

**REORGANIZING STATE HEALTH AGENCIES TO MEET  
CHANGING NEEDS**  
*State Restructuring Efforts In 2003*

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## EXECUTIVE SUMMARY

In 2003, most states began the year struggling to protect even their highest priority programs from budget reductions. The downturn in state tax revenue collections compounded by the rising cost of the Medicaid program and of health care in general forced states to cut \$11.8 billion from their fiscal 2003 enacted budgets. These cuts represented the second largest budget shortfall after fiscal 2002, when 38 states cut their budgets by nearly \$13.7 billion. The shortfalls in 2003 were severe enough to affect even priority programs traditionally spared budget cuts, such as K-12 education, higher education, public safety, and aid to towns and cities.<sup>1</sup>

As a result of fiscal pressures, almost every state sought to generate cost savings by allocating public resources more effectively. Because of the prominence of health care costs in most state budgets, health care was placed at the forefront of state cost-containment efforts. Moreover, many governors placed an emphasis on downsizing, reorganizing, and streamlining state government in order to achieve efficiencies and create cost-savings.<sup>2</sup>

This report provides a nationwide snapshot of state health agency organizational structures and examines state efforts to restructure these agencies during 2003. It also describes the focus, goals and overall outcomes of restructuring efforts. Because of Medicaid's prominence in state budgets, it places special emphasis on changes affecting the Medicaid program and its placement in state organizational structures. It also highlights the organizational placement of the State Children's Health Insurance Program (SCHIP) and the Title V Maternal and Child Health Services Block Grant (Title V MCH) program.

This report examines the broad spectrum of restructuring efforts during 2003. It is a snap-shot in time, exploring examples that arose between January and July of 2003, with some follow-up discussion in the fall of that year. NGA looks forward to the opportunity in the near future to go more in depth with some of the critical areas of reorganization, as well as outcomes from these efforts.

### State Health Agency Restructuring Trends

During 2003, almost half of the states (22) considered, planned, or implemented structural changes to their state health agency. At least eight of these initiatives were part of broader statewide efforts to transform state government. The Medicaid program was a key component of restructuring efforts in over half of the 22 states—and yet, the Medicaid program was not the only driver of organizational change or state cost-containment efforts. Restructuring states sought to streamline programs and services, improve resource allocation, create cost-savings, enhance managerial oversight of programs, and improve the quality of services.

The 22 states that considered planned, or implemented state health agency restructuring initiatives in 2003 varied considerably in the roles and responsibilities they assigned to their state health agency, as well as in where they placed the agency within the executive branch. Over half of the restructuring states made *intra-agency* changes that affected departments and systems within the agency (e.g., consolidation or elimination of some components of an agency). Eight states implemented *interagency* changes among

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<sup>1</sup> National Association of State Budget Officers (NASBO) and National Governors Association (NGA), *Fiscal Survey of the States* (Washington, DC: December 2003). Available at <http://www.nasbo.org/publications.php>.

<sup>2</sup> T. Nodine, *Governors' State-of-the-State Addresses for 2003: A Summary of Prevalent Themes* (Washington, DC: National Governors Association. 2003).

agencies separate and independent of one another (e.g., the consolidation of five departments into one). Among the 22 states with state health agency restructuring initiatives in 2003, several trends emerged:

- **Clustering health and related human services programs.** At least 18 states considered clustering, collapsing, or otherwise consolidating their health-related activities into one or a smaller number of organizational entities. Several of these initiatives involved organizational change affecting multiple health programs (e.g., Medicaid, SCHIP, and the Title V MCH program).
- **Continuing shifts towards health and human services umbrella structures.** Since 1996, there has been a trend towards using an umbrella agency model to house all or most state health and human services programs. Entering 2003, 21 states reported that their health agency was a component of an umbrella structure, compared with 16 states in 1996. During 2003, no states dismantled umbrella structures where they already existed; in fact, several states considered forming *new* umbrella structures to house their health and human services programs.
- **Consolidating health-related functions.** Nearly all of the 22 restructuring states sought to consolidate their health programs around the core services they provide, functions they perform, and/or special populations they serve. Most abandoned structures that were organized categorically (i.e., a single program providing a core set of services). In fact, several states characterized their restructuring initiatives as an effort to move away from programmatic “silos”—i.e., programs that operate independently even though they may serve the same populations.
- **Centralizing program support functions.** Many state health agency restructuring initiatives involved consolidating various administrative systems and managerial functions (e.g., communications, human resources, legal services, budget and financing, and information technology functions). In many cases, states also sought to overhaul antiquated data systems, particularly as part of efforts to streamline eligibility and enrollment processes for Medicaid and other public programs.
- **Restructuring involving gubernatorial and legislative authority.** The impetus and authority for restructuring varied considerably from state to state, along with the mechanisms used for planning and implementation. To varying degrees, nearly all of the 22 restructuring initiatives involved gubernatorial and/or legislative approval. Only a few initiatives were authorized by the state’s health secretary or commissioner alone, and those few were usually contained within divisions or branches of the state health agency. The most common mechanism used to plan and implement a health agency restructuring initiative was a state health agency work group or task force. Often such work groups were made up of members both internal and external to the health agency and were led by the secretary or commissioner of health. Governors in several states established an Office of Health Policy and Planning within the immediate office of the governor to advise their ongoing health care reform efforts.

## Effects on Medicaid, SCHIP, and the Title V MCH Program

Although state Medicaid spending growth appeared to be slowing,<sup>3</sup> it remained a significant issue for states and a significant focus of state health agency restructuring initiatives in 2003. In 15 of the 22 states with health agency restructuring initiatives, the initiatives impacted the state Medicaid program. Several initiatives also affected SCHIP and state Title V MCH programs. Where Medicaid was affected, states implemented structural changes to contain Medicaid costs, maximize organizational efficiencies, leverage federal matching funds, and improve data collection. Many of the changes affecting Medicaid were also tied to broader plans for reforming the health care system as a whole. Among the changes were the following:

- **Elevating Medicaid within the state health agency or executive branch.** Because of the Medicaid program's size and scope, four states planned to elevate Medicaid in the executive branch of state government, and one state planned to elevate Medicaid within its existing state health agency structure. A few states even considered elevating Medicaid to report directly to the governor. (The Medicaid authority already reports directly to the governor's office in at least two states nationwide.)
- **Reorganizing SCHIP together with the Medicaid program.** Among the restructuring states with separate SCHIP programs, there were no states that sought to restructure SCHIP to the exclusion of Medicaid. In fact, organizational changes affecting Medicaid and SCHIP were often tied to broader plans for reforming the health care system as a whole.
- **Consolidating Title V MCH programs into a single entity focused on family health.** Title V MCH programs were affected in 13 of the 22 states with health agency restructuring initiatives. In many cases states were centralizing Title V MCH programs with other programs serving similar populations. At least 31 of the 50 states now organize their Title V MCH programs together with other child and family-related programs—e.g., the Special Supplemental Food and Nutrition Program for Women, Infants and Children (WIC), family planning, immunizations—into a division or organizational unit of family health.

## Restructuring Challenges and Opportunities

Some of the most significant challenges facing restructuring states involved staffing changes and the complexities associated with merging divergent program philosophies and federal funding streams. Several states reported that challenges occurred most often during the implementation and transition phases of organizational change. However, proper planning and effective communication helped to minimize many of these challenges.

The top challenges identified by restructuring states during 2003 included the following:

- merging divergent service delivery models and philosophies into a common vision and system;
- overcoming internal and external resistance to change;
- maintaining staff morale during staffing changes and program relocation;
- ensuring smooth day-to-day operations and seamless service delivery;

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<sup>3</sup> V. Smith, R. Ramesh, K. Gifford, and E. Ellis (Health Management Associates) and Victoria Wachino (Kaiser Commission on Medicaid and the Uninsured), *States Respond to Fiscal Pressure: State Medicaid Spending Growth and Cost Containment in Fiscal Years 2003 and 2004—Results from a 50 State Survey*. (Washington, DC: Kaiser Commission on Medicaid and the Uninsured, September 2003).

- addressing the complex legal questions that arise when merging public funding streams; and
- creating an integrated data system and coordinating a smooth transfer of electronic information.

Many states noted that restructuring their health agency along with broader efforts to transform state government provided an opportunity to improve the quality and efficiency of services. Officials in such states are hoping that restructuring initiatives will reduce costs, result in a better use of limited resources, and maximize existing funding streams.

# 1. INTRODUCTION

In 1996, the National Governors Association (NGA) released a report entitled *Transforming State Health Agencies to Meet Current and Future Challenges*,<sup>4</sup> which described state initiatives to restructure their health agencies. At the time, 28 states were reexamining the roles and responsibilities of their state health agencies and considered, planned, or implemented structural changes to affect the agency's organizational culture, work processes, administrative functions, and/or decision-making processes. These changes were motivated by several factors, including anticipated reductions in federal funding; an influx of managed care in the health care marketplace; the expanding role of state health agencies in welfare reform; the devolution of federal program and funding authority to states; and an interest in streamlining state government.

This report updates the NGA's 1996 study by examining efforts by states to restructure their state health agencies in 2003. The environment differed from the environment in 1996 in that most states were faced with significant state fiscal crises in 2003. The downturn in state tax revenue collections, compounded by the rising cost of the Medicaid program and of health care in general, forced states to cut \$11.8 billion from their fiscal year 2003 enacted budgets. The magnitude of these cuts was exceeded only by those of the previous year, when 38 states had to cut their budgets by nearly \$13.7 billion. The result in 2003 was that states had to face the difficult choice of trimming even priority programs traditionally spared budget cuts, such as K-12 education, higher education, public safety, and aid to towns and cities.<sup>5</sup>

Not surprisingly, the state fiscal crisis was the overriding theme in governors' 2003 state-of-the-state addresses. Many governors emphasized downsizing, reorganizing, and streamlining state government in order to achieve efficiencies and create cost-savings.<sup>6</sup> Moreover, the prominence of health care in most state budgets placed state health agencies at the forefront of these restructuring efforts.

This report examines in detail initiatives by states to restructure their state health agencies during 2003. Because of Medicaid's prominence in state budgets, special emphasis is placed on changes affecting the Medicaid program and its placement in state organizational structures. The report also highlights the impact of restructuring on two selected programs: the State Children's Health Insurance Program (SCHIP) and the Title V Maternal and Child Health (Title V MCH) Services Block Grant.

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<sup>4</sup> National Governors Association (NGA), *Transforming State Health Agencies to Meet Current and Future Challenges* (Washington, DC: 1996).

<sup>5</sup> National Association of State Budget Officers (NASBO) and National Governors Association (NGA), *Fiscal Survey of the States* (Washington, DC: December 2003). Available at <http://www.nasbo.org/publications.php>

<sup>6</sup> T. Nodine, *Governors' State-of-the-State Addresses for 2003: A Summary of Prevalent Themes* (Washington, DC: National Governors Association, 2003).

As described in the *Methodology* section below, this report covers restructuring efforts undertaken during 2003. Many of the states were early in the development and planning phases of restructuring overall, and particularly with Medicaid programs. Some agencies have also undertaken restructuring since the closing of the survey portion of this report in summer 2003, and are not therefore included. This report therefore attempts to address restructuring in a broad manner, and as a snap-shot in time, but NGA also looks forward to the opportunity to explore these new structures and their impact in greater depth in the future.

## Methodology

In July 2003, a survey was sent to governors' health policy staff in all 50 states (see Appendix A for a copy of the survey). The survey sought to address the following questions:

- Which states are restructuring their state health agency in 2003, and what is the nature of their restructuring initiatives?
- What are the driving forces and trends in state health agency restructuring in 2003?
- How is state health agency restructuring in 2003 affecting the placement of the state Medicaid program, SCHIP, and the Title V MCH block grant program?
- What are the key opportunities for and challenges to state health agency restructuring in 2003?

Governors' staff in all 50 states either completed the survey or forwarded it to a health agency administrator for completion. Follow-up contact was made with respondents and other relevant health agency staff to clarify responses and obtain additional

## Figure 1: Key Terms and Definitions

For purposes of this report, **restructuring** is the process of merging different organizational cultures, work processes, leadership, and decision-making styles, requiring fundamental changes to long-standing internal administrative arrangements and management constructs. It is a level of organizational change that is more considerable than *reorganization* (which we define as the shifting or consolidation of organizational entities with no changes to organizational culture) and less considerable than *reengineering* (which refers to fundamental efforts to redesign how an organization conducts business).

Based on the 1996 NGA survey, this report further classifies state health agencies according to the policy or program areas they oversee. Such areas typically include public health, primary care, mental health, substance abuse, the Medicaid program, and human services. State health agencies are often structured to administer some combination of these programs based on four organizational models:

- **Traditional public health agency**—a type of state health agency that oversees public health and primary care only. While it may also administer one other health-related program (i.e., environmental health, alcohol and drug abuse, etc.), its responsibilities are usually limited to improving or protecting the overall health status of the public.
- **Super public health agency**—a type of state health agency that oversees both (a) public health and primary care and (b) substance abuse and mental health. This would likely include administering services supported by the federal Substance Abuse Prevention and Treatment (SAPT) Block Grant and the Community Mental Health Services (CMHS) Block Grant programs.
- **Super health agency**—a type of state health agency that oversees (a) public health and primary care and (b) the state Medicaid program.
- **Umbrella agency**—a type of state health agency oversees (a) public health and primary care, (b) substance abuse and mental health, and (c) the Medicaid program, as well as (d) other human services programs.

Source: National Governors Association (NGA), *Transforming State Health Agencies to Meet Current and Future Challenges* (Washington, DC: 1996).

information as needed. Completed surveys were obtained from all 50 states.

In several cases, state health agency restructuring efforts were in the early stages of planning or development when the survey was conducted. Thus, additional follow-up contact between October and December 2003 was made to capture the most current information on state restructuring initiatives (see Appendix B for state health agency contacts). In addition, supplemental background information including organizational charts, state restructuring reports, press releases, executive orders, presentations, and legislation were collected and reviewed if available.

For consistency and comparability, the definitions and state health agency classifications set forth in the 1996 NGA report on restructuring initiatives were used for this study; key terms and definitions are shown in Figure 1. Survey respondents were asked whether the state's executive branch had considered restructuring since January 1, 2003. Thus, this report may not capture state health agency restructuring initiatives that occurred between 1996 (when the first NGA survey on state health agency restructuring was conducted) and December 2002.

States vary considerably in their organizational structures, as well as in the roles and responsibilities that they assign to their state health agencies. A state health agency structure that is effective in a rural state may not be optimal to meet the demands of a more urban state. Other variables—including organizational leadership, culture, mission, and structure—can also influence a government agency's effectiveness.<sup>7</sup> Thus, this report makes no effort to compare which organizational structures promote greater efficiencies than others.

## Organization of the Report

The remainder of this report is organized as follows:

- **Section 2** presents an overview of state health agency restructuring initiatives in 2003;
- **Section 3** explores the effects of state health agency restructuring initiatives on Medicaid, SCHIP, and the Title V (MCH) program; and
- **Section 4** identifies broad trends in restructuring initiatives, along with the challenges and opportunities in restructuring.

Related background material and additional resources are also presented in several appendices:

- **Appendix A** contains the state health agency restructuring survey administered in 2003;
- **Appendix B** identifies state health agency contacts for the 22 states that considered, planned, or implemented structural changes to their state health agencies in 2003;
- **Appendix C** provides an overview of the 22 state health agency restructuring initiatives that occurred during 2003;
- **Appendix D** profiles the health agency restructuring efforts of four states (Alaska, Maine, Nebraska, and Texas);

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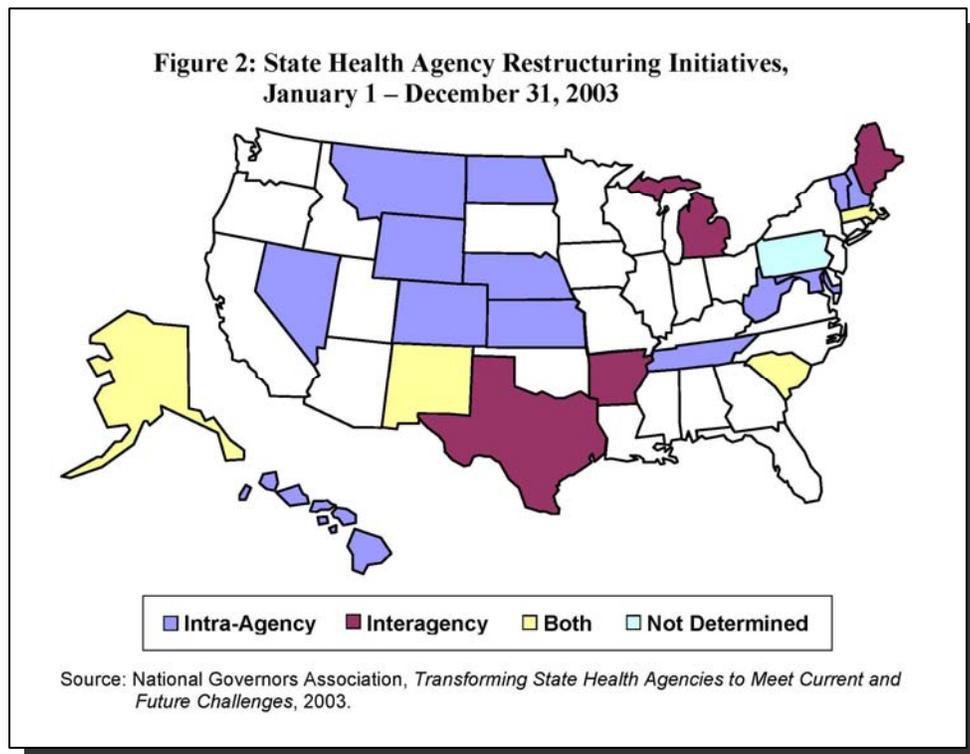
<sup>7</sup> H. G. Rainey and P. Steinhauer. "Gallopers: Developing Elements of Theory of Effective Government Organizations." *Journal of Public Administration Research and Theory* 9(1):1-32, 1999.

- **Appendix E** summarizes the organizational placement of public health, Medicaid, SCHIP, and Title V MCH programs in the 50 states; and
- **Appendix F** lists additional resources for individuals who want to learn more about efforts to restructure state health agencies.

## 2. OVERVIEW OF STATE HEALTH AGENCY RESTRUCTURING INITIATIVES

In 2003, the restructuring of health agencies was a top priority in states, as it was in 1996 when NGA released its first report documenting such initiatives.<sup>8</sup> During 2003, at least 22 states (see Figure 2) considered, planned, or implemented structural changes to their state health agencies. A common goal of these restructuring efforts was to allocate resources more effectively and improve the quality of services. Highlights of the restructuring activity that occurred during 2003 are summarized below:

- Twelve states—**Colorado, Hawaii, Kansas, Montana, Nebraska, Nevada, New Hampshire, New Mexico, North Dakota, Tennessee, West Virginia, and Wyoming**—were combining or separating divisions or units within the state health agency.
- Five states—**Alaska, Maine, Massachusetts, Texas, and Vermont**—were retooling or consolidating agencies within an existing health and human services umbrella agency.
- Two states—**Maryland and Pennsylvania**—were still in the early planning phases of restructuring.
- **South Carolina** was considering an initiative that would result in a *new* health and human services umbrella structure.



<sup>8</sup> NGA, *Transforming State Health Agencies*, 1996.

- **Arkansas** transferred a program outside of the existing health agency structure and considered establishing a new health and human services umbrella agency.
- **Michigan** moved an external program into the state health agency.

Organizational changes in more than half of the restructuring states in 2003 were occurring within the state health agency; however, changes in eight of the restructuring states were occurring among multiple agencies. Restructuring that affects only one agency and takes place within the agency (e.g., the consolidation or elimination of some components of the agency) is referred to as *intra-agency restructuring*. Restructuring that affects multiple agencies and takes place *among* agencies (e.g., the consolidation of five departments into one) is referred to as *interagency restructuring*.

Additional information about each of the 22 state health agency restructuring initiatives that occurred during 2003 is provided in Appendix C. The appendix includes summaries of the status of each state health agency before and after restructuring, the time frame for implementation of restructuring initiatives, key features of each initiative, the health programs and services affected, and the processes adopted for implementation. Restructuring initiatives in four states—**Alaska, Maine, Nebraska, and Texas**—are profiled more extensively in Appendix D. General observations about and highlights of all 22 state health agency restructuring initiatives are presented in the discussion that follows.

## State Health Agency Organizational Trends

Common state health agency organizational structures are identified in Figure 3. In 18 of the 22 states with restructuring initiatives in 2003, the overall structure of the state health agency remained the same; however, several significant changes *within* the health agency organizational structure occurred in several states. For example, both **Massachusetts** and **Texas** continued use of an umbrella organizational structure to house health and human services programs; however, they significantly restructured the departments and functions within that umbrella structure.

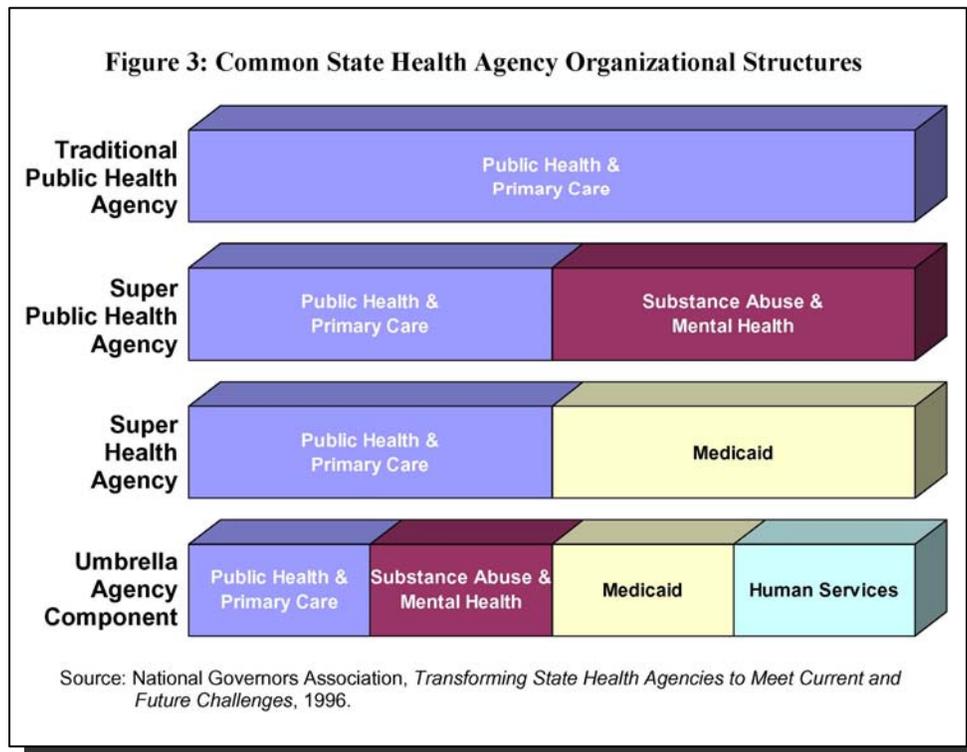
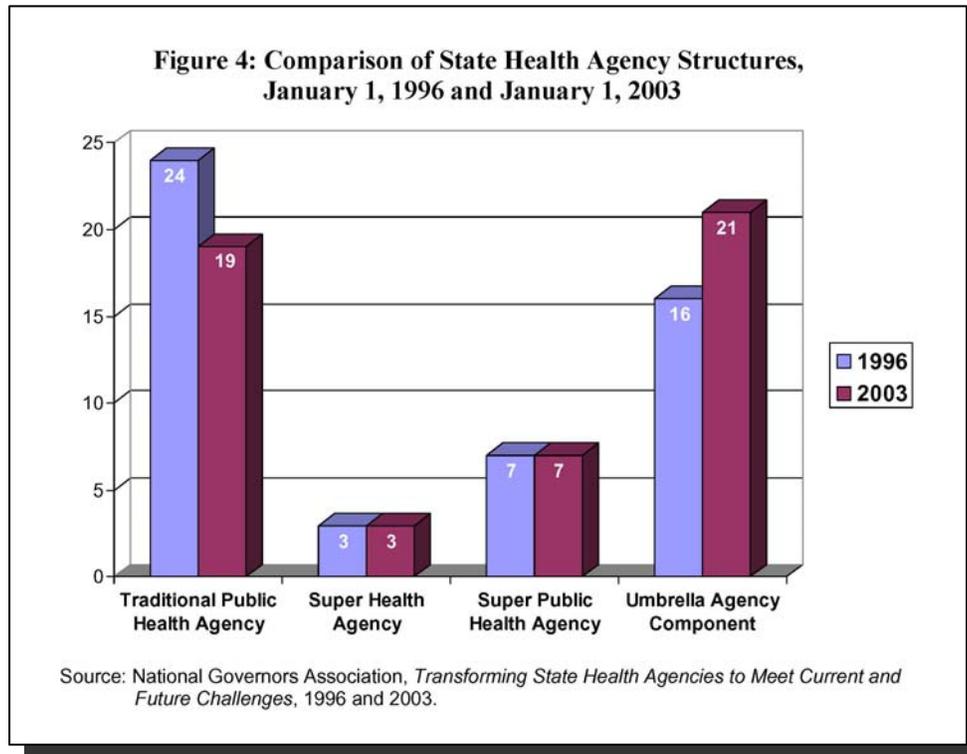


Figure 4 compares state health agency structures in the 50 states at the beginning of 1996 and the beginning of 2003. As can be seen, 21 states organized health programs using a health and human services umbrella structure in 2003; since 1996, there has been a slight trend towards using an umbrella agency model to house all or most state health and human services programs. Only 19 states reported having traditional public health agencies in 2003, as compared with 24 states in 1996.



Several states considered forming umbrella structures to house health and human services programs in 2003, and no states were dismantling these structures. In **Arkansas**, the administration attempted a complete reorganization of state government that would have merged the state's Departments of Health, Human Services, and Social Security Disability Determination into a Department of Health and Human Services. That measure failed during the state's 2003 legislative session, but discussions continued.

Several restructuring states expressed interest in ensuring that there was an identifiable entity focused on public health and core public health functions within the overall state health agency structure. In fact, a few states were exploring ways to strengthen the administration of these core functions. In **Nebraska**, for instance, the Health and Human Services Policy Cabinet was exploring alternatives to improve the way its public functions are carried out, in light of restructuring changes that occurred in 1996. (A case study of the Nebraska restructuring initiative and lessons learned since 1996, along with case studies of initiatives in three other restructuring states, is presented in Appendix D.)

Although the primary reasons for state health agency restructuring differed from state to state in 2003, several key themes emerged. Predominant motivations for restructuring noted in the 2003 survey include a desire to streamline programs and services, to improve resource allocation, to generate overall cost-savings for the state, to enhance managerial oversight of programs, and/or to improve the quality of services. Interestingly, even though many states are concerned about escalating state Medicaid budgets, only one state specifically cited the reduction of Medicaid costs as a primary reason for restructuring its state health agency.

## Consolidation of Programs Around Health-Related Functions

The consolidation of health programs—and, in some cases, human services programs—was a predominant theme in state health agency restructuring initiatives in 2003. At least 18 states considered clustering, collapsing, or otherwise consolidating their health-related activities into one or a smaller number of organizational entities. States were instituting a number of changes designed to improve the quality of services delivered while making better use of existing resources.

With few exceptions, states appeared to be shifting away from organizational structures built around specific health conditions (e.g., HIV/AIDS). Instead, states were streamlining their program activities around the core service(s) they provide, functions they perform, and/or special population(s) they serve. Several states characterized their restructuring initiatives as an effort to replace programmatic “silos”—i.e., entities where multiple programs operate independently yet often serve the same populations. In many cases the programmatic silos were being replaced with organizational structures centered on common goals, functions, and outcomes.

**Arkansas**, with legislative approval, moved its Bureau of Alcohol and Drug Abuse Prevention from the Department of Health to the Department of Human Services in 2003. This transfer, which took effect July 1, 2003, consolidated all substance abuse and mental health-related services in one service unit.<sup>9</sup>

The **Colorado** Department of Public Health and Environment consolidated its public health programs by merging its Division of Health Promotion and Disease Prevention with the Division of Prevention and Intervention Services for Children and Youth. Combining these divisions was intended to streamline the state’s health promotion and disease prevention activities, improve resource allocation, and create overall cost-savings for the state. These changes were initiated by the department’s executive director and were being implemented by agency staff. A Division Integration Team made up of directors from each core program area was meeting regularly to examine ways to better integrate functions (e.g., public health surveillance, program evaluation) common to many of the division’s programs. In fact, “integration” was such a priority in the new Public Health Division that it was incorporated into all staff performance reviews.

In **Kansas**, the Department of Health and Environment consolidated six of its bureaus into four by combining the bureau that had overseen credentialing of adult care homes and health occupations with another that had overseen the licensure and regulation of child care providers. It also transferred oversight of the nursing facilities to the Department on Aging. The Bureau of Health Promotion was moved to the office of the director of the Department of Health and Environment to improve interdepartmental coordination around population-based issues.

By executive order, **Michigan** transferred its health facilities and health professional licensure functions from the Department of Industry Services to the Department of Community Health. The interagency transfer was intended to reduce administrative silos by consolidating all health functions in a single agency.

## Centralization of Program Support Functions

Many states with restructuring efforts in 2003—including **Alaska**, **Massachusetts**, and **Texas**—were centralizing support functions such as communications, human resources, legal services, budget and financing, and information technology. States viewed such centralization as a way to streamline related

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<sup>9</sup> Arkansas General Assembly, 84<sup>th</sup> Regular Session (2003), House Bill 2900 (became Act 1717 on Apr. 24, 2003).

administrative functions that previously were located in multiple departments or bureaus. Centralization was designed to minimize duplication and save administrative costs.

Efforts to improve outdated data systems were a core goal of many restructuring initiatives—and in some cases, a factor in driving restructuring. This observation was particularly true for states seeking to streamline eligibility determination processes for multiple public programs such as Medicaid and the Special Supplemental Food and Nutrition Program for Women, Infants and Children (WIC).

As part of more significant changes to its health agency structure, **Alaska** created an Office of Program Review within the Department of Health and Social Services, to improve coordination among its divisions. It also created the Office of Financial Management Services to help each division strategically manage their funding. The Office of Financial Management also houses the department's key administrative functions (e.g., information technology, human resources, grants management, and budgeting) and is charged with helping each division to strategically manage its funding. (A profile of Alaska's restructuring initiative, along with restructuring initiatives in three other states, is presented in Appendix D.)

## Restructuring Governance and Authority

The impetus and authority for restructuring a state health agency, along with the mechanisms used to plan and implement such an initiative, varied considerably from state to state. In 2003, nearly every state health agency restructuring initiative required gubernatorial and/or legislative approval. Only a few initiatives were authorized by the health secretary or commissioner alone, and those were usually contained within divisions or branches of the health agency itself.

In at least 11 of the 22 states with restructuring initiatives in 2003, the state health official led the planning, development, and implementation of the initiative. In other states, executive staff in the governor's office led the restructuring initiative, working closely with key agency directors, steering committees, or task forces. A few states even established executive offices focused on health care reform.

Some states, including **West Virginia**, were able to implement intra-agency restructuring without legislation. Other states with more significant interagency initiatives, such as those in **Texas**, required administrative and legislative approval. In states such as **Colorado**, where restructuring was conducted within the state health agency, it was expected that the legislature ultimately would approve the restructuring initiative; state agency budgets and programmatic line-items that reflect the new organizational structure had to be approved through the state's legislative appropriations process.

In **Kansas**, structural changes to the Department of Health and Environment were recommended in a special study directed by the secretary. The study was part of a larger gubernatorial initiative, called Kansas BEST (Budget Efficiency Savings Team), which directed all agencies to identify ways to reduce costs and inefficiencies.<sup>10</sup> It was expected that future studies would examine how the state health agency's Division of Environment might be restructured to consolidate its five bureaus.

**New Mexico** Governor Bill Richardson issued an executive order in May 2003 establishing a three-phase project entitled, "New Mexico Performance Review" led by the Department of Finance and Review. This project involves evaluating and reviewing the organizational management of executive branch agencies to

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<sup>10</sup> Kansas Governor's Office, "Policies, Initiatives, and Grants: Performance Teams." Available at <http://www.ksgovernor.org/performteam.html>.

ensure efficient functioning and delivery of services.<sup>11</sup> During Phase I of the project, state government services and organizational structures were evaluated, and alternative ways to deliver services were considered. Town hall meetings, convened by the state's lieutenant governor, in conjunction with the four cabinet secretaries for the Departments of Health, Human Services, Aging and Long-Term Care, and Children, Youth and Families, were held throughout New Mexico. New Mexico's restructuring initiative required legislative approval during the 2004 legislative session.<sup>12</sup>

**South Carolina** Governor Mark Sanford issued an executive order that established the Commission on Management, Accountability and Performance (MAP) in June 2003.<sup>13</sup> He charged the MAP Commission with recommending changes to various government systems and services to reduce costs, increase accountability, improve services, consolidate duplicative functions, and return functions to the private sector whenever possible. In November 2003, the MAP Commission recommended restructuring the state's health and human services system by doing the following:

- authorizing a single cabinet secretary to oversee all health and human services agencies;
- creating a senior services division that reports directly to this cabinet secretary;
- realigning health and human services divisions to better serve clients; and
- creating a new health finance department to serve as the state's Medicaid authority.<sup>14</sup>

Governor Sanford acted on one of the Commission's recommendations by issuing an executive order moving administration of two federal programs—the Child Care Development block grant and the Social Services block grant—from the Department of Health and Human Services to the Department of Social Services.<sup>15</sup> In a separate effort, the South Carolina legislature considered a bill to reform the state's Medicaid program.<sup>16</sup> The legislature was expected to take up other MAP Commission recommendations when it reconvened in 2004.

## Executive-Level Offices Focused on Health Care Reform

States' interest in improving the public health care system in 2003 was evident in a variety of restructuring initiatives focused on Medicaid restructuring and health care reform—e.g., gubernatorial offices overseeing state health care reform efforts, task forces examining a range of health agency restructuring options which include Medicaid, and special studies to specifically examine current Medicaid policies and ways to optimally structure the program.

In **Kansas**, Governor Kathleen Sebelius established the Office of Health Planning and Finance by executive order in October 2003 to focus on health care quality, affordability, accessibility, and financing.<sup>17</sup> The creation of the office was prompted by concerns over rising health care costs and the

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<sup>11</sup> New Mexico Governor, Executive Order 2003-013, "Establishing A Framework for the Implementation of the State Government Performance Review," May 9, 2003. Available at <http://www.governor.state.nm.us/>.

<sup>12</sup> New Mexico Legislature, 46<sup>th</sup> Legislature (2004 Regular Session), House Bill 322 (signed Mar. 8, 2004); House Bill 271 (signed Mar. 8, 2004).

<sup>13</sup> South Carolina Governor, Executive Order 2003-15, "Creating the Governor's Commission on Management, Accountability and Performance," June 10, 2003. Available at <http://www.scgovernor.com/>.

<sup>14</sup> South Carolina Governor's Commission on Management, Accountability and Performance. *Final Report*, Sept. 30, 2003. Available at <http://www.mapcommission.sc.gov/>.

<sup>15</sup> South Carolina Governor, Executive Order 2003-26, "Transferring Child Care and Block Grant Programs from DHHS to DSS," Nov. 17, 2003. Available at <http://www.scgovernor.com/>.

<sup>16</sup> South Carolina Legislature, 115<sup>th</sup> Regular Session (2003-2004), House Bill 3768 (under consideration as the South Carolina Health and Human Services Reorganization and Accountability Act of 2003).

<sup>17</sup> Kansas Governor, Executive Order 03-21, "Establishing the Governor's Office of Health Planning and Finance" (October 23, 2003). Available at [http://www.ksgovernor.org/docs/exec\\_order0321.html](http://www.ksgovernor.org/docs/exec_order0321.html).

numbers of uninsured. The Office of Health Planning and Finance was expected to serve as a convener of health policy initiatives that assure coherent and collaborative agency data collection, analysis and policy development. Other functions of the office included the following: (1) coordinating health care policy initiatives brought forth by members of the state's health and human services cabinet; (2) convening providers, advocates, elected officials and business leaders to plan a comprehensive approach for addressing health care costs, quality and accessibility; (3) developing a multiyear plan focusing on short, mid-, and long-term solutions; and (4) coordinating public purchasing of health care by state agencies to improve quality and the cost-effectiveness of health care.

In January 2003, **Pennsylvania** Governor Edward Rendell issued his first executive order creating the Office of Health Care Reform in the governor's executive office structure, "marking the beginning of a new era of streamlined healthcare in state government."<sup>18</sup> The Office of Health Care Reform was assigned responsibility for coordinating the administration's health care reform agenda. Its director holds a cabinet-level position and chairs a newly established health care reform cabinet whose members include the secretaries of health, public welfare, aging, insurance, the adjutant general, and the director of policy. In 2003, the Office of Health Care Reform was focusing its work on key health policy issues facing Pennsylvania, including medical malpractice, long-term care, and prescription drugs. The expectation was that efforts to restructure the state's health and human services functions would be considered in 2004 within the context of state health care reform plans.

On his first day in office, **Maine** Governor John Baldacci issued an executive order to establish the Office of Health Policy and Finance. The Office was given primary responsibility for cross-agency health policy and consolidated budgeting. Gov. Baldacci also ordered the Office to develop and propose legislation for universal coverage of all Maine's citizens. The Office Director holds a cabinet post, and chairs the Cabinet Council on Health, a interagency taskforce. The Office has an advisory group on implementing the Governor's health reform agenda, led by the director and composed of a variety of stakeholders. The Office was funded with some executive office resources, but was also permitted to seek additional funding from foundations.

## Agency-Level Task Forces or Steering Committees

The mechanism states most commonly used to plan and implement a health agency restructuring initiative in 2003 was a health agency work group or a task force made up of members both internal and external to the health agency. Planning processes ranged from a health commissioner working with a small internal staff work group to more elaborate grassroots planning processes involving town hall meetings, state conferences, and websites devoted to restructuring. These planning activities enabled key stakeholders to provide input to the process; considered the use of information and the need for data; and kept staff, community groups, and providers apprised of efforts.

The **Maryland** General Assembly passed House Bill 761 in May 2003 to create a task force to study the reorganization of the Maryland Department of Health and Mental Hygiene.<sup>19</sup> The legislation, which took effect on October 1, 2003, established a large task force membership representing the Department of Health and Mental Hygiene, the Department of Budget and Management, provider groups, local health agencies, advocacy groups, and others. Maryland was one of a few states in 2003 whose restructuring plans were to be overseen by the General Assembly. The task force was to be co-chaired by a member of the Senate and a member of the House, and it was to be staffed by Maryland's Department of Legislative

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<sup>18</sup> Pennsylvania Governor, Executive Order 2003-1, "Commonwealth's Health Care Reform Agenda," Jan. 21, 2003. Available at <http://www.state.pa.us/papower/cwp/view.asp?A=11&Q=432505>

<sup>19</sup> Maryland General Assembly, 417<sup>th</sup> Regular Session (2003), House Bill 761 (enacted May 22, 2003).

Services, a nonpartisan legislative support agency. The task force was expected to issue its report to the Maryland General Assembly by December 1, 2004.

In May 2003, ongoing discussions in **Vermont** about the best way to deliver health and human services led the General Assembly to pass House Bill 450,<sup>20</sup> which outlined several key goals and principles for restructuring the way health and human services are delivered throughout the state. In addition, House Bill 450 authorized the new Agency of Human Services (AHS) secretary to make certain changes to the agency's structure.

To comply with the mandate in House Bill 450, the AHS secretary and deputy secretary implemented an extensive six-month inquiry process to gather information from consumers, employers, contracted providers, advocates and other partners, to inform initial restructuring recommendations. AHS surveyed 4,000 providers, state employees, and advocates; held town hall meetings in each of Vermont's 12 regions; and convened 18 focus groups with teen parents, incarcerated youth, families of children with special health needs, and other individuals who otherwise might not have participated in the planning process. Throughout the planning process, AHS devoted an entire portion of its website to the initiative in order to keep stakeholders informed.

The resulting plan<sup>21</sup> called for merging mental health services, substance abuse services and public health services in a single department within the umbrella human services agency and proposed creating a free-standing Office of Vermont Health Access to administer the state's Medicaid program, also within the human services agency. The most far-reaching element called for an integrated field structure for all aspects of human services: health, mental health, economic benefits, protective services, vocational services and corrections. The plan was unanimously approved by the General Assembly's Joint Fiscal Committee in May 2004, and implementation of the plan began soon thereafter.

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<sup>20</sup> Vermont Legislature, 2003-2004 Session (2003), H 450 (became law May 29, 2003).

<sup>21</sup> Vermont Agency of Human Services, *Final Report to the Legislative Oversight Committee on Human Resources Reorganization, Vermont Legislature, 2003-2004 Session* (February 2004). Available at <https://www.ahsnet.ahs.state.vt.us/Council/>.

### 3. RESTRUCTURING INITIATIVES RELATED TO MEDICAID, SCHIP, AND THE TITLE V MCH BLOCK GRANT

In recent years, rising health care costs have prompted many states to examine ways to streamline programs and services and to improve efficiencies in key health care programs, particularly Medicaid. The Medicaid program played a far greater role in state health agency restructuring efforts in 2003 than it did in 1996. At least 15 initiatives in the 22 states with state health agency restructuring initiatives in 2003 impacted the placement or structure of the state Medicaid program. The objectives of most restructuring initiatives that affected the Medicaid program in 2003 were to contain costs, maximize federal funding through organizational efficiencies, and enhance information and technology platforms to improve data collection. Several of the initiatives that affected the Medicaid program were tied to broader plans for reforming health care and containing costs overall.

Highlights of state health agency restructuring initiatives in 2003 that affected Medicaid and the related SCHIP and Title V MCH programs include the following:

- Four states planned to elevate Medicaid in the executive branch of state government and one state planned to elevate Medicaid within its existing state health agency structure. A few states even considered elevating Medicaid to report directly to the governor. The Medicaid authority already reports directly to the governor's office in at least two states nationwide.
- In states with separate SCHIP plans, no health agency restructuring initiatives focused on SCHIP to the exclusion of Medicaid.
- State Title V MCH programs were affected in 13 of the 22 states with health agency restructuring initiatives. In many cases, states centralized their MCH program within the same division or organizational unit as other programs serving similar populations. (At least 31 of the 50 states already organize their state Title V MCH programs and other child and family-related programs into a single division or organizational unit of family health.)

State health agency restructuring trends in 2003 that affected Medicaid, SCHIP, and the state Title V MCH program are discussed further below. Appendix E highlights the organizational placement of Medicaid, SCHIP, and the state Title V MCH programs in each of the 50 states. For the 22 states that considered, planned, or implemented structural changes to their state health agencies in 2003, that appendix identifies the placement of these programs both before and after restructuring. (In some cases, states were still in the early phases of planning in 2003, so it was too early to tell how restructuring would ultimately affect the placement of these programs in state organizational structures.)

#### Medicaid

Medicaid is the nation's major public health insurance program for low-income Americans. Authorized by Title XIX of the Social Security Act, Medicaid is a means-tested entitlement jointly financed by the federal government and the states.<sup>22</sup> The prominence of the Medicaid program in state budgets places it at the forefront of state efforts to contain rising health care costs.

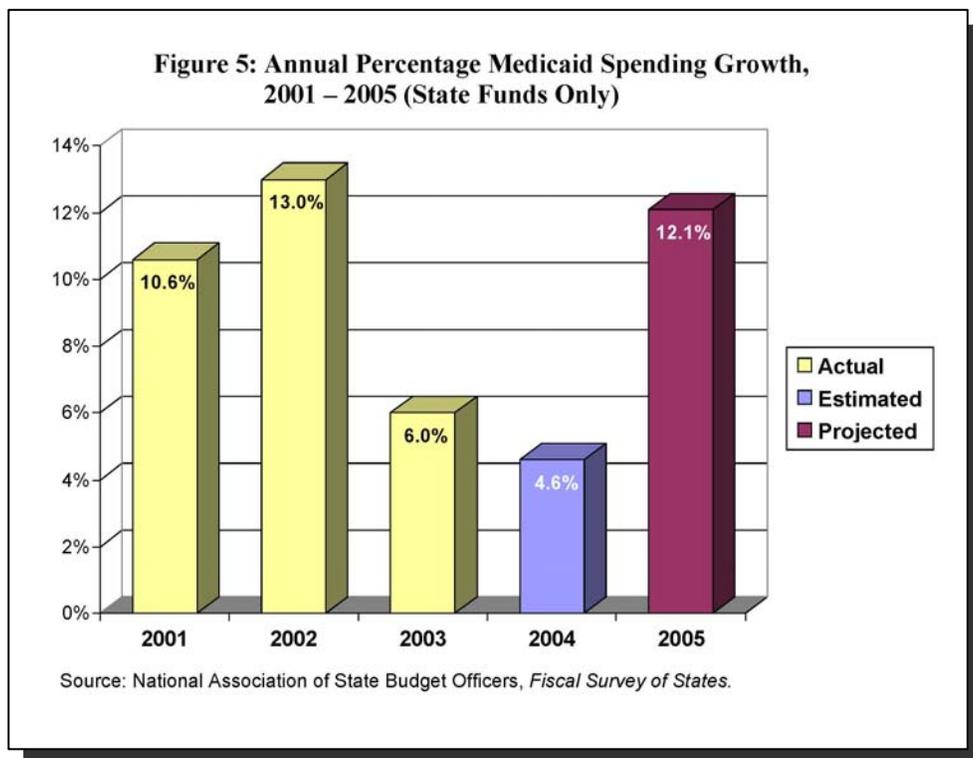
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<sup>22</sup> U.S. Census Bureau, "Health Insurance Coverage in the United States: 2002," *Current Population Reports* September 2003.

During 2003, nearly 12 percent of the U.S. population obtained their health insurance coverage through Medicaid. The program’s size and complexity have grown to the point that Medicaid accounts for about one-fifth of all state spending.<sup>23</sup> In fact, Medicaid is now the second largest line item in most state budgets (second only to K-12 education) and is the largest source of federal funds for most states.<sup>24</sup>

In fiscal year 2003, responding to the state fiscal crisis, every state froze or reduced Medicaid provider rate increases; 46 states implemented prescription drug cost controls; 25 states restricted Medicaid eligibility; 18 states restricted or reduced Medicaid benefits; and 17 states imposed patient cost-sharing measures in their Medicaid programs.<sup>25</sup> These efforts—combined with temporary fiscal relief Congress provided in 2003—helped slow annual percentage growth in the state share of Medicaid spending from 13.0 percent in 2002 to 6.0 percent in 2003.<sup>26</sup>

Twenty-three states experienced Medicaid budget shortfalls in fiscal year 2003. Entering 2004, 18 states anticipated the need to close Medicaid budget gaps in the current fiscal year.<sup>27</sup> Although the budget outlook improved somewhat during 2004, the end of federal fiscal relief in June, combined with continued spending pressure, was expected to cause the state share of Medicaid spending to rise sharply in fiscal year 2005, crowding out state spending on other public priorities. Figure 5 shows the expected annual percentage growth in state expenditures for Medicaid from fiscal year 2001 to fiscal year 2005.



<sup>23</sup> NASBO and NGA, *Fiscal Survey of the States*, 2003.

<sup>24</sup> Kaiser Commission on Medicaid and the Uninsured, “Financing the Medicaid Program: The Many Roles of Federal and State Matching Funds,” Policy Brief, Kaiser Family Foundation, Washington, DC, January 2004.

<sup>25</sup> Kaiser Commission on Medicaid and the Uninsured, “State Fiscal Conditions and Medicaid,” Fact Sheet, Kaiser Family Foundation, Washington, DC, November 2003).

<sup>26</sup> NASBO and NGA, *Fiscal Survey of the States*, 2003.

<sup>27</sup> NASBO and NGA, *Fiscal Survey of the States*, 2003.

## Placement of Medicaid in the State Organizational Structure

In at least 15 of the 22 state health agency restructuring initiatives in 2003, organizational changes affecting the Medicaid program's structure were considered, planned, or implemented. In fact, several states considered changing or elevating the Medicaid program's placement within the existing state health agency structure and in some cases within the executive branch of government. The Medicaid authority already reports directly to the governor's office in at least two states nationwide.

In 2003, **Massachusetts**, **New Hampshire** and **Texas** proposed elevating Medicaid within the state's overall organizational structure. **Alaska** was the only state that in 2003 elevated Medicaid within the existing state health agency structure. Other states—for example, **New Mexico**—made significant changes to state Medicaid policy but made no changes to the organizational placement of the Medicaid program. In **Maryland**, a task force was examining several restructuring options, including one that would place the Medicaid program in its own separate agency.

**Massachusetts'** restructuring of its health and human services system included the creation of a single state agency for Medicaid within the Executive Office of Health and Human Services (EOHHS). The state's Medicaid program had previously been housed in the division of medical assistance, one of 15 organizational entities under the former EOHHS structure. Other changes moved the office of long-term care under elder affairs, and the office of acute and ambulatory care was placed under a newly created office of health services. The state also developed and began testing and implementing a Medicaid data warehouse to facilitate program and financial analysis.

Several states formed task forces to examine their current policies and recommend ways the state Medicaid program could be restructured. For example, **Maryland** established a 25-member task force to study the reorganization of its Medicaid program, housed in the Department of Health and Mental Hygiene.<sup>28</sup> Concerned that the size and complexity of the Medicaid program may overshadow smaller programs located within the existing department, the task force is considering a number of proposals, including one that would place the Medicaid program within its own agency. Another proposal would relocate Medicaid eligibility determinations—currently housed in a separate department—to the Medicaid authority itself. The task force was expected to issue its report to Maryland's General Assembly by December 1, 2004.

## The State Children's Health Insurance Program (SCHIP)

SCHIP provides public insurance coverage to children of low-income families who lack private health insurance and are ineligible for Medicaid due to family income. SCHIP is a means-tested grant program jointly funded by the federal government and the states. States can elect to expand Medicaid, create a separate SCHIP program, or implement a combination program. For SCHIP, as for Medicaid, the federal government matches each state's spending at an established rate that varies by state. The federal matching rate for SCHIP is generally higher than it is for Medicaid; however, for SCHIP, there is a cap on the total amount of federal funds that states can receive, whereas no such cap exists for Medicaid. Among states with separate SCHIP programs, there were no restructuring initiatives in 2003 that focused on SCHIP to the exclusion of Medicaid.

In **Montana**, the rising costs of mental health, Medicaid, and SCHIP led to a House Joint Resolution calling for a study of health programs administered by the Department of Public Health and Human

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<sup>28</sup> Maryland General Assembly, 417<sup>th</sup> Regular Session (2003), House Bill 761 (enacted May 22, 2003).

Services with recommendations for restructuring the department.<sup>29</sup> Under the auspices of the Montana Public Health Advisory Council, the department was considering potential policy changes and guiding principles regarding the state's Medicaid and SCHIP programs. A final report outlining recommended changes to the state's Medicaid and SCHIP programs was expected to be released in June 2004.

Through a separate initiative, a new Division of Child and Adult Health Resources was created to house Medicaid, SCHIP, children's mental health programs, and services for children with special health care needs.

## **The Title V Maternal and Child Health (MCH) Block Grant Program**

States leverage Title V MCH Services Block Grant program funds from the federal government to support a range of programs and services designed to improve the health and well-being of women, children and youth, including those with special health care needs, and their families. Among the many purposes for which the block grant funds can be used are providing and ensuring mothers and children access to quality MCH services; reducing infant mortality and the incidence of preventable diseases and handicapping conditions; and promoting the health of children by providing preventive and primary care services for low-income children.

Within federal guidelines for Title V MCH funds, states are given considerable flexibility to use the funds to design and implement health programs that range from infrastructure building services (e.g., needs assessment, quality assurance) to provision of direct health care services. The Title V statute requires states to meet several conditions as part of their state funding allocation. These requirements include coordination of Title V activities with Medicaid's Early and Periodic Screening, Diagnostic and Treatment program (EPSDT), the Special Supplemental Food and Nutrition Program for Women, Infants, and Children (WIC), and other health, family planning, and developmental disability programs to avoid duplication of effort. States also are required to provide outreach and enrollment services to pregnant women and infants who qualify for Medicaid.

At least 31 of the 50 states now organize their Title V MCH programs and other child and family-related programs into a single division or organizational unit of family health. The programs and services most frequently located in these family health entities included family planning, child safety, childhood immunizations, nutrition programs, child abuse prevention, women's health, and school health programs. Most of these family health organizational entities appear to have been created prior to January 2003. During 2003, only two restructuring initiatives—in **North Dakota** and **Wyoming**—resulted in a change from a Maternal and Child Health Division to a Family Health Division.

State Title V MCH programs were affected in 13 of the 22 states with health agency restructuring initiatives in 2003. The Title MCH programs were impacted by efforts to centralize health-related programs and functions within the same division or organizational unit. Such efforts follow the trend of realigning health-related programs according to the core service(s) delivered and populations served.

In **North Dakota**, the Division of Maternal and Child Health, which previously housed women's health, MCH nursing and nutrition programs, oral health, injury prevention, and domestic violence/rape crises prevention, was placed in a newly created Section of Community Health. The new section contained six divisions: the Divisions of Tobacco Control, Cancer Prevention, Injury Prevention, Family Health, Chronic Disease, and Nutrition and Physical Activity. The six divisions were aligned on the basis of the

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<sup>29</sup> Montana State Legislature, 58<sup>th</sup> Legislative Assembly (2003 Regular Session), House Bill 13 (became law 3/17/2003).

major state health objectives identified through various state public health initiatives, such as the Healthy North Dakota project.

**Nevada** was consolidating its various early childhood intervention programs, formerly located within the larger human services umbrella agency, into the state's public health agency in 2003. As a result of restructuring, the Early Intervention Program (Part C of the Individuals with Disabilities Education Act) was to be located within the health division together with the Title V MCH program and other related programs serving women, children, and their families.<sup>30</sup> Some states, such as **Alaska**, have implemented more significant changes to the Title V MCH program by organizing MCH activities in a way that differentiates the activities according to whether they are eligibility-based or more population-based. (A case study of the Alaska restructuring initiative is presented in Appendix D.)

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<sup>30</sup> Nevada Governor, *Executive Budget for the 2003-2005 Biennium*. Presented to the 72<sup>nd</sup> Session of the Nevada State Legislature, January 13, 2003. Available at <http://budget.state.nv.us/>.



## 4. RESTRUCTURING TRENDS, CHALLENGES, AND OPPORTUNITIES

A state's ability to improve public health, finance and deliver health care services, and adapt to new challenges in a dynamic health care environment is affected by many factors, including the placement of its state health agency, the agency's roles and responsibilities, and leadership. State health agency restructuring was nearly as prevalent in states in 2003 as it was in 1996. Whereas 28 states considered, planned, or implemented state health agency restructuring in 1996, 22 states did so in 2003.

### State Health Agency Restructuring Trends

Nearly all of the 22 state health agency restructuring initiatives in 2003 were affected by the state fiscal crisis, compounded by the rising cost of the Medicaid program and of health care in general. As discussed in this report, a number of trends were observed in state health agency restructuring initiatives in 2003:

- **Clustering health and related human services programs.** In 2003, at least 18 states considered clustering, collapsing, or otherwise consolidating their health-related activities into one or a smaller number of organizational entities. Several of these initiatives involved organizational change affecting multiple health programs (e.g., Medicaid, SCHIP, and the Title V MCH program).
- **Continuing shifts towards health and human services umbrella structures.** Since 1996, there has been a trend towards using an umbrella agency model to house all or most state health and human services programs. Entering 2003, 21 states reported that their health agency was a component of an umbrella structure, as compared to 16 states in 1996. During 2003, no states dismantled these structures where they already existed. In fact, several states considered forming *new* umbrella structures to house their health and human services programs in 2003.
- **Consolidating health-related functions.** Nearly all of the states with restructuring initiatives in 2003 sought to consolidate their health programs around the core services they provide, functions they perform, and/or special populations they serve. Most were abandoning structures that were organized categorically (i.e., a single program providing a core set of services). In fact, several states characterized their restructuring initiatives as an effort to move away from programmatic “silos”—i.e., programs that operate independently even though they may serve the same populations.
- **Centralizing program support functions.** Many state health agency restructuring initiatives involved consolidating various administrative systems and managerial functions (e.g., communications, human resources, legal services, budget and financing, and information technology functions). In many cases, states also sought to overhaul antiquated data systems, particularly as part of efforts to streamline eligibility and enrollment processes for Medicaid and other public programs.
- **Restructuring involving gubernatorial and legislative authority.** The impetus and authority for restructuring in 2003 varied considerably from state to state, as did the mechanisms used for planning and implementation. To varying degrees, nearly all of the 22 restructuring initiatives involved gubernatorial and/or legislative approval. Only a few initiatives were authorized by the state's health secretary or commissioner alone, and those few were usually contained within

divisions or branches of the state health agency. The most common mechanism used to plan and implement a health agency restructuring initiative was a state health agency work group or task force. In many cases, such work groups were made up of members both internal and external to the health agency, and they were frequently led by the secretary or commissioner of health. Governors in several states established an Office of Health Policy and Planning within the immediate office of the governor to advise their ongoing health care reform efforts.

- **Elevating Medicaid within the state health agency or executive branch.** Because of the Medicaid program's large size and scope, four states planned to elevate Medicaid in the executive branch of state government and one state planned to elevate Medicaid within its existing state health agency structure. A few states even considered elevating Medicaid to report directly to the Governor. (The Medicaid authority already reports directly to the governor's office in at least two states nationwide.)
- **Reorganizing SCHIP together with the Medicaid program.** Among the restructuring states with separate SCHIP programs, there were no states that sought to restructure SCHIP to the exclusion of Medicaid. In fact, organizational changes affecting Medicaid and SCHIP were often tied to broader plans for reforming the health care system as a whole.
- **Consolidating Title V MCH programs into a single entity focused on family health.** Title V MCH programs were affected in 13 of the 22 states with health agency restructuring initiatives in 2003. In many cases, states were centralizing Title V MCH programs within the same division or organizational unit. At least 31 of the 50 states now organize their Title V MCH programs together with other child and family-related programs (e.g., WIC, family planning, immunizations) into a division or organizational unit of family health.

Finally, although not a question that was specifically explored in states, the organization of state public health functions in state health agencies emerged an area of significance. Several state administrators expressed a concern that as a result of efforts to organize programs and services functionally, a focus on public health functions was diminished (i.e., there was no identifiable public health agency or department within the state organizational structure). This concern was mainly expressed in those states where the state health agency is part of an overall health and human services umbrella structure.

## Restructuring Challenges and Opportunities

States report that challenges in restructuring their state health agencies often occur during the implementation and transition phases of organizational change. Many of the challenges reported in 2003—the merging of divergent program philosophies, dealing with staffing changes, and addressing issues related to the merging of complex funding streams—were consistent with the challenges identified in previous restructuring efforts.

The top challenges reported by states with health agency restructuring initiatives in 2003 included the following:

- merging divergent service delivery models and philosophies into a common vision and system;
- overcoming internal and external resistance to change;
- maintaining staff morale during staffing changes and program relocation;
- ensuring smooth day-to-day operations and seamless service delivery;
- addressing the complex legal questions that arise when merging public funding streams; and
- creating an integrated data system and coordinating a smooth transfer of electronic information.

Many states noted that restructuring the state health agency along with broader efforts to transform state government provides an opportunity to improve the quality and efficiency of their services, as well as to realize significant cost reductions through more effective use of scarce resources. Proper planning to ensure a smooth transition can help address the challenges often brought by restructuring. In addition, ongoing communication—with program staff, members of the legislature, advocacy groups, providers, and other key stakeholders—was reported to be key to the successful restructuring of a state health agency.

## **Conclusion**

Although the focus of state health agency restructuring initiatives varied from state to state in 2003, one thing was common to all the restructuring initiatives—the goal of streamlining services while improving the level and quality of services delivered. Recognizing the need to serve clients no matter what “door” they enter, one state official even remarked, “[prior to restructuring] we were not looking at the whole person, but a basket of eligibility requirements.”

Regardless of the outcomes of restructuring or how states approach a restructuring initiative, it is important to recognize that restructuring is not an isolated event. Rather, it is an ongoing process requiring a continuous examination of an agency’s mission, delegated functions, management structure, and overall effectiveness. In many ways, as evidenced by the states identified in this report, restructuring provides an opportunity to streamline programs, allocate resources more effectively, enhance managerial oversight and program accountability, and improve the quality of client services.