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The Coordination and Implementation of the Affordable Care Act in Texas: Medicaid Eligibility and the Environmental Context

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The Coordination and Implementation of the Affordable Care Act in Texas: Medicaid Eligibility and the Environmental Context

by

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Dedication

To my mother, brother, and father for guiding me to where I am supposed to go.

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Abstract

The Coordination and Implementation of the Affordable Care Act in Texas: Medicaid Eligibility and the Environmental Context

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The University of Texas at Austin, 2012

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The Affordable Care Act (ACA) seeks to increase the low-income population's access to health care coverage by expanding Medicaid eligibility and providing subsidies to individuals meeting certain income thresholds. The citizens of Texas would benefit greatly from the ACA provisions, as the state offers limited opportunities for individuals to access insurance, evidenced by the 6.3 million residents without health care coverage. But political leaders in Texas have a long-standing commitment to limited government, low taxes, and states' rights in a federal system of government. In the 1990s, Texas legislators, with bipartisan support, laid the groundwork over the last decade for the minimal, yet significant preparations that administration used to coordinate ACA implementation. Yet legislators' commitment to limited government and states' rights placed additional constraints on the ability of the Texas Health and Human Services Commission (HHSC) to implement ACA provisions by refusing to utilize the 82nd legislative session to prepare the state for impending deadlines. Instead, administrators developed an interagency effort, the Eligibility Modernization Project (EMP), to

streamline eligibility determinations and increase clients' access to information and services. EMP's initiatives mirror ACA provisions, but also seeks to achieve policy goals that both Republican and Democratic legislators support, such as providing effective and efficient eligibility determinations. Nevertheless, legislators and administrators must go beyond EMP's efforts to adequately prepare the eligibility system for impending ACA deadlines. Policy recommendations include further streamlining and integrating the health subsidy system with a state-based health insurance exchange, increasing access to coverage by expanding Medicaid eligibility, adequately preparing the workforce for changes, and promoting long-term planning. These solutions will provide a sounder infrastructure for HHSC to prepare for ACA coordination and implementation, while increasing access to health care coverage for the low-income population.

Table of Contents

Chapter One

INTRODUCTION

With the highest rate of uninsured individuals and one of the most limited Medicaid programs in the nation, Texas has much to gain under the Affordable Care Act (ACA). The ACA seeks to increase the accessibility of health insurance coverage, especially for the low-income, "working poor" population. But Texas legislators have grappled with the role of the state as a provider in health care and social services. State policies often promote low taxes, provisions to decrease dependence on social services, and the delegation of the healthcare "safety net" to local entities.[1] Policy debates over who should pay for healthcare and how it should be provided contribute to tensions regarding the role and duties of the government, public, and private sectors. These tensions create challenges for administrators who often implement state programs with limited resources.

Administrators face uncertainties about the extent to which the state will adopt certain features of the ACA. With the Supreme Court decision designating most of the ACA constitutional, states must modernize their eligibility systems and coordinate with health insurance exchanges to streamline health subsidy program determinations. Although Texas legislators operate in a polarized environment that makes cooperation and collaboration with the federal government difficult, administrative implementers have begun to develop innovative interagency means to develop a foundation for ACA

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[1] Cal Jillson, *Lone Star Tarnished: A Critical Look at Texas Politics and Public Policy* (New York, NY: Routledge, 2012), 128.; Sharon Silow-Carroll and Greg Moody, *Lessons from High- and Low-Performing States for Raising Overall Health System Performance*, issue brief (Washington D.C.: Commonwealth Fund, 2011) 5.; Local entities in Texas are already pressed with high property taxes and limited state assistance, as Texas is one of seven states without an income tax.

implementation. These administrative means build upon the bipartisan efforts from the 1990s to modernize the eligibility process.

This report analyzes policies, policy goals, and the means to achieve the goals that legislators and implementers have utilized to enhance and modernize the Medicaid eligibility system. The body of this Policy Report focuses first, in Chapter 2, on the historic efforts, and next, in Chapter 3, on the tenuous preparation for changes in the health care system and specifically, the eligibility process for Medicaid.

THE UNIQUE STATE OF TEXAS – DIFFERENCES AND CONSTRAINTS

The State of Texas has unique geographic, demographic, and socioeconomic differences that all contribute to complexities in the policy formation surrounding social service provisions and eligibility processes.[2] As the second largest state in the United States, covering over 268,601 square miles,[3] landscapes range from highly populated urban areas, like Austin and Houston, to spacious rural areas in West Texas and the Panhandle, to multiple cities and townships bordering Mexico. With a population over 25 million individuals,[4] Texas' demographics include a high and increasing rate of Hispanics,[5] an increasing number of undocumented immigrants,[6] and a growing elderly population,[7] all of whom face a variety of health challenges and care needs. Texas also faces an increasingly dire primary healthcare workforce shortage, as well as shortages of

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2 Sharon Silow-Carroll and Greg Moody, *Lessons from High- and Low-Performing States for Raising Overall Health System Performance*, issue brief (Washington D.C.: Commonwealth Fund, 2011), 4.

3 NSTATE, "The Geography of Texas," Texas Geography from Netstate, last modified July 26, 2012, accessed August 2, 2012, http://www.netstate.com/states/geography/tx_geography.htm.

4 U.S. Census Bureau, "Texas QuickFacts from the U.S. Census Bureau," U.S. Census Bureau, last modified June 7, 2012, accessed August 2, 2012, http://quickfacts.census.gov/qfd/states/48000.html.

5 Susan Combs, Texas Comptroller of Public Accounts, "Demographics - Texas in Focus," Window on State Government, accessed August 2, 2012, http://www.window.state.tx.us/specialrpt/tif/population.html.

6 Ibid.

7 Ibid.

registered nurses and other health care providers.[8] In 2011, Texas had 69.5 primary care physicians to every 100,000 of the population, on average.[9] In Texas, 29 of the 254 counties are without any primary care physicians.[10] The diversity of health care recipients can strain health care service coordination and delivery, and the strain is further exacerbated by the inaccessibility of health care providers.

Of the 25 million individuals who reside in Texas, 16.8 per cent are living under the federal poverty level (FPL).[11] Texas is ninth in the nation for high income disparity between the top and bottom income levels,[12] as well as one of the top five states in the nation with high income disparity between top and middle-income levels.[13] The income disparities contribute to high poverty rates, as well as poorer health outcomes.[14] The poorer health outcomes contribute to the rising cost of the state's contribution to serve this population, leading to debates regarding how funding should be spent to promote healthy initiatives and efficient, streamlined care.

As health conditions become more serious, the cost of providing services tends to increase. The Texas Medicaid system covers a proportion of the uninsured population, but its eligibility requirements are mostly limited to pregnant women and children who meet certain income thresholds of the FPL. In Texas, Medicaid is truly considered the 'safety net' for low-income mothers, children, disabled and elderly, medically needy, the

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8 Ryan Murphy and Thanh Tan, "Interactive: Primary Care Workforce Shortages 2001-2011," Texas Tribune, last modified March 27, 2012, accessed August 2, 2012, http://www.texastribune.org/library/data/primary-care-workforce-shortages/.

9 Ibid.

10 Ibid.

11 U.S. Census Bureau, "Texas QuickFacts from the U.S.," U.S. Census Bureau.

12 Jared Bernstein, Elizabeth McNichol, and Andrew Nicholas, *Pulling Apart: A State-by-State Analysis of Income Trends*, technical report (Washington D.C.: Center for Budget and Policy Priorities, 2008), 7.

13 Ibid.

14 Silow-Carroll and Moody, *Lessons from High- and Low-Performing*, 2.

"deserving" populations. Though Texas has over 20% of their state budget dedicated to the Medicaid program,[15] it is a state with one of the lowest per capita spending on Medicaid.[16]

THE AFFORDABLE CARE ACT

The Patient Protection and Affordable Care Act and Health Care Education Reconciliation Act were signed into law in March of 2010 to create the Affordable Care Act (ACA). [17] The ACA mandates that all individuals have health coverage, calls for the establishment of venues to make insurance more accessible, and aims to make care more quality-based. It is estimated that nationally, over 32 million uninsured citizens will have access to health care coverage through Medicaid eligibility expansion or subsidies to purchase insurance through exchanges. Texas citizens will benefit from federal health care reform provisions. In 2009, it was estimated that Texas had 6,500,500 uninsured people,[18] including the second highest rate of unenrolled, but eligible Medicaid individuals.[19] In 2010, the U.S. Census Bureau designated Texas with the highest rate of

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15 Texas Tribune, "Tribpedia: Medicaid," Tribpedia, accessed August 3, 2012, http://www.texastribune.org/texas-health-resources/medicaid/about/.

16 Cal Jillson, *Lone Star Tarnished: A Critical Look at Texas Politics and Public Policy* (New York, NY: Routledge, 2012), 128.; Texas House of Representatives Legislative Study Group, *Texas on the Brink*, by Texas Legislative Study Group, research report (Austin, TX: Texas House of Representatives, 2011), 5.

17 Texas Health and Human Services Commission. "*Federal Health Care Reform*." Texas Medicaid and CHIP in Perspective: The Pink Book. (Austin: Texas Health and Human Services Commission, Ed. 8th. 2011), 1.

18 Ibid., 2.

19 Ezra Klein, "The Supreme Court Forces States to Make a Big Medicaid Decision. Here's How They'll Do It.," *WonkBlog*, entry posted June 29, 2012, accessed August 3, 2012, http://www.washingtonpost.com/blogs/ezra-klein/wp/2012/06/29/the-supreme-court-forces-states-to-make-a-big-medicaid-decision-heres-how-theyll-do-it/?hpid=z1.

uninsured citizens at 24.6 per cent.[20] The Texas Health and Human Services Commission (HHSC) expects that the ACA will reach 63 per cent of this population.[21]

Texas was one of the 26 states that challenged the two core provisions of the ACA, the individual mandate and the Medicaid eligibility expansion. Texas legislators, political appointees and executive branch members chose to delay major ACA implementation until the Supreme Court determined the constitutionality of the law. In the meanwhile, Texas state agencies are preparing for federal health care reform by improving the eligibility system and processes, building upon the bipartisan agreements from the 1990s to achieve policy goals that both conservative and liberal legislators support.

STATE COORDINATION AND IMPLEMENTATION IN TEXAS

The federal government depends heavily on state and local governments to implement complex social service programs. While the federal government may designate general means for state agencies to utilize, the state must interpret the means for their own system, processes, and clients. The federal government is depending on state agencies and legislators to conceptualize ACA coordination and integrate numerous systems in order to determine health subsidy program eligibility. States implementing ACA provisions can collaborate with the federal government and receive substantial amounts of funding. But states that are not, like Texas, are making limited headways on implementation and receive little to no funding for their preparations. Texas has yet to develop co-ownership of ACA, much less take on a leadership role. Texas legislators pride themselves on developing innovative solutions for their own residents, but their

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[20] Center for Public Policy Priorities. *Texas Health Care 2011: What Has Happened and the Work that Remains*. (Austin, TX: Center for Public Policy Priorities, 2011), 17.

[21] Health and Human Services Commission, *Federal Health Care Reform*, 2.

adamant stance against "Obamacare" has led to HHSC's inability to adequately prepare for large system developments and changes. While Texas administrators say the agencies will be prepared to implement ACA provisions, the preparation occurs in limited capacity and causes a strain on interagency operations. These conditions may lead to inefficient planning, decreased quality of service delivery, weakened workforce relations, and an increased cost to taxpayers.

In the current environment, conservative and liberal Texan legislators do not agree about the role of the state government or the means to implement policy. Nor do they view ACA with the same perspectives, as some see the ACA as interfering with the state's right to make its own health decisions, while others see it as an opportunity to expand health coverage. This division skews administrators' implementation efforts to build more effective, efficient systems and processes, negatively affecting service delivery for vulnerable populations. The unstable and "unsuccessful" implementation has political consequences,[22] though, in the short term, Republican legislators, who are the majority in the Texas House and Senate, claim victory in upholding their vision of states' rights and limited government. Long-term political consequences, especially with the onset of implementing ACA provisions, are unforeseen for both political parties.

CHAPTER OVERVIEW

In Chapter Two, I provide an overview regarding the first modernization efforts from the Texas legislature and HHSC to replace the eligibility system, integrate privatized positions, and outsource contract system development and service delivery. I draw parallels with the classical model regarding policy implementation, whereby legislators determined the goals and designated HHSC as the state agency to achieve

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[22] Robert T. Nakamura and Frank Smallwood, *The Politics of Policy Implementation* (New York, NY: St. Martin's Press, 1980), 118.

those goals. Texas legislators went beyond the classical model to determine the means of implementation by requiring the integration of private contractors, and diminished administrators' capacity to lead a successful privatization implementation by concurrently removing state workforce positions and decreasing agency funding.

In Chapter Three, I outline ACA provisions, the potential impact the law has on expanding coverage, and the Supreme Court decision regarding the constitutionality of the law. I address legislators' efforts during the 82nd legislative session to enhance or diminish HHSC's capacity to integrate ACA provisions. The polarized environment during the 82nd legislative session did not allow state agencies to legally begin ACA implementation. This could hinder agencies' ability to meet ACA deadlines, but an internal HHSC effort to modernize the eligibility processes will facilitate a smoother transition to ACA provision implementation.

In Chapter Four, I provide policy recommendations that will best prepare HHSC for upcoming ACA implementation. The ACA promotes collaboration and leadership for legislators and administrators to implement a program that is unique to their state's need. Texas legislators must rethink the role of the state government in the new system of care that the ACA develops. Legislators and administrators must take advantage of federal funding, the expansion of Medicaid, the development of a state-based exchange, and change eligibility policy now to shift to a eligibility process that provides real-time determinations, electronically verifies client information, and coordinates with the health insurance exchange to create a 'no wrong door' entry for consumers.

For evidence and sources, I draw on numerous documents, including reports, press releases, and bill analyses from state, federal, and think tank organizations. I will utilize the insight and knowledge I gained from my experience as a health and human services policy intern in the office of the Honorable Senator Royce West during the 82nd

legislative session in 2011, as well as my internship with the Eligibility Modernization Project team at the Texas Health and Human Services Commission in Spring 2012. From these internship experiences, I gained deep insights both in the legislative and executive branches of Texas government and the interactions between them.

Chapter Two

As a federal program facilitated by states, eligibility determinations for Medicaid must follow particular guidelines to obtain federal funding. But states have the ability to develop and coordinate the social service eligibility system and processes to meet their residents' needs. This chapter will provide an overview of Texas' partial privatization of the eligibility process during the mid-1990s to 2011 that incorporated outside contractors into the service delivery model and modernized the technological system. As the analysis will show, the initial years were fraught with problems, exacerbated by the loss of institutional memory, insufficient training for staff, and unrefined pilots. But these beginning efforts allowed the Health and Human Services Commission (HHSC) to explore innovative means in regards to effectiveness and efficiency, and paved the way for further system and process modernization in the future.

The use of technology can enhance the determination process by organizing client data, verifying case information, and incorporating policy logics to determine particular program eligibility. An automatic and user-friendly system is one of the core components of streamlined, timely eligibility determinations. The eligibility processes engage the system and workers to facilitate the clients' determination. Texas' previous and current processes are based upon a 'caseworker model' of eligibility determination, where a worker has ownership of a particular case and handles all the case processing until eligibility is determined.[23] More recent efforts from legislators and HHSC have emphasized a move towards assembly line work to remove the caseworker as central point of contact and divide case processing tasks among staff. The transition to assembly

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[23] Dorothy Rosenbaum and Stacy Dean, *Improving the Delivery of Key Work Supports*, technical report (Washington D.C.: Center on Budget and Policy Priorities, 2011), 42.

line work is an attempt to make the eligibility determination more efficient for state workers and applicants, and hopefully, cost-effective for the state.

The policy creation and implementation of a new eligibility process for Texas included components from the classical model of hierarchical decision-making. The hierarchical model divides the political and administrative spheres in order to formulate and implement policies. Legislators determine the policy's goal/s and designate an entity to coordinate the implementation.[24] Administrators carry out the implementation in order to achieve the particular policy goals. The divide can make the policy formulation process more efficient, but can also contribute to gaps in policy makers' knowledge about agency capacity, capability, and operations,[25] undermining the intentions of a policy. But the division may serve the policy formulation process well in polarized environments, as the classical model determines implementation is "nonpolitical and technical" in nature.[26] The division allows administrators to further conceptualize the policy goals, [27] removing the task from policy makers, and perhaps, potential conflict between political parties.

Policy goals of achieving cost effectiveness and efficiency are both general ideas Republican and Democratic members of the Texas legislature can agree.[28] But the means to achieve policy goals in state operations are more subjective and based on assumptions of what will work for a system. [29] Goals are general, but legislators can mandate means

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24 Robert T. Nakamura and Frank Smallwood, *The Politics of Policy Implementation* (New York, NY: St. Martin's Press, 1980), 9.

25 Ibid., 34.

26 Ibid., 10.

27 B. Guy Peters, *The Politics of Bureaucracy*, 3rd ed. (White Plains, NY: Longman, 1989), 153.

28 Nakamura and Smallwood, *The Politics of Policy*, 10.; In Texas, the Democrats, as late as the 1990s, shared with Republicans a belief in 'limited government' and low taxes and thus, both parties exhibited conservative beliefs.

29 Deborah Stone, *Policy Paradox: The Art of Political Decision Making*, 2nd ed. (New York, NY: W. W. Norton & Company, 1997), 61; 65.

that are laden with values they hope will connect with the greater public and/or serve their political interest.[30] The legislative pressure on administrators to make the means successful can inhibit implementation capacity by placing additional constraints on coordination. The "tight linkages" placed on administrators by legislators contribute to implementation failure.[31]

Texas completed the implementation of a new social service eligibility system and process after an eight-year roll out in December 2011.[32] Texas legislators' decision to contract out for system development, privatize eligibility workforce, and expand clients' access through call centers were new means to achieve effectiveness and efficiency. Implementation of the new eligibility system was long, difficult, and costly,[33] not because the means were inappropriate per se, but because of legislators' push to make the privatization successful.

As this chapter will develop, I demonstrate that efficiency efforts were slow to show results due the dynamics of coordination and the legislative pressure on HHSC to implement strategies successfully. In the push to meet policy goals through privatization, legislators set up an unstable foundation for the initial implementation by limiting resources, including time, funding, and state workforce positions. These pressures contributed to a weak foundation for implementation, negatively affected worker morale, and decreased service efficiency during the new system roll out.

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30 Nakamura and Smallwood, *The Politics of Policy*, 69; Stone, *Policy Paradox: The Art of Political*, 65.

31 Nakamura and Smallwood, *The Politics of Policy*, 113.

32 U.S. Department of Agriculture Supplemental Nutrition Assistance Program (SNAP) Modernization Workgroup, *State's SNAP Business Process Re-Engineering (BPR) Efforts*, comp. Program Developmental Division, research report (2011), 36.

33 Center for Public Policy Priorities, *Eligibility System Progress Report*, issue brief no. No. 08-335 (Austin, TX: 2008), 1-8, accessed July 14, 2012, http://www.cppp.org/research.php?aid=771&cid=3&scid=7.

THE POLICY FORMATION OF TIERS

The legacy eligibility system, System for Application, Verification, Eligibility, Referral, and Reporting (SAVERR), was in place for 30 years before a new system was developed.[34] SAVERR supplemented face-to-face interviews in field offices by providing an organizational system to gather the client's information.[35] The system was slow, cumbersome, and technologically inappropriate for the gathering and processing of information. Workers manually entered information for each social service program and processed eligibility for each service separately.[36] The system provided no historical case information, as any changes applied to an application overwrote any previous information,[37] so HHSC maintained a physical filing system of historical case information for reference. The filing systems were localized by region, making the sharing of information and procedures less efficient. The filing systems also included unnecessary costs – space, printing, and the time spent learning and organizing the system. According to the *Austin American Statesman*, HHSC officials determined the SAVERR monthly costs to be $1 million.[38]

The Texas legislature provided the financial and policy guidance to the Department of Human Services (DHS) to oversee SAVERR and determine the eligibility process. In 1991, HB 7 restructured the health and human services agencies to establish

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34 Texas Health and Human Services Commission, "It's Time to Expand the Ways Texans Apply for State Services," news release, June 18, 2004, accessed July 14, 2012, http://www.hhs.state.tx.us/news/release/061804_ServiceDelivery.shtml.

35 Patrick Michels, "Tale of TIERS," Government Technology, last modified August 31, 2007, accessed December 11, 2011, http://www.govtech.com/security/Tale-of-TIERS.html.

36 Texas Health and Human Services Commission, *HB 3575 Eligibility System Transition Plan*, by Texas Health and Human Services Commission, report (Austin, TX: 2007), 4.

37 Texas Health and Human Services Commission, "It's Time to Expand," news release.

38 Corrie MacLaggan, "After Spending $500 Million, Texas Is Back Where It Started," *Austin American Statesman* (Austin, TX), November 29, 2011, accessed January 2, 2012, http://www.statesman.com/news/content/region/ legislature/stories/04/25/25benefits.html.

an umbrella agency to oversee all agency functions, the Health and Human Services Commission (HHSC).[39] HHSC also included a new governing board with members appointed by the governor.[40] In 1993, during the 73rd legislative session, DHS / HHSC requested appropriations for the development of a new eligibility system, but the request for funding allocation was denied.[41] Instead, the following legislative session passed bills to review the eligibility system and determine the feasibility of privatizing development contracts and the eligibility workforce.[42] These two bills, SB 1675 and HB 1863, prompted new attempts to decrease cost and increase efficiency by allocating components of eligibility work to private entities.

Language in Senate and House bills overlapped to emphasize the development of a streamlined eligibility system with the potential to privatize work operations. SB 1675, led by Democratic Senator Zaffrini, delegated additional oversight duties to the HHSC as a follow up to HB 7,[43] including developing and implementing a new eligibility system plan that achieved a one per cent savings from streamlining services.[44] After assessing streamlining capacity and determining work functions, HHSC was required to explore local government and private contract options to administer the eligibility determination work.[45]

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39 H.B. 7, 1991 Leg., 1t Spec. Sess. (Tex.) (enacted).

40 Ibid.

41 MacLaggan, "After Spending $500 Million.

42 HB 2777, 75th Leg., 1st Reg. Sess (Tex. 1997) (enacted). Accessed January 2, 2011. http://www.legis.state.tx.us/tlodocs/75R/billtext/html/HB02777F.htm.

43 Senate Research Center, *74(R) SB 1675 House Committee Report - Bill Analysis*, by Senate Research Center, issue brief (Austin, TX: 1995), accessed January 3, 2012, http://www.legis.state.tx.us/tlodocs/74R/analysis/html/SB01675H.htm.

44 Ibid.

45 Ibid.

HB 1863, filed by Republican Representative Hilderbran with support from numerous Democrats, sought welfare reform to decrease individuals' "dependence on state assistance," while increasing federal matching funds.[46] DHS was designated as the entity to assist individuals seeking assistance, but was allowed to contract the work with a local government or private entity if found cost-effective.[47] HB 1863 also delegated responsibilities to DHS and the new Texas Workforce Commission (TWC) to incorporate welfare services with workforce resources in order to demote dependency on the social services.[48]

Prompted by SB 1675 and HB 1863, HHSC and the Texas Council on Competitive Government developed a blueprint of a new eligibility system for a contracted entity to implement and coordinate, privatizing over 13,000 state employee positions.[49] The request sent to the federal government for funding was denied, as it was interpreted to fully privatize eligibility determinations.[50] At the time, federal law only authorized public employees to determine eligibility for social services to maintain integrity.[51]

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46 Senate Research Center, *74(R) HB 1863 Senate Committee Report - Bill Analysis*, issue brief (Austin, TX, 1995), accessed January 1, 2012, http://www.legis.state.tx.us/tlodocs/74R/analysis/html/HB01863S.htm.

47 Ibid.

48 H.B. 1863, 74th Leg., 1st Reg. Sess. (Tex.). Accessed January 2, 2012.; http://www.legis.state.tx.us/tlodocs/74R/billtext/html/HB01863F.htm.; Pamela Winston, *Welfare Policymaking in the States: The Devil in Devolution*, American Governance and Public Policy series (Washington, D.C.: Georgetown University Press, 2002), 158.

49 Center for Public Policy Priorities, *Privatization of Health and Human Services Eligibility Determination*, technical report, The Policy Page: An Update on State and Federal Action 56 (Austin, TX: 1997), 1.

50 Center for Public Policy Priorities, *Privatization of Health and Human*, 2.

51 Domestic Social Policy Division, Privatization and Welfare Administration, Rep. No. 109-RS22034, at 1-5 (2005).

Nationally, there was a conservative push to privatize aspects of government services to increase efficiency, cut costs, and limit government intervention.[52] Welfare and social services were particularly under attack as unsustainable, costly programs that encouraged an individual's dependence on the government.[53] In 1996, President Bill Clinton signed the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA), spearheaded by Republicans, to reform the previous welfare structure.[54] This shift of framework included time limits of benefits, work requirements and incentives, and potentials for program waivers.[55] PRWORA transformed welfare services, but also gave states the opportunity to reinterpret their role in social service delivery and increased workforce privatization options.[56]

In 1997, the 75th Texas Legislature authorized the development of a new eligibility system through HB 2777, led and supported by Democrats.[57] Many Democratic legislators expressed concerns about the ongoing privatization efforts and incorporated provisions to increase the integrity of the contracting process.[58] Instead of emphasizing efficiency, Democrats' new goal for the system was to increase the quality

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52 Pamela Winston et al., *Privatization of Welfare Services: A Review of the Literature*, research report (Mathematica Policy Research, 2002), Chapter 1, accessed July 7, 2012, http://aspe.hhs.gov/hsp/privatization02/index.htm.

53 Ibid.; Domestic Social Policy Division, Privatization and Welfare Administration, Rep. No. 109-RS22034, at 4 (2005).

54 Bill Clinton, "How We Ended Welfare, Together," *The New York Times* (New York, NY), August 22, 2006, Opinion, accessed July 5, 2012, http://www.nytimes.com/2006/08/22/opinion/22clinton.html.

55 Office of Child Support Enforcement, "U.S. Department of Health and Human Services," HHS Fact Sheet PRWORA, accessed July 15, 2012, http://www.acf.hhs.gov/programs/cse/pubs/1996/news/prwora.htm.

56 Winston et al., *Privatization of Welfare Services:*,

57 H.B. 2777, 75th Leg., 1st Reg. Sess (Tex. 1997) (enacted). Accessed January 2, 2011. http://www.legis.state.tx.us/tlodocs/75R/billtext/html/HB02777F.htm.

58 Senate Committee Report, 75(R) HB 2777 - Bill Analysis, S. 75, 1st Reg. Sess. (Tex. 1997). Accessed July 15, 2012. http://www.legis.state.tx.us/tlodocs/75R/analysis/html/HB02777S.htm.

of delivery and expand clients' access to services.[59] The bill allowed contracting for development and technical assistance if the partnership could demonstrate a positive cost-benefit analysis for the state, outlined performance measures, and increased quality of service delivery.[60] This report was to be made available for public comment for ten days.[61]

Legislators' previous and current attempts to privatize aspects of the eligibility workforce prompted backlash from liberal advocacy groups. Opponents and supporters of privatization disagreed on the outcomes of privatization, including the kind of service delivery quality and the cost of outsourcing.[62] Proponents for privatization thought that the bidding process increased competition and therefore, decreased the cost of services.[63] Service quality would be encouraged through the competition and performance metrics put into place to hold the private entities accountable. [64] Opponents of privatization disagreed – the cost to train new employees, learn the system, and implement would be expensive.[65] Private entities also faced a conflict of interest to keep costs down and could be encouraged to do so by decreasing the number of eligibility determinations (and thus, enrollments to state programs).[66] Private entities encountered increased speculation regarding eligibility work because it was a relatively new industry, only recently encouraged through PRWORA provisions.

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59 Ibid.

60 H.B. 2777, 75th Leg., 1st Reg. Sess (Tex. 1997) (enacted). Accessed January 2, 2011. http://www.legis.state.tx.us/tlodocs/75R/billtext/html/HB02777F.htm.

61 Ibid.

62 Domestic Social Policy Division, Privatization and Welfare Administration, Rep. No. 109-RS22034, at 4 (2005).

63 Ibid.

64 Domestic Social Policy Division, Privatization and Welfare Administration, Rep. No. 109-RS22034, at 4 (2005).

65 Ibid.

66 Ibid.

In 2001, during the 77th legislative session, HHSC received the legislative appropriations to develop and implement the Texas Integrated Eligibility Redesign System (TIERS), through the contracted entity, Deloitte. [67] TIERS was developed as an integrated system that allowed for multiple social services eligibility checks including TANF, Supplemental Nutritional Assistance Program (SNAP), and Medicaid. [68] TIERS integrated automated phone services, mail, fax, and online for individuals to apply.[69] These additional venues allowed individuals to access the system beyond visiting to a local office for a face-to-face interview. [70] The decreased traffic to local offices would free up eligibility workers and leasing space,[71] cutting costs to the operation of the eligibility system.

THE IMPLEMENTATION OF TIERS AND ONGOING POLICY FORMATION EFFORTS

In 2003, TIERS was introduced as a pilot in the five eligibility offices in Travis and Hays Counties. Both pilots had complications generating reports required by state and federal guidelines, populating data entry, and matching the eligibility policy to client information in order to make determinations.[72] Concurrently, the 78th legislation session invoked additional policy decisions that negatively impacted the new system implementation. This included restructuring the health and human services agencies into

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67 Texas Health and Human Services Commission, "TIERS Procurement Information," TIERS Procurement Information, last modified November 26, 2005, accessed July 15, 2012, http://www.hhsc.state.tx.us/programs/tiers/procurement.html.

68 Center for Public Policy Priorities, *TIERS of Relief*, issue brief no. 139, The Policy Page (Austin, TX: 2001), 1.

69 Texas Health and Human Services Commission, "HHSC Plan Provides Consumers, Community Groups with Options," news release, Octobr 21, 2004, accessed July 15, 2012, http://HHSC Plan Provides Consumers, Community Groups With Options.

70 Center for Public Policy Priorities, *TIERS of Relief*, Ibid.

71 U.S. Department of Agriculture Supplemental Nutrition Assistance Program (SNAP) Modernization Workgroup, *State's SNAP Business Process*, 36.

72 Michels, "Tale of TIERS," Government Technology.

five overarching entities with HHSC as the guiding umbrella agency,[73] decreasing the HHSC budget by $42.5 million General Revenue and removing 901 fulltime employees (FTEs),[74] and requiring HHSC to implement eligibility determination center call centers if found cost effective.[75] The request for call centers and the reduction of FTEs changed the TIERS system coordination, as well as the eligibility delivery system that was previously based on human interaction.

HHSC determined that call centers were cost effective and would save the state over $45 million over a five-year period. This prompted call center integration into TIERS.[76] But there were concerns over the methodology used to determine cost-effectiveness. The State Auditor's Office determined the cost-effectiveness of privatizing some of the eligibility workforce to be $1.1 million over five years, not 45 million.[77] Advocacy organizations expressed concerns that the notions of effectiveness and efficiency were based on successful TIERS implementation, and the restructured operations would enhance service quality.[78] The Austin-based liberal think tank Center for Public Policy Priorities (CPPP) noted the implementation plan was quick, provided no time for reevaluation, and did not consider the privatized staff's knowledge of the eligibility requirements.[79]

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73 H.B. 2292, 78th Leg., 1st Reg. Session (Tex. 2003) (enacted). Accessed July 15, 2012. http://www.legis.state.tx.us/tlodocs/78R/billtext/html/HB02292F.htm.

74 Texas Health and Human Services Commission, *Eligibility System Update*, report, Legislative Oversight Committee Eligibility System Update (Austin, TX: 2008), 3.

75 H.B. 2292, 78th Leg., 1st Reg. Session (Tex. 2003) (enacted). Accessed July 15, 2012. http://www.legis.state.tx.us/tlodocs/78R/billtext/html/HB02292F.htm.

76 Texas Health and Human Services Commission, *HB 3575 Eligibility System*, 9.

77 Center for Public Policy Priorities, *CPPP Statement on Draft State Auditor's Report*, issue brief (Austin, TX: 2005).

78 Ibid., 2.

79 Ibid.

Due to issues regarding the reconfiguration of the system and current issues with TIERS, HHSC pulled away from the contract with Deloitte, and entered into a new contract with Accenture.[80] Accenture received a five-year $899 million contract to operate four call centers across the state.[81] Eligibility determination tasks were assessed for privatization capacity.[82] Privatized workers in call centers could apply case changes to clients' accounts, verify information for eligibility, process case documents, and provide information to clients.[83] Clients could access the call centers through 2-1-1 with expanded business hours.[84] Accenture would provide a majority of the employees to staff the call centers, while state employees would serve in support roles in the centers. This would meet federal guidelines, as state employees would still make the final eligibility determination.

In early 2006, Accenture implemented TIERS incorporated call centers in Travis and Hays Counties.[85] But it was soon determined that Accenture and the TIERS system were failing to meet goals following integration. Accenture workers' inexperience in the eligibility system and lack of training regarding policy negatively affected the quality of service, and caused slow case processing times and high application errors.[86] HHSC noted that Accenture employees insufficiently reported on cases and postponed elevated

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80 Center for Public Policy Priorities, *Eligibility System Update*, research report, HB 3575 (Austin, TX: 2008), 14.

81 Texas Health and Human Services Commission, "HHSC Estimates $646 Million in Savings from Call Centers," news release, June 30, 2005, accessed July 15, 2012, http://www.hhs.state.tx.us/news/release/063005_CallCenters.shtml.

82 U.S. Department of Agriculture Supplemental Nutrition Assistance Program (SNAP) Modernization Workgroup, *State's SNAP Business Process*, 35.

83 Center for Public Policy Priorities, *State Moves Forward with*, 5.

84 Texas Health and Human Services Commission, "HHSC Estimates $646 Million," news release.

85 Texas Health and Human Services Commission, *HB 3575 Eligibility System*, 10.

86 Ibid., 11; Texas Health and Human Services Commission, "HHSC Issues 30-Day Review of New Eligibility System," news release, May 4, 2006, accessed July 15, 2012, http://www.hhs.state.tx.us/news/release/050406_30Day_Review.shtml.

case referrals to state workers,[87] causing increased handling times.[88] State staff also required training on the new eligibility system, which increased initial estimated costs.[89] Media outlets cited opposition from clients, state workers, and advocacy groups who feared additional rollouts would continue to provide inadequate service to state recipients.[90] The issues that arose ultimately reduced the quality of services to clientele, as eligibility workers, both the contracted and the state employees, were unprepared to make adequate eligibility determinations under the new, integrated system. The externalities created by the decision to privatize, and privatize quickly, affected a vulnerable population with limited political power.[91] The delayed eligibility determinations further postponed enrollment and social service benefit redemption.

In December 2006, HHSC revised the contract with Accenture. Instead of the $899 million contract, Accenture would receive $543 million to continue to revamp the system and provide private employees to staff call centers.[92] HHSC also reassessed the eligibility determination process to reemphasize the role of state workers, instead of relying on contracted workers. Executive Commissioner of HHSC, Albert Hawkins, clarified that contracts with the state would be used to enhance current operations, not provide core eligibility functions.[93] Efforts to move away from privatization were

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87 Ibid.

88 U.S. Department of Agriculture Supplemental Nutrition Assistance Program (SNAP) Modernization Workgroup, *State's SNAP Business Process*, 35.

89 Texas Health and Human Services Commission, "HHSC Issues 30-Day Review," news release.

90 MacLaggan, "After Spending $500 Million.

91 Stone, *Policy Paradox: The Art of Political*, 72.

92 Texas Health and Human Services Commission, "Transforming Eligibility Services," New System Includes Convenient Office Locations, last modified February 1, 2007, accessed July 15, 2012, http://www.hhs.state.tx.us/consolidation/IE/TransEligServices.shtml.

93 Texas Health and Human Services Commission, "HHSC Announces New Strategy to Modernize Eligibility System," news release, December 21, 2006, accessed July 15, 2012, http://www.hhs.state.tx.us/news/release/122006_EligSystem.shtml.

applauded by advocacy groups, but they noted the lack of FTEs would strain the transition back to state workers.[94]

The implementation of TIERS and the incorporation of a privatized workforce negatively affected the morale and effectiveness of state staff. Some state employees viewed the TIERS implementation and the integration of contracted staff to be forced,[95] given that state worker input about the system and procedures was never solicited.[96] During the TIERS and call center implementation, the state eligibility workforce underwent high turnover and low retention rates. An *Austin American Statesman* article stated that in September 2007, HHSC hired 1,010 workers and by March 2008, 72 per cent of the employees resigned.[97] The previous disastrous rollout caused frenzy among state eligibility workers both in and outside of the two counties. Caseworkers oversaw high caseloads, but also lacked adequate training about the TIERS system. Full transition to TIERS had not occurred, so state workers had had to learn, work, and use the new and legacy systems.[98] This caused slower case management, case turnover, and diminished system capacity.

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94 Center for Public Policy Priorities, *CPPP Statement on HHSC's New Strategy for Enrollment in Public Benefits*, publication (Austin, TX: 2006).

95 Texas SNAP Employee, *Ramblings of an HHSC Employee Admist Chaos* (blog), accessed July 15, 2012, http://hhscemployee.blogspot.com/.

96 U.S. Department of Agriculture Supplemental Nutrition Assistance Program (SNAP) Modernization Workgroup, *State's SNAP Business Process*, 35.

97 Corrie MacLaggan, "Pay Raises, Faster Promotions Aim to Combat Rapid Turnover," *Austin American Statesman* (Austin, TX), March 23, 2008, Region, accessed July 15, 2012, http://www.statesman.com/news/content/region/legislature/stories/03/23/0323workers.html.

98 Texas Health and Human Services Commission, *Eligibility System Update*, report, Legislative Oversight Committee Eligibility System Update (Austin, TX: 2008), 7.

A NEW STRATEGY

In less than three months, HHSC terminated the entire contract with Accenture, cutting all private contracted positions and ceasing system reconfiguration.[99] In April 2007, the State Inspector General recommended that a single program manager oversee the future TIERS rollout, but ultimately, stressed that any additional TIERS expansion be ceased.[100] Instead, HHSC received federal approval to issue short -term contracts to address underlying system issues in order to continue expansion.[101] In addition, during the 80th legislative session, HB 3575 was passed to establish an Eligibility System Oversight Legislative Committee to provide a venue for legislators to keep up to date with implementation.[102] HB 3575 also required HHSC to develop a Transition Plan by January 2008 to facilitate TIERS' complete rollout.[103] Complete roll out of TIERS faced opposition from advocacy groups regarding the original cost-effectiveness analysis, the necessary staffing levels, and service quality, as the federal guidelines for eligibility timeliness were not met in the two counties with TIERS rollout for over a year.[104] More conservative think tanks argued that the expansion was necessary because of the cost of upkeep for two separate eligibility systems.[105] The maintenance of both systems was expensive: TIERS training was still underway, and the SAVERR programming was

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99 U.S. Department of Agriculture Supplemental Nutrition Assistance Program (SNAP) Modernization Workgroup, *State's SNAP Business Process*, 36.

100 Paul Burka, "TIERS Critiqued by Inspector General," *Burka Blog*, entry posted April 18, 2007, accessed July 15, 2012, http://www.texasmonthly.com/blogs/burkablog/?p=445.

101 Texas Health and Human Services Commission, *HB 3575 Eligibility System Transition Plan*, by Texas Health and Human Services Commission, report (Austin, TX: 2007), 11.

102 Ibid., 2.

103 Center for Public Policy Priorities, *Eligibility System Subcommittee to Consider Transition Plan*, issue brief (Austin, TX: 2007), 1.

104 *Transition Plan Mandated by H.B. 3575: Hearings on 3575 Before the Health and Human Services Commission, Subcommittee on Eligibility System on the Transition Plan*, 80th Leg., 1st Reg. Sess. (Tex. 2007) (statement of Anne Dunkleburg, Center for Public Policy Priorities).

105 Corrie MacLaggan, "Advocates for People with Disabilities Worry about Impact," *Austin American Statesman* (Austin, TX), July 15, 2008, Region.

failing to configure with newer technology systems. For example, during FY2007, the SAVERR system was inaccessible to workers for 2,600 hours.[106] TIERS also faced increased turnover time due to the amount of information that was needed to check for service eligibility.[107]

HHSC's decision to discontinue the original contract with Deloitte, and then create a new contract with Accenture to develop and reconfigure TIERS, created an unstable foundation for implementation.[108] Accenture was expected to construct the system for call center interoperability. In addition, Accenture, though knowledgeable of the structure, did not create TIERS, and had to staff and train their staff to work the system under specific eligibility policies. Contracted Accenture employees worked with state eligibility workers in an assumingly hostile environment, as legislators were decreasing eligibility FTEs. These elements created a costly and unproductive rollout. The initial system was not prepared for full implementation or the incorporation of privatized staff. But the high cost and political capital spent on authorizing a system with privatized elements encouraged both legislators and HHSC to continue TIERS implementation. Yet it was not acknowledged that administrators did not have the capacity – time, resources, funding – to successfully privatize aspects of the eligibility system.

With an implementation plan and accountability structure set up for HHSC, in the fall of 2007, the State Auditor's Office (SAO) assessed the system's capacity for continued implementation. SAO concluded the system accurately determined eligibility

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106 Ibid.

107 Ibid.

108 Brian Heaton, "Texas Rolls out TIERS Eligibility System after 8-Year Transition," Government Technology: Solutions for State and Local Government, last modified December 20, 2011, accessed July 16, 2012, http://www.govtech.com/health/Texas-TIERS-Rollout.html.

for multiple services, but the operation design and client data collection were inefficient, and required higher storage levels to determine eligibility.[109] The SAO noted most cases were still prepared in field offices with face-to-face interviews and case eligibility determinations conducted by SAVERR.[110] Only about 12 per cent of total cases in Hays and Travis Counties were facilitated through TIERS, with low timeliness processing rates.[111] With the SAO report, TIERS was set to roll out to additional counties. HHSC contracted back with Deloitte to facilitate the rest of the implementation and reconfiguration of the system with call centers.[112] The Transition Plan and SAO audit designated the Department of Information Resources, the state agency that addresses information technology, to manage eligibility call centers, along with data management.[113] HHSC estimated over eight million records needed to be converted to TIERS, and over 7,000 state employees would need TIERS training. [114]

Throughout 2008, HHSC worked the Transition Plan to roll out the TIERS eligibility system throughout the regions. TIERS was used in Travis, Hays, and Williamson counties, and was expanded to Women's Health Program participants, which included people from outside of the rollout areas.[115] HHSC received more staff for the rollout, and throughout 2009, implemented the TIERS system with high conversion rates and low errors. At this time, Executive Commissioner Hawkins retired,[116] and new

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109 Texas Health and Human Services Commission, *Eligibility System Update*, 11.

110 Texas State Auditor, *An Audit Report on the Health and Human Services Commission's Texas Integrated Eligibility Redesign System (TIERS)*, technical report no. Vols. 08-009. (Austin, TX: 2007).

111 Ibid.

112 Michels, "Tale of TIERS," Government Technology.

113 Texas State Auditor, *An Audit Report on the Health*.

114 Texas Health and Human Services Commission, *Eligibility System Update*, 13.

115 Ibid.,7.

116 Texas Health and Human Services Commission, "Well-wishers Say Goodbye to 'Thoughtful, Responsible Leader' Hawkins," *InTouch*, September/October 2009, http://www.hhsc.state.tx.us/stakeholder/Sept_Oct09/2.html.

Executive Commissioner Thomas Suehs chose an external project consultant to oversee all implementation efforts.[117] Suehs and the project consultant concluded employee buy-in could be enhanced through better communication and promotion of the reconfiguration.[118] TIERS training for state employees received a makeover in March/April of 2010 to include more interactive demonstrations and discussion on policy integration.[119] By fall of 2010, HHSC noted in their newsletter that 94 per cent of Medicaid applications were processed within 30 days,[120] though from August to September of 2010, there was a significant decrease of 40,000 SNAP submitted applications,[121] perhaps allowing the workforce to focus on processing Medicaid applications.

In 2010, the TIERS system was reported to serve $25.7 billion in social services benefits annually.[122] The system runs on little administrative overhead, a reported 3 per cent of the $680 million annual budget to run the system.[123] Currently, TIERS is efficiently and effectively determining eligibility and enrolling clients into social

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117 Brian Heaton, "Stanley Stewart," Public CIO: Technology Leadership in the Public Sector, last modified February 29, 2012, accessed July 16, 2012, http://www.govtech.com/pcio/Stanley-Stewart.html; Heaton, "Texas Rolls out TIERS," Government Technology: Solutions for State and Local Government.

118 Heaton, "Texas Rolls out TIERS," Government Technology: Solutions for State and Local Government.

119 Texas Health and Human Services Commission, "TIERS Training Gets a Makeover," *InTouch*, March/April 2010, accessed July 16, 2012, http://www.hhsc.state.tx.us/stakeholder/March_April10/4.html.

120 Texas Health and Human Services Commission, "HHSC Eligibility Offices Continue Improvement," *InTouch*, September/October 2010, accessed July 16, 2012, http://www.hhsc.state.tx.us/stakeholder/Sept_Oct10/1.html.

121 Texas Health and Human Services Commission, "SNAP, TANF and Medicaid Timeliness Reports," Research and Statistics, accessed August 1, 2012, http://www.hhsc.state.tx.us/research/timeliness.shtml.

122 *Social Services Eligibility Systems: Hearings Before the Health and Human Services Committee*, 82d Leg., 1st Reg. Sess. (Tex. 2010) (statement of Celia Cole, Center for Public Policy Priorities).

123 Ibid.

services. In January 2011, all but two regions reported timeliness levels of over 95 per cent.[124] In December 2011, the TIERS rollout was complete.

CONCLUSION

The TIERS development and implementation was an early modernization effort to bring improvements to procedures and technology to increase efficiency, effectiveness, client accessibility, and the quality of service delivery. During TIERS rollout, features were added to enhance the eligibility determination. TIERS now links with an online portal, the Self Service Portal, for clients to apply for benefits through an integrated service application, check status of their submitted application or changes, and view benefits. These modernization efforts utilize technology to automate more case processing tasks and increase client access to case information in order to decrease calls and visits to local offices.

The process to implement TIERS and incorporate privatized positions in the eligibility system did not reach its intended goal. Completion took eight years, service quality diminished and a vulnerable population received the brunt of the impact through delayed eligibility decisions, and the state workforce experienced immense turnover and decreased retention. The initial policy formation allowed administrators the autonomy to determine the outputs in order to achieve the goals legislators sought, but the subsequent decisions to incorporate contract staff and a new mode of service delivery during system development placed a severe constraint on implementation. [125] Legislators strived for quick savings, even going further to demonstrate their faith in the political choice to

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124 Texas Health and Human Services Commission, "Timeliness: Food Stamps, TANF, and Medicaid," The Health and Human Services Commission Research and Statistics, last modified October 2011, accessed January 2, 2012, http://www.hhsc.state.tx.us/research/FMTtimeliness.html.

125 Anita Harbert and Jennifer Tucker-Tatlow, *Review of the Research: Call Centers and Web-based Eligibility Systems*, comp. Karisa Hughes, research report (San Diego, CA: Academy for Professional Excellence, 2010), 18.

privatize by concurrently cutting FTE positions and HHSC funding. Administrators were expected to make a political decision successful, not thoroughly assess, develop, and reevaluate the eligibility process.

This is not to say that legislators do not have the technical knowledge or policy expertise to determine the means to achieve the end goal. The initial failure of incorporating contracted staff does not mean that privatizing eligibility components is inappropriate for Texas. But legislators' drive to quickly and successfully implement a new eligibility process with limited resources diminished the policy's goal to achieve effectiveness and efficiency.

With the upcoming deadlines to implement ACA provisions, the eligibility system and processes must be equipped to take on increasing caseloads, determine eligibility in real time, and become operable with health insurance exchanges that are facilitated by another entity. Currently, legislators have not designated a legal entity to implement the major provisions to expand Medicaid eligibility or develop an exchange. Instead, Republican legislators in Texas have stifled the capacity of HHSC and other state agencies to implement the necessary ACA provisions. Without the legislative approval, administrators must find additional ways to prepare the system for the upcoming deadlines.

Chapter Three

The Affordable Care Act (ACA) is envisioned to provide citizens a streamlined, simplified, consumer-friendly system to obtain health insurance by 2014.[126] Citizens meeting certain eligibility thresholds will receive federal subsidies to purchase insurance through an exchange or, in some states, become newly eligible for Medicaid. In order to facilitate enrollment, the ACA requires interoperability between Medicaid, Children's Health Insurance Program (CHIP), and the health insurance exchanges to streamline eligibility determinations and reduce gaps in coverage.[127] These provisions will change the way individuals navigate the health care system for coverage.

This chapter will provide an overview of the ACA provisions, including the technical details that further conceptualize operations, and the 82nd legislative session's stakeholders, issues, and leadership that contributed to the foundation for ACA implementation. I will then examine current modernization efforts, how these efforts will enhance current system operations, and demonstrate their link to ACA provisions.

THE CONSTITUTIONALITY OF THE AFFORDABLE CARE ACT

President Obama undertook federal health care reform in a polarized political environment with extreme animosity between Democrats and Republicans. Since its conception in 2010, the constitutionality of the ACA has been questioned, primarily the two main provisions that seek to increase health insurance access: the individual mandate to obtain insurance and the Medicaid eligibility expansion.

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126 U.S. Department of Health and Human Services Centers for Medicare and Medicaid Services, *Medicaid IT Systems: Supporting the Affordable Care Act*, by Rick Friedman, report, Webinar (Washington, D.C.: 2011), 3.

127 Kaiser Family Foundation's Commission on Medicaid and the Uninsured, *Explaining Health Reform: Building Enrollment Systems That Meet the Expectations of the Affordable Care Act*, issue brief, Focus on Health Reform 8108 (Washington, DC: 2010), 1.

The Supreme Court of the United States (SCOTUS) ruled on June 28, 2012, that the individual mandate of the ACA was constitutional.[128] The individual mandate requires citizens, who are subject to paying an income tax, to obtain health insurance or submit to a penalty fee. Many opponents of the ACA viewed the individual mandate as an overexpansion of the federal government's power to regulate activity, [129] or actually, an individual's inactivity to purchase a commercial good.[130] Others viewed the mandate as a necessary component to keep insurance accessible and maintain health care costs. If the mandate was invalid, individuals who were sicker, had high care costs, or were otherwise in need of health insurance were expected to be the sole population to purchase insurance in the exchange.[131] This adverse selection would decrease risk sharing and raise premiums, increasing the cost of health insurance and decreasing the accessibility of insurance.[132] Under the SCOTUS decision, the fee for being uninsured was considered a tax, a power delegated to Congress by the Commerce Clause, and therefore, constitutional.[133]

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128 U.S. Department of Health and Human Services, et al. v. State of Florida, et al., 11-398 U.S. (2012).

129 Charlie Fried, "Reagan's Solicitor General: 'Health Care Is Interstate Commerce. Is This a Regulation of It? Yes. End of Story.'," interview by Ezra Klein, *Ezra Klein's Wonk Blog*, entry posted March 28, 2012, accessed July 23, 2012, http://www.washingtonpost.com/blogs/ezra-klein/post/reagans-solicitor-general-health-care-is-interstate-commerce-is-this-a-regulation-of-it-yes-end-of-story/2011/08/25/gIQAmaQigS_blog.html;%20http://nymag.com/daily/intel/2012/03/contrived-theory-of-the-obamacare-lawsuit.html.

130 Adam Liptak, "Supreme Court Upholds Health Care Law, 5-4, in Victory for Obama," *New York Times* (New York, NY), June 28, 2012, U.S..

131 Washington Post, "Q&A: Supreme Court Decision on Obama's Health Care Law Is Unlikely to Be the Last Word," *The Washington Post* (Washington, D.C.), June 29, 2012, accessed June 29, 2012, http://www.washingtonpost.com/business/economy/qanda-supreme-courts-decision-on-obamas-health-care-law-unlikely-to-be-the-last-word/2012/06/27/gJQAmMM35V_story.html.

132 Larry Levitt and Gary Claxton to The Henry J. Kaiser Family Foundation: Health Reform Source newsgroup, "Is a Death Spiral Inevitable If There is No Mandate?," June 19, 2012, accessed July 23, 2012, http://healthreform.kff.org/notes-on-health-insurance-and-reform/2012/june/is-a-death-spiral-inevitable-if-there-is-no-mandate.aspx.

133 Liptak, "Supreme Court Upholds Health," U.S..

SCOTUS ruled that requiring states to expand Medicaid eligibility or lose their current federal funding for Medicaid was unconstitutional.[134] This was deemed a coercive act beyond the Spending Clause, as states must have the option to choose to participate in the program, and after admittance, submit to the set conditions.[135] Though there is high federal matching funding available to states to expand Medicaid to a new population,[136] there is concern that states led by more conservative governments will reject the expansion, and limit the ACA's proposed reach to increase coverage, especially to individuals with low-incomes. Many legislators from conservative states emphasized that the expansion would severely deplete their state budgets and remove funding from education and other social priorities.[137]

Texas was one of 26 states that brought suit against the federal government over the constitutionality of the ACA. Governor Rick Perry stated that Texas would not implement the health insurance exchange or expand Medicaid eligibility, thus entrusting a federally-facilitated exchange for the state and declining over $76 billion dollars in federal funding to expand Medicaid (2014-2020).[138] Attorney General Greg Abbott deemed the SCOTUS decision regarding expansion was a "victory,"[139] and pledged to

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134 Ibid.

135 Kevin Russell, "Court Holds That States Have Choice Whether to Join Medicaid Expansion," *Supreme Court of the U.S. Blog*, entry posted June 28, 2012, accessed July 23, 2012, http://www.scotusblog.com/2012/06/court-holds-that-states-have-choice-whether-to-join-medicaid-expansion/.

136 Josh Barro, "Court Takes Away Medicaid Stick, but Leaves Big Carrot," *Bloomberg View*, June 28, 2012, Opinion, accessed July 23, 2012, http://www.bloomberg.com/news/2012-06-28/scotus-takes-away-medicaid-stick-but-leaves-big-carrot.html.

137 Chicago Tribune, "Florida Says No to Two Healthcare Features," *Chicago Tribune* (Chicago, IL), June 1, 2012, News.

138 Anne Dunkelberg, "Guest Column: Health Reform Ruling Is Good for TX," *Texas Tribune* (Austin, TX), June 29, 2012, Health Reform and Texas, accessed July 23, 2012, http://www.texastribune.org/texas-health-resources/health-reform-and-texas/guest-column-health-reform-ruling-good-tx/.

139 Marilyn Werber Serafini and Phil Galewitz to Kaiser Health News newsgroup, "Ruling Puts Pressure On States To Act," June 28, 2012, accessed July 23, 2012,

continue to file lawsuits regarding ACA in an attempt to dismantle the remaining provisions.[140] The outgoing Executive Commissioner of Health and Human Services Commission (HHSC), the entity designated to coordinate ACA efforts, stated in a press release that expanding Medicaid eligibility without reforming the broken system was a mistake, and would increase state costs.[141] HHSC stated they were pleased the ruling allowed states to push back against the expansion, but the agency would work with the legislature for further direction.[142]

MODERNIZATION EFFORTS AS MEANS TO PREPARE

Despite Texas citizens' immense need for accessible health insurance, legislators have insufficiently prepared Texas for ACA implementation. With both the State Medicaid Director, Billy Milwee, and HHSC Executive Commissioner, Thomas Suehs, leaving their positions,[143] ACA coordination and implementation efforts by HHSC will be further strained. Without a legal designation to begin implementation, HHSC must seek new means beyond legislative action to integrate the state Medicaid system with the health insurance exchange and provide real time determinations.

Administrators developed the Eligibility Modernization Project (EMP) to assess the current system operations, procedures, policy, and contracts, and develop means to make the processes more efficient. These modernization efforts will set up a foundation

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http://www.kaiserhealthnews.org/Stories/2012/June/28/pressure-on-states-to-act-after-supreme-court-ruling.aspx.

140 Emily Ramshaw and Shefali Luthra, "With Health Reform Constitutional, What Happens in TX?," *Texas Tribune* (Austin, TX), June 28, 2012, Texas Weekly, accessed July 23, 2012, http://www.texastribune.org/texas-health-resources/health-reform-and-texas/supreme-court-rules-federal-health-reform/.

141 Texas Health and Human Services Commission, "HHSC Statement on Affordable Care Act Ruling," news release, June 28, 2012.

142 Ibid.

143 Emily Ramshaw, "HHSC Commissioner Tom Suehs Retiring in August," *Texas Tribune* (Austin, TX), June 14, 2012, Texas Weekly.

for potential Medicaid eligibility expansion, if Texas legislators and Governor Perry decide to do so. The modernization efforts allow HHSC to prepare for the potential changes to the health care delivery system by aligning goals with ACA provisions, and the interagency efforts avoid legislative coordination and the political implications regarding official ACA implementation. The division between policy makers and implementers allowed the agency to develop innovative means to enhance operations and procedures.

Agencies provide stable environments in which bureaucratic leaders deal with the vagaries of changes in elected officials. The role of implementers in EMP is significantly different than the agency role in the first modernization efforts that occurred with Texas Integrated Eligibility Redesign System (TIERS). With EMP, HHSC determined the goals and means to achieve the goals. The role of EMP regarding this kind of interagency effort and division between implementers and legislators could be described as "Bureaucratic Entrepreneurs." Bureaucratic Entrepreneurs calls into question the dominance of legislative power because implementers frame, influence, and determine the policy goals and have the "sufficient power to convince the formal policy makers to adopt those goals."[144] The power exists from expert knowledge of the current agency operations, and the understanding of the effects of the ACA provisions on those operations and clientele. Within this linkage, implementers determine the means to carry out the goals.[145] At the same time, EMP is consistent with the past trends to increase technology, efficiency, effectiveness of state operations, and deemphasize the role of the state eligibility workforce.[146] Thus, these moves are less risky forms of change in the polarized political

144 Nakamura and Smallwood, *The Politics of Policy*, 133.
145 Ibid.
146 See Chapter Two for more detail.

environment, hostile to federal health care, than overt preparation for ACA. If Texas were able to get social service block grants, as conservative legislators support, these modernization systems would also be effective.

In the bureaucratic sphere, HHSC can communicate with various intermediaries to develop means to meet particular goals. Unlike the implementation of TIERS, HHSC engages and works with various stakeholders. HHSC can also allocate specific resources, like funding and staff, to the project that legislators may have not done otherwise.[147]

THE AFFORDABLE CARE ACT

Maintenance of Effort (MOE)

The ACA and American Recovery and Reinvestment Act of 2009 prohibits states from implementing more restrictive eligibility levels to Medicaid that have been in place since July 2008.[148] States must uphold the maintenance of effort (MOE) for adults until January 2014 and until September 2019 for children in order to receive federal funding for Medicaid.[149] HHSC is uncertain if the SCOTUS decision will affect the MOE requirement,[150] but this requirement was separate from the Medicaid expansion provision and can still be considered valid under the SCOTUS decision.[151]

Medicaid Expansion

Currently, Texas offers Medicaid to pregnant woman and infants up to 185 per cent, children aged 1-5 up to 133 per cent, children 6-19 up to 100 per cent, and working

147 Nakamura and Smallwood, *The Politics of Policy*, 53-57.

148 Texas Health and Human Services Commission, *Texas Medicaid and CHIP*, 3-4.

149 Ibid.

150 A. Bradley, "ACA Ruling Leaves Ambiguity about Medicaid MOE Provision," American Network of Communities Options and Resources, last modified July 5, 2012, accessed July 17, 2012, http://www.ancor.org/news/2012/07/aca-ruling-leaves-ambiguity-about-medicaid-moe-provision.

151 Center for Public Policy Priorities, *What We Know about the Medicaid Expansion*, technical report, Policy Page (Austin, TX: Center for Public Policy Priorities, 2012), 4.

parents up to 14 per cent of the FPL.[152] In 2014, the ACA expands Medicaid eligibility to 133 per cent of the Federal Poverty Line (FPL) for individuals under 65 years old. In 2001, for a family of four at 133 per cent of FPL, annual earnings would amount to $29,700,[153] constituting this population as the "working poor." Insurance coverage is often inaccessible to this population because of a lack of disposable income and worker-sponsored insurance.[154] The ACA provision will allow 5 per cent of income disregards for most Medicaid eligible individuals, making eligibility thresholds at 138 per cent of the FPL.[155] Currently, disregards or deductions vary by state or populations.[156] Disregards often help individuals become eligible for Medicaid by discounting certain family expenses or earnings,[157] but can also increase administrative burdens and program complexity. [158] Most Medicaid programs in Texas have disregards.[159]

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152 Kaiser State Health Facts to The Henry J. Kaiser Foundation: Kaiser State Health Facts newsgroup, "Texas - Kaiser State Health Facts," 2010, accessed July 23, 2012, http://www.statehealthfacts.org/mfs.jsp?rgn=45&rgn=1.; Texas Health and Human Services Commission, *Presentation to the Senate Health and Human Services and Senate State Affairs Committees on the Affordable Care Act*, technical report (Austin, TX: Texas Health and Human Services Commission, 2012), 8.

153 U.S. Department of Health and Human Services, "Healtcare.gov," Affordable Insurance Exchanges: Simple, Seamless and Affordable Coverage - Medicaid, CHIP and the Affordable Care Act, last modified August 12, 2011, accessed December 30, 2011, http://www.healthcare.gov/news/factsheets/2011/08/exchanges08122011c.htm.

154 James W. Henderson, *Health Economics and Policy*, 5th ed. (Mason, OH: South-Western, Cengage Learning, 2012), 197.

155 Texas Health and Human Services Commission, *Texas Medicaid and CHIP*, 3-5.

156 Tricia Brooks and Jennifer Mezey, "ACA Propels States to Adopt Best Practices in Simplification and Alignment," *Say Ahhh! A Children's Health Policy Blog*, entry posted August 18, 2011, accessed December 11, 2011, http://theccfblog.org/2011/08/aca-propels-states-to-adopt-best-practices-in-simplification-and-alignment.html.

157 Donna Cohen Ross, *Determining Income Eligibility in Children's Health Coverage Programs: How States Use Disregards in Children's Medicaid and SCHIP*, report (Washington D.C.: Kaiser Commission on Medicaid and the Uninsured, 2008), 2.

158 Brooks and Mezey, "ACA Propels States to Adopt," *Say Ahhh! A Children's Health Policy Blog*.

159 Texas Health and Human Services Commission, *Texas Medicaid and CHIP*, 3-5

The eligibility expansion will transform the impression of Medicaid's purpose as a "safety net" for vulnerable populations.[160] Texas' current Medicaid enrollment is mostly composed of females and individuals under the age of 21. Those currently enrolled in Texas include poor children under 19 years old (children receiving Temporary Assistance for Needy Families (TANF) benefits, children in foster care, and newborns), poor elderly, disabled, TANF receipts, pregnant women up to 185 per cent of FPL, and medically needy (pregnant women and children who are not eligible for Medicaid benefits, but cannot otherwise afford medical costs).[161] ACA will collapse the various population groups into four subpopulations that are eligible for Medicaid: children, pregnant women, parents, and the newly eligible adult group with income at 138 per cent of the FPL.[162] HHSC identified four new Texas-specific Medicaid populations, including former foster youth through 25 years old, eligible CHIP children (between 100 and 133 per cent of FPL), childless adults, and parents/caretakers (between 12 and 133 per cent of FPL).[163] While it is estimated that currently 1.2 million to 2 million Texans, ages 19 to 65 with income at 133 per cent of the FPL are uninsured,[164] HHSC estimates that ACA Medicaid expansion will bring in 1.3 million newly eligible individuals onto the Medicaid caseload in 2014, 21 per cent of the uninsured population in Texas.[165]

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160 U.S. Department of Health and Human Services Centers for Medicare and Medicaid Services, *Medicaid IT Systems: Supporting,* 3.

161 Texas Health and Human Services Commission, *Texas Medicaid and CHIP*, 1-3.

162 U.S. Department of Health and Human Services, "Healtcare.gov," Affordable Insurance Exchanges: Simple, Seamless and Affordable Coverage - Medicaid, CHIP and the Affordable Care Act.

163 Texas Health and Human Services Commission, *Texas Medicaid and CHIP*, 3-3.

164 Chris Tomlinson, "Texas' Cost For Expanding Medicaid Is Revised Down," *Star-Telegram* (TX), July 12, 2012, State, accessed July 16, 2012, http://www.startelegram.com/2012/07/12/4096819/texas-cost-for-expanding-medicaid.html#storylink=cpy.; Center for Public Policy Priorities, *Texas Health Care 2011*, 10.

165 Texas Health and Human Services Commission, *Texas Medicaid and CHIP*, 3-2 -3-3.

Federal Medical Assistance Percentage (FMAP)

The newly eligible Medicaid population will garner an enhanced Federal Medical Assistance Percentage (FMAP).[166] FMAP are assistance payments from the federal government to subsidize social services,[167] and states with lower per capita incomes receive higher FMAP payments.[168] From October 2011 to September 2012, Texas' FMAP for individuals currently eligible for Medicaid was about 58 per cent.[169] Between 2014 and 2016, the federal government will provide a FMAP at 100 per cent for newly eligible populations, and will incrementally decrease and remain at 90 per cent in 2020.[170] Because individuals who are newly eligible will merit a higher FMAP, state governments must be able to track this population separately from the previously eligible population to receive the higher payments.[171] HHSC estimated the expansion cost to the state is $92 million in 2014, and $1.3 billion through 2017, with $2.4 billion of federal funding available in 2014, and $24 billion through 2017.[172]

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166 Carrie Au-Yeung and John Czajka, *Modified Adjusted Gross Income: Implications for Medicaid Eligibility Systems under the ACA*, technical report, State Health Access Reform Evaluation (Washington, D.C.: Robert Wood Johnson Foundation, 2011), 1.

167 Assistant Secretary for Planning and Evaluation, "Federal Medical Assistance Percentages or Federal Financial Participation in State Assistance Expenditures FMAP," Office of Health Policy, last modified November 10, 2011, accessed August 3, 2012, http://aspe.hhs.gov/health/fmap.htm.

168 Evelyne Baumrucker, *Medicaid: The Federal Medical Assistance Percentage (FMAP)*, research report (Washington D.C.: Congressional Research Service, 2010), 4.

169 U.S. Department of Health and Human Services, *Federal Financial Participation in State Assistance Expenditures; Federal Matching Shares for Medicaid, the Children's Health Insurance Program, and Aid to Needy Aged, Blind, or Disabled Persons for October 1, 2011 through September 30, 2012*, by U.S. Department of Health and Human Services, report (Washington, D.C.: U.S. Department of Health and Human Services, 2010), 2.

170 Healthcare.gov. *Affordable Insurance Exchanges*.

171 Au-Yeung and Czajka, *Modified Adjusted Gross Income:*, 1.

172 Texas Health and Human Services Commission, *Presentation to Joint Committee for Senate State Affairs and Health and Human Services*, by Texas Health and Human Services Commission, report (Austin, TX: 2010), 13.

Modified Adjusted Gross Income (MAGI)

To standardize income rules, all health subsidy programs will use Modified Adjusted Gross Income (MAGI) to determine a household's eligibility for the filer and their dependents.[173] This includes individuals eligible for Medicaid, CHIP, exchange subsidies or exchange cost-sharing benefits.[174] MAGI will exclude prior income-counting determinations for Medicaid, including child support payments, Social Security benefits, alimony payments, and certain pre-tax contributions.[175] The annual federal income tax will be verified through a federal data hub established by the Centers for Medicare and Medicaid Services (CMS).[176] Self-attestation must be accepted for most eligibility criteria, including pregnancy, except citizenship and immigration status.[177] The state must develop standards to define what is considered reasonably compatible if the electronic verification and the self-attestation are inconsistent.[178] MAGI populations' eligibility redeterminations automatically occur every 12 months, unless there are circumstances that may change the individual's eligibility.[179] If there is a change that makes an individual ineligible, the system should automatically screen the individual's eligibility for other health subsidy programs.[180]

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173 Kaiser Family Foundation's Commission on Medicaid and the Uninsured, *Explaining Health Reform: Eligibility and Enrollment Processes for Medicaid, CHIP, and Subsidies in the Exchanges*, issue brief, Focus on Health Reform 8090 (Washington, D.C.: 2010), 4.

174 Ibid.

175 Kaiser Family Foundation's Commission on Medicaid and the Uninsured, *Explaining Health Reform: The New Rules for Determining Income under Medicaid in 2014*, issue brief, Focus on Health Reform 8194 (Washington, D.C.: Kaiser Family Foundation, 2011), 2-3.

176 Department of Health and Human Services, *State Exchange Implementation Questions and Answers*, by Centers for Medicare and Medicaid Services, report (Baltimore, MD: 2011), 2.

177 Department of Health and Human Services, *Application, Verification, Renewals*, by Centers for Medicare and Medicaid Services, issue brief, Weekly Webinar with States (Washington, D.C.: 2012).

178 Deloitte, *Federal Guidance on the Medicaid Eligibility: Notice of Proposed Rule Making*, issue brief (n.p.: Deloitte Development, 2011), 13.

179 Centers for Medicare and Medicaid Services, *Application, Verification, Renewals*.

180 Ibid.

System Interoperability

The state Medicaid and CHIP eligibility systems must be interoperable with the exchange system to determine individuals' eligibility for particular health subsidy programs.[181] This promotes the 'no wrong door' approach where an individual can apply through any system, receive an eligibility assessment and determination, and be transferred to the program without any further action on their part. To coordinate this process, states must use a single, streamlined application to screen eligibility for the various health subsidy plans.[182] The eligibility systems will determine if the person is eligible for Medicaid as part of the previous or newly eligible population. If the individual is not eligible for Medicaid, their subsidy and/or advance payment is determined and applied to the insurance of their choice. Information on the health subsidy program information must be available on a website and include a web portal to apply for coverage.[183] To promote the use of the website and web portal, the ACA includes a provision to establish state Navigator programs and a consumer call center to assist individuals seeking information and applying for services.[184] Though not the legally designated entity by the legislature, the Texas Department of Insurance (TDI) oversees the planning of the health insurance exchange and must coordinate with HHSC for system interfacing.

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181 Department of Health and Human Services, *Enhanced Funding Requirements: Seven Conditions and Standards*, by Centers for Medicare and Medicaid Services, report (Baltimore, MD: U.S. Department of Health and Human Services, 2011), 8.

182 Tricia Brooks and Jennifer Mezey, *Fulfilling the Promise of 2014: Aligning and Simplifying Medicaid and CHIP Enrollment for Children and Parents*, report, Aligning and Simplifying Enrollment (Washington, DC: Center for Children and Families, 2011), 2.

183 Kaiser Family Foundation's Commission on Medicaid and the Uninsured, *Explaining Health Reform: Eligibility*, 2.

184 Texas Health and Human Services Commission, *Presentation to Joint Committee*, 8.

Health Care Exchanges

In January 2014, individuals and small businesses can buy coverage through health care exchanges.[185] The exchanges will house insurance plans where individuals can compare benefits and prices to promote competition and drive down costs.[186] The states have some kind of flexibility to decide the operational aspects of the exchange, including what kind to implement, who will run it, and what insurers and plans are offered in the market.[187] States have the option to implement a statewide exchange, multiple regional exchanges with plans that are reflective of the region's needs, interstate exchanges with other states, or a federally-facilitated exchange. Exchanges can be run by state or non-profit entities.[188]

Within the exchange, individuals with income levels between 139 and 400 per cent of FPL without other opportunities to obtain health insurance coverage are eligible for subsidies. In addition, individuals with income between 139 and 250 per cent of FPL are eligible for cost-sharing opportunities based on sliding scales.[189] The exchange system will also assess individual's eligibility to receive advance tax credits that go directly to insurers.[190]

It is estimated that in 2019, five million Texans will participate in the exchange.[191] Without the Medicaid expansion, some of the newly eligible Medicaid

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185 Ibid., 4.

186 Robert Pear, "Health Care Exchanges Rules to Be Set," *New York Times* (New York, NY), March 3, 2012, Health, accessed July 20, 2012, http://www.nytimes.com/2012/03/10/health/policy/obama-administration-to-set-health-care-exchange-rules.html.

187 Ibid.

188 Texas Health and Human Services, *Presentation to Joint Committee*, 4.

189 Kaiser Family Foundation's Commission on Medicaid and the Uninsured, *Determining Income for Adults Applying for Medicaid and Exchange Coverage Subsidies: How Income Measured with Prior Tax Return Compares to Current Income at Enrollment*, issue brief, Focus on Health Reform 8168 (Washington D.C.: 2011), 1.

190 Ibid., 2.

191 Texas Health and Human Services Commission, *Presentation to the Senate*, 6.

population can seek subsidized coverage through the exchange, but this will be significantly less people than who the expansion could reach. Individuals with income below 133 per cent of FPL will not be eligible for health insurance subsidies.[192] Of the three million individuals who would have been newly eligible under Medicaid, less than a half a million will be eligible for subsidies through the exchange, those with income between 100 to 138 per cent of FPL.[193] In Texas, subsidies will be available for newborns, children one to 18 years old, and pregnant women up to 200 to 400 per cent of FPL, up to 133 to 400 per cent of FPL for individuals who receive Supplemental Security Income (SSI), or are aged or disabled.[194] Parents with income 14 to 133 per cent of the FPL and childless adults with income below 133 per cent of FPL would be ineligible for subsidies.[195] The exchange will then include a mix of low-income individuals purchasing insurance through subsidies, low-income individuals purchasing with cost-sharing opportunities, and middle to high-income individuals purchasing through other means. The small portion of individuals who were considered newly eligible for Medicaid will receive subsidies, but these subsidies may not cover the cost of purchasing insurance. This may skew the kind and quality of health plans in the exchange. If individuals have no other means to purchase insurance, they may choose one of low quality to have some

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192 Robert Pear, "Uncertainty Over States and Medicaid Expansion," *The New York Times* (New York, NY), June 28, 2012, U.S., [Page #], accessed August 9, 2012, http://www.nytimes.com/2012/06/29/us/uncertainty-over-whether-states-will-choose-to-expand-medicaid.html?r=1&nl=todaysheadlines&emc=edit_th_20120629.

193 Marilyn Werber Serafini to Kaiser Health News newsgroup, "How the SCOTUS Medicaid Ruling Could Save Money," July 11, 2012, accessed August 9, 2012, http://www.kaiserhealthnews.org/Stories/2012/July/11/SCOTUS-medicaid-ruling-could-save-money.aspx.; Scott Hensley, "Medicaid Expansion: Who's In? Who's Out?," *NPR Health Blog*, entry posted July 5, 2012, accessed August 9, 2012, http://www.npr.org/blogs/health/2012/07/05/156312388/medicaid-expansion-whos-in-whos-out.

194 Texas Health and Human Services Commission, *Presentation to the Senate*, 8.

195 Ibid.

kind of coverage. States can also develop a basic health program (BHP).[196] The BHP would function like the Medicaid program, where the state would contract the plan out to insurers or health care providers and the federal government would fund 95 per cent of what would have been spent on subsidies.[197] BHP would serve individuals with income between 133 and 200 per cent of FPL and legal immigrants with income below 133 per cent of the FPL,[198] reaching a particular vulnerable population and increasing their likelihood to receive care.

Health Plans

The state must certify and manage all qualified health plans in the exchange, including rating each plan based on quality and price.[199] Originally, the U.S. Department of Health and Human Services (HHS) was to develop the essential health benefits (EHB) that must be included in all plans in the exchange, but then gave states some flexibility to determine the specifics of their EHB.[200] Services must include services in at least ten of these areas:

> "1) ambulatory patient services, (2) emergency services, (3) hospitalization, (4) maternity and newborn care, (5) mental health and substance use disorder services, including behavioral health treatment, (6) prescription drugs, (7) rehabilitative and habilitative services and devices, (8) laboratory services, (9) preventive and wellness services and chronic disease management, and (10) pediatric services, including oral and vision care."[201]

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196 Centers for Medicare and Medicaid Services, *Essential Health Benefits Bulletin*, by Center for Consumer Information and Insurance Oversight, report (Washington D.C.: U.S. Department of Health and Human Services, 2011), 1.

197 Stan Dorn, *The Basic Health Program Option under Federal Health Reform: Issues for Consumers and States*, issue brief (Washington, D.C.: Urban Institute, 2011), 1:3.

198 Ibid.

199 Texas Health and Human Services Commission, *Presentation to Joint Committee*, 7.

200 Center for Consumer Information and Insurance Oversight, *Essential Health Benefits Bulletin*. (2011), 1.

201 Ibid.

Development and Implementation Funding

In January 2013, the federal government will conduct a readiness review of the health exchange system,[202] and it must be fully operational by October 2013.[203] Eligibility systems, the exchange, the interfacing must be operable by Summer 2013.[204] In January 2015, the exchange must be self-sustaining.[205] To prepare for system coordination, the federal government has offered funding opportunities to subsidize IT development. States are eligible for exchange and eligibility system interoperability funding if they meet seven rules that promote system coordination, interoperability, and performance metrics.[206] Funding opportunities are also flexible to the states' individual timelines and strategies to phase in development, authorizing reimbursement up to December 2015.[207] Currently, states receive a 50 per cent federal match to modernize eligibility systems.[208] Under ACA eligibility system development, Texas can receive a 90 per cent match for system changes, and 75 per cent match for upkeep and management.[209] HHSC estimated that over a two-year period, $24 million dollars would have to be spent for data center expansion and TIERS interoperability.[210] In 2010, Commissioner Suehs presented a revised HHSC budget reflecting ACA funding opportunities for eligibility

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202 Texas Health and Human Services Commission, *Presentation to Joint Committee*, 4.

203 Texas Health and Human Services Commission, Comments on the Proposed Regulation for the Establishment of Exchanges and Qualified Health Plans, CMS-9989-P (Tex. July 2011).

204 Cindy Mann et al. to State Exchange Grantees, Medicaid and CHIP Directors, Health and Human Services Directors, "Additional Guidelines to States on OMB Circular A-87 Cost Allocation Exception," January 23, 2012. IBID

205 Texas Health and Human Services Commission, *Presentation to Joint Committee*, 4.

206 Tricia Brooks, "90/10 Rule Is Final: Time to Upgrade to a More Reliable & Efficient Model," *Say Ahhh! A Children's Health Policy Blog*, entry posted April 15, 2011, accessed December 11, 2011, http://theccfblog.org/2011/04/9010-rule-is-final-time-to-upgrade-the-junker.html.

207 Mann et al. to State Exchange Grantees, Medicaid and CHIP Directors, Health and Human Services Directors, "Additional Guidelines to States."

208 Texas Health and Human Services Commission, *Presentation to Joint Committee*, 2.

209 Ibid.

210 Ibid.

information technology (IT).[211] The updated estimates included a decrease of over seven million General Revenue (GR) funds and an increase of about one million of All Funds (federal funding) to build system capacity.[212] To establish interfacing between Medicaid and exchange, the updated estimate included a decrease of about four million GR funds.[213] Both opportunities for federal funding would save the state over eleven million dollars. Suehs noted that that administrative and eligibility workforce costs were unknown until legislators decide the extent of ACA implementation.[214]

The federal government will also cover the funding to develop and implement health insurance exchanges through December 2014.[215] Funding is available for each kind of exchange, including state-based, state partnerships, and the interfacing with federally facilitated exchanges.[216] HHSC estimated the endeavor to cost $12 million in 2012, with about 68 per cent of the cost covered by the federal government.[217] The Legislative Budget Board and TDI also estimated eligible federal grants totaling $334.2 million over three years to implement and maintain the exchange.[218] In 2010, Texas received a million-dollar Planning Grant to coordinate efforts between TDI and HHSC,[219] consider the feasibility of regional exchanges, and determine the health needs of different

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211 Ibid., 14.

212 Ibid.

213 Ibid.

214 Ibid.

215 Center for Consumer Information & Insurance Oversight, "Exchange Establishment Cooperative Agreement Funding FAQs," The Center for Consumer Information & Insurance Oversight, last modified 2012, accessed August 9, 2012, http://cciio.cms.gov/resources/factsheets/hie-est-grant-faq-06292012.html.

216 Ibid.

217 H.B. 636, 2011 Leg., 1st Reg. Sess. (Tex. 2011). Accessed December 30, 2011. http://www.legis.state.tx.us/tlodocs/82R/fiscalnotes/html/HB00636I.htm>.

218 Ibid.

219 Texas Health and Human Services Commission, *Texas Medicaid and CHIP*, 3-12.

Texan population groups.[220] In February 2012, it was reported that TDI returned 90 per cent of the Planning Grant back to the federal government.[221] Currently, Texas is ineligible for additional exchange funding until progress is made with exchange Planning Grant appropriations.[222] But because of political efforts in the 82nd legislative session and Governor Perry's declaration to veto a state exchange bill, no entity is legally designated to begin the implementation of a health insurance exchange. It can be assumed that a federally facilitated exchange will be implemented within Texas and state agencies will work with the federal government to coordinate system interfacing.

TEXAS' PREPARATION FOR THE AFFORDABLE CARE ACT

Legislators in both the House and the Senate have been displaced from the planning and coordination processes occurring within TDI and HHSC. Often, ACA discussion has been riddled with ideological debate or surface level discussions. HHSC is planning for ACA implementation, but cannot explicitly display their progress because of the political environment. For example, the Texas Senate's Health and Human Services and the State Affairs Committee issued a charge to examine the ACA, its impact on the state budget, the SCOTUS decision, and ensure "the state does not expend any resources until judicial direction is clear."[223] But in August 2010, HHSC released a Request for Proposal to select a consulting group to assist in the planning of ACA implementation,

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220 U.S. Department of Health and Human Services, "Exchange Planning and Establishment Grants: Grant Awards List," Healthcare.gov, last modified March 22, 2011, accessed August 9, 2012, http://www.healthcare.gov/news/factsheets/2010/07/grantawardslist.html.

221 Thanh Tan, "Health Leaders Say They're Ready for Federal Reforms," *Texas Tribune* (Austin, TX), February 27, 2012, State Agencies, [Page #], accessed August 9, 2012.

222 U.S. Department of Health and Human Services, "States Receive More Flexibility, Resources to Implement Affordable Insurance Exchanges," news release, [Page #], November 29, 2011, accessed December 30, 2011, http://www.hhs.gov/news/press/2011pres/11/20111129a.html.

223 Senate Health and Human Services Committee, "Notice of Public Hearing - Charge One," news release, 2012, accessed August 9, 2012, http://www.legis.state.tx.us/tlodocs/82R/schedules/html/C6102012080109001.HTM.

including coordinating work with the TDI.[224] In June 2011, during the 82nd legislative special session, Public Consulting Group received the contract to "design, develop, and implement" ACA provisions.[225]

In the media and political spheres, it looks as though the state agencies are doing nothing in regards to ACA implementation. But in reports to both House and Senate committees, HHSC and TDI provide brief overviews on their current ACA efforts. In a presentation to the House Committee on Public Health on the Implementation of ACA, Billy Milwee, the outgoing State Medicaid and CHIP director, reported that HHSC was tracking over 40 ACA related grants and analyzing the expansion of Medicaid on the processes, system interfacing, and essential health benefits package.[226] Legislators did not ask for specifics on ACA planning, but did inquire if HHSC was sufficiently prepared for implementation.[227] Milwee said the agency was prepared.[228]

Legislators had the opportunity during the 82nd legislative session to prepare state agencies for ACA coordination and implementation. Unfortunately, the session was particularly treacherous: the political climate was heavily one-sided, with Republicans comprising the majority of the House and Senate, and Texas was facing a budget shortfall of an estimated $27 billion dollars. The combination of strong partisan majorities and budget deficits influenced solutions that emphasized conservative platforms, particularly

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224 Texas Health and Human Services Commission, "RFP: 529-11-0008," Health and Human Services Commission, last modified June 28, 2011, accessed July 18, 2012, http://www.hhsc.state.tx.us/contract/529110009/announcements.shtml.

225 Ibid.

226 Texas Health and Human Services Commission, Presentation to House Committee on Public Health on Implementation of Federal Patient Protection and Affordable Care Act (ACA), 2012, at 1-8 (Tex. 2012).

227 *Implementation of the Federal Patient Protection and Affordable Care Act (ACA): Hearings Before the House Committee on Public Health*, 2012 House, Interim (Tex. 2012) (statement of Billy Milwee, State Medicaid and CHIP director).

228 Ibid.

budget cuts.[229] The ideological divide contributed to symbolic, political gestures disregarding ACA and the federal government, rather than facilitating coordination efforts for Texas state agencies.

82ND LEGISLATIVE SESSION

Since the end of November 2011, the federal government determined that 29 states were in process of developing health insurance exchanges.[230] A major state legislative decision is to determine the kind of exchange and designate a governmental agency or non-profit to execute its implementation.[231] If a state chooses not to designate an entity, the federal government will facilitate the exchange.[232] During the 82nd session, two bills were introduced to establish the Texas Health Insurance Connector, a statewide health insurance exchange. Democrat Senator West and Republican Representative Zerwas introduced SB 1510 and HB 636, respectively. SB 1510 was referred to State Affairs and did not receive a hearing, while HB 636 was left pending in the Insurance committee. The legislative inactions will not allow HHSC or TDI to meet exchange operational deadlines, thus causing missed opportunities for funding and discouraging innovative state solutions that are reflective of consumer needs. HHS may default implementation decisions to Governor Perry, and without legislative input, could possibly cause further strain to the coordination efforts.

While some efforts to overtly prepare for ACA implementation failed, there were a variety of bills introduced and signed into law that sought to coordinate health care,

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229 Thanh Tan, "Texas Budget Negotiators Pass $15 Billion in Cuts," *Texas Tribune* (Austin, TX), May 26, 2011, Legislature, accessed August 9, 2012, http://www.texastribune.org/texas-legislature/82nd-legislative-session/texas-budget-negotiators-pass-15-billion-in-cuts/.

230 U.S. Department of Health and Human Services, "States Receive More Flexibility," news release.

231 Texas Health and Human Services Commission, *Presentation to Joint Committee*, 4.

232 Ibid.

promote quality care, and minimize costs. These bills mirrored ACA provisions and would facilitate further ACA implementation, but did not explicitly imply legislators' support of the law. This included the establishment of community-based organizations to help individuals apply for services (similar to a navigator program) and the restructuring of payment and service delivery in Medicaid. HB 2610, led by Democratic members and a Republican, establishes a training program for community or faith-based organizations to educate and help social service applicants apply for services.[233] SB 7, introduced by Republican Senator Nelson, chairperson of the Health and Human Services Committee, passed during the special session with a number of revisions. SB 7 mirrors ACA provisions to contain cost and coordinate care by implementing the use of health homes, quality-based payments based on positive health outcomes, and rules to establish health-care collaboratives, similar to affordable care organizations.[234] The fiscal note reports a positive impact of almost $470 million in the biennium,[235] demonstrating a cost-effective benefit for the state. But the enrolled version also included two symbolic moves by Republican legislators to reject the ACA. The enrolled version of SB 7 included two bills that were not passed during the 82nd Regular Session, HB 5 and HB 13.[236] HB 5 called for federal approval to opt out of Medicaid, CHIP, and Medicare and instead allow federal health care funds to be in a block grant format.[237] HB 13 required HHSC to apply for an 1115 Medicaid waiver for eligibility flexibility and request copayments from Medicaid

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233 H.B. 636, 2011 Leg., 1st Reg. Sess. (Tex. 2011). Accessed December 30, 2011. http://www.legis.state.tx.us/tlodocs/82R/fiscalnotes/html/HB00636I.htm>.

234 S. 7, 82d Gen. Assem., 1st Reg. Sess. (Tenn. 2011) (enacted).

235 Ibid.

236 Center for Public Policy Priorities, *Major Medicaid-CHIP 2013-2013 State Budget Decisions: A Mix of Cuts, IOUs, "Efficiencies" and Gray Areas*, research report (Austin, TX: Center for Public Policy Priorities, 2011), 5.

237 H.B. 5, 82d Leg., 1st Reg. Sess. (Tex. 2011) (enacted).

clientele for services.[238] With these bills, Republican legislators sent a message to President Obama that Texas did not approve of the current reform efforts and was better equipped to conceptualize the state Medicaid system.

Republican legislators' symbolic gestures to reject the ACA contributed to a poor implementation foundation for HHSC and TDI. Neither HHSC nor TDI has the legal ability to implement ACA provisions, but must still prepare for health care reform in limited ways, giving the nation an impression that Texas is doing nothing to prepare. HHSC is preparing for ACA implementation through interagency operations by modernizing the eligibility system, procedures, and processes. By addressing interagency processes through modernization efforts to seek more efficient and effective processes, HHSC can prepare for ACA provision implementation while avoiding the ideological debate regarding federal health care reform. As an interagency action, HHSC developed the Eligibility Modernization Project (EMP) to assess the capacity of the eligibility process, develop means to make the policy, procedures and system more streamlined, and implement the proposed means. The following section will provide an overview of three modernization efforts, including the Self Service Portal (SSP), state office lobby modernization, and the establishment of Community Based Organizations (CBOs) for application and case assistance.[239]

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[238] H.B. 13, 82d Leg., 1st Reg. Sess. (Tex. 2011) (enacted).

[239] Most of the information presented in the Eligibility Modernization Project – Current Modernization Efforts Chapter section was gathered during my internship at HHSC from January 2012 to May 2012. The three modernization efforts I present are in the public knowledge domain, though some of citations I use are from unpublished documents.

ELIGIBILITY MODERNIZATION PROJECT

The Eligibility Modernization Project (EMP) was developed in May 2011 to increase eligibility determination efficiency and improve customer service.[240] An analysis of the eligibility business processes found that the current model of operations, engaging the caseworker to facilitate information and assist clients, was inefficient.[241] The current model promoted case ownership, which decreases the portability of cases and made it difficult to assess worker performance due to the lack of case processing standards. To develop means to address inefficiencies and ineffectiveness, EMP staff engaged various stakeholders,[242] including consultants, in-house IT staff, and eligibility supervisors and workers. EMP staff visited other states,[243] like Utah and Florida, to analyze their ongoing modernization efforts. EMP then created broad concepts and complements, and is incrementally implementing new business processes.

The EMP sought to increase client self-service usage and local client assistance through system enhancements, increasing clients' technology access, and developing partnerships with community organizations. These modernization efforts sought to change the service delivery model by deemphasizing the role of a state worker in the eligibility determination process through enhancing client self-sufficiency. Modernization would utilize the eligibility workforce to focus on core tasks, like determining eligibility, and client services, like application assistance and case inquiry, would be delegated to

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240 Eligibility Modernization Project, *Executive Committee Briefing Presentation* (Austin, TX: Texas Health and Human Services Commission), 2.

241 Eligibility Modernization Project, *Executive Committee Briefing Presentation* (Austin, TX: Texas Health and Human Services Commission), 4.

242 Texas Health and Human Services Commission Eligibility Modernization Project, *Internship - Health and Human Services Commission (HHSC) Management Analyst/Business Analyst Intern*, by Cherie Hinch (Austin, TX: Texas Health and Human Services Commission), 1, PDF.

243 Sara Hill, Sara Hill's Experience - IT Project Portfolio Manager, Sara Hill LinkedIn Profile, last modified 2011, accessed July 22, 2012, http://www.linkedin.com/pub/sara-hill/15/6a6/651.

community organizations or electronic resources. EMP recognized that changing the eligibility system to include more technological processes may be a shock to clients, perhaps to those who were unprepared to navigate technology or without access to computers and the Internet. In order to increase client self-sufficiency and technological uses, EMP sought to provide means to clients to access and learn the new systems. This includes providing more technology to local eligibility offices ("lobby modernization") and partnering with Community Based Organizations (CBOs) to assist clients with the technology, and providing them with access to resources.

Self Service Portal

The Self Service Portal (SSP) is considered the "foundation" of modernization.[244] SSP is a web portal integrated on YourTexasBenefits.com that allows individuals to apply online, check the status of their application and program benefits, and receive account information. [245] EMP seeks to enhance SSP features, so the eligibility workforce is able to receive more information, streamline data entry though page logic and automation, and solicit relevant information, all of which will cut down on other case processing tasks.[246] By engaging technology, clients can access case information 24 hours, seven days a week, removing the need to go to local offices or call for assistance. The enhancements to SSP will change how workers receive information and the case history storage, relying heavily on electronic imaging, system capacity, and upkeep. It will also change how a client interacts with the eligibility process, removing reliance on a

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244 Eligibility Modernization Project, *Executive Committee Briefing Presentation* (Austin, TX: Texas Health and Human Services Commission), 8.

245 Texas Health and Human Services Commission, "Welcome to Your Texas Benefits," Your Texas Benefits, accessed August 9, 2012, https://www.yourtexasbenefits.com/ssp/SSPHome/ssphome.jsp.

246 Eligibility Modernization Project, *Executive Committee Briefing Presentation* (Austin, TX: Texas Health and Human Services Commission), 8.

state worker, and increasing the need for clients to have knowledge of and access to technology. EMP sought to increase technology access by placing these tools in the community.

Lobby Modernization – Rutherford Office in Austin, TX

During my internship with the EMP, I was given the opportunity to visit the modernized lobby in the Rutherford office in Austin, TX, the largest serving eligibility office of the 311 in the state.[247] To analyze a modernized office space, I will describe how the customer service workflow is set up and how the technology is utilized. A "technology clerk" greets all individuals at the entrance of the office. The clerk is key to lobby modernization, as they are the first to filter client needs and direct them to the appropriate technological mean. If the individual went to the office to apply for services, they are directed to computer stations in a corner of the office. Workers will assist the individual in the navigation of YourTexasBenefits.com, set up a user account, and help them apply for services online. By establishing a user account, clients will be able to view case information and program benefits outside of the office, investing the client in the YourTexasBenefits.com website. Workers will educate the client on the use of the technology and benefits of using SSP, thus increasing their knowledge of new enhancements. Paper applications are available, but are not displayed in the open to clients in order to decrease their usage. If an individual has a particular question regarding their case and if it is less of a case-processing task, they are directed to a phone bank to ask their question to a call center worker.[248] If clients have a need that includes a core function that can only be conducted by an eligibility worker, their need is recorded

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247 Memorandum by Asha Dane'el, "Rutherford Office," February 2012.

248 In the near future, EMP hopes to direct clients seeking interviews to the phone bank to call for an on-demand interview to further decrease the need for office visits.

and they are placed on a queue controlled by a technological customer flow management system. Individuals take a seat in the lobby to wait for their number and service window number to be displayed. The Rutherford Office's management system also includes a ticker to measure each client's wait time and the time spent at the service window to provide worker performance metrics.

Community Based Organizations

EMP hopes that educating clients and processing their needs with technology will deter local office visits and ultimately increase administrative cost effectiveness. Eventually, lobby modernization technology will be phased out to decrease leasing spaces and office equipment costs,[249] though local offices will still provide some technology access. In order to do so, EMP is fostering partnerships with Community Based Organizations (CBOs) to provide clients with application and case assistance. EMP hopes to create an extensive CBO network around the state to delegate much of the client assistance, rather than utilize state workers for help. This will allow clients to access technology and information outside of local office hours,[250] and give them further training on new technology features. There are three different levels of CBO/state partnerships: (1) Level One CBOs supply clients a computer to access the YourTexasBenefits.com website, (2) Level Two CBOs assist clients with application via YourTexasBenefits.com, (3) Level Three CBOs provide application and case monitoring assistance via the YourTexasBenefits.com website.[251] CBOs can and will include a range of providers, including faith-based, county offices, and other organizations where

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249 Eligibility Modernization Project, *Executive Committee Briefing Presentation* (Austin, TX: Texas Health and Human Services Commission), 15.

250 Eligibility Modernization Project, *Executive Committee Briefing Presentation* (Austin, TX: Texas Health and Human Services Commission), 16.

251 Ibid.

accessing social services, like poverty alleviation and family violence counseling, is core to serving their clients and achieving their mission. HHSC will provide CBOs with training, certification, and assistance to enhance their ability to serve clients. The certification process and the ability for HHSC to generate metrics of CBO-submitted applications will be beneficial for organizations that seek grants and funding for operations.

CONCLUSION

The Eligibility Modernization Project (EMP), being a part of the Texas Health and Human Services Commission (HHSC), a state agency, is able to implement new means to address policy goals because they are operating outside of the political sphere.[252] HHSC chose to explicitly operate outside of the political sphere because of the polarized environment regarding Affordable Care Act (ACA) implementation. As part of the implementation process, HHSC is nonpolitical,[253] yet core leaders in the organizations offer leadership that is cognizant of the political environment and its constraints and challenges to implementation. But because implementation leaders operate in two different spheres-- within their own organizations and in the political sphere-- they must respond and adhere to the political context to achieve goals. As authors Nakamura and Smallwood describe, "Since implementers are often political actors in their own right, they pay attention to both the written directives *and* other political cues in assessing how they are expected to interpret their instructions."[254] Leaders in HHSC acknowledged the polarized environment surrounding ACA implementation, but also identified the need to prepare the state agency for new eligibility

252 B. Guy Peters, *The Politics of Bureaucracy*, 3rd ed. (White Plains, NY: Longman, 1989), 153.
253 Nakamura and Smallwood, *The Politics of Policy*, 10.
254 Ibid., 40.

business processes. EMP is HHSC's creation to prepare a foundation for ACA implementation, while also achieving general policy goals (effectiveness and efficiency) that both conservative and liberal legislators agreed on. Moreover, HHSC leaders drew on the agency's institutional history and its successful management of previous political environments by adopting modernization strategies that increased technology efficiency and reduced state employee costs (as analyzed in Chapter 2). The adoption of computer assistance in lobby office modernization and the move toward Community Based Organizations represent efforts consistent with institutional history and the limited-government, cost-effectiveness aims that operate in the current political environment.

ACA provisions seek to modernize eligibility processes and systems, as well as increase individuals' access to health care. The law places more emphasis on the state to oversee the insurance market and regulate service delivery. ACA's goals align with Texas' goals to cut costs, streamline eligibility determinations, and increase service quality. Most conservative Texan legislators are adamantly against ACA implementation, but HHSC and legislators are both creating policies and means that mirror ACA provisions. As Texas prepares for the upcoming ACA deadlines, legislators must focus on long-term solutions to the current issues affecting the most vulnerable populations in Texas. This may mean crossing political party lines and developing consensus around policies that prompt ACA implementation in order to serve Texas citizens and increase health care insurance access. To these topics I now turn in the concluding chapter.

Chapter Four

REPORT OVERVIEW

In this report, I have examined Texan implementers' and legislators' means in order to achieve health policy goals in political environments, with a special focus on Medicaid eligibility processes. I provided an overview of the first modernization efforts to change the eligibility system through privatization and technology, Affordable Care Act (ACA) provisions that will change the eligibility determination process, and legislative efforts during the 82nd legislative session that helped or hindered implementers' capacity to coordinate and begin planning. The Texas Health and Human Services Commission (HHSC) developed an interagency project, the Eligibility Modernization Project (EMP), to assess and develop new eligibility system processes and policies, allowing administrators to develop their own means to achieve general policy goals, while creating a foundation to facilitate future ACA provision implementation.

In this concluding chapter, I will offer recommendations to legislators and HHSC to promote a streamlined and integrated health subsidy system, increase access to coverage, prepare the HHSC for the new eligibility processes, and promote long-term planning. My recommendations are based on thorough analysis from agency reports, introduced and engrossed bills, and two internship experiences, the latter of which was a full-time semester experience at HHSC. I also draw on documentation from other southern (Louisiana and Mississippi) and western (Utah) conservative states that provide models for ACA preparation. These recommendations will contribute to solutions that provide a sounder infrastructure for HHSC to prepare for ACA coordination and implementation with the ultimate goals of better serving the vulnerable population of Texas while at the same time, heeding constraints on budgetary resources.

OVERVIEW OF FINDINGS

Texas is a state with one of the highest uninsured rates in the nation. But legislators have strived to address the fallacies of the health care delivery system in order to increase the accessibility of the eligibility process and facilitate efficient enrollments. After a decade of efforts to reduce operating costs, incorporate privatized positions, and modernize technology, Texas has developed a functioning eligibility system. But as the ACA deadlines approach regarding interoperable health subsidy program systems and real time determinations, Texas agencies may not be prepared for the influx of determinations and enrollments. Part of the lack of preparation results from the policy formulations that rely on concepts of limited government, low taxation, and strong commitments the rights of states to develop their own solutions.

Policies created to achieve higher service quality, effectiveness, and efficiency in state operations are often misguided due to tension both within the legislature and between the legislative and executive branches. Yet, good leadership in HHSC has allowed some planning and preparation to occur, such as increasing citizens' access to technology through partnerships with Community Based Organizations and modernized office lobbies. To meet policy goals, Texas legislators have both determined and delegated the formation of means to achieve goals. Though legislators may have some kind of expertise to determine the means to implement health policies, the political environment does not facilitate an appropriate infrastructure for full and successful ACA implementation. Administrative implementers have internally taken the opportunity to modernize the eligibility process by assessing and developing solutions to streamline determinations and provide additional resources for clientele and the state workforce in order to prepare a foundation for ACA implementation. Texas' polarized environment,

biennial legislative sessions, and desire for limited state government help delegate this power to implementers.

The first modernization efforts by HHSC sought to replace the legacy eligibility system with the Texas Integrated Eligibility Redesign System (TIERS). During the eligibility system development, legislators created the means to achieve cost effectiveness and efficiency by privatizing aspects of case processing. The pressure from legislators to implement the means of privatization, while concurrently cutting agency funding and state workforce positions, contributed to a weak foundation to implement the new modernized system. The management of the TIERS implementation also contributed to growing resistance from various stakeholders, including state eligibility workers, advocacy groups, and liberal legislators. After eight years, the implementation of the new eligibility system was complete in 2011 when project tasks were restructured and legislators provided an accountability structure for implementers.

While the first modernization attempts were occurring, ACA was passed in 2010 to reform federal health care, streamline eligibility determinations, and expand access to health insurance coverage. ACA implementation was not received well in Texas, as many legislators chose to avoid the use of the 82nd legislative session in 2011 to prepare the HHSC and the Texas Department of Insurance (TDI) for ACA coordination and implementation. Instead, amidst a highly polarized environment, HHSC chose to internally modernize their eligibility system and processes to prepare for system interfacing with health insurance exchanges, real time determinations, and increasing caseloads. The Eligibility Modernization Project (EMP) is an interagency creation that allows administrators to prepare for ACA deadlines, but the concepts and components also align with legislators' policy goals of effectiveness and efficiency. The Self Service Portal (SSP), enhancements to office lobbies to provide more technological resources,

and partnerships with Community Based Organizations (CBOs) seek to increase clients' access to information and the means to apply for health insurance coverage. Administrators, as both political players and implementers, were able to navigate among stakeholders in a tense environment and create an interagency project to align state agency priorities with ACA provisions.

With the recent Supreme Court decision, legislators can use the 83rd legislative session to legally designate authority and funding to the appropriate agencies to further implement ACA provisions. HHSC can take further action internally regarding ACA provisions and EMP developments to continue to prepare the state for deadlines in 2014.

RECOMMENDATION ONE – STREAMLINE HEALTH SUBSIDY PROGRAMS

Exchange

To best prepare for a streamlined and integrated health subsidy system, state legislators must elect an entity to implement a state exchange. States that have made the least progress on the development of their exchange have the most to gain under the ACA, including increasing insurance coverage and decreasing uncompensated care by $3.7 billion.[255] In January 2013, the Secretary of the Department of Health and Human Services (HHS) will determine if a state exchange will be operational by January 2014. Since the 83rd legislative session will begin a week after the HHS deadline, Governor Perry should authorize a state entity to begin implementation activities. To follow this decision, legislators during the 83rd legislative session should designate a legal entity in charge of the health insurance exchange. The Texas Department of Insurance (TDI) has already begun research and assessment of the market to prepare for coordination. TDI's

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255 Fredric Blavin, Matthew Buettgens, and Jeremy Roth, *State Progress Toward Health Reform Implementation: Slower Moving States Have Much to Gain*, technical report (Washington D.C.: Robert Wood Johnson Foundation, 2012), 3.

agency functions include regulating the insurance market, consumer protection, providing education, and licensing insurance agencies.[256] All these duties fall into the scope of what the coordinator and implementer of the health insurance exchange does, though the scale will be grander and the market will be bigger. The legislators should prepare TDI by allocating additional staff and funding for coordination and development.

A state-facilitated exchange/s will allow HHSC leaders and legislators to be involved in planning and regulation. Mississippi is one of the sole conservative South states implementing a state-based exchange.[257] Though two bills failed to pass in the Mississippi legislature, the insurance commissioner was able to implement based off a statute that sought to serve high-risk individuals.[258] The insurance commissioner chose to do so because it would serve Mississippi's best interest to develop an exchange reflective of the state's needs, increase coverage to insurance, and utilize the federal funding incentives that were available.[259] A state-facilitated exchange will allow Texas legislators to regulate plans and service benefits in the exchange. For example, during the 82nd legislative session, Republican Zerwas presented HB 363 to establish a health insurance exchange bill that excluded abortion from the plans. Conservative legislators could regulate what is offered in health plan if the state establishes its own exchange/s. Texas also has the option to provide a regulatory umbrella structure to establish various exchanges in the state. A regional exchange may best serve Texan citizens because of the diverse socioeconomic and demographic populations. The income disparity between

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256 Texas Department of Insurance, "Texas Department of Insurance Compact with Texans," Insurance & HMOs, last modified July 20, 2012, accessed August 9, 2012, http://www.tdi.texas.gov/webinfo/compact.html.

257 Jeffery Hess to Kaiser Health News newsgroup, "Mississippi Builds Insurance Exchange, Even as It Fights Health Law," March 14, 2012, accessed March 21, 2012, http://www.kaiserhealthnews.org/stories/2012/march/15/mississippi-insurance-exchange.aspx.

258 Ibid.

259 Ibid.

high- and low- income populations may skew plan benefits and costs for vulnerable populations in the exchange. Regional exchanges can include groupings of plans with costs that are reflective of the particular region, allowing for greater competitive and plan selections.

If Governor Perry chooses to implement a federally-facilitated exchange, HHSC must be prepared to collaboratively work with HHS to facilitate a smooth integration with the eligibility system. HHSC administrators and implementers, though politicizing their language in regards the ACA, must step outside their political role to avoid symbolic measures to displace the law.[260] Centers for Medicare and Medicaid Services (CMS) heavily promotes the need to coordinate efforts between the federal and state governments, while "harmonizing exchange policy with existing state programs and laws whenever possible."[261] This includes meeting state licensure and solvency requirements, network adequacy standards if available, rate review programs, marketing standards, and consumer complaint programs.[262] While the federal government wishes to align initiatives with the state government, state legislators must also align priorities to best serve Texas citizens.

The federally-facilitated exchange must coordinate with the state to integrate the eligibility systems, though that process is unknown. CMS offers State Operations Technical Assistance Teams (SOTA) to prepare the state for operational changes. Each state will have a specific team, composed of regional and central CMS staff, to prepare for January 2014 implementation, including system, financial, and benefit components.[263]

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260 J. Lester Feder, "States May Test HHS Power on Reform," *Politico* (Washington, D.C.), March 12, 2012.

261 Department of Health and Human Services, *State Exchange Implementation Questions and Answers*, by Centers for Medicare and Medicaid Services, report (Baltimore, MD: 2011), 3.

262 Ibid., 3-4.

263 All-State phone call by Centers for Medicare and Medicaid, Washington, D.C., March 20, 2012.

The goal of SOTAs is to offer state governments more relevant and specific guidance on ACA development and implementation. HHSC and TDI should keep up with federal guidance and continue to push for explicit instructions regarding development. But legislators should also allow HHSC to develop their own solutions to service, interoperability, and procedures to ensure that the unique needs of Texas citizens are being best served.

It is necessary for legislators to designate a legal entity to implement the exchange in order to exploit the federal funding available for development. Texas has already obtained Medicaid Information Technology Architecture (MITA) funding to modernize their Medicaid systems.[264] The MITA funding included projects to address healthcare reform, pay for performance measures for employees, client portals, and an electronic document management systems.[265] This funding allowed HHSC to address issues under the political radar, while also allowing them to develop their systems and procedures.

Application

An individual must be offered an application to determine eligibility to any health subsidy program. The federal government imagines a "smart" application, where the entered information will generate only the necessary questions to follow up.[266] The information will auto-populate data entries as needed. When the application is submitted, the information is automatically verified through the state and federal resources. Utah

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264 Texas Health and Human Services Commission, "Texas Joins National Effort to Make Medicaid More Consistent, Accessible," *InTouch*, January/February 2009.

265 Texas Health and Human Services Commission, *Texas State Self-Assessment: To Be Roadmap*, by Texas Health and Human Services, report (Austin, TX: Texas Health and Human Services Commission, 2009), 3.

266 Kaiser Family Foundation's Commission on Medicaid and the Uninsured, *Explaining Health Reform: Building Enrollment Systems That Meet the Expectations of the Affordable Care Act*, issue brief, Focus on Health Reform 8108 (Washington, DC: 2010), 3.

currently uses a similar smart application that generates application-specific questions and links to a verification rules engine to determine eligibility. HHSC noted their concerns about the use of a single application,[267] as they currently use an integrated application for a variety of social services, beyond health subsidy programs. HHSC can use an additional, integrated application as a supplement to the health subsidy application, as using an integrated application for other social services program aligns with ACA provisions to increase access to safety net services.[268] It is in HHSC's best interest to develop its own application.[269] By developing its own application, HHSC will be better able to facilitate smoother system interoperability and prepare Community Based Organizations (CBOs) to assist individuals in applying for health subsidies. Though the state is expected to offer application assistance in person, electronically, and on the phone, CBOs can facilitate a large portion of the application and case inquiry help. CBOs will also be educating clientele on new technology means. The state must provide CBOs adequate resources, including training and other incentives to provide client assistance. Incentives can include grant seeking or supplying the CBO with the technology resources.

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267 Texas Health and Human Services Commission, Comments on Proposed Regulation for Medicaid, Children's Health Insurance Program (CHIP) Eligibility, Enrollment, Simplification, and Coordination (CMS-23490-P), (Tex. 2011).

268 Kaiser Family Foundation's Commission on Medicaid and the Uninsured, *Explaining Health Reform: Building*, 6.

269 Texas Health and Human Services Commission, Comments on Proposed Regulation for Medicaid, Children's Health Insurance Program (CHIP) Eligibility, Enrollment, Simplification, and Coordination (CMS-23490-P), at 1-11 (Tex. 2011).

RECOMMENDATION TWO - INCREASE ACCESS TO COVERAGE

Expand Medicaid Eligibility

Texans who are in the low-income, working poor population category are in dire need of health coverage. Texas has the highest rate of uninsured individuals at 6.3 million.[270] Under the ACA Medicaid eligibility expansion, only 1.3 million individuals would be newly eligible.[271] This new population would generate a 100 per cent federal matching assistance payment (FMAP) for the first year and incrementally decrease to a 90 per cent match by 2020. Texas should utilize this federal funding to provide coverage to a vulnerable population. By expanding Medicaid eligibility, this population will have access to health insurance and services previously unattainable. HHSC already has the legislative authority to expand Medicaid eligibility in 2014 in order to obtain federal matching funds under the Human Resource Code.[272] This increased access to services may eventually lead to lower state health services costs, as individuals are accessing services when needed and preventing potential health conditions.[273]

If Texas chooses to not implement Medicaid expansion, the cost of uncompensated care will be passed on to local governments, county hospitals and their expensive emergency room care, and health care providers. These costs will be reimbursed at a significantly lower rate in 2014 because ACA provisions expected all

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270 Sarah Kliff, "Why Texas Has the Highest Percentage of Uninsured People in the U.S.," *WonkBlog*, entry posted August 15, 2011, accessed August 9, 2012, http://www.washingtonpost.com/blogs/ezra-klein/post/why-texas-has-the-highest-percentage-of-uninsured-people-in-the-us/2011/08/02/gIQA1wIdHJ_blog.html.

271 Texas Health and Human Services Commission, *Texas Medicaid and CHIP in Perspective*, report, The Pink Book 8th (Austin, TX: Texas Health and Human Services Commission, 2011), 3-2-3-3.

272 Authority and Scope of Program; Eligibility, Tex. Hum. Res. Code Ann. § 32.024.

273 Alan Weil, *A State Policymakers' Guide to Federal Health Reform*, report (Washington, D.C.: National Academy for State Health Policy, 2009), 14.

states would expand Medicaid eligibility levels.[274] This will decrease the federal share of uncompensated care, and it can be expected that state legislators will further push the cost to local and county governments. Health care providers may increase costs on other services to subsidize the uncompensated care, increasing health care costs for all Texans.

Whether Texas expands Medicaid eligibility or not, it will be in their best interest to offer the Basic Health Program (BHP) in the exchange for individuals between 133 and 200 per cent of the Federal Poverty Line (FPL) and legal immigrants with income below 133 per cent of FPL. If the state does not expand Medicaid, working poor populations will be able to access the BHP through the exchange, allowing them to participate in a Medicaid-like program and increase their access to coverage. BHP federal funding is available for 95 per cent of what would have been spent on subsidies for the states to contract out the plan to providers. ACA provisions allow the state to contract out for health care service coordination, similar to the 1115 Medicaid waiver that Texas obtained to expand managed care. Managed care has recently been applied to most of the Texas Medicaid population.[275] Conservative legislators promote a managed care payment system, similar to Medicaid block grants that allow the state to decide how to use the Medicaid funding. In the case of managed care, the state chose to contract out the coordination of health services. Federal funding is available for the state to contract out BHP service coordination.

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274 Phil Galewitz to Kaiser Health News newsgroup, "States Balk at Expanding Medicaid," July 2, 2012, accessed August 9, 2012, http://www.kaiserhealthnews.org/Stories/2012/July/02/state-costs-Medicaid-expansion.aspx.

275 Texas Health and Human Services Commission, *Texas Medicaid and CHIP*, 1-5.

Uphold Maintenance of Effort

The Maintenance of Effort (MOE) requires states to maintain their current eligibility thresholds until 2014 for adults and 2019 for children. MOE is important to uphold so states do not backtrack on eligibility thresholds as the ACA expands Medicaid eligibility. Efforts to implement stricter eligibility thresholds would permit the ACA provisions to roll out more efficiently and effectively by allowing expansion upon the current rate of eligibility.

Additional Means

The state can begin to align eligibility thresholds and reporting across social service programs, and offer other means to individuals to access coverage easily. The thresholds across populations all differ, causing administrative burden to process the application according to the population's unique rule. It also increases complexity for individuals trying to access the services, as their age or income level eligibility may be different according to the program. Aligning thresholds will decrease administrative burdens and simplify the system logics, decreasing the complexity of the eligibility system.

ACA provisions require an integrated health subsidy system where redeterminations can occur through the automatic data verification. Texas legislators should increase opportunities for individuals to become automatically enrolled in health subsidy programs to facilitate the enrollment of the currently eligible Medicaid population. Due to the individual mandate, Texas is expecting higher Medicaid enrollment rates from the previously eligible Medicaid populations. HHSC estimated the increased enrollment costs to the state to be $193 million in 2014, and $1.8 billion until

2017.[276] HHSC estimates the open enrollment period will create an influx of applications and enrollment, potentially creating issues for the state workforce to annually to serve these individuals.[277] Express Lane Eligibility (ELE) will increase the enrollment and retention of individuals in the programs.[278] ELE, or the sharing of information from multiple data sources, can actually replace Modified Adjusted Gross Income (MAGI) for eligibility determinations.[279] ELE will enroll more individuals into health subsidies program, decreasing the influx of individuals applying during open enrollment periods, decreasing the administrative costs and burdens of further processing separate applications, and increasing access to coverage. This can move eligible children currently on the Children's Health Insurance Program (CHIP) to their new Medicaid designation and enroll the eligible populations to other state social service programs.[280] Louisiana is the first state to offer the Children's Health Insurance Plan Reauthorization Act's (CHIPRA) automatic enrollment through ELE.[281] Children of families that apply to any state social services are screened for CHIP eligibility, and if they are found eligible, are automatically enrolled after receiving parents' consent.[282] Louisiana has cut procedural

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276 Texas Health and Human Services Commission, *Presentation to the Senate Health and Human Services and Senate State Affairs Committees on the Affordable Care Act*, technical report (Austin, TX: Texas Health and Human Services Commission, 2012), 13.

277 Texas Health and Human Services Commission, Comments on the Proposed Regulation for the Establishment of Exchanges and Qualified Health Plans, CMS-9989-P (Tex. July 2011).

278 Kaiser Family Foundation's Commission on Medicaid and the Uninsured, *Explaining Health Reform: Uses of Express Lane Strategies to Promote Participate in Coverage*, report, Focus on Health Reform 8212 (Washington D.C.: Henry J. Kaiser Family Foundation, 2011), 1.

279 Ibid., 2.

280 Kaiser Family Foundation's Commission on Medicaid and the Uninsured, *Explaining Health Reform: Uses*, 1.

281 The Urban Institute, *Louisiana Breaks New Ground: The Nation's First Use of Automatic Enrollment through Express Lane Eligibility*, research report (Washington, D.C.: Urban Institute, 2012), 1.

282 Ibid.

denials to almost 1 per cent,[283] expanding insurance access and decreasing gaps in coverage.

HHSC has the capacity to implement ELE since the agency delivers all health subsidy eligibility determinations. Though the cost will increase in the short term to cover individuals on Medicaid, the utilization of additional workforce positions during annual open enrollment periods and the cost of uncompensated emergency room care can surpass the cost of providing services to the newly enrolled Medicaid population. The administrative costs to process ELE applications are almost 90 per cent of the administrative costs of initially processing an application.[284] Texas legislators would appreciate the cost savings and the likely decreased administrative burdens. Louisiana even noted that the ELE implementation allowed a smoother transition after a reduction of 20 per cent of the eligibility workforce.[285] ELE also reached more vulnerable, uninsured populations in particular regions.[286]

Through 1996 welfare reforms, states were able to remove asset test requirements to determine Medicaid eligibility.[287] Currently, 48 states do not require an asset test for children, and 24 states do not require the test for parent eligibility determination.[288] Texas requires an asset test to determine Medicaid eligibility for children and parents, [289] a measure that could be considered to maintain program integrity. But in 2001, a study by

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283 Ibid., 2.

284 Ibid., 15.

285 Ibid., 22.

286 Ibid., 11.

287 Vernon K. Smith and Eileen Ellis, *Eliminating the Medicaid Asset Test for Families: A Review of State Experiences*, report (Washington D.C.: Kaiser Commission on Medicaid and the Uninsured, 2001), 3.

288 Tricia Brooks and Jennifer Mezey, *Fulfilling the Promise of 2014: Aligning and Simplifying Medicaid and CHIP Enrollment for Children and Parents*, report, Aligning and Simplifying Enrollment (Washington, DC: Center for Children and Families, 2011), 6.

289 Ibid.

the Kaiser Commission on Medicaid and the Uninsured showed that few families were determined to be ineligible for Medicaid due to asset testing.[290] The study also found the removal of required asset tests significantly decreased administrative burdens by removing a complexity of the eligibility process.[291] The federal government has also encouraged Texas to remove asset test requirements.[292] If Texas would remove the required asset test, the state would begin to streamline care and increase enrollment of eligible individuals.

RECOMMENDATION THREE - PREPARE HHSC FOR THE NEW ELIGIBILITY PROCESS

Modernization will facilitate a foundation for ACA provision implementation.[293] HHSC should continue to make EMP's efforts a priority by allocating the appropriate staff and funding resources to make the concepts a success. Through EMP, HHSC has already begun to assess TIERS and other business processes to enhance current capacities. EMP and HHSC should continue to incrementally implement components to allow for revision and evaluation. To avoid issues that the original TIERS rollout faced, HHSC should develop a mechanism to identify issues and provide in house information technology (IT) solutions. Pilots should be utilized to provide the space for the workforce to experiment with alternative technology systems and include mechanisms for user feedback.

Organizational change theories emphasize the need to address individual's psychological process of accepting change, and implementing an intervention according

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290 Smith and Ellis, *Eliminating the Medicaid Asset*, 14.

291 Brooks, *Fulfilling the Promise of 2014*, 2.

292 *Eligibility System: Hearings Before the Senate Committee on Health and Human Services*, 81st Leg., 1st Reg. Sess. (Tex. 2009) (statement of Center for Public Policy Priorities).

293 Kaiser Family Foundation's Commission on Medicaid and the Uninsured, *Explaining Health Reform: Building*, 2.

to their receptiveness to the change.[294] Steps to incorporate new changes must occur incrementally, as expecting employees to quickly accept changes can create opposition.[295] It is essential for HHSC to continue to incorporate employee feedback and ideas with ongoing EMP efforts. Not only is employees' input vital, as the institutional knowledge is extremely useful, but engaging employees will facilitate the new system and process changes. HHSC can also provide sufficient resources to employees to promote engagement and decrease burnout,[296] including work flexible hours, pay for performance initiatives,[297] and an adequately staffed workforce.

HHSC should promote EMP concepts that will meet Texas' unique service delivery needs, such as the statewide distribution of cases. This allows workers to access cases around the state and by skill set, to equalize the workload and utilize the staff to their full potential. This would remove the current practice of distributing cases by zip code, but instead, place all cases into a queue where an eligibility worker would be assigned a case based on need or skill set (like language skills, such as Spanish or Vietnamese). A workflow management tool can enter certain characteristics of an employee or case, and permits the agency to gather certain metrics that could be used to evaluate worker performance.

EMP should continue to expand lobby modernization efforts and the community partnership program. Low-income individuals do use technology, though it may be limited or inaccessible. Only 39 per cent of low-income Texans (less than $25,000

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294 Janice M. Prochaska, James O. Prochaska, and Deborah A. Levesque, "A Transtheoretical Approach to Changing Organizations," *Administration and Policy in Mental Health* 28, no. 4 (March 2001).

295 Ibid., 129.

296 Arnold B. Baker and Wilmar B. Schafeli, "Positive Organizational Behavior: Engaged Employees in Flourishing Organizations," *Journal of Organizational Behavior*, no. 29 (2008): 150.

297 U.S. Department of Labor, "Implications of Workplace Change," Futurework - Chapter 7, accessed August 2, 2012, http://www.dol.gov/oasam/programs/history/herman/reports/futurework/report/chapter7/.

income) have broadband Internet at home.[298] But the low-income population does use the Internet. For example, 62 per cent of low-income individuals (less than $30,000 income) have access to the Internet,[299] with higher usage among younger generations. It will be in the state's best interest to supply electronic resources and application help for individuals in order to promote the new health subsidy system and promote electronic handlings of application, case inquiry, and automation.

CONCLUSION

Both the Executive Commissioner of HHSC and the State Medicaid Director are leaving their positions by fall, 2012, before implementation of the Affordable Care Act is over. The polarized political environment diminished HHSC administrators' ability to legally implement ACA provisions for Texas, but instead, led them to publically play a part in the polarized environment, while inexplicitly implementing interagency solutions to develop infrastructure to implement ACA provisions if need be.

As what was demonstrated during the 82nd legislative session with the state budget deficit and shortfall, conservative legislators refused to develop additional revenue streams or utilize the Rainy Day fund to pay for vital social services. For the 83rd legislative session, Governor Perry developed the budget compact initiative to keep a balanced budget, limit state spending, oppose tax increases, preserve the Rainy Day fund, and cut unnecessary spending.[300] This initiative perpetuates the stalemate between political parties and leaves little room for collaboration or policy development that will enhance vulnerable population's access to services.

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298 Eligibility Modernization Project, "Technology Use by Low-Income Americans" (unpublished report, April 2012), 12.

299 Ibid., 2.

300 Office of the Governor Rick Perry, "Texas Budget Compact," Economic Development, last modified May 2012, accessed August 9, 2012, http://governor.state.tx.us/initiatives/txbudgetcompact/.

Legislators must reassess their role and that of the state government in providing health care. Better health care promotes individuals' ability to compete in the economic market. If we can improve our workforce, we can begin to increase the quality of life for all individuals and enhance Texas' ability to solicit even more investment for economic development. The preparation to modernize and streamline the state eligibility system will be vital to provide individuals with accessible coverage and decrease gaps in coverage.

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