interviews are useful in qualitative research when broad exploration of a topic is indicated.[15] The first round of key informant interviews was completed during the summer of 2006, and the second round of interviews was conducted between December 2006 and May 2007. The interviews included AHCA officials at headquarters and in area offices, representatives from Medicaid reform plans, and other stakeholders. In total, 107 interviews were completed. Interviews were conducted in person and a minimum of 2 members of the evaluation team were present for each interview.

Qualitative data obtained from the interviews were analyzed using an iterative, exploratory approach. Data from the interview transcripts were organized into categories on the basis of the themes using content analysis as a thematic coding technique.[16,17] Consistent with a grounded theory approach,[18] emergent themes were identified by the investigators and examined further in subsequent interviews. The investigators identified overarching themes through a collaborative analytic process on the basis of their interview experiences. Interview transcripts were then coded using the initially identified themes, and confirmatory quotations were selected from the text. After the coding process was completed, the investigators compared their findings to assure reliability of the themes. The investigators then merged their findings to create a summary of overarching themes and supporting documentation.

## Results

Results are presented in 2 sections. The first section describes implementation progress, and the second section highlights perspectives on the implementation based on structured interviews with key stakeholders.

### Implementation Progress

Publicly available data were used in this portion of the analysis. Data were obtained from both AHCA's annual report[1] on Florida's Medicaid Reform and the organizational report issued by the University of Florida[14] to facilitate the description of implementation progress in the first year.

#### *Managed care enrollment*

As of March 31, 2007, beneficiaries in Reform counties had 17 managed care plans to choose from, including 16 options in Broward County and 7 options in Duval County. Of these plans, 6 were PSNs and 10 were health maintenance organizations. Reform plans were allowed to modify their benefits packages within limits. Although 4 plans offered no modified benefits, the others offered a variety of additional benefits. Eight plans provided an over-the-counter drug benefit, and 6 plans offered adult dental coverage. One plan included an adult vision benefit, and 3 plans included a circumcision benefit.

By the end of March 2007, almost 80% of beneficiaries transitioning to Reform plans made voluntary choices through the Choice Counseling program. Beneficiaries making active choices increased from 65% in September 2006 to almost 80% in March of 2007. Most voluntary enrollments (63% in March 2007) occurred via the phone; however, 27% (March 2007) occurred in face-to-face interview sessions. No data exist to indicate why 20% of beneficiaries did not make a voluntary choice. One possible explanation might be an issue with proper phone numbers and addresses of Medicaid-eligible citizens. However, this is speculation.

By March 1, 2007, approximately 166 674 beneficiaries were enrolled in Medicaid Reform managed care plans, representing 11.8% of the total Medicaid population in Florida. This represented a shift from 89% to 97% managed care in Broward County and 67% to

92% managed care in Duval County. Overall, the transitions resulted in a 3% shift statewide from fee-for-service MediPass to Medicaid managed care.

### *Disease management and prevention*

By the end of the early implementation phase of Reform, managed care plans had in place the 5 disease management programs indicated by AHCA. In addition, the plans were working with AHCA on the collection and reporting of quality performance measures. Thirteen of the total 33 performance measures were to be reported at the end of December 2007.

### *The Opt-Out program*

The Opt-Out program received 20 calls from interested beneficiaries from its inception through March 2007, and of these calls, only 3 resulted in participation. Of the 3 beneficiaries choosing to utilize the Opt-Out program, 2 disenrolled by the end of this time period.

### *EBR program*

Between September 2006 and March 2007, a total of 84 289 Medicaid beneficiaries received credits for healthy behaviors, and the number of enrollees receiving credits steadily increased over this time period. This represented approximately $2.4 million in credits. As of March 2007, only $26 000 in credits were utilized by beneficiaries to make purchases.[1,14]

## Themes

Themes reflect the implementation experiences of key personnel at AHCA headquarters and their area offices, and the experiences of key stakeholders from participating managed care organizations.

### *Theme 1: Reform was developed and implemented quickly*

The development and implementation of Medicaid Reform was done in an expedited manner because of the timeline mandated by the state legislature. The opinion that such a timely implementation was truly remarkable was echoed by AHCA key stakeholders.

> I think largely the most challenging aspect is really the timeline.

The majority of agency respondents agreed that AHCA effectively and quickly achieved a monumental task with the implementation of Reform. However, the aggressive timeline required many AHCA staff to take on additional Reform-related duties in addition to completing normally required work.

### *Theme 2: Florida's Medicaid agency was fundamentally changed by Reform experience*

Stakeholders reported that the Medicaid Reform initiative changed the way that AHCA conducts day-to-day business. Agency for Health Care Administration was committed to implementing Reform through a disciplined, specific "project management" approach. This involved the organization of key agency stakeholders into teams including content experts, AHCA staff, and dedicated project managers. These teams opened the lines of communication between internal departments including area offices that did not effectively interact before Reform. The timeline for Reform development and implementation was integrated into the project management process and this kept AHCA moving forward at a fast pace. In addition, project management established clear accountability and timely availability of information. This new approach led to a new way of thinking about the development and implementation of other AHCA initiatives.

> We've seen a revolution in Medicaid in that now people are talking across bureaus, they are thinking in a team concept.

Agency for Health Care Administration also developed new approaches to working with and communicating with external constituents. Managed care plans indicated that, in the Reform implementation process, the access to AHCA staff was unprecedented. Overall, managed care plans were pleasantly surprised with how smoothly development and implementation occurred. Communication was cited as the most positive aspect of the implementation process.

The Reform implementation process has led to the cultivation of relationships between plans and the area offices in the local communities. Area offices are now directly charged with solving problems and interacting with plans and providers.

> There was also the idea of getting outside of the agency, our providers, our beneficiaries, our advocates, the legislators to buy into Reform and to listen to what we were saying. I think that's been outreach. . .

A series of outreach initiatives were used to communicate with beneficiaries, including an informational telephone line, letters, a media campaign, and town hall style meetings. A technical advisory panel composed of health plan executives, providers, and beneficiary advisory group representatives was legislatively mandated. The technical advisory panel was found to be an important forum for external constituents to communicate with AHCA. Dealing with advocacy groups who opposed aspects of Reform proved challenging. The management of misinformation and misconceptions about Reform forced

AHCA to constantly ensure the availability of accurate information.

### *Theme 3: Leadership at all levels*

Strong leadership, at all levels, was critical to the development and implementation of Reform. From the governor's office to the front line AHCA staff, commitment to Reform was evident.

> Leadership has been wonderful in trying to get us what we need to make this work well.

Upper management clearly communicated its commitment to the success of Reform to both internal and external stakeholders. Feedback was solicited from internal staff, AHCA area offices, Medicaid beneficiaries, participating managed care plans, providers, and other interested parties. The AHCA staff was empowered to make the decisions necessary for the implementation of Reform.

> The Agency has a vision and everyone knows his or her individual roles. . . leadership has mobilized all key individuals. Pace is fast and accurate with clear vision from Governor's office and AHCA leadership.

### *Theme 4: Significant resource investment in reform*

The dedication of resources including funding, human resources, vendors, information, and time were valuable in the development and implementation of Reform. Although legislative funding of the initiative was considered a critical success factor, some anxiety remains that future funding might be at risk.

> . . . . we've had to do a lot of work in a compressed time frame but you know it was a priority so the resources were dedicated and it's getting done.

Reform stretched AHCA's human resources because of its aggressive timeline and staffing levels. Employees were responsible for Reform activities in addition to their existent work activities. Therefore, vendors, including consultants and other subject matter experts, were a valuable resource during development and implementation because they provided both experience and manpower.

> . . . . one of the key concepts that allowed us to succeed is we brought in subject matter experts when we needed them.

### *Theme 5: Technical difficulties or "bumps in the road"*

Although managed care plans painted a positive picture of AHCA during the Reform development and implementation process, criticisms were raised. Reflecting the indifferent sentiment of some, one respondent described the Reform implementation process as "not catastrophically awful."

Many complaints relate to communication or technical matters. Some plans cited difficulty getting answers to certain questions or issues because of the fact that AHCA did not yet know the answer to the question. The Reform evolved during its implementation, which lead to uncertainty on the part of the agency and unanswered questions. Also, some managed care plans indicated that contact people changed frequently, making it difficult to know who within the agency could answer questions appropriately. Plans suggested that you might get a different answer or resolution to an issue depending the individual responding to the inquiry. Many changes occurred throughout the Reform process, and more technical assistance on the front end would have been helpful.

> We would like to have quick response with clear cut guidance that is consistent across plans. This is not happening. . . different answers depending upon who you talk to. . .

Technical issues related to the organizational forms of the managed care plans were cited. Provider service networks are new forms of managed care plans created for the Reform that are owned and operated by health care providers, primarily physician practices or hospitals. These plans were not capitated in the beginning of the Reform, but they were supposed to be on a level-playing field with the capitated health maintenance organizations also participating in the Reform. The same quality improvement initiatives and regulatory requirements are required of both types of plans; however, the fundamental differences in organizational form made achieving parity difficult. Some health plans suggested that AHCA does not yet know how to manage provider service networks and that AHCA worked exclusively with the Florida Association of Health Plans during development and implementation. This close relationship made nonmember plans feel like their input was not welcome.

A relatively large technical problem having to do with claims and payments was experienced by some plans (PSNs) early in the Reform implementation process. This issue was partially due to a change in fiscal intermediary that was occurring during the initial implementation. The technical glitch resulted in delayed payment to providers, and this often led to hard feelings. This payment issue was more of a problem with PSNs than health maintenance organizations, which further demonstrated issues related to the different organizational forms.

Another bump in the road related to the auto assignment process and transition of beneficiaries into managed care plans in the first months of Reform. A

process designed to equitably transition beneficiaries who did not make an active choice into managed care plans was used. However, some plans were not satisfied with their auto assignment enrollment numbers and perceived that certain plans were getting favorable treatment in this process.

### *Theme 6: Administrative burden associated with reform*

Managed care plans participating in Reform cited increased administrative burden related to implementation. Some plans continued to operate in both Reform and non-Reform counties; therefore, the administrative costs related to operating 2 plans were magnified. The short timeline from Reform application to implementation was a major burden for participating plans. The application was deemed onerous and redundant for plans already participating in Florida Medicaid. One plan spokesperson stated that although they successfully completed the process, it took a lot of "pain" to get there, including overworked staff, external consultants, and additional costs.

Issues with information systems and the extra reporting requirements of Reform increased the administrative burden for participating plans. The reporting of encounter data was the largest change to reporting requirements, and getting the data has proven to be a "big burden." With regard to tracking quality indicators, plans agreed that 33 metrics were too many. Additional training processes and system modifications were necessary for many participating plans, and many organizations added new employees and new functions.

> A lot of work!. . .average member stays with us 9 months so we are not going to see any return on investment. There is value here, but how much is enough vs. too much.

## Discussion

Based on our analysis, the 5 factors necessary for a successful policy implementation were present in the case of Florida's Medicaid Reform: (1) goal consensus, (2) flexibility, (3) cultural change, (4) resources, and (5) leadership. However, the implementation was not without its challenges or bumps in the road.

The implementation and early operation of Florida's Medicaid Reform initiative appears to have been successful in transitioning beneficiaries to managed care organizations in a relatively short period of time and offering a variety of plans from which beneficiaries may choose to join. Agency for Health Care Administration was successful in identifying and contracting with managed care plans, and as of March 2007, around 80% of beneficiaries were making voluntary plan choices. Both Broward and Duval Counties were successful in achieving more than 90% enrollment in managed care plans; however, Duval County transitioned a larger number of enrollees into managed care plans. Participating plans were operating mandatory disease management programs, and they were beginning the collection of required quality metrics. The design and implementation of the EBR program was successful, but it did take some time for beneficiary participation to begin. Finally, although the Opt-Out program was implemented, poor participation in this program was observed.

Achieving goal consensus was particularly challenging in this policy implementation because of the variety of stakeholder organizations involved in the process. Internally, AHCA and its organizational units had to learn to communicate and develop linkages never before cultivated. Externally, AHCA had to communicate with the organizations that would be participating in the Medicaid Reform initiative. To facilitate consensus, this new emphasis on communication among all parties was critical.

Maintaining flexibility was also a priority of AHCA in the development and implementation of Reform. Throughout the process, AHCA solicited feedback from various stakeholders and tried to integrate this feedback into the development and implementation process. Although stakeholders were appreciative that their feedback was actually used in the process, this did create some issues in the implementation process. Managed care plans responded that sometimes AHCA did not actually know the answer to a question or solution to an issue because plans were constantly evolving. Although flexibility is important in the implementation process, maintaining a balance between the appropriate amount of flexibility and too much uncertainty proved challenging.

Medicaid Reform resulted in a near cultural revolution for AHCA. The application of project management to this initiative changed the way the entire agency communicates and responds to external partners. This did not go unnoticed by external stakeholders, and this cultural change within the agency was so strong that external organizations believe AHCA to be fundamentally changed by the Reform experience. Often, culture can present a major challenge in the implementation of a significant change in operations for an organization or multiple organizations in a system. However, AHCA embraced the challenge and their commitment to Reform resulted in a significant change to their culture.

The state dedicated a significant amount of resources to the agency to facilitate the implementation of Reform. Financial resources were dedicated to this initiative, and these were used to provide support in the form of vendors and information exchange. One shortcoming in the provision of resources for the Reform

initiative appeared in the human resources area. Agency for Health Care Administration staff was charged with the task of carrying out day-to-day responsibilities in addition to new Reform expectations.

From the perspective of the managed care plans, the implementation of Reform was a significant resource drain. Many of these organizations ended up operating duplicate plans (Reform and non-Reform), which resulted in redundancy in a number of areas. Also, the reporting requirements and administrative burden associated with Reform resulted in the need for new information systems and staff for these organizations. A policy implementation of this magnitude could not be successful without adequate resources. Key stakeholders argue that they still did not have enough resources to adequately implement Reform.

Without strong leadership from the state and AHCA, the implementation of Reform could never have been accomplished in such a short time frame. Within AHCA, leaders communicated their commitment to this policy initiative to staff at all levels. This message transcended the organization and inspired AHCA employees to put in the extra work and effort necessary to implement Reform in a relatively short time frame. Without such leadership and support for project management, the cultural changes that occurred within the agency would not have been successful. In addition, the leadership helped facilitate necessary resources for the implementation of this Reform into place.

Although the implementation of changes defined by the authors of the reform appears to have been largely successful, it is too soon to assess the consequences of this implementation on cost, quality, and access to care within Florida's Medicaid program. Early data analysis on 3 years of beneficiary surveys indicates that participants have a fairly high degree of satisfaction associated with their health care. Comparisons in Broward and Duval counties between pre- and post-Reform surveys show a decline in satisfaction with overall health care and health plan but an increase in satisfaction with one's personal doctor.[19] An analysis of the cost of the Medicaid Reform indicates little change on per member per month expenditures when comparing pre- and post-Reform spending.[20] These results are based on early data collection, and more definitive results will be available once more time passes and more data can be collected.

## Conclusion and Recommendations

Although the implementation of such a major initiative was not without bumps in the road, other public health agencies seeking to make policy changes of this magnitude can learn from Florida's experience. Communication with all participants is a critical success factor. Adequate resources are imperative to the success of the process, and finally, strong leadership is essential. Commitment to this reform was evident at every level of the organization. Learning from the experiences of others is one way to ensure that their mistakes are not repeated. The implementation of Florida's Medicaid Reform provides a tremendous amount of information for other public health leaders to absorb and use.

Although this article addresses implementation as defined by the extent to which the designer's plans are fulfilled, future evaluation of Florida's Medicaid Reform must address the consequences of the program action. Looking ahead, evaluating the success of this reform will entail determining the impact the changes have made on cost, quality, and access. One of the major challenges associated with this type of evaluation involves data availability and standardization. Although all of the participating managed care programs are required to begin reporting experience data that can provide some insight on beneficiary health behaviors and status, the collection of this data has proved difficult for the state. Furthermore, the quality of the reported data might not be completely uniform among plans. In addition, the number of plans joining and leaving Medicaid Reform makes data analysis challenging. Finally, the cycling of Medicaid beneficiaries on and off of Medicaid will make any improvements of health status as a result of Reform programs difficult to measure.

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