Agency Strategic Plan

For the Fiscal Years 2005 – 2009 Period

Texas Workers' Compensation Commission

Commission Members	Dates of Term	Hometown
Representing Employers:		
Mike Hachtman, Chairman	3-20-03 to 2-01-05	Houston
William A. Ledbetter, Jr.	5-07-04 to 2-01-05	North Richland Hills
Lonnie Watson	5-12-99 to 2-01-05	Cleburne
Representing Wage Earners:		
Edward J. Sanchez	5-23-03 to 2-01-05	Houston
Carolyn J. Walls	6-10-03 to 2-01-05	San Antonio
Eddie Wilkerson	7-01-02 to 2-01-05	LaPorte

June 30, 2004

Signed: ______________________________
Richard F. Reynolds, Executive Director

Approved: ______________________________
Mike Hachtman, Chairman

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STATE OF TEXAS

VISION, MISSION, AND PHILOSOPHY

TEXAS VISION

Working together, we can accomplish our mission and achieve these priority goals for our fellow Texans:

- Assuring open access to an educational system that not only guarantees the basic core knowledge necessary for citizenship, but also emphasizes excellence and accountability in all academic and intellectual undertakings;

- Creating and retaining job opportunities and building a stronger economy that will lead to more prosperity for our people, and a stable source of funding for core priorities;

- Protecting and preserving the health, safety and well-being of our citizens by ensuring healthcare is accessible and affordable, and our neighborhoods and communities are safe from those who intend us harm; and

- Providing disciplined, principled government that invests public funds wisely and efficiently.

THE MISSION OF TEXAS STATE GOVERNMENT

Texas State government must be limited, efficient, and completely accountable. It should foster opportunity and economic prosperity, focus on critical priorities, and support the creation of strong family environments for our children. The stewards of the public trust must be men and women who administer state government in a fair, just, and responsible manner. To honor the public trust, State officials must seek new and innovative ways to meet state government priorities in a fiscally responsible manner.

THE PHILOSOPHY OF TEXAS STATE GOVERNMENT

The task before all state public servants is to govern in a manner worthy of this great state. We are a great enterprise, and as an enterprise we will promote the following core principles:

- First and foremost, Texas matters most. This is the overarching, guiding principle by which we will make decisions. Our state, and its future, is more important than party, politics, or individual recognition.
- Government should be limited in size and mission, but it must be highly effective in performing the tasks it undertakes.
- Decisions affecting individual Texans, in most instances, are best made by those individuals, their families, and the local government closest to their communities.
- Competition is the greatest incentive for achievement and excellence. It inspires ingenuity and requires individuals to set their sights high. And just as competition inspires excellence, a sense of personal responsibility drives individual citizens to do more for their future and the future of those they love.
- Public administration must be open and honest, pursuing the high road rather than the expedient course. We must be accountable to taxpayers for our actions.
- State government has a responsibility to safeguard taxpayer dollars by eliminating waste and abuse, and providing efficient and honest government.
- Finally, state government should be humble; recognizing that all its power and authority is granted to it by the people of Texas, and those who make decisions wielding the power of the state should exercise their authority cautiously and fairly.

RELEVANT TEXAS PRIORITY GOALS AND BENCHMARKS

Texas Priority Goals: Regulatory

To ensure Texans are effectively and efficiently served by high-quality professionals and businesses through clear standards, compliance, and market-based solutions.

Benchmark

Number of utilization reviews conducted for treatment of occupational injuries.

The regulatory benchmark most applicable specifically to the Texas Workers' Compensation Commission is the number of utilization reviews conducted for treatment of occupational injuries. Although the Commission does not conduct utilization reviews as they are typically defined, quality of health care including appropriate utilization for treatment of occupational injuries is an important issue to the Commission.

The Commission monitors medical utilization patterns of health care providers through reviews of the care provided by health care providers including those making medical decisions on behalf of insurance carriers. The reviews are performed under the direction of the Medical Advisor and include reviews of clinical evaluations, recommendations, treatment decisions, and clinical outcomes relating to health care.

The Commission began conducting quality of care reviews of health care providers and insurance carriers in Fiscal Year 2003. The Commission conducted 24 quality of care reviews of health care providers and 4 quality of care reviews of insurance carriers in Fiscal Year 2003. The target established at the time the FY 2004-2005 Legislative Appropriations Request was prepared in 2002 were to conduct 28 quality of care reviews of health care providers in FY 2004 and 30 in FY 2005. The target established for reviews of insurance carriers were to conduct 8 reviews in FY 2004 and 10 in FY 2005. However, the Commission expects to significantly exceed these original projections due to the additional resources dedicated to these efforts through a grant from the Texas Mutual Insurance Company and experience in conducting these reviews.

In addition to reviewing the care being provided by individual health care providers, the Commission is exploring systemic options for ensuring that care provided to injured employees is consistent with established scientific norms and that injured employees return to the workforce as quickly and appropriately as possible. The use of disability management processes, including the use of treatment guidelines, is one possible option being considered.

Texas Priority Goal: General Government

To support effective, efficient and accountable state government operations and to provide citizens with greater access to government services while reducing service delivery costs

Benchmarks

Number of state services accessible by Internet

Savings realized in state spending by making reports / documents / processes available on the Internet

The Commission has used its website as the primary avenue for distribution of publications and communications with system participants for the past several years. The Commission maintains all news releases, rule proposals, and over 200 safety and health publications, resource and training materials pertaining to all aspects of the workers compensation system on its website. Additionally, the Commission's Business Process Improvement (BPI) Project has incorporated the ability for: 1) attorneys to file their fees online, 2) the public to locate employer insurance coverage information and doctors approved to provide treatment, and 3) doctors to apply to be on the Approved Doctor's List via the internet.

Through the BPI project, the Commission will significantly increase the services available through the internet over the next several years. Most all agency services will be made accessible via self-service applications. Some of the enhancements that will be implemented during the next two years include the following:

- Ability for injured employees, beneficiaries, or their designated representatives to file first reports of injury, occupational disease or fatality online (both English or Spanish online filings will be supported);
- Ability for doctors to file maximum medical improvement and impairment rating reports online;
- Collection of medical billing data, including pharmacy and dental data that is not currently collected;
- Ability for system participants to obtain on-line access, and if a party to a claim, view claim information online; and
- Ability for carriers to accept or deny the compensability of a claim online.

The following initiatives are slated for implementation in 2006-2007:

- Ability to request and track medical and/or indemnity dispute resolution online;
- Ability for claim or dispute parties to view dispute information online, exchange dispute-related materials electronically, and view upcoming scheduled proceedings or the outcomes of those held;
- Ability to file for attorney fees online or to electronically transfer billing data to the Commission, with an added enhancement of automated orders to carriers to reduce processing cycle time;

- Ability to file supplemental income benefit information online;
- Designated doctor appointment management and tracking system;
- Implementation of agency's e-enforcement system and an improved online workplace injury prevention and safety system; and
- Completed automation framework to support any new initiatives that may result from the 79th Legislative session (actual implementations may require additional/separate funding).

TEXAS WORKERS' COMPENSATION COMMISSION

MISSION AND PHILOSOPHY

MISSION

The mission of the Texas Workers' Compensation Commission is to:

- provide a regulatory framework to facilitate timely, appropriate and cost-effective delivery of benefits and quality health care so that workers can return to productive roles in the workforce; and
- assist employers in the provision of safe workplaces.

PHILOSOPHY

The Texas Workers' Compensation Commission is responsible and accountable to the people of Texas. We strive to provide excellent service to all customers in the most efficient manner while adhering to the highest standards of ethics and fairness.

EXTERNAL/INTERNAL ASSESSMENT

AGENCY OVERVIEW

The first Texas workers' compensation statute was enacted in 1913. Over the years there have been many changes. The Texas Workers' Compensation Commission was established April 1, 1990 as part of a broad effort to reform the state's workers' compensation system. In 1995, the Legislature adopted the Sunset Advisory Commission's recommendation to continue the agency through 2007. With the passage of HB2600 in 2001, the agency's sunset date was changed to 2005.

The Commission's legal authority and general duties are described in Chapter 402 of the Texas Workers' Compensation Act, Texas Labor Code, Title 5, Subtitle A. The Commission's primary responsibilities in the workers' compensation system are prioritized as follows:

- Provide customers with information about their rights and responsibilities;
- Administer a benefit delivery system to ensure employees with job-related injuries and illnesses receive fair and appropriate benefits in a timely and cost effective manner;
- Ensure appropriate health care for injured employees with fair and reasonable reimbursement for health care providers;
- Ensure compliance with the Texas Workers' Compensation Act and Commission rules;
- Minimize and resolve disputes at the agency level, as soon as possible without having to go to court;
- Certify and regulate large private employers that qualify to self-insure;
- Promote safe and healthy workplaces; and
- Manage the responsibilities and funds of the Subsequent Injury Fund.

Unlike other states, workers' compensation insurance is not mandatory in Texas except for governmental entities and other businesses specified by statute. While many states provide exemptions from the requirement to have workers' compensation insurance for very small employers, Texas is the only state that does not require private Texas employers to provide workers' compensation coverage for their employees. As of December 31, 2003 (reported August 31, 2003), approximately 313,000 (71%) of Texas employers provide workers' compensation coverage for their employees.

As a result of the voluntary nature of coverage in Texas, the Commission must administer processes that are not common in other states. For instance, tracking whether or not an employer has workers' compensation insurance and maintaining a mechanism for other system participants, such as health care providers to have easy access to that information is critical.

Service Populations

The population of Texas reached 22,118,509 in 2003, according to the latest estimates from the U.S. Census Bureau[1],

[1] Source: Business and Industry Data Center; The Texas Economy. Retrieved February 25, 2002, from http://www.bidc.state.tx.us/overview/2-2te.htm#Population

and the Commission interacts with a wide variety of these citizens in fulfilling its duty as the regulator of the Texas workers' compensation system. However, since the workers' compensation system originated as a "contract" between employers and employees, the Commission considers its primary service populations to be injured employees, beneficiaries of employees fatally injured on the job, and employers.

Other key service populations include health care providers, insurance carriers, all employees regardless of whether injured or not, non-covered employers to whom the Commission provides health and safety resources and services in an attempt to prevent occupational injuries and illnesses, attorneys, and research/academic institutions. All of these populations serve crucial roles in fulfilling the purpose of a workers' compensation system.

In keeping with the agency's philosophy, the Commission strives to provide information and excellent customer service to all customers.

Public Perception

System participants are often operating from adversarial positions, which make performance evaluation difficult because satisfaction or dissatisfaction does not always correlate with the agency's performance of its duties.

The Commission's responsibilities and purpose are frequently misunderstood. Some of the misconceptions include:

- The Commission pays benefits to injured workers or pays medical bills;
- The Commission (TWCC) is the Texas Workforce Commission (TWC);
- The Commission is oriented to support the interests of carriers or injured employees; and
- The Commission's performance can be measured through the "workers' compensation system" measures.

The general public often confuses the Commission's responsibilities with insurance carriers who are the payers of workers' compensation benefits. Additionally, due to similarities in the name and workforce-related functions, the public often confuses the Texas Workers' Compensation Commission (TWCC) with the Texas Workforce Commission (TWC).

The Commission serves as the regulator of all participants in the system. These regulatory and dispute resolution functions require trying to discern the appropriate balance amongst all participants' competing interests.

Many of the performance measures tracked by the agency are system-related measures and are a reflection of system performance rather than a reflection of actual Commission functions. The data that the Commission tracks, analyzes, monitors for enforcement purposes, and reports may lead citizens to believe that the Commission is actually performing all of the measured activities, such as paying benefits timely.

The Commission attempts to clearly delineate the various functions performed by the agency through outreach efforts such as training programs and publications.

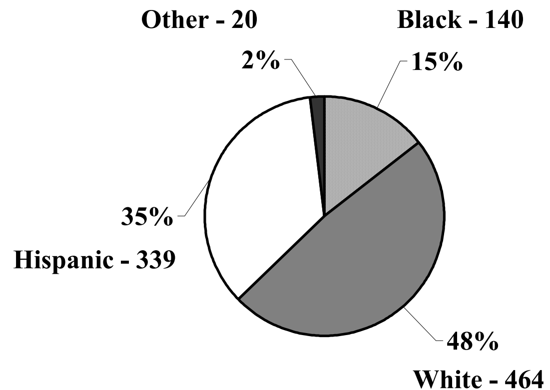
AGENCY ORGANIZATION

Staffing

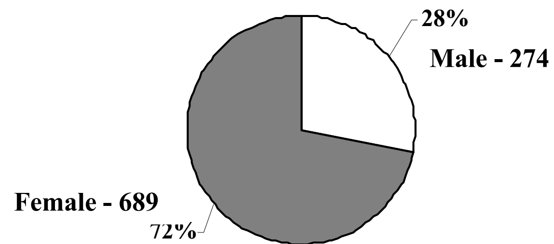
The Commission is authorized to employ 1,050 employees during the Fiscal Year 2004-2005 biennium; however, an Article IX provision reduces the Commission's cap to 1,042 in order to meet the legislatively adopted human resource staff-to-staff ratio. Approximately fifty-five percent of staff is located in the agency's central office and forty-five percent is located in field offices across Texas.

The Commission is committed to attracting, developing, and retaining the most qualified and diverse personnel to perform the functions of the agency. Compared to civilian labor force statistics, the percentages of the Commission's workforce in each of the EEO job categories who are black, hispanic, and female compare favorably – higher in most instances.

Workforce By Ethnicity
Source: Texas Workers' Compensation Commission, August 31, 2003



Workforce By Gender
Source: Texas Workers' Compensation Commission, August 31, 2003



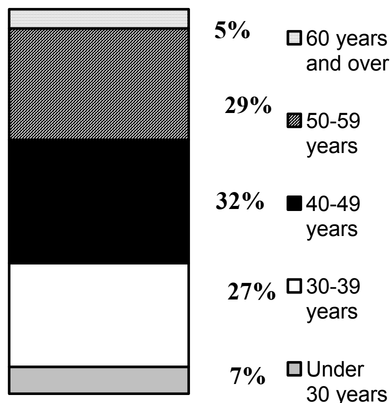
Commission Equal Employment Opportunity Statistics

Fiscal Year 2003								
Job Category	Total Positions	Minority Workforce Percentages						
		Black		Hispanic		Female		
		Agency	Civilian Labor Force %	Agency	Civilian Labor Force %	Agency	Civilian Labor Force %
Official/Administrators	20	5%	7%	10%	12%	40%	32%
Professional	495	10%	9%	27%	11%	61%	47%
Technician	42	10%	14%	31%	19%	38%	39%
Protective Services	0	0%	18%	0%	22%	0%	21%
Para-Professional	103	20%	18%	45%	31%	94%	56%
Administrative Support	300	22%	20%	47%	26%	89%	80%
Skilled Craft	0	0%	10%	0%	30%	0%	10%
Service/Maintenance	3	0%	18%	100%	44%	0%	25%

Source: Equal Employment Opportunity Commission's National Employment Summary EEO-4 2000 and EEO-1 2001; http://tchr.state.tx.us/wkfrc.htm

Distribution of Workforce By Age

Source: Texas Workers' Compensation Commission, August 31, 2004



The chart above reflects the distribution of Commission employees by age. The average age of a Commission employee is 45 as of August 31, 2003. The statewide average age is 43.

Thirty-one percent (31%) of Commission employees have less than four years of tenure. The average tenure of a Commission employee is eight years as of August 31, 2003. The statewide average tenure is also eight years.

From FY 1999 through FY 2001, the Commission's turnover rate was steady at 19%. The turnover rate decreased in FY 2002 to 14% and held steady at 14% in FY 2003, compared to the state turnover rate of 18.7%, including intra-agency transfers, in FY 2003.

In FY 2002, 12% percent of Commission terminations were due to retirement, while 29% of the terminations were due to retirement in FY 2003.

More than one-third of Commission staff is 50 or more years old; therefore, the Commission's workforce could be significantly affected by retirement through FY 2009. At least 141 people (14%) will become eligible during this time, including 36 in management or supervisory positions. The Commission is currently developing a succession planning program to mitigate some of the adverse affects of staff turnover, including retirement. The program will also develop and nurture future potential leaders.

Commissioners. The Commissioners of the agency are part-time Commissioners. Three Commissioners represent wage earners and three Commissioners represent employers. The governor designates a member of the Commission as the chairman to serve in that capacity for a two-year term expiring February 1, of each odd numbered year.

SB 287, 78th Legislature, sets staggered, two-year terms for the Commissioners. The terms of the current members expire February 1, 2005. The governor is to appoint one member representing employers and two members representing wage earners to terms expiring February 1, 2006, and one member representing wage earners and two members representing employers to terms expiring February 1, 2007.

The Commissioners' primary responsibilities include:

- Adopting rules;
- Hiring the Executive Director and the Director of Internal Audit;
- Directing the internal audit function;
- Setting reasonable fees for specified services provided by the Commission;
- Considering and recommending legislative changes;

- Preparing an annual financial report; and
- Imposing sanctions that deprive a person of the right to practice before the Commission for more than 30 days.

The Commissioners must meet at least once each quarter, but may meet at any other time at the call of the chair or as provided by Commission rules. The Commission's high volume of rulemaking activity typically requires meetings on a more frequent basis than quarterly.

In FY 2002 the Commissioner's held seven public meetings and nine public hearings. In FY 2003 the Commissioner's held ten public meetings and four public hearings.

Executive Director. The executive director is the executive officer and administrative head of the agency. The executive director exercises all rights, powers, and duties imposed or conferred by law on the Commission except for rulemaking and other rights, powers and duties specifically reserved by statute for members of the Commission. Three deputy executive directors are assigned particular areas of responsibility and support the executive director in the day-to-day management of operations in their areas.

Staffing Structure. The Commission is organized into several functional areas to perform the responsibilities authorized by the Texas Workers' Compensation Act and to maintain a balanced workers' compensation system. A brief description of these areas and their responsibilities follows. The agency's organizational chart can be found in Appendix B.

- **Compliance and Practices** monitors compliance with applicable statutes and rules, identifies system abuse, and assesses fines and penalties against system violators.

- **Customer Services** responds to requests for information about system participants' rights and responsibilities; answers questions related to claims; facilitates in the resolution of problems; and monitors the agency's customer service levels. Senior ombudsmen located in Customer Services mentor and train ombudsmen located in all field offices and provide assistance to injured workers with medical disputes that have been appealed to the State Office of Administrative Hearings (SOAH).

- **Field Offices** provide claim record creation and maintenance, customer assistance, dispute resolution and ombudsman services to system participants throughout the state.
  Ombudsman Assistance Program assists unrepresented injured employees, employers and other parties at dispute resolution proceedings.

- **Hearings** conducts administrative dispute resolution to resolve disputes in a timely, consistent, and impartial manner.

- **Medical Advisor** advises the Commission on medical issues such as rule development and removal from the Approved Doctor's List, and serves as the Chair of the Medical Quality Review Panel and the Health Care Network Advisory Committee.

- **Medical Review** monitors and regulates the delivery of medical benefits to ensure that injured workers receive reasonable, necessary, and quality health care and to control medical costs; establishes fee guidelines, medical policies and procedures; provides training and education on medical issues and return-to-work; resolves medical disputes on issues pertaining to medical fees, and uses the medical expertise of independent review organizations (IROs) to resolve prospective and retrospective medical necessity issues.

- **Self-Insurance Regulation** administers a regulatory program for large private employers certified by the Commission to self-insure for workers' compensation.

- **Workers' Health & Safety** administers state and federal health and safety programs to promote safe workplace practices and reduce injuries and illnesses in Texas workplaces.

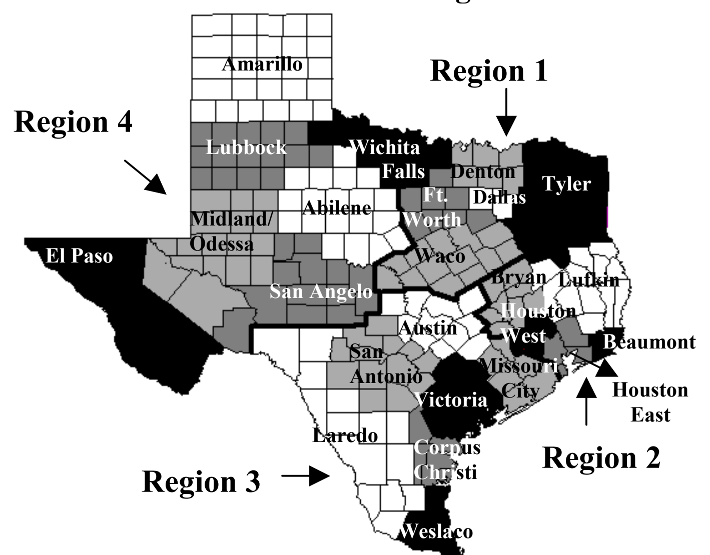
Service Locations

The Commission's central office is located in Austin and provides technical support for the agency by developing rules, regulations and operational procedures, responding to requests for information under the Public Information Act, monitoring system participants, conducting research and analysis on system data, and reporting performance to internal and external customers. The central office also provides administrative support such as developing and maintaining information systems, human resources, budget, and facility management.

Also located in Austin is the agency's record center. The record center currently provides safe storage and maintenance of more than 1.4 million workers' compensation claim files in paper form, approximately 31,000 reels of microfilm and 1.0 million microfiche with claim file information, and 2.0 million employer insurance coverage files in paper form. The Commission is statutorily required to keep each claim and coverage record for fifty years. The creation of e-claim files through the document management systems being implemented as a part of the BPI Project will simplify the Commission's record maintenance efforts in future years.

The Commission has established twenty-four field offices, divided into four regions and strategically located across Texas, as depicted in the map below. Field office locations are determined by claim activity and demand for services in the geographic area.

Field Office Locations and Regions



Field offices provide claims services, customer services, dispute resolution services and ombudsman services. Additionally, employees responsible for health and safety assistance are located in nineteen field offices. Employees responsible for fraud investigations are located in five field offices.

In addition to the dispute resolution services provided in all field offices, the Commission has two facilities, located in Uvalde and Mt. Pleasant, for the sole purpose of holding dispute proceedings. The Uvalde and Mt. Pleasant facilities assist in ensuring that injured workers will have to travel no more than seventy-five miles from their residence to a benefit review conference or contested case hearing.

The Commission has developed an ongoing process of evaluation to ensure field offices are appropriately located throughout the state and staffed based on customer need. The evaluations are used to determine if a field office should be established, enlarged, relocated, divided, or downsized.

Bordering States. A customer service issue that is unique to all of the bordering areas of the state is how best to serve the needs of employees who were working in Texas when injured but now reside in other bordering states. If an injured employee lives in a bordering state and in a county or parish that is contiguous to the Texas border, the closest field office handles the workers' compensation claim. The Victoria Field Office handles claims for injured workers living outside Texas in counties that do not adjoin the Texas border.

Texas-Mexico Border. To meet the needs of customers along the Texas-Mexico border, the Commission has seven field offices and one dispute proceeding facility located in Uvalde.

Field offices serving counties located along the Texas-Mexico border, as specified by statute[2], are represented in the table below:

Field Offices Serving the Texas-Mexico Border Region

Field Office	Texas Counties Served	
Corpus Christi	Jim Wells Live Oak San Patricio	Kleberg Nueces
El Paso	Brewster El Paso Jeff Davis	Culberson Hudsbeth Presidio
Laredo	Brooks Duval Jim Hogg La Salle McMullen Val Verde Zapata	Dimmit Edwards Kinney Maverick Starr Webb Zavala
Midland	Pecos	Reeves
San Angelo	Crockett Sutton	Kimble Terrell
San Antonio	Atascosa Bexar Kerr Real	Bandera Frio Medina Uvalde
Weslaco	Cameron Kenedy	Hidalgo Willacy

A growing Hispanic workforce and its concentration in the high-growth border region has created unique challenges in the provision of services and injury

[2] Specific border counties required to be included in the Strategic Plan are identified in the Government Code § 2056.002 (e)(3).

prevention programs. To meet that challenge, the Commission contracts with Spanish-speaking translators as needed for our most complex dispute resolution proceedings, and provides workplace safety and health training courses in Spanish. In addition, the Commission requires Spanish-speaking proficiency of job applicants for particular positions; however, it is becoming increasingly difficult to find Spanish-speaking persons with the necessary training and education to meet job requirements in particular health and safety positions.

Texas-New Mexico Border. In accordance with the adjacent county parameters discussed earlier, the Lubbock, Amarillo, and El Paso field offices serve customers along the Texas-New Mexico border. This area also has a large portion of Spanish-speaking customers that poses the same unique challenges as those faced by offices on the Texas-Mexico border.

Texas-Oklahoma/Arkansas Border. Field offices located in Amarillo, Wichita Falls, Tyler and Denton serve customers along the Texas-Oklahoma border. The Tyler field office also provides customer assistance to injured workers residing in Arkansas counties bordering Texas.

Texas-Louisiana Border. To serve the Commission's customers located along the Texas-Louisiana border, the Commission has a field office in Tyler, Beaumont, and Lufkin and a dispute proceeding facility in Mt. Pleasant. Counties, specified by statute[3], located along the Texas-Louisiana border are served by the Tyler field office and are identified in the table below:

Field Office Serving the Texas-Louisiana Border Region

Field Office	Texas Counties Served	
Tyler	Bowie	Camp
	Cass	Delta
	Franklin	Gregg
	Harrison	Hopkins
	Lamar	Marion
	Morris	Panola
	Red River	Rusk
	Smith	Titus
	Upshur	Wood

FISCAL ASPECTS

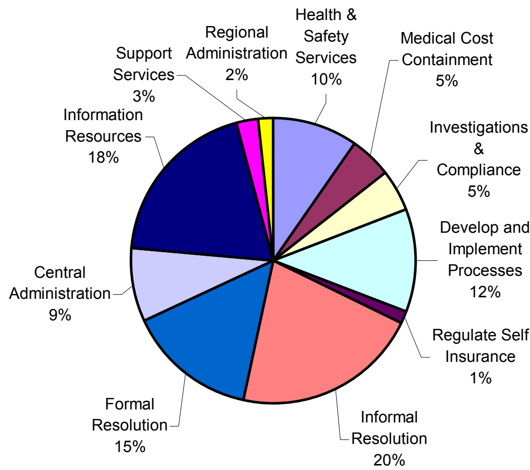
Budget

For the Fiscal Year 2004-2005 biennium, the Commission has been appropriated $101,771,518. This appropriation includes $3.56 million for the continuation of the Business Process Improvement (BPI) project, which began during the FY 2000-2001 biennium. Total appropriations for FY 2004-2005 were reduced due to statewide requirements for space allocation and mandated human resource staff-to-staff and management–to-staff ratios. These reductions are reflected in the appropriated amount above. Not reflected in the amount above is $5.1 million per year appropriated for administration of the Subsequent Injury Fund.

[3] Specific border counties required to be included in the Strategic Plan are identified in the Government Code § 2056.002 (e)(3).

Distribution of Funds by Strategy
Fiscal Years 2004-2005

Source: General Appropriations Act



Funding

Maintenance Taxes. The agency's primary source of revenue is generated by a self-balancing maintenance tax established by the Texas Workers' Compensation Act. The maintenance tax is paid by insurance companies that issue workers' compensation insurance policies in Texas.

The maintenance tax is set at an amount to cover the Commission's operations, but not to exceed 2% of total gross workers' compensation premiums collected in the previous calendar year. The statute requires that any over-collections or spending reductions in the Commission's budget be accounted for in the setting of the maintenance tax for the following year (hence the term "self-balancing"). The tax is collected by the Texas Comptroller of Public Accounts and is deposited in the states' General Revenue Fund. The maintenance tax rate for 2004 is 1.125% of the gross premiums collected January 1, 2003 through December 31, 2003.

In addition, certified self-insurers are assessed a regulatory fee for the administration of the self-insurance program, as well as paying the Commission maintenance tax. The Commission collects the maintenance and regulatory fees paid by certified self-insurers, and those funds are deposited in the General Revenue Fund.

Approximately 93% of the Commission's funding is appropriated by the Legislature from these funds in the General Revenue Fund collected through the maintenance tax and regulatory fee.

Federal Funds. Federal grants and earned federal funds account for approximately 4% of the agency's appropriations. These grants allow the Commission to provide safety consultation services to Texas employers without charge, provide health and safety training, and collect data on workplace safety.

Most of the Commission's federal grants require annual training and participation in national workgroups at sites designated by the federal agencies providing the training. These training opportunities and meetings often take place outside of Texas. Limitations on out-of-state travel have an affect on the Commission's ability to expend federal funds and, potentially, to comply with grant requirements.

Other Funding Sources. The remainder of the Commission's appropriated funding comes from a number of sources. The Commission collects fees for audits, inspections, seminars, consultations, publication sales, and reproduction of documents. As more information and services are provided through agency websites, the amount of funding generated

through fees may decrease. In addition, the Commission collects administrative penalties from businesses or individuals who violate the Texas Workers' Compensation Act or Commission rules. Revenues related to administrative penalties, which are appropriated to the Commission, are limited by a ceiling set by the state's General Appropriations Act.

Texas Mutual Insurance Company Grant. In 2003, the Commission received a grant for $2.198 million from the Texas Mutual Insurance Company *(TMIC)*. The grant was authorized by the Commission's and TMIC's enabling statutes for the purpose of controlling and lowering medical costs and ensuring the quality of medical care. As of May 31, 2004, $834,354 has been expended/encumbered on the quality of care review process, leaving a balance of $1,363,646.

Subsequent Injury Fund. The Subsequent Injury Fund (SIF) is an account in the General Revenue Fund, and is funded from compensable death benefits on claims in which there is no legal beneficiary. The primary purposes of the fund are:

- To pay lifetime income benefits (LIBs) to injured workers who become eligible for those benefits because of a second work-related injury;
- To reimburse insurance carriers for benefits paid based on a Commission decision or order that is later reversed or modified; and
- To reimburse insurance carriers for the portion of benefits paid to injured workers based on the wages earned at jobs held at the time of injury, but other than the one at which the injury occurred (for injuries occurring after July 1, 2002).

The total assets of the SIF as of August 31, 2003 were approximately $40 million; however, the projected cash value of the LIBs (based on estimated life expectancies) payable to injured workers eligible for such benefits through the SIF was approximately $10 million.

Prior to Fiscal Year 2004, the SIF was a special fund in the state treasury and was not included in the Commission's appropriations. With the adoption of HB 3318 during the 78th Legislature, the SIF is now an account in the General Revenue Fund and will be reflected in the agency's future appropriations. In Section 11.56 of the FY 2004-2005 General Appropriations Act, the Commission was appropriated all necessary funds for the payment of SIF liabilities, which were estimated to be $5.1 million per year.

Method of Financing. The table below reflects the Commission's method of financing for the current biennium.

METHOD OF FINANCING
Fiscal Years 2004-2005

General Revenue	$ 94,709,814
Earned Federal Funds	448,813
Federal Funds	4,045,516
Appropriated Receipts	2,535,375
Interagency Contracts	32,000
Subtotal	**$101,771,518**
As of 9/1/03, the remaining balance of the $2.198 million TMIC grant is:	2,090,883
Subsequent Injury Fund	10,200,000
TOTAL	**$114,062,401**

Contract Workforce and Historically Underutilized Businesses

The Commission typically only uses independent contractors, temporary workers supplied by staffing companies, contract company workers and consultants

where the Commission does not have necessary skill sets or expertise and when additional resources are needed for a limited time.

The Commission attempts to solicit the services of Historically Underutilized Business (HUB) vendors and to bring HUB vendors into the HUB program with all procurement/bid opportunities. The Commission uses the Texas Building and Procurement Commission's (TBPC) Centralized Master Bidders List/HUB directory as its primary source for notifying businesses of procurement opportunities.

Below are ways the Commission strives to increase the use of HUBs:

- Contact a minimum of five HUBs on procurements between $2,000 and $10,000;
- Contact a minimum of ten HUBs on procurements from $10,000 to $25,000;
- Distribute HUB vendor information internally to agency staff who are contracting for services to encourage the use of HUB vendors;
- Always attempt to use HUB subcontractor's with professional contracts greater than $100,000; and
- Participate in TBPC and other agencies' Economic Opportunity Forums, seminars, and conferences, contingent upon funding availability.

Progress resulting from Commission efforts to increase the use of HUBs includes:

- Solicited more HUB vendors than required for certain procurements;
- Last two fiscal years was at or above the state wide percent of total HUB expenditures in the fiscal year;

Percent of HUB Expenditures		
	FY 2002	**FY 2003**
Statewide	11.3%	13.0%
TWCC	15.4%	13.1%

- Percent of HUB expenditures in the Commodity category has been above the statewide percent for the last three fiscal years; and
- The percent of HUB expenditures in the Other Services category has increased each year since FY 2001.

The Commission's goal is to meet or exceed the percentages reflected in the chart on the next page. The 2004 goals are based on the Commission's performance during the previous two years. Because of the nature of the Commission's statutory responsibilities, the Commission does not typically award contracts in the Heavy Construction, Building Construction, and Special Trade categories.

The Commission's performance in Other Services Contracts is well below the State goal; however, the Commission has shown improvement (7.89% in FY 2002; 8.79% in FY 2003). A significant portion of the Commission's expenditures in this category is for computer mainframe and disaster recovery services through the contract with Northrop Grumman at the Disaster Recovery Operations Center in San Angelo. Therefore, those expenditures are not eligible for HUB participation.

HUB GOALS AND COMMISSION PERFORMANCE

Procurement Category	TWCC Performance		TWCC Goals	State Goals*
	FY 2002	FY 2003	FY 2004	
Heavy construction other than building contracts	N/A	N/A	N/A	11.9%
Building construction, including general contractors and operative builders' contracts	N/A	N/A	N/A	26.1%
Special trade construction contracts	0.00%	0.00%	0.00%	57.2%
Professional services contracts	0.00%	0.00%	0.00%	20.0%
Other services contracts	7.89%	8.79%	8.34%	33.0%
Commodities contracts	28.60%	23.17%	25.14%	12.6%

N/A – Not Applicable
*Source – Texas Building and Procurement Commission

The Commission will continue to make a good faith effort to include HUBs in procurement opportunities when purchasing goods and services. Future plans to increase the use of HUBs include the following:

- Implement a Mentor Protégé Program; and
- Establish and maintain a web page that educates HUBs about the Commission's procurement policies and procedures, and provides information on contracting opportunities.

Capital Assets/Lease Issues

Capital Assets. The Commission's capital needs over the next several years can be classified into the following categories – technology replacement, new technology necessary for support of the self-service, automated delivery of services being developed through the Commission's Business Process Improvement Project, and facility security. Prior to purchase or lease of any capital asset, an evaluation of costs and the benefits that are expected to result from the investment is conducted. The tight financial situation faced by the agency and the state has required even closer scrutiny of all planned capital projects.

Technology Replacement and Enhanced Use. Extended life cycle replacement schedules and limited funding due to changing economic times has been a large factor in the replacement of hardware critical to Commission operations, such as personal computers and printers. Cost benefit analyses performed at the end of leases for personal computers has prompted the agency to buy out the hardware and to buy ongoing maintenance for existing leased computers instead of replacing such computers with new equipment. The next biennium (FY 2006-2007) will be the earliest opportunity to perform Commission-wide replacements of personal computers. At that time, most of the Commission desktop and laptop workstations will be over four years old, and Commission printers will be over five years in age, rendering them virtually obsolete.

In the last two years, the Commission has focused on the reconfiguration of the central office local area network (LAN) to meet continually increasing requirements and to provide a constant availability of critical Commission systems. The Commission has emphasized procurement of hardware and software to provide for high availability, increased storage

capacity, and improved scalability for future growth. Using its older, less-powerful equipment, the Commission implemented a lab environment to test new configurations and changes prior to distribution. This process has contributed to a decrease in Commission downtime and increased access to information systems, email and other critical systems necessary to provide customers with important information.

New Technology for BPI Project Automation Implementation. The Commission's goal to provide our customers with appropriate "self-service" access to public information and eliminate the need for information on paper has increased pressure to move toward processes that are less paper-intensive. In making technology selections under the Business Process Improvement (BPI) project, the Commission is making every effort to define the functional requirements for integration with the new automation system being developed through the BPI project, e-mail systems, document management solutions, and web-enabled technology that are generally compatible with our customers' systems.

Security/Safety Enhancements. The Commission places a high priority on the safety of its employees and customers and continually evaluates the need for additional security at its central and field offices.

Due to the adversarial nature of the workers' compensation environment, some unhappy customers may feel their livelihoods are at stake and, at times, fault Commission staff for their predicament. Therefore, it is the Commission's ultimate goal to ensure that all offices are physically secure, by requiring electronic access through locked doors from the lobby to the rest of the building. Additionally, the Commission is working toward installing theater style windows for reception stations in all field offices to enhance the level of protection to staff that receive visitors as they enter the facility. Several field offices already have received security enhancements, and the Commission will continue to include such enhancements as leases are replaced or renewed.

Other security and safety-related issues being considered or implemented for both central and field offices include:

- Automatic External Defibrillators (AEDs) in case of emergencies;
- Double doors in hearing and benefit review rooms for quick egress in event of security incidents; and
- Panic alarms for receptionists to alert the office of an emergency.

Office Leases. The Commission has a total of twenty-four field offices, two additional facilities for the sole purpose of conducting dispute proceedings, a records retention center and a central office. All facilities are leased except for two (Waco and El Paso) that are located in state office buildings.

Currently, there are five field offices in which the Commission is co-located with other agencies (San Angelo, Weslaco, Austin, Waco, and El Paso). The central office is located in a building in which a division of the Texas Parks and Wildlife Department (TPWD) also resides.

As existing lease terms expire, the Commission will be evaluating the space requirements and making reductions where possible to comply with the new

space planning requirements. Through these evaluations, the Commission will strive to comply with TBPC's goal of an 80/20 ratio of open office space to closed office space and the statutory requirement of 135 square feet for each FTE. Since the Commission has unique requirements, such as the need for office space to conduct dispute hearings for injured workers, the Commission will request exceptions to the 135 square foot per FTE limitation when negotiating new leases.

Four leases expire during the FY 2004-2005 biennium: Ft. Worth, Amarillo, Lufkin, and Houston East. The Ft. Worth lease was renewed at a substantially lower rate. Commission-specific requirements for the Amarillo and Lufkin Field offices have been submitted to TBPC, including the request to remain in the current locations. The Commission anticipates that the Houston East field office will be relocated into a state owned building.

Of the remaining leases, fifteen will expire during the FY 2006-2007 biennium. The agency's record center lease will also expire during the FY 2006-2007 biennium.

At the Commission's request, the TBPC has included a "regulated party clause" in all new Commission leases since August 1, 2001. This precludes lessors from leasing space in the same or contiguous space with Commission offices to participants in the Texas workers' compensation system (e.g., healthcare providers, attorneys, etc.). Eight Commission leases currently include the "regulated party clause."

TBPC has advised agencies it is implementing procedures to reduce state lease costs. In the past, with TBPC approval, Commission-specific items were incorporated in the lease rate. These items include data/audio cabling, electrically operated door locks and panic alarms, and build-out features such as theater style windows in lobby areas. In addition, nearly all TWCC leases currently include utilities and janitorial services in the lease rate. The TBPC has indicated to state agencies that these items will no longer be included in the lease rate as leases are renewed or replaced. Although this may result in a lower lease cost, the Commission may have to fund these specific items from other Commission appropriated funds.

The Commission will evaluate the expected cost savings due to space reduction and any additional costs projected for future leases. Any additional projected expenditures associated with increased lease rates, Commission specific requirements, and/or moving expenses will be included in the FY 2006-2007 Legislative Appropriations Request (LAR).

Key Organizational Events and Areas of Change and Impact

Sunset Review. As noted earlier, the Commission's Sunset date is September 1, 2005. The Sunset review process and the legislative attention to workers' compensation issues during the interim and the next legislative session may have a substantial impact on the agency, both organizationally and operationally. Included in the issues being considered is the governance structure for the agency.

Transition from Data Entry to Imaging of Workers' Compensation Documents. The Commission will implement the first phase of an e-Claim Processing System in

September 2004. The new processing system will involve the transition from data entry to imaging of workers' compensation-related documents, and will significantly move the agency towards a paperless environment. Previously, if a paper claim file was needed at another field office, it was copied and mailed to the appropriate office. After September 2004, the claim will be submitted electronically, and claim file information will be accessible online at field offices for authorized parties. New processes associated with imaging and creating electronic files will require new skill sets and expertise for some staff and the deployment of other staff to new functions. The provision of training on the new processes and functions for staff affected by these changes and other changes resulting from the BPI project will be critical during the next several years.

Designated Doctor Scheduling Function Moved to Central Office. The Designated Doctor Scheduling function for selected field offices is currently being moved to the central office to increase process consistency and to free-up field office staff for other customer service activities.

TECHNOLOGICAL DEVELOPMENTS

Commission stakeholders sometimes perceive business with the Commission as paper intensive, cumbersome and complex. Consequently, the Commission has carefully planned technology initiatives to support the agency's most critical and the most urgent needs of its customers--all while aligning with the state Information Resources strategic direction.

The Commission's goals for the use of information technology are: 1) to bring more online services to the citizens; 2) to provide opportunities for self-service by customers; and 3) to replace the Commission's mainframe automation system that no longer serves the agency's needs.

Business Process Improvement (BPI) Project. The BPI Project is the umbrella project that is guiding the Commission through process re-engineering. Under the BPI project, the Commission is developing secure web-based applications accessible to participants in the workers' compensation system. Participants will be able to access information without filing paper forms and requiring interaction with a Commission staff person.

The new applications are being developed on an infrastructure that is in line with the technology selections being made by most state agencies that are also replacing mainframe legacy systems. Additionally, programming standards are being used that are mainstream and offer reusable coding modules that will save time when creating new application modules.

To date, the BPI Project has implemented automated applications to enhance the search capabilities for employers' coverage information and to file Approved Doctor List (ADL) applications and manage the ADL. The project is currently pushing toward its delivery of the first phase of the e-Claim Processing System. This phase, slated for Fall 2004, will support the coverage processing system, the notice of injury system, and the agency's paperless claim file program that will allow parties to a claim to review claim information online.

With the remaining funding appropriated for the project in FY 2004-2005, the agency will complete the e-Claim Processing System and will develop applications to support related claim processing enhancements, such as:

- Ability for injured employees, beneficiaries, or their representatives to file first reports of injury, disease or fatality online (both English or Spanish online filings supported);
- Ability for doctors to file maximum medical improvement and impairment rating reports online;
- Data collection of medical billing data, to include pharmacy and dental data not currently collected;
- Data collection of indemnity subsequent report data, to include improved electronic data interchange (EDI) file tracking processes to ensure data reporting compliance;
- Ability for system participants to obtain access, and as parties to a claim, view claim information online; and
- Ability for carriers to accept or deny the compensability of a claim online.

The agency will seek funding for the BPI initiative for the 2006-2007 biennium, which represents the last two years of the project as it was originally presented. With the first priority being to establish more cost efficient and effective processes for system participants and a second priority of getting off of the agency's mainframe system that is costly and difficult to support and maintain, the following initiatives are slated for implementation in FY 2006-2007:

- Ability to request and track medical and/or indemnity dispute resolution online;
- Ability for claim or dispute parties to view dispute information online, exchange dispute-related materials electronically, and view upcoming proceedings scheduled or the outcomes of those held;
- Design for return-to-work data collection;
- Ability to file for attorney fees online or to electronically transfer billing data to the Commission, with an added enhancement of automated orders to carriers to reduce processing cycle time;
- Ability to file supplemental income benefit information online;
- Designated doctor appointment management and tracking system;
- Implementation of agency's e-enforcement system and an improved online workplace injury prevention and safety system; and
- Completed automation framework to support any new initiatives that may result from the 79th Legislative session (actual implementations may require additional/separate funding).

Information Security. The Commission has recognized information security as an integral business function due to the proliferation of more advanced and destructive attacks on statewide automated systems. The increasing mobility of data continues to challenge the state's ability to secure and protect its information.

The ability to detect intrusion attempts is critical to the agency's ability to assure the public of the Commission's stewardship of its information. In the course of moving to a more heavily automated system, continuing to comply with the confidentiality provisions regarding workers' compensation information is of utmost importance. The Commission periodically works with the

Department of Information Resources to successfully test the security mechanism in place to deter people without proper authorization from accessing information through automated systems. Additionally, network enhancements will be implemented by August 31, 2005 to more rapidly detect and hinder network intrusions and assist in the diagnosis of such intrusions. Current processes exist, but additions to these processes regarding the management of patches to various software packages and detection software will greatly increase our ability to find and quarantine such attacks.

Health Insurance Portability and Accountability Act (HIPAA). The Health Insurance Portability and Accountability Act (HIPAA) was passed into law in 1996. Title II, Administrative Simplification, of the Act requires health plans, providers and other entities that perform functions or activities involving the use and/or disclosure of protected health information to implement administrative and technical standards for the electronic exchange of health information and the implementation of maintenance procedures to ensure privacy of the information. HIPAA requirements include:

- implementation of electronic transaction standards, code sets and identifiers for the exchange of health information;
- adoption of security standards; and
- adoption of privacy regulations.

Although health information involving workers' compensation is not under the jurisdiction of HIPAA, the vast majority of workers' compensation health care providers and insurance carriers are still required to comply with the provisions due to their involvement in other health care benefit systems that fall under the scope of this legislation (such as group health insurance programs). Specific transactions that are being addressed by HIPAA that are duplicated in the workers' compensation system include: health claims, or equivalent encounter information, health claims attachments, health care payment and remittance advice, health claim status, referral certification and authorization, and the first report of injury. Therefore, the standards being adopted and incorporated into all upcoming BPI initiatives will be HIPAA-compliant.

HIPAA standards provide a mechanism for the Commission to standardize medical billing data, begin collecting pharmacy and preauthorization data, and provide guidance as to how to be mindful of privacy issues as we develop our new processes and systems.

In order to avoid the development of duplicate systems with different standards or mechanisms, the Commission is monitoring the status of rules being processed/adopted to ensure that efficiencies are maintained in the workers' compensation system. Additionally, the rules are monitored to determine how system participants interact with entities covered by the legislation.

Distance Training and Service Delivery. The economic slowdown, operating resource reductions, and travel limitations, coupled with the continuing need to introduce new skills to staff, has encouraged agency use of innovative training techniques. Some of the various training techniques being used include: virtual classrooms, self-paced web-based training, and traditional classroom training. Additionally, when acquiring

new technologies for the BPI project, the Commission assures inclusion of various forms of training to assist in the timely development of technical skills to support the new systems.

The use of "virtual" classrooms through the use of video and teleconferencing has assisted in improving timeliness and quality of information sharing between agency offices without incurring travel costs or the loss of productivity. The Commission has begun conducting some dispute proceedings, meetings and conferences for both internal and external parties through the use of these technologies.

Additionally, the Commission has also automated the training for individuals who are Approved Professional Sources and must take biennial update training. These external system participants can now complete a training module on the Commission's web site to meet the training requirement.

Telecommunications/Call Center. Since the telephone continues to be the Commission's primary interface with the customer, especially injured employees, improvements in telephonic service delivery provide information and services in a quicker and more efficient manner. The Commission has been upgrading the telephone systems to place the Commission in a position to be ready to implement "call center" technologies that can aid in the improvements in communications with our customers.

The Commission's 24 field offices all have full customer service capability – telephonic and walk-in. Customers call the office in their service area directly or use the toll-free number, which routes the call to the office closest to its point of origin. A "call center" will route all general information calls to a central location then route that customer to the appropriate customer service agent. The staff availability analysis and routing will be invisible to the caller. The Commission anticipates that the "call center" will be created in FY 2006. With enhanced electronic claim file data resulting from scanning claim information into the new e-claim system, customer service staff will have easy access to claim data when dealing with agency customers. The anticipated outcomes of a "call center" include:

- Faster call response times;
- Improved efficiency by assuring appropriately skilled staff is available to handle telephone calls;
- Efficient handling of incoming calls which will be done in a manner that is invisible to our customer; and
- Lower telephone operating costs because of the Commission's routing of incoming calls instead of the current system of having the telephone company route our calls for a fee.

The Commission plans to keep minimum customer services staff resources in place in local field offices to continue to provide service to those customers who walk in to our offices. The creation of call center(s) will allow the Commission to meet the demands of a growing customer base.

SERVICE POPULATIONS AND DEMOGRAPHICS

Primary Service Populations

Over the next five years, Texas is projected to add 525 people every day to its population. It is estimated that Texas

will be among the top three fastest growing states in the U.S. and that by 2010, the population will be approximately 24.2 million.[4] It has also been projected that Texas could more than double its population by the year 2030.[5]

Population growth has a significant impact on the Texas labor market – especially considering the fact that sixty-five percent of the population is employed.[6] This percentage represents the highest rate of employed population in Texas history and is above the national average.[7] Total employment in Texas is projected to increase by over 1.8 million jobs between 2000 and 2010, rising to nearly 13 million.[8]

Labor Force Demographics

Population growth projections indicate that the Texas labor market will become increasingly older, Hispanic, and urbanized.[9]

Increasingly Older. The elderly population is expected to increase by twenty-two percent between 2000 and 2010.[10] This rapid growth will lead to a more mature workforce and could impact the workers' compensation system by leading to an increase in the number of elderly workers experiencing on-the-job injuries. Although older workers do not experience occupational injuries as frequently as their younger counterparts, their injury severity is greater. This is evidenced by the fact that older workers oftentimes take significantly longer to return to their jobs after experiencing an occupational incident.[11]

While the workforce will become older in the coming years, it will also begin to experience the effects of the retirement of the baby boom generation. Although baby boomers begin to reach traditional retirement age starting in 2011, a section of this population will opt for early retirement. This is likely to result in a skilled labor shortage as key positions retire, taking with them critical knowledge and skills.[12]

Like the overall economy, this phenomenon could impact the internal operations of the Commission. In response to the need to ensure that its workforce is ready for the retirement of key management positions, the Commission has implemented a leadership-training program to train individuals for management positions within the agency. The program will promote among current staff the potential to move into management and other leadership roles.

Increasingly Hispanic. Within four years, Anglos will constitute less than half of the State's population. If current trends continue, Hispanics will become the majority ethnic group in the state between

[4] Gattis, D. (December 2002). "Jobs in the 21st Century," *Texas Labor Market Review* published by the Labor Market Information Department of the Texas Workforce Commission.
[5] Texas Workforce Commission (TWC). (September 2002). "The Texas Economy: An Age of Global Economic Opportunity," p.5.
[6] Ibid. p. 40.
[7] Ibid. p. 43
[8] Ibid. Gattis.
[9] Ibid. TWC, "The Texas Economy: An Age of Global Economic Opportunity," p. 35.
[10] Ibid. Gattis.
[11] Texas Workers' Compensation Commission (1997-2002). Bureau of Labor Statistics Annual Survey of Occupational Injuries and Illnesses, analysis of median days away from work.
[12] Ibid. TWC, "The Texas Economy: An Age of Global Economic Opportunity," p. 38.

2026 and 2035.[13] This increase in minority population will be reflected in the characteristics of the workforce and in the distribution of occupational injuries and illnesses.

The growing number of Hispanic workers has led to the increase of services provided to this ethnic group. In order to serve Spanish speaking customers, the Commission provides important forms and documents in Spanish, as well as bilingual assistance in dealing with customer service matters. The Commission supplies Hispanic workers with safety training and resources in Spanish. The Commission is also actively involved in a partnership with the Justice and Equality in the Workplace Alliance in which the Mexican, South and Central American Consulates have agreed to refer Hispanic workers to Commission services and to assist the Commission in educating Hispanics about the rights of injured workers.

Increasingly Urbanized. According to the Texas Association of Counties, forty-one percent of the population lives in just four counties:[14] Harris, Dallas, Tarrant, and Bexar. However, it is expected that by 2040 the Capital Area (Travis) will surpass the greater San Antonio (Bexar) region in total population.

Regarding population growth, due to an increased Hispanic population, the fastest growing regions of the state will be South Texas and the Lower Rio Grande Area, followed by the Capital Area. The slowest growing areas through 2040 will be Northwest Texas, West Texas, and the Panhandle region as people move toward metropolitan areas where employment growth is concentrated.[15]

Location of Commission offices and staffing of those offices will continuously be reviewed to make necessary adjustments as appropriate to meet population demands.

ECONOMIC VARIABLES

After a growth-oriented economic environment for ten straight years, the national economy went into a recession in 2001. Since that time, the Texas economy experienced losses in employment (155,500 jobs lost) and flattened output (decline and slow growth of Texas gross state product).[16] At this time, it appears that the overall Texas economy is experiencing an upswing as job growth has been positive since the third quarter of 2003, and gross state product figures have grown since the second quarter of 2002.[17]

Poverty and Education. The recent economic downturn has undoubtedly had its effects on the working poor of Texas. The Texas poverty rate is the seventh highest in the nation. In 2003, the poverty rate in Texas was 15.6 percent overall – three points higher than the U.S. rate.[18]

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[13] Miller, J. (October 2002) "The Hispanic Republic of Texas: It's coming. Soon," *National Review*. Retrieved March 18, 2004 http://www.findarticles.com/cf_dls/m1282/19_54/92049012/print.jhtml. p. 11.
[14] Ibid. TWC, "The Texas Economy: An Age of Global Economic Opportunity," p. 39.
[15] Ibid. p.39.
[16] Thompson, J. (May 2002). "How to Call Texas Recessions," Federal Reserve Bank of Dallas, *Expand your Insight*. Retrieved on March 21, 2004 http:/www.dallasfed.org/eyi/regional/0305recession.html p.4.
[17] Ibid. p.4.
[18] Center for Public Policy Priorities. (2003). "Texas Poverty Fact Sheet," Retrieved March 19, 2004 http://www.cppp.org/products/fastfacts/poverty.html p.1.

The poor are concentrated in the State's largest cities and along the Texas/Mexico border. The most impoverished areas of the State are located in South Texas Valley region, particularly the Starr-Zapata County area and Hidalgo County with poverty rates of over 50 percent and 36.2 percent respectively.[19]

Low wages in many of the growth sectors of Texas' economy contribute to the state's large working poor population. Approximately 1.7 million people live in working poor families, 48% of which include one or more full-time, year-round workers.[20] Poverty rates are significantly higher for the large and growing Hispanic population. Studies have shown that per capita incomes in border cities with majority Hispanic populations such as El Paso, Laredo, and McAllen ranged between fifty and sixty percent of the state average.[21] Regarding ethnic make-up, over a quarter of the State's poor population is Hispanic, followed by 18.8 percent blacks and 7.3 percent Anglos.[22]

Workers' wage and poverty levels are linked to grade of education completed. Texas falls behind the nation in educational attainment. While for most of the nation, the number of adults without a high school diploma has decreased; Texas is among eight states that have experienced a rise in the number of adults who have not graduated.[23] In addition, when compared with the nation, Texas has a lower rate of college-educated adults. The low education levels are most pronounced in the high-growth border regions than in the rest of the state.[24]

Lower than average educational attainment leads to lower wages, and thus could have economic implications for Texas. In addition, workforce trends reveal a shift to occupations that require a higher level of skill and education. Nationally, most of the job loss experienced during the economic downturn was concentrated in production, craft, and agriculture occupations, while employment in managerial, technical, and professional jobs grew significantly.[25]

Studies of injured employees' return to work patterns show that factors such as low education levels, Spanish speaking, and low wages result in employees having a more difficult time returning to work. The Commission is currently exploring whether through the use of disability management model interventions may be used to mitigate the poor return to work outcomes.

The Commission must also consider the fact that many low-skilled and low-educated workers obtain employment in high hazard occupations in construction, manufacturing, and agriculture industries, thus increasing their likelihood of being injured or killed on the job. According to recent studies conducted by the Commission in conjunction with the Bureau of Labor Statistics, Hispanic workers accounted for thirty-six percent

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[19] Ibid. p.2.
[20] Ibid. p.3.
[21] Fullerton, T. (Third Quarter 2001) "Education Attainment and Border Income Performance," Federal Reserve Bank of Dallas, *Economic and Financial Review*. p.3.
[22] Ibid. Center for Public Policy Priorities. p 2.
[23] Taylor, L. (January/February 2003). "Region Lags Nation in Educational Attainment," Federal Reserve Bank of Dallas, *Southwest Economy*. Retrieved on 3/19/2004 http://dallasfed.org/research/swe0301a.html p. 2.
[24] Ibid. p.4.
[25] Ibid. TWC, "The Texas Economy: An Age of Global Economic Opportunity," p. 70.

of work-related injuries and illnesses[26] and thirty-five percent of fatalities. In addition, even though Texas experienced an all time low in the number of total occupational fatalities in 2002, Hispanic workers' representation in the overall number of fatalities increased from thirty-one percent in 2001 to thirty-five percent in 2002.[27]

As the number of Hispanic workers employed in hazardous industries continues to rise, the need for outreach, intervention, and service provision to this segment of the population will increase. Alliances with organizations such as Justice and Equality in the Workplace Alliance will enable the Commission to better serve the growing Hispanic population. The need for continued development of worker health and safety programs and resources, as well as continued efforts to provide information in plain, simple language and in Spanish and to facilitate an injured worker's timely return to work will become increasingly necessary.

Occupation and Industry. In the past, the U.S. and Texas economies relied heavily on the goods-producing industries (mining, manufacturing, construction, etc.) for job creation. However, over the last decade, jobs in the goods-producing sectors have remained flat, while job growth in service industries grew by twenty-four percent.[28] Between 2000 and 2010, professional and service occupations are expected to add the most jobs, and are projected to grow the fastest. Accounting for most of that growth will be occupations found in health, computer, and education-related fields.[29]

Despite the growth in these industries, many jobs in the service industries are being performed in other countries as corporations are taking advantage of the educated and less expensive white-collar labor force available in other countries. Whereas manufacturing plants have moved to countries such as Mexico and the Far East in the past; now, call centers and engineering and accounting services are moving to India, Ireland, and the Philippines.[30]

In Texas, the need for computer skills will continue to grow due to advances in computer technology and demand for improved applications and performance. Computer software engineer professions are expected to grow by seventy-five percent, adding 40,000 jobs by 2010. Other occupations expected to grow are computer support specialists, network administrators, database administrators, and desktop publishers. Customer service representatives, particularly in the technology field, is the occupation expected to add the most jobs overall by 2010.[31]

By the year 2010, twenty-six percent of the population will be school-age children. Demand for teachers will continue as this population grows and as

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[26] Texas Workers' Compensation Commission (2002). Bureau of Labor Statistics Annual Survey of Occupational Injuries and Illnesses.

[27] Texas Workers' Compensation Commission (2001-2002). Bureau of Labor Statistics Census of Fatal Occupational Injuries.

[28] Tristan, David. (July 2003). "The Emerging Labor Market," *Texas Labor Market Review* published by the Labor Market Information Department of the Texas Workforce Commission. p. 1.

[29] Ibid. Gattis. p.1.

[30] Ibid. Tristan. p.2.

[31] Ibid. Gattis. p.1.

teachers leave the field for retirement or to seek better pay and benefits.[32]
Because of the rapid growth of the elderly population, the Texas Workforce Commission has projected a dramatic increase in the need for health service occupations. Physical therapist aides, medical assistants, and social service assistants are expected to increase by nearly forty-eight percent by 2010. Physician assistants will experience a growth of over forty-four percent, and personal and home health care aides are projected to increase by nearly thirty-three percent.[33]

Aside from industry expansion, the demand in some occupations is expected to grow because of workers leaving for other jobs or retiring. Leading the list of occupations with the largest anticipated replacement needs are retail salesperson and cashier occupations, which are projected to have over 200,000 job openings during the decade.[34]

The changing occupational mix and the increasing number of jobs in the above mentioned occupational fields could have implications for the workers' compensation system. According to the Texas Workforce Commission, occupations such as cashiers, retail salespersons, and truck drivers are among the top 20 occupations adding the most jobs through 2010.[35] These are also occupations that have ranked among the highest in terms of frequency of occupational injuries and illnesses and median days missed from work.

Recent Bureau of Labor Statistics survey data indicate that occupational injuries and illnesses to cashiers resulted in 36 median days away from work – the highest of any occupational group. Truck drivers experienced the highest number of occupational injuries and illnesses per 100 full-time workers and recorded an average of 21 days away from work. These figures are relatively high considering the fact that the median number of days away for all occupations is 12 days.[36] Because median days away from the job is a primary indicator of injury and illness severity, it could be projected that injuries and illnesses experienced by such large and rapidly-growing occupational groups could have a significant financial impact on the workers' compensation system.

IMPACT OF STATE AND FEDERAL STATUTES/REGULATIONS

Sunset Review and Legislative Interim Studies

The continuation of the Commission will require the passage of Sunset legislation during the 79th Legislature. Through the Sunset review process and the work of interim committees looking at workers' compensation issues in both the House and Senate, fairly significant changes in the operations of the workers' compensation system and/or of the Commission are likely. Most of the issues being studied during the interim revolve around efforts to control medical costs and improve the medical outcomes of

[32] Ibid.
[33] Ibid.
[34] Ibid.
[35] Texas Workforce Commission. (2002) "Texas Workforce Long-Term Projections, Occupational Highlights, 2000-2010," Published by the Labor Market Information Department of the Texas Workforce Commission

[36] Texas Workers' Compensation Commission (2000-2002). Bureau of Labor Statistics Annual Survey of Occupational Injuries and Illnesses.

injured workers in Texas' workers' compensation system. Through the legislative process and Commission efforts, some of the expected changes include alternate methods for delivering medical care; establishing utilization standards and possible limits on the provision of medical care; mechanisms for improving the return-to-work outcomes for injured workers; and reporting on and monitoring the actions of doctors, insurance carriers, and other system participants with respect to their decisions on medical care.

Federal Involvement

Historical Involvement. For the most part, state workers' compensation programs have been primarily responsible for handling and regulating workplace injuries, other than those injuries and illnesses suffered by federal employees. From the early 1900's, workers' compensation systems have been defined at the state level rather than on a national level.

The Commission's interaction with federal agencies and policies has typically been limited to the receipt of federal grants and coordination with federal agencies handling health, safety, and medical issues. The following are some examples of the Commission's work with federal entities:

- a federal grant from the Occupational Safety and Health Administration (OSHA) allows the agency to provide free safety and health consultations to small, private Texas employers;
- through Bureau of Labor Statistics grants, the Commission collects occupational injury, illness, and fatality information annually; and
- under provisions of the Social Security Act, the Commission is required to report adjudicated actions or decisions against healthcare providers such as removals from the Approved Doctor List and certain administrative violations to the Healthcare Integrity and Protection Data Bank.

Recent Federal Activity. Issues at the federal level that impact the Commission include: new OSHA recordkeeping systems and automation; the transition from the Standard Industry Classification (SIC) System to the North American Industrial Classification System (NAICS) codes; the implementation of OSHA's FY 2003 - 2008 Strategic Management Plan; the Department of Energy program for employees exposed to beryllium; and the relationship between Medicare and the Commission's medical fee guidelines.

Changes in OSHA Recordkeeping Systems and Automation. Two of the Commission's programs are affected by OSHA reporting and data collection changes. OSHA changed its reporting requirements effective January 1, 2002 for the Log of Work-Related Injuries and Illnesses, which is used to track and record work-related injuries and illnesses. The new requirements are designed to produce better information about occupational injuries and illnesses while simplifying the overall recordkeeping process for employers. These changes eliminated the ability to directly compare the 2002 injury and illness rates (which were reported in December 2003) with previous years' rates due to the additional types of occupations now included.

2002 Occupational Injury and Illness Rate Per 100 Full-Time Workers	
U.S.	**5.3**
Texas	**4.3**

The OSHCON program currently transmits program activity data to OSHA via antiquated technology. Parts and programming available for this system are limited at best, and the potential for the system to fail is great. OSHA is working toward the ability to transmit data via the internet. Until those systems are completely developed, OSHA has introduced a standalone system, which enables manual transmission of information to OSHA if the NCR system fails. Texas is one of two states that have implemented the system statewide.

Transition from Standard Industry Classification (SIC) System to the North American Industrial Classification System (NAICS) Codes. OSHA changed its reporting requirements to use NAICS instead of SIC for industrial classifications in CY 2003. NAICS was developed by the Federal Office of Management and Budget, in cooperation with Canada and Mexico, to replace the SIC system. NAICS, like SIC, was developed as a standard to classify employers by industry type. NAICS is based on grouping business and production processes together. It also reflects the enormous changes in technology and the growth and diversification of services that have developed in recent decades. The new system replaces or revises approximately 60% of the previously available SIC industries, and provides 358 new industries not identified at all under the SIC.[37]

In September 2000, the Texas Workforce Commission (TWC) began issuing NAICS to new businesses. The Texas Workers' Compensation Commission began requiring the first report of injury to be submitted with NAICS codes in July 2003. The Commission also began using NAICS to collect industry data for the 2003 Annual Survey of Occupational Injuries and Illnesses that it conducts in conjunction with the Bureau of Labor Statistics.

Based on initial experience using NAICS, it appears that the transition to NAICS may affect several functions performed by the Commission. Since the appropriate codes are not available online through the Commission's website or the Texas Workforce Commission's website, it may be difficult for the carrier to identify the appropriate six-digit code to be used when reporting injuries of an employer. Additionally, since the new codes break industries down to further levels, it is anticipated that the number of businesses surveyed through the BLS grant at the six-digit level could be too small to provide valid statistical samples for injury and illness analyses at that level.

Another phenomenon that could impact the validity of future data collection is the trend of U.S. businesses outsourcing processes and services to other countries, as stated in the population and workforce demographics portion of this plan. Businesses that change their processes by outsourcing may require reassignment of NAICS codes by TWC. Failure to do so

[37] U.S. Department of Labor (2001). "Report on the American Workforce," p. 99.

could result in injury and illness data categorized incorrectly in analysis.

Additionally, the state average weekly wage (SAWW) is used to set maximum and minimum workers' compensation benefit amounts and until 2004, was calculated using the SAWW for the manufacturing industrial sector. However, with the implementation of the NAICS codes, a completely different group of employees fell into the manufacturing sector. Using the SAWW for manufacturing as defined under NAICS would have raised the SAWW by hundreds of dollars. Instead of allowing for that change, the Legislature set the SAWW by statute for the 2004-2005 biennium, with the expectation that a long-term methodology will be included in Sunset legislation.

OSHA's FY 2003 - 2008 Strategic Management Plan. The OSHCON program is 90% funded by a federal grant from the U.S. Department of Labor – OSHA. The terms of the grant require that the consultation program support the goals and strategies of OSHA's Strategic Management Plan (SMP), which was published in May 2003. In terms of reducing injuries and illnesses, target industries in this plan include construction; general industry; landscaping/horticultural services; oil and gas field services; preserve fruits and vegetables; concrete, gypsum and plaster products; ship and boat building and repair; and public warehousing and storage. In addition, physical hazards being targeted by OSHA include amputations in manufacturing and construction; ergonomics; blood lead levels; and silica related disease.

Historically, OSHA has targeted industries and hazards based on analysis of data collected in the Annual Survey of Occupational Injuries and Illnesses. Such is the case with the 2003 – 2008 SMP, although additional emphasis has been placed on the number of people participating in outreach and training programs in the following areas of emphasis: youth; immigrant employers and workers; small businesses; workplace violence; transportation; ergonomics; and the afore-mentioned targeted industries.

In support of OSHA's SMP, the OSHCON program focuses its resources on providing consultations to employers in these industries and with these hazards, as well as participating in activities and events that address the target industries, hazards, and areas of emphasis. The OSHCON program strategizes each year to work with trade associations, business organizations, Chambers of Commerce, small business development centers, and state and federal agencies to identify and communicate with employers and employees about relative safety and health issues, OSHCON program information, and other Commission worker health and safety resources.

Energy Employees Occupational Illness Compensation Program Act.[38] The Energy Employees Occupational Illness Compensation Program Act of 2000 established a federal program to provide compensation to employees of the Department of Energy (DOE), its contractors and subcontractors, and companies that provided beryllium to the

[38] Department of Energy. The Energy Employees Occupational Illness Compensation Program. Retrieved from http://www.eh.doe.gov.advocacy/intro.html on April 8, 2004.

DOE and have contracted certain diseases due to exposure.

The statute provides that covered employees (federal and non-federal) who suffer from a cancer caused by radiation, chronic beryllium disease, or chronic silicosis are eligible for a lump sum payment of $150,000 for disability, and payment for future medical expenses associated with that disease. If the worker is deceased, the lump sum payment will be provided to survivors.

Facilities located in Texas and covered under the Act are[39]:

- AMCOT, Fort Worth, Atomic Weapons Employer
- Mathieson Chemical Co., Pasadena, Atomic Weapons Employer
- Medina Facility, San Antonio, Dept. of Energy Facility
- Pantex Plant, Amarillo, Dept. of Energy Facility
- Sutton, Steele and Steele Co., Dallas, Atomic Weapons Employer
- Texas City Chemicals, Inc. Texas City, Atomic Weapons Employer

The only facility currently in operation in Texas is the Pantex Plant in Amarillo.

The Commission has entered into an agreement[40] with the DOE, effective September 16, 2002, as required by the Act, to allow the DOE's Office of Worker Advocacy, in cooperation with the Department of Labor, to assist workers with these occupational illnesses in filing state workers' compensation claims.

Since the Act contemplates that the federal government will provide medical coverage, this may limit the impact to the Texas workers' compensation system; however, it is not known if the insurance carrier will be reimbursed through the federal program for the payment of medical benefits if the employee elects to file for medical benefits under the state system.

A covered employee (other than a federal employee) may elect to file a claim with the federal program or the state workers' compensation system, or both. A few claims of chronic beryllium disease have been filed with the Commission; however, all are currently no-lost time claims and no income benefits have accrued.

Medicare and the Commission's Medical Fee Guidelines. During the 77th Texas Legislature, House Bill 2600 (HB2600) was passed with new requirements for Texas workers' compensation medical fee guidelines. The new statutory provisions require using the most current reimbursement methodologies, models and values or weights used by the Centers for Medicare and Medicaid Services (CMS), including applicable payment policies relating to coding, billing, and reporting. Little to no federal involvement with fee guidelines occurred until this change in the Texas Labor Code.

Based on the statutory requirements, the Commission adopted a new Medical Fee Guideline in April 2002, which became effective August 1, 2003. In April 2004, the Commission adopted an Ambulatory Surgical Center Fee Guideline, Rule

[39] Federal Register. Vol. 68, No. 139. Monday, July 21, 2003. Notices, Department of Energy. Retrieved from http://tis.eh.gov/advocacy/info/FRNotice_CoveredFacilities703.pdf on April 8, 2004.

[40] Memorandum of Understanding (MOU) between the U.S. Department of Energy (DOE) and the State of Texas. Retrieved from http://tis.eh.doe.gov/advocacy/stateagreements/state_agencies.html on April 8, 2004.

134.402, which will become effective September 1, 2004. This fee guideline will follow the CMS reimbursement methodologies used for payment to Ambulatory Surgical Centers, as the Act requires.

In applying these new guidelines, the Commission's direction to system participants has been that where Medicare payment policies conflict with the Commission's Act and Rules on medical necessity, the Commission's Act and Rules take precedence.

To stay abreast of changes to CMS policies, the Commission attends local Medicare carrier training and education and in turn provides workers' compensation system participants with information regarding the application of these policies. The Commission reviews federal policy changes by subscribing to listserv email distribution information from CMS, Trailblazer Health (Medicare Texas Part B carrier), and Palmetto GBA (Medicare Texas DME carrier). The Commission also obtains information regarding these policies by various other means, such as interaction with vendors, software products purchased, and internet publications. On an ongoing basis, Medicare policy changes are reviewed and compared to the Texas Workers' Compensation Act and Rules and feedback from stakeholders is gathered, so that any relevant policy changes may be considered.

Additionally, the Commission has organized a medical fee guideline Technical User's Group (TUG) with external system participants (5 insurance carrier representatives, including self insured employers, and 5 healthcare providers) to discuss issues that have been derived from a variety of sources regarding implementation of the 2002 Medical Fee Guideline. Results of this group's work may be included in the publication of educational documents such as a "Frequently Asked Questions."

After system participants become familiar with the policies under the fee guidelines and the Commission's administration of these policies that use standardized coding, billing, and methodology, there should be fewer disputes regarding medical reporting, billing and reimbursement because of:

- a familiarity and predictability of reimbursement amounts;
- the changes in Medicare reimbursement system will be reflected in the workers' compensation system as they become effective keeping the system current and therefore reducing disputes relating to the amount of reimbursement; and
- current coding, billing and reporting policies clarify the proper coding for some professional medical services, about which there were uncertainties and disputes under the previous 1996 MFG.

In addition to reducing disputes, the standardized components of the Medicare system should decrease the cost and time required for the Commission to review or revise the fee schedules.

IMPACT OF CURRENT AND OUTSTANDING COURT CASES

In addition to statutory changes, the determinations made through court rulings have a potentially significant effect on Commission operations. The following

are the significant cases that have been appealed to the courts for resolution.

Issue - Validity of Commission's 1996 Medical Fee Guideline (§134.201); Rules 133.300 - 133.304 (relating to payment, dispute, and audit of bills by insurance carriers); and one-year limitation on filing medical disputes (Rule 133.305).

Status - The Supreme Court delivered its opinion on May 28, 2004 affirming the portion of the court of appeals' judgment which held that TWCC substantially complied with the statutory procedural requisites of the APA in promulgating the medical fee guidelines and acted within its designated powers in limiting specific medical fee reimbursements and the time to seek medical dispute resolution. Additionally, since the Supreme Court concluded that TWCC did not delegate its power to private entities, they reversed the portion of the court of appeals judgment that is contrary to this conclusion. Finally, the Supreme Court overruled the constitutional challenges to TWCC's fee guidelines and time limitations for commencing medical dispute resolution.

Issue - Because 1992 hospital fee guideline was invalidated, whether Rule 133.305 (one-year limitation on filing medical disputes) is valid and must be enforced by the Commission and the State Office of Administrative Hearings.

Status - 3rd Court of Appeals affirmed the district court's ruling that the Commission's one-year rule for filing requests for medical dispute resolution is applicable to hospital fee disputes based upon the invalidation of the 1992 hospital fee guideline; the Supreme Court denied petition for review. Hospitals filed motion for rehearing. Awaiting the Supreme Court's decision on the motion.

Issue - Whether the standard for determining how much hospitals should be paid for services rendered under the invalidated 1992 Hospital Fee Guideline should be a percentage of hospital charges or the standards set out in §413.011 of the Act.

Status - 3rd Court of Appeals rendered decision that the standards in §413.011 should be applied to determine if additional reimbursement should be paid; petition for review has been filed with the Texas Supreme court by hospitals - pending decision whether Supreme Court will grant petition.

Issue - Whether the Commission has authority to conduct a desk review of a health care provider's medical services to workers' compensation claimants

Status - District court upheld the Commission's authority to request records relating to treatment of injured employees by a medical doctor and to audit those records; the 3rd Court of Appeals affirmed the District Court's ruling. Notice of appeal has been filed with the Supreme Court.

Issue - Whether medical disputes over small amounts of money per claim for pharmacy bills, where Commission has no prior expertise, should be resolved on a claim-by-claim basis through an administrative proceeding or by decision of the court, and whether pharmacies can set a higher "usual and customary charge" for workers' compensation prescriptions

than for prescriptions in other health care systems or for individuals.

Status - District Court granted a partial summary judgment denying a common law action for negligent misrepresentation and dismissed a claim for declaratory judgment; case has been appealed to the 3rd Court of Appeals. Oral argument was heard on April 28, 2004; awaiting Court's decision.

Issue - Challenge to Commission's application and interpretation of Commission rule 133.308 concerning independent review organization (IRO) medical necessity reviews which requires the medical provider requesting an IRO review to pay the IRO fee at the time the requestor files the documentation requested by the IRO.

Status - District court upheld Commission's rule requiring that providers go through the Commission's medical dispute process; this case has been appealed to the 3rd Court of Appeals; oral arguments heard on May 26, 2004; awaiting Court's decision.

Issue - Whether the Commission's Hazardous Employer program as currently administered (and as revised to comply with the ruling in Ben Robinson v. TWCC) is preempted by federal law.

Status - District court ruled that Commission's Hazardous Employer program as administered was not preempted by federal law; case has been appealed to the 3rd Court of Appeals where it is pending.

Issue - Validity of Commission's 2002 Medical Fee Guideline (§134.202); decision could determine whether the Commission can sustain guidelines that include Medicare payment policies as directed by the Texas Legislature in 2001.

Status - District court ruled that in enacting the guideline, the Commission complied with the requirements of the law and that the rule is valid and is effective for services provided on or after August 1, 2003; the 3rd Court of Appeals affirmed District Court's decision.

Issue - Validity of Commission rule 133.304(i) which requires insurance carriers to apply a consistent methodology when paying for treatments and services for which the Commission has not established a maximum allowable reimbursement; whether the standards of §413.011 of the Act should be applied to services provided in Ambulatory Surgical Centers to determine reimbursement.

Status - District court ruled that Commission rule 133.304(i) was invalid because it delegated the Commission's authority to establish fee guidelines to insurance carriers; district court also found that the §413.011 standards are the appropriate standards to use in determining reimbursement for services provided in Ambulatory Surgical Centers; the Commission appealed a portion of the ruling to the 3rd Court of Appeals; oral argument heard on March 3, 2004; awaiting decision.

Issue - Whether the denial of a doctor's application seeking to be admitted to the Commission's new Approved Doctor List can be appealed to the State Office of Administrative Hearings.

Status - Four cases currently pending – two in state district court, two in federal district court (temporary injunction has been issued in the two state court cases; temporary restraining order (TRO) not granted in either federal case, preliminary injunction to be considered by court in one federal case; preliminary injunction denied and case dismissed in the other federal case).

Issue - Whether the Commission's Appeals Panel is limited to a review of legal sufficiency only; whether a declaratory judgment action is redundant to judicial review remedies specifically provided by the Texas Labor Code in Chapter 410.

Status - 3rd Court of Appeals ruled that the Appeals Panel has the authority to perform a factual sufficiency review and that venue is not jurisdictional in nature; the redundancy issue was not addressed by the Appeals Court; petition for review denied by the Supreme Court.

Issue - Payment of interest for late paid medical bills; issues exist on when and what amounts should be paid, what constitutes a complete medical bill, and whether disputes on small amounts of interest per claim must go through the administrative process or should be decided by the court.

Status - Pending in District Court.

Issue - Issues over the applicability of Tex Lab. Code Sections 410.208 (includes, in part, allowing claimant penalty of 12% of amounts of benefits recovered if insurance carrier refuses or fails to comply with a final order or decision of the Commission), 416.002 (allows recovery of exemplary damages of the greater of four times the amount of actual damages or $250,000 if an insurance carrier breaches its duty of good faith and fair dealing), and 408.221 (including, in part, allowing a claimant to recover reasonable and necessary attorneys fees if claimant prevails on an issue on which judicial review is sought by the insurance carrier). Also requests the court to decide applicability of Commission rules 42.15 (Old Law definitions rule pertaining, in part, to medical bills), 133.304 (requiring carrier to pay interest from the 60th day after the date of receipt of a complete medical bill if paid after the 60th day, "without order of the Commission"), 134.803 (calculating interest payments), and 152.1 to 152.5 (Commission rules on representation before the Commission and payment of attorneys fees).

Status - Pending in District Court.

Issue - Challenge to the constitutionality of the current Commission procedures (and the matrix) used to select designated doctors.

Status - Pending in District Court.

SELF-EVALUATION AND OPPORTUNITIES FOR IMPROVEMENT

Accomplishments

Low Dispute Rate. Even though there are many potential opportunities for dispute between the parties in a claim, the vast majority of workers' compensation claims proceed through the system with no disputes. Of the injuries with at least one day of lost time (i.e., claims that are

required to be reported to the Commission), only about 18% of them have an income benefit dispute arise during the life of the claim. Less than 6% of all claims involve compensability issues, including extent of the injury. If a dispute arises, the Commission works toward resolving the issue(s) as quickly as possible. In some cases, a single claim may have multiple disputes filed during the life of the claim.

Income Benefit Dispute Resolution. In keeping with the goal of resolving disputes at the lowest, most informal level, the Commission has consistently resolved approximately 68% (including denials and withdrawals) of all income benefit disputes received without parties having to attend an official resolution proceeding. The average timeframe required to resolve disputes not going to a dispute proceeding is approximately 10 days (including denials and withdrawals). The average timeframe required to resolve all disputes including those going through the various dispute proceedings, from the date the dispute is received through the conclusion of the final level of resolution is approximately 46 days.[41]

Increased Designated Doctor Requests. The enactment of a 2001 statutory change to use designated doctors to address questions on maximum medical improvement and impairment ratings, rather than waiting to use their expertise later in the dispute resolution process, resulted in an increase of over 350% in the number of designated doctor requests in 2002.

The assumed effect of the statutory change had been that the increased use of designated doctors would be offset by a decrease in the number of requests for a Required Medical Exam (RME) by insurance carriers. However, the increase in designated doctor requests was greater than the decrease in requests for an RME. The increase in designated doctor requests was a significant workload increase since designated doctor requests are much more time consuming to process than RME requests because an appointment must be scheduled and the associated correspondence regarding the appointment distributed to the system participants. Commission staff handled the increased workload during a time when resources were decreasing as a result of budget reductions.

The increase in designated doctor requests in the first year appears to have been higher than what will be usual volume because insurance carriers were using the new process to attempt to obtain maximum medical improvement (MMI) and impairment rating (IR) on many of their claims. Designated doctor scheduling decreased in 2003 (from 72,367 in 2002 to 57,013 in 2003); however, requests for required medical exams (RMEs) increased (from 27,072 in 2002 to 35,539 in 2003). At this point, it appears insurance carriers are requesting RME's in an attempt to dispute the designated doctor's MMI/IR although the designated doctor's decision holds presumptive weight. The outcome of these disputes may determine whether the volume of RME's will remain at the current level.

Medical Quality Control. The Commission is making strides to improve the quality of health care provided to workers injured on the job. Multiple mechanisms are being used to address the

[41] Source – FY 2004 LAR 3rd Quarter Performance Measures Report.

state's high medical costs and medical utilization while ensuring the provision of appropriate care.

Since the enactment of statutory changes made by the 77th Legislature, the Commission has developed and implemented a process for conducting quality reviews of medical care provided in the workers' compensation system. Implementation of the medical quality review process included: development of rules for the review of healthcare practices and the actions the Commission may take in response to reviews; creation of a Medical Quality Review Panel (MQRP) of health care providers to review medical files and provide medical opinions on care being provided; appointment of an executive committee of the MQRP; requesting statutory changes to provide MQRP members with immunity from lawsuits and to allow increased sharing of information between the Commission and the medical licensing boards; and development of utilization reports based on the medical data submitted to the Commission.

The medical quality review process is being used to identify doctors who will not be certified for the Approved Doctor List (ADL) or will be removed. Doctors must be certified for the ADL or have received a temporary exception to the requirement to be on the ADL, in order to provide and be reimbursed for health care in the workers' compensation system.

Since the program began in January 2003, 58 quality of care reviews of health care providers, and 4 quality of care reviews of insurance carriers have been conducted through May 31, 2004. Actions resulting from quality of care reviews and other licensing board actions include:

- Recommended no action to be taken on 11 Medical Doctors, 2 Doctors of Chiropractic and 1 Occupational Therapist;
- Issued Letters of Concern to 4 Medical Doctors, 2 Doctors of Chiropractic, 1 Doctor of Osteopathy, and 1 Diagnostic and Testing Center;
- Issued Warning Letters to 3 Doctors of Chiropractic, 1 Physical Therapist, and 1 Podiatrist;
- Entered into Agreements with 1 Medical Doctor and 2 Doctors of Chiropractic;
- Denied admission to ADL to 16 Medical Doctors, 3 Doctors of Osteopathy, and 7 Doctors of Chiropractic; and
- There are denials/removals pending on 4 Medical Doctors, and 3 Doctors of Chiropractic.

Enforcement. The Commission enforces the workers' compensation system's statute and rules through fraud detection and the issuance of administrative violations identified during audits and complaint investigations. In the last few years, accomplishments have been realized in these enforcement areas.

Working with federal agencies, criminal indictments have been secured against several health care providers with large practices that were primarily comprised of treating injured workers. Through audit efforts, the Commission identified a problem with the manner in which insurance carriers were reporting benefit payments. The statistics on the average days to initiate benefits have steadily declined with the continued audit enforcement efforts and correction of the reporting error. Additionally, agency enforcement efforts have resulted in improved compliance by health care

providers in timely filing reports of maximum medical improvement / impairment rating.

Penalty Rules. Rules containing the methodologies for calculating penalties for the various types of violations were adopted by the Commission and became effective October 1, 2003. These rules offer incentives for high compliance and disincentives for low compliance. The rules and the calculator tool are available to the public on the Commission's website to assist system participants in understanding the possible penalties associated with non-compliance with the Act and rules. Although it is too early to identify the impact of the new rules, system participants have given positive feedback regarding the opportunity to understand exactly how the penalty amount is calculated, and it is anticipated that there will be a decrease of disputes filed by the system participants concerning the amount of the penalty.

Successful Criminal Cases. The Commission has an excellent working relationship with other state and federal agencies and local prosecutors in efforts to combat fraud. In FY 2003, 22 cases were referred for prosecution in which $10,776,314 of fraud was detected. Additionally, in that year there were 10 convictions resulting from referrals made in 2003 and prior years. There have been 25 cases referred for criminal prosecution so far in FY 2004 (September through May) in which $453,803 of fraud was detected, and there have been 13 convictions (not necessarily resulting from the 25 referrals for the year). Sentences have included restitution payments, a removal from the Approved Doctor's List (ADL), fines, jail time, deferred adjudication, deportation, disbarment, and probation.

Workforce Training. The Commission has successfully leveraged technology to provide staff with much of the subject matter training required to perform job functions. With staff dispersed in offices throughout the state, the ability to provide training without incurring travel expenses is critical. The agency's New Employee Orientation and the required introductory training requirements are provided on-line via the agency's intranet. Additionally, staff have taken IS Security training and Ethics training online via the intranet.

Teleconferences and videoconferences are held routinely to disseminate information and to provide guidance. Those sessions are also made available through the intranet to allow all Commission staff access to the information on an "as and when needed" basis.

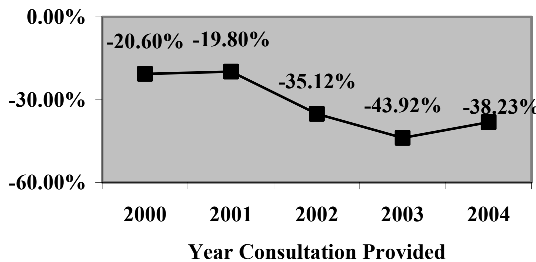
Additionally, staff in the Commission's field offices and central office receives safety training including information on office ergonomics and workplace violence prevention. In preparation for the move of over 500 staff in the Commission's central office in 2003, training was provided regularly to staff on safe lifting techniques, workstation adjustments, ergonomics, and safety features of the new building. No injuries related to move activities were reported before, during, and after the central office relocation.

Business Process Improvement Initiative. As discussed in the Technology section of the strategic plan, the Commission has begun replacing its antiquated mainframe-based automation system. The new automated systems will enable the Commission to convert from a heavily

paper-driven agency to one that allows participants in the workers' compensation system to use web-based tools to manage workers' compensation claims and access increased amounts of information.

Safer Workplaces in Texas. Based on an annual survey of employers nationwide, Texas' injury rate is almost 20% below the national rate. Although the Commission is not able to directly correlate the services it provides with the statewide injury rate, there is evidence that after receiving education and consultation services from the Commission, many employers experience a reduction in injury rates. In FY 2003, employers receiving inspection and consultation services from the Commission experienced a 44% reduction overall in injury rates.

Percentage Change in the Injury Rate for Employers Provided On-Site Consultations and Inspection Services
FY 2000 – FY 2004 (3rd Quarter)[42]



Improved Customer Service and Distribution of Data. According to the Customer Service Survey conducted November 2003 through March 2004, the key customer groups interacting with the Commission reported higher than average levels of customer satisfaction with the services they received from September 1, 2002 through August 31, 2003. The Commission, through a contract with the University of North Texas, surveyed injured employees (those receiving ombudsman assistance and those who were not assisted by an ombudsman), employers, health care providers, and insurance carriers. All five customer groups rated the Commission, using a five-point scale (strongly disagree to strongly agree), on issues such as facility location and cleanliness, staff's ability to respond to questions, comprehensibility of information provided, and timeliness of service.

The overall customer satisfaction scores for all groups were above three; however, scores indicated a slight decrease for all customer groups since the 2002 survey. Given the fact that service provision can be within a stressful or an adversarial environment, the survey results confirm that agency staff continues to maintain their professionalism and general courtesy in communicating and working with our various customers; however, the survey also indicates some areas needing additional attention. Based on feedback from the survey, the Commission will continue to focus on providing information in easily accessible formats regarding all aspects of the workers' compensation system. For additional information, the Customer Service Report can be found on the Commission's website.

The Commission continually strives to improve the ability to provide customers with the information and services they need to function in the workers' compensation system. Some of the recent efforts include increased web delivery of information and implementation of a customer courtesy hotline.

[42] Source: FY 2000 – 3rd Quarter FY 2004 LAR Performance Measures Reports

<u>Increased Web Delivery of Information</u>. Use of websites has dramatically expanded the agency's ability to serve customers. Currently, almost all agency notices and publications are available on the site, and system participants routinely use the site to remain informed on Commission business and policy. At this time, the Commission is currently working to reorganize website information for easy access by each type of system participant and to present critical information for employees in Spanish.

During the last year, the Commission has developed an online curriculum for doctors wishing to be certified for participation in the system. Doctors have been complimentary of both the curriculum itself and the convenience of being able to access and complete the training as their schedules allow.

Through the combined use of statistical reporting tools and deployment through websites, the Commission has improved the amount and types of workers' compensation data that is available to internal and external customers. A visitor to the agency's external website is now able to define specific injury information needed, such as location, costs, and industrial distribution, and receive the output without having to make a request through the Public Information process. Additionally, numerous workload reports have been developed and are distributed for management purposes through the agency's intranet system.

<u>Customer Courtesy Hotline</u>. A new addition to the Commission's customer service efforts is a hotline number, known as the Customer Courtesy Hotline, which has been designated for reporting concerns about service provided by Commission staff. Reports on calls received via the hotline are reported to executive management and the Commissioners. Complaints are reviewed to determine whether there are specific instances or possible emerging patterns of behavior that need to be addressed at the employee level. Specific instances are referred to the Director of Customer Services for review, resolution, and disciplinary action (if necessary).

Since March 2003, when the hotline was implemented, the Commission has received a total of 102 calls, 55 of which were misdirected calls. Of the 47 calls regarding customer courtesy, 11 were compliments, 34 were complaint calls, and 2 included both a compliment and complaint.

Involvement In and Recognition by National Workgroups. On the federal level, the Commission has enjoyed many successes in working with Federal health and safety entities. On numerous occasions, program staff has served as pilot testers for various processes and systems. Texas' input on these systems has had a significant impact, on a national level, in the way that these systems were developed and released.

The OSHCON program pilot tested the main form that is used in the documentation and analysis of site hazard criteria. Additionally, the OSHCON program is providing personal computer tablets to consultants to facilitate real-time report completion and OSHA standard referencing while at an employer's worksite. This model has also been demonstrated to other state consultation programs at the national OSHCON conference.

Furthermore, at the nationwide 2004 OSHA Conference, the OSHCON program received a special recognition. Texas was recognized for: 1) performing more consultations than any other state, 2) having more employers on the Safety and Health Achievement Recognition Program (SHARP), and 3) leading the nation in technological innovation and having a formal, verifiable means to show consultation results. The recognition is a reflection of the years of support and dedication the agency puts into the program.

The Commission has also been integrally involved in the testing and development of new initiatives in the BLS survey program. Commission staff served as the first state program to pilot test a new system developed by the National Institute of Occupational Safety and Health (NIOSH) with the Bureau of Labor Statistics (BLS). Texas greatly affected the development and final outcome of this system, which analyzes the cost factors associated with occupational fatalities.

The program has also developed systems and procedures, which have been used as best practices models for BLS nationwide. Many states are formally adopting Texas' methods for gathering data from larger employers.

Opportunities for Improvement

Disability Management. Commission staff is currently developing a draft rule(s) on treatment guidelines and disability management. Disability management is a set of interventions that occur over the life of the injury – from onset to recovery – that ensure the worker is "properly accommodated and that future lost time and work disability" are minimized.

A key goal of disability management is to successfully return an injured worker to work as early as possible. Although return to work reduces costs associated with disability, medical management and income replacement, most important is the positive effect that appropriate early return to work has on the injured worker's quality of life. Studies have shown that injured workers who fail to recover suffer in many facets: loss of active and long-term earning power, lower functional levels, dependence on the healthcare system for their injury and other related disorders, and psycho-social distress, which affects self-esteem and personal relationships. Improving return-to-work rates reduces the negative aspects of a workplace injury and can help workers maintain and potentially improve their quality of life.

Prospective Review of Medical Care Not Requiring Preauthorization. Absence of a clear method for handling the denial of future medical care and the denial of pharmaceutical services is presenting problems in the delivery of medical care to injured workers. A rule is proposed to resolve the pretreatment impasse between insurance carriers and health care providers regarding health care that, by rule, does not require preauthorization, but is informally being denied in advance by insurance carriers on the basis of medical necessity and, in some instances, relatedness to the compensable injury. As a result, injured employees may effectively be denied health care reasonably required by the nature of the injury as and when needed. The absence of a process to resolve these disputes (and the detrimental consequences that arose in one specific case) was recently noted by the United States Court of Appeals for the

Fifth Circuit in Gregson v Zurich Am. Ins. Co., 322 F.3d. 883, 887.

The proposed rule requires the Commission to facilitate an active dialogue between the insurance carrier and doctor proposing the care. If the dialogue breaks down and resolution remains appropriate, the Commission may order a medical examination of the injured employee. If, in the opinion of the examining doctor, the proposed care is medically necessary and related to the compensable injury, an opportunity is provided for the parties to reach an agreement regarding the care. If negotiation fails at this point, the Commission shall issue an interlocutory order to ensure that the injured employee receives prompt, appropriate and necessary medical care. An insurance carrier may later appeal the Commission's order. The rule will be considered for adoption in August 2004, and, if adopted, will be implemented in the fall of 2004.

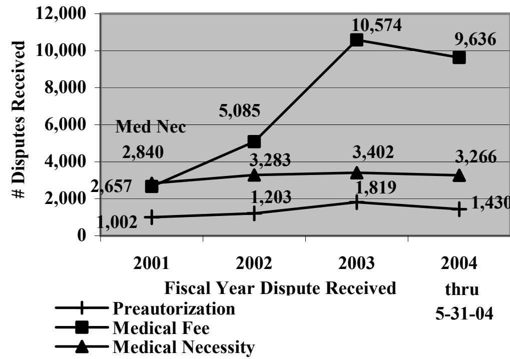
Implementing Medical Fee Guidelines Based on Medicare. In August of 2003, the Commission implemented a medical fee guideline that includes the use of Medicare reimbursement methodologies and payment policies. The adoption and successful defense of this medical fee guideline that will reduce medical costs and is consistent with statutory intent is a significant accomplishment. Implementation of the new guideline, however, presents a number of potential challenges.

- Like other system participants, the Commission will be challenged during upcoming months and years to find effective ways to stay abreast of changing Medicare policies and procedures, and to analyze and provide policy guidance on the application of those changes in the workers' compensation system.
- Implementation will require that the Commission monitor and assess the impact of the new guideline on the system, including affects on medical costs, access to health care, and efficacy of care that is being provided.
- The volume of medical fee disputes may increase even further in the short term as system participants seek policy guidance for the application of the Medicare payment policies through the dispute resolution processes.
- Although updates to Medicare reimbursements and policies are automatically incorporated in the guideline as developed, the Commission is still required by statute to update medical fee guidelines every two years. Compliance with that statutory provision will likely require the continued expenditure of enormous amounts of time and resources for the development and defense of future guideline updates.

Timeliness for Processing Medical Disputes. With the enactment of the statutory changes regarding medical dispute resolution made by the 77th Legislature through House Bill 2600, in which independent review organizations (IROs) were charged with reviewing preauthorization (prospective) and retrospective medical necessity disputes, the number and timeframes for resolution of medical disputes received by the Commission has been significantly affected. However, the Commission is exploring methods for reducing the

number of disputes being filed and the timeframes required to handle those disputes.

Number of Medical Disputes Received
Data as of May 31, 2004



In FY 2003, approximately 41% of IRO decisions were not made within the required timeframes. The Commission, in cooperation with the Texas Department of Insurance, is working to improve the timeliness of the IRO decision.

- *Preauthorization Disputes*. For preauthorization disputes, the respondent has seven days to respond to the request for medical dispute resolution, and the IRO is required to issue a final decision within 20 days of receipt of the IRO fee. The most recent statistics show improvement in the timeframes to handle these disputes. In FY 2002, the first year in which IROs reviewed these types of cases, the average days from receipt of the dispute by the Commission to complete a preauthorization dispute was 63 days. In FY 2003, the average timeframe was 74 days; however, through May 31, 2004, the average timeframe in FY 2004 has decreased to 48 days.

- *Medical Necessity Disputes*. For medical necessity disputes, the respondent has 14 days to respond to the request for medical dispute resolution, and the IRO is to issue a final decision within 30 days of receipt of the IRO fee. In FY 2002, the first year in which independent review organizations (IROs) reviewed these types of cases, the average days to complete a dispute was 155 days. In FY 2003, the average timeframe decreased slightly to 153 days, and in FY 2004, through May 31, 2004, the average days to complete a medical necessity dispute is 136 days.

- *Medical Fee Disputes*. For medical fee disputes, the respondent has 14 days to respond to the request for medical dispute resolution, and after the respondent provides a response to the initial request, both parties are then provided with an additional 14 days to submit all documentation necessary to resolve the fee issues. In FY 2002, the average timeframe to complete a medical fee dispute was 87 days. The average has continued to increase due to the substantial increase in the number of medical fee disputes received by the Commission, and the implementation of the new Medical Fee Guidelines. The average timeframe in FY 2003 was 148 and in FY 2004, through May 31, 2004, the average is 154.

  As of May 31, 2004, there are 13,263 medical fee disputes pending resolution. Of these, approximately 4,000 are related to pharmaceutical services (and an additional 16,000+ disputes have been filed but not processed at the request of the disputing parties). The Commission

has only issued decisions in a few of these pharmacy disputes at the disputing parties' request. These decisions have been appealed to the State Office of Administrative Hearings for further resolution. In addition, the responding party in these disputes has filed suit in district court over these disputes. Therefore, the pharmacy disputes will continue to age and increase the timeframe to resolve medical disputes.

The Commission has proposed a new medical dispute resolution rule for resolving low-dollar disputes. Disputes of pharmaceutical services are expected to be one of the most common issues handled through the new rule. This alternative medical dispute process, as written, involves completing a retrospective medical necessity dispute within 30 days and will have a review fee of $100 as opposed to the current IRO fee for review of $650.

Electronic Medical Billing. One of the common complaints of the Commission's implementation of a Medicare-based fee guideline is that it does not require a mechanism for electronic billing between the health care providers and the insurance carriers, as is the case with Medicare. In the Medicare system, the Centers for Medicare and Medicaid Services (CMS), contracts with two intermediaries to process bills in their ever-changing system. These two carriers specialize in Medicare payment policies and have software programs that are specifically designed and maintained using the most up to date Medicare policies. These automated tools allow for fewer disputes over billing and much shorter payment timeframes.

In the Texas workers' compensation system, there are over 250 workers' compensation carriers, and the additional bill review entities that may be under contract with the carriers, that need to be taken into consideration while determining how to incorporate electronic billing into the workers' compensation system. Furthermore, the need for documentation on whether the medical care being billed for is related to a compensable injury adds additional complication to the use of electronic billing in a workers' compensation environment. However, with the Spring 2005 implementation of a new, nationally recognized format for electronic submission of medical billing data to the Commission, carriers will be better positioned to make the necessary system modifications to allow for electronic billing from and remittance to the health care providers. The Commission is presently identifying options for adoption of full electronic billing from the health care providers to the insurance carriers and to the Commission.

Reduction of Dispute Timeframes. Although the Commission is proud of its success in resolving most disputes as early in the dispute resolution process as possible, ensuring that all disputes are handled quickly continues to require the agency's attention.

Additional dockets via video conferencing are being conducted in an effort to conduct Benefit Review Conferences (BRC's) as timely as possible and to address the increase in the average number of days to resolve a dispute. Conducting BRCs via video conferencing allows the Commission to: 1) cover dockets without a Benefit Review Officer (BRO) traveling to the location, and 2)

achieve a more equitable workload throughout the State.

Some Contested Case Hearing (CCH) cases are conducted by telephone, such as attorney fee cases and agreements, which are short in length. Conducting these cases by telephone leaves a docket space available for those hearings requiring more time. Commission staff is studying opportunities to conduct more CCH's by telephone or videoconferencing and any associated process or rule changes that would be required.

The Commission is also working toward automating BRO reports and CCH decisions through its BPI initiative. The automation will allow time previously spent on manually preparing reports/decisions to be spent on BRC's and CCH's. In the meanwhile, the agency has streamlined the content of the decisions and orders to reduce writing time, allowing more time to be spent on hearing cases.

Business Process Improvement Initiative. As stated in the accomplishments section, the Commission has made significant movement toward developing automated systems to make communications between all system participants and access to necessary information easier. However, developing the systems and educating Commission staff, as well as all external parties using the system, will be a major undertaking for the next several years.

System Participant Input in Policy and Rulemaking. One of the complaints of workers' compensation system participants is a desire to have more involvement earlier in the Commission's rulemaking and policymaking processes. Although the Commission has held meetings with a stakeholder group on key issues prior to drafting rule proposals since the passage of HB2600 and input is requested from the public when rules are proposed through the APA process, the Commission has committed itself to trying new methods for participation in the agency's policymaking. One of the new methods that has been employed with development of rules regarding disability management has been the distribution of draft rules for comment and discussion prior to the rules being formally proposed through the APA process. These efforts are being undertaken with the recognition that consensus will not be possible on all issues in an environment as adversarial as the workers' compensation system. However, the initial response from stakeholders has been very positive.

Staff Retention and Morale. Attracting and retaining a workforce that has the necessary skills and expertise is essential in performing the Commission's responsibilities. With a significant number of long-tenured employees expected to take advantage of the retirement incentive adopted by the 78th Legislature, implementation of a well-defined succession plan has increased in importance. Additionally, the changing nature of some of the agency's business functions will require either training existing staff or hiring new staff with skill sets that are different than those used in the past.

Although the Commission did not participate in the Survey of Organizational Excellence in FY 2004, staff from throughout the agency did discuss issues affecting employee morale during the strategic plan development process. Adjusting to a constantly changing environment has been one of the most

significant challenges for staff over the past few years. Changes have included: implementing a number of statutory and rule changes, and developing and implementing new business processes and the associated automation tools through the Business Process Improvement Project. With the Sunset review process and the current legislative interest in workers' compensation issues, staff is aware that additional change is certain in the future. Managing the stress associated with a changing environment and timely communicating information are critical management responsibilities in maintaining a workforce that is ready and able to adapt to the changing environment and that continues to perform functions necessary to meet the agency's mission and goals.

CONCLUSION

The Commission will experience significant changes in some of the functions it performs, in the tools that are used, and possibly in the organization and governance of the agency over the next five years. These changes will challenge the organization, as well as all participants in the workers' compensation system, at times. However, we are confident that with the staff's dedication and the willingness to have open communications internally and externally, the changes will bring positive results.

TEXAS WORKERS' COMPENSATION COMMISSION GOALS

- **TO ENSURE THE COST EFFECTIVE DELIVERY OF APPROPRIATE BENEFITS**
- **TO MINIMIZE AND RESOLVE DISPUTES**
- **TO PROMOTE SAFE AND HEALTHY WORKPLACES**
- **TO EFFECTIVELY MANAGE THE RESPONSIBILITIES AND FUNDS OF THE SUBSEQUENT INJURY FUND**

OBJECTIVES AND OUTCOME MEASURES

OBJECTIVE 1.1: To ensure appropriate payment of income benefits and health care for injured employees and fair and reasonable reimbursement for health care providers through 2009 to allow for appropriate return to work

Outcome Measure:
1.1.1 Average Medical Cost per Texas Workers' Compensation Case

OBJECTIVE 1.2: To monitor compliance with applicable statutes and rules and identify fraudulent activity in the workers' compensation system through 2009

Outcome Measures:
1.2.1 Average Number of Days for the Required Initial Benefit Payment to be Issued after Benefits Begin to Accrue

1.2.2 Percentage of Notices of Injury Received by the Insurance Carrier On or Before the Benefit Eligibility Date

1.2.3 Percentage of First Benefit Payment Timely Made by Insurance Carriers

OBJECTIVE 1.3: Improve efficiency of communication processes in the workers' compensation system by 2009

Outcome Measures:
1.3.1 Percentage of Documents Received and Maintained Electronically by the Commission

1.3.2 Percentage of Injury Records Created in Three Days or Less

OBJECTIVE 1.4: To certify and regulate large private employers that qualify to self-insure

Outcome Measure:
1.4.1 Percentage of Market Share of Certified Self-Insurance to the Total Workers' Compensation Insurance Market

OBJECTIVE 2.1: Resolve 99% of benefit and medical benefit disputes in the Commission's system through 2009

Outcome Measures:
2.1.1 Percentage of Benefit Dispute Cases Resolved by the Commission's Informal Dispute Resolution System

2.1.2 Percentage of Medical Benefit Dispute Cases Resolved By Initial Administrative Decision

2.1.3 Percentage of Benefit Dispute Cases Resolved by the Commission's Formal Dispute Resolution System (Beginning With Contested Case Proceedings)

2.1.4 Percentage of Benefit Dispute Cases In Which Unrepresented Parties Received Ombudsman Services for Benefit Review Conferences

2.1.5 Percentage of Benefit Dispute Cases In Which Unrepresented Parties Received Ombudsman Services for Contested Case Hearings

2.1.6 Average Number of Days to Resolve Benefit Disputes

2.1.7 Percent of Appealed Medical Fee Disputes Resolved Prior to a Formal Hearing at SOAH

OBJECTIVE. 3.1: To contribute to keeping the Texas overall incidence rate of injuries and illnesses below the national incidence rate through 2009

Outcome Measures:

3.1.1 Statewide Incidence Rate of Injuries and Illnesses per 100 Full-time Employees

3.1.2 Percentage Change in the Injury Rate for Employers Provided Consultations and Inspection Services

OBJECTIVE 4.1: To ensure proper financial administration of and appropriate payment of benefits to injured employees and reimbursements to insurance carriers through the Subsequent Injury Fund.

Outcome Measure:

4.1.1 Total Payments Made Out of the Subsequent Injury Fund For Lifetime Income Benefits and Reimbursements to Insurance Carriers

STRATEGIES AND OUTPUT, EFFICIENCY AND EXPLANATORY MEASURES

STRATEGY 1.1.1: Establish and maintain rules, guidelines, and programs (e.g., doctor monitoring, healthcare delivery networks, general education on medical rules and processes, and approved doctors list/designated doctors list (ADL/DDL) training and certification) that ensure appropriate utilization of medical services and the quality of medical providers

Output Measures:

1.1.1.1 Number of Quality of Care Reviews of Health Care Providers Completed

1.1.1.2 Number of Quality of Care Reviews of Insurance Carriers Completed

1.1.1.3 Number of System Participants Who Received Medical Benefit Training

1.1.1.4 Number of Electronic Medical Benefit Products and Services Distributed

1.1.1.5 Number of Persons Receiving Return-to-Work Training Products and Services

Efficiency Measures:

1.1.1.1 Average Number of Days to Complete Quality of Care Reviews of Health Care Providers

1.1.1.2 Average Number of Participants per Return-to-Work Seminar

STRATEGY 1.2.1: Monitor and enforce compliance of healthcare providers, insurance carriers, employees, employers, attorneys, and other participants with the statute and rules through audits, fraud investigations, and administrative violation referral reviews and take appropriate enforcement action.

Output Measures:

1.2.1.1 Number of Fraud Investigations Completed

1.2.1.2 Number of Criminal Cases Referred to Prosecuting Authorities

1.2.1.3 Number of Administrative Violation Referral Reviews Completed

1.2.1.4 Number of Compliance Audits Completed

Efficiency Measures:

1.2.1.1 Average Number of Days to Complete a Fraud Investigation

1.2.1.2 Average Number of Days to Complete a Compliance Audit

1.2.1.3 Average Number of Days to Complete an Administrative Violation Referral Review

Explanatory Measures:

1.2.1.1 Number of Convictions Resulting from Criminal Cases Filed with Prosecuting Authorities

1.2.1.2 Total Number of Violation Notices Issued

1.2.1.3 Number of Administrative Remedies Resulting from Fraud Investigations

STRATEGY 1.3.1: Develop and implement processes to receive, provide and maintain information in an electronic format

Output Measures:

1.3.1.1 Number of Documents Received and Maintained Electronically by the Commission

1.3.1.2 Number of Injury Records Created

1.3.1.3 Number of Injury Records Created for Income/Indemnity Injuries

Efficiency Measure:

1.3.1.1 Average Number of Days to Create Injury Records

Explanatory Measure:

1.3.1.1 Estimated Percentage of Employers Reported Participating in the Workers' Compensation System

STRATEGY 1.4.1: Ensure that certified self-insuring employers meet statutory financial, claims administration, and safety requirements through an ongoing process of qualifying, renewing, and revoking certification

Output Measures:

1.4.1.1 Number of Companies in the Certified Self-Insurance Program

1.4.1.2 Number of Self-Insurance Applicants or Renewals Certified

Efficiency Measure:

1.4.1.1 Average Cost per Company in the Certified Self-Insurance Program

Explanatory Measure:

1.4.1.1 Total Self-Insurance Regulatory Fee Paid By Certified Self-

Insurers for the Prior Calendar Year

STRATEGY 2.1.1: Provide injured workers, employers, and insurance carriers with information about their rights and responsibilities; minimize and resolve benefit disputes as informally as possible by talking with the participants and conducting compensation benefit review conferences

Output Measures:

2.1.1.1 Number of Benefit Dispute Cases Resolved Prior to a Benefit Review Conference (BRC)

2.1.1.2 Number of Compensation Benefit Dispute Cases Concluded in Benefit Review Conference

Efficiency Measure:

2.1.1.1 Average Number of Days From the Request for Benefit Review Conference to the Conclusion of the Benefit Review Conference

Explanatory Measure:

2.1.1.1 Number of Benefit Dispute Cases Received by the Commission

STRATEGY 2.1.2: Minimize and resolve medical benefit disputes, before being appealed to the State Office of Administrative Hearings, by talking with participants and conducting medical dispute resolution reviews (including reviews by Independent Review Organizations)

Output Measure:

2.1.2.1 Number of Medical Benefit Dispute Cases Resolved By Initial Administrative Decision

Efficiency Measure:

2.1.2.1 Average Number of Days To Conclude Medical Dispute Cases By Initial Administrative Decision

Explanatory Measure:

2.1.2.1 Number of Medical Dispute Cases Received by the Commission

STRATEGY 2.1.3: Conduct benefit contested case hearings; conduct reviews when participants appeal decisions made by benefit contested case hearings officers, and provide arbitration

Output Measure:

2.1.3.1 Number of Compensation Benefit Dispute Cases Concluded in Contested Case Hearings

Efficiency Measure:

2.1.3.1 Average Number of Days From the Request for a Contested Case Hearing to the Distribution of the Decision

Explanatory Measure:

2.1.3.1 Number of Appeals Panel Decisions Filed for Judicial Review

STRATEGY 2.1.4: Process medical disputes that are appealed under the Administrative Procedure Act

Output Measure:

2.1.4.1 Number of Appealed Medical Fee Disputes Resolved Prior to a Formal Hearing at SOAH

Efficiency Measure:

2.1.4.1 Average Number of Days Saved through Resolution of Medical Fee Disputes Prior to Formal Hearing at SOAH

STRATEGY 3.1.1: Develop and provide health and safety services (e.g., needs analyses, education, consultations, investigations and inspections) to employers, employees, academic institutions, and other entities in the Texas workplace

Output Measures:

3.1.1.1 Number of Inspections, Consultations, and Investigations Provided to Employers

3.1.1.2 Number of Notifications Sent to Employers Meeting Minimum Criteria for Classification as Hazardous

3.1.1.3 Number of Texas Employers Receiving Safety Educational Products/Services

3.1.1.4 Number of Texas Employees Receiving Safety Educational Products/Services

3.1.1.5 Number of Electronic Safety and Health Publications Distributed

Efficiency Measure:

3.1.1.1 Average Cost per Consultation/ Inspection/Investigation

Explanatory Measures:

3.1.1.1 Number of Health and Safety Related Hotline Reports Received

3.1.1.2 Nationwide Incidence Rate of Injuries and Illnesses per 100 Full-time Employees

STRATEGY 4.1.1: Pay authorized benefits timely and appropriately to injured employees who meet the statutory criteria for lifetime income benefits (LIBs) due to a second work-related injury and reimburse insurance carriers for eligible: (1) overpayment of benefits; (2) multiple employment benefits; and (3) pharmaceutical benefits

Output Measures:

4.1.1.1 Number of Injured Workers Receiving Lifetime Income Benefit (LIBs) Payments Through the SIF

4.1.1.2 Number of Requests for Reimbursement for Overpayment of Benefits Processed

4.1.1.3 Number of Requests Filed for Reimbursement of Multiple Employment Benefits Paid

Efficiency Measure:

4.1.1.1 Average Days from Close of Quarter to Payment of Requests for Reimbursement that are Approved

HISTORICALLY UNDERUTILIZED BUSINESSES

GOAL A: To establish and carry out procurement policies that include Historically Underutilized Businesses (HUBs)

OBJECTIVE A.1: To make a good faith effort to utilize HUBs in the competitive bid process on all goods and services purchased to the fullest extent possible

Outcome Measure:
Percentage of total contracts/bids awarded annually by TWCC to HUBs

STRATEGIES:
A.1.1 Continue to use the following procurement solicitation procedures:
- Procurements $2,000 to $10,000, five HUBs must be contacted
- Procurements $10,000 - $25,000, ten HUBs must be contacted

A.1.2 Establish and maintain a web page that educates HUBs about TWCC's procurement policies/procedures

A.1.3 Encourage the use of HUB vendors by distributing HUB vendor information internally to appropriate agency staff

A.1.4 Continue to track, promote and share information with TWCC procurement card users regarding TWCC's HUB participation through procurement card program

A.1.5 Continue to participate in HUB forums, conferences or conventions that provide HUBs contract opportunities and/or training for agency purchasing staff, contingent upon funding availability

A.1.6 Implement a Mentor Protégé Program

Output Measures:
- Number of contracts/bids awarded by TWCC
- Number of contracts/bids awarded to HUBs

APPENDIX A

DESCRIPTION OF THE COMMISSION'S PLANNING PROCESS

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DESCRIPTION OF THE COMMISSION'S PLANNING PROCESS

The Commission's planning process is an ongoing component of agency operations. Much of the current plan is based on input received from system stakeholders through the Sunset review process and the legislative interim studies on workers' compensation and the Commission.

At the end of each Legislative session, new statutory requirements are identified to be included in the agency strategic plan. In December 2003, the "strategic planning team" was created to develop the FY 2005-2009 strategic plan. The team was formed with representatives from each division of the agency. Meetings were held on an as needed basis from January through June 2004 to discuss and gather input for the required components of the strategic plan, responsibilities/deadlines of each division representative, and status. Meetings were also held with division directors and deputy executive directors throughout the planning process on specific portions of the plan.

In December, an action plan was developed which included all required components of the strategic plan, the staff person responsible for developing each component, and a projected start and end date. The action plan was based on requirements from the Strategic Plan instructions issued by the Legislative Budget Board (LBB) and Governor's Office of Budget, Planning and Policy (GOBPP), and updated as needed. The previous strategic plan instructions were used until the new instructions were available.

The strategic planning and budget structure, including the agency mission, philosophy, goals, objectives, and strategies was revised in February by executive management. Changes proposed included 1) a change in goal priority; and 2) a new goal, objective, and strategy to reflect the Subsequent Injury Fund, which the agency administers and which was moved to General Revenue by the 78th Legislature.

The Commission reviews performance measures and definitions on an ongoing basis and identifies necessary changes throughout the biennium. Proposed revisions to measures and definitions for the FY 2006-2007 biennium, for the most part, were for clarification and emphasis on particular elements. The proposed budget and planning structure was submitted on April 2, 2004. Commission staff worked with the LBB and GOBPP analysts to finalize the budget and planning structure.

During fall of 2003, the Commission contracted with the University of North Texas to assist the agency with the customer service satisfaction survey. Five customer groups were surveyed. The survey responses were analyzed and a Customer Service Report was prepared and submitted to the LBB and the GOBPP on June 1, 2004.

The external/internal assessment and workforce plan portions of the strategic plan were developed January through June 2004. Input for those portions of the plan was gathered through communications with team members throughout the agency and executive management.

The Commissioners were briefed on the strategic planning process in April. They,

and the executive director, deputy executive directors, and directors, were provided with a draft of the Strategic Plan in early May for their review and input.

After incorporating recommended modifications to the Plan, the final document was prepared and presented to the Commissioners at their public meeting on June 17, 2004 for approval. After submission to the required agencies, the Strategic Plan and the Customer Service Report are posted on the agency's website.

APPENDIX B

TEXAS WORKERS' COMPENSATION COMMISSION ORGANIZATIONAL CHART

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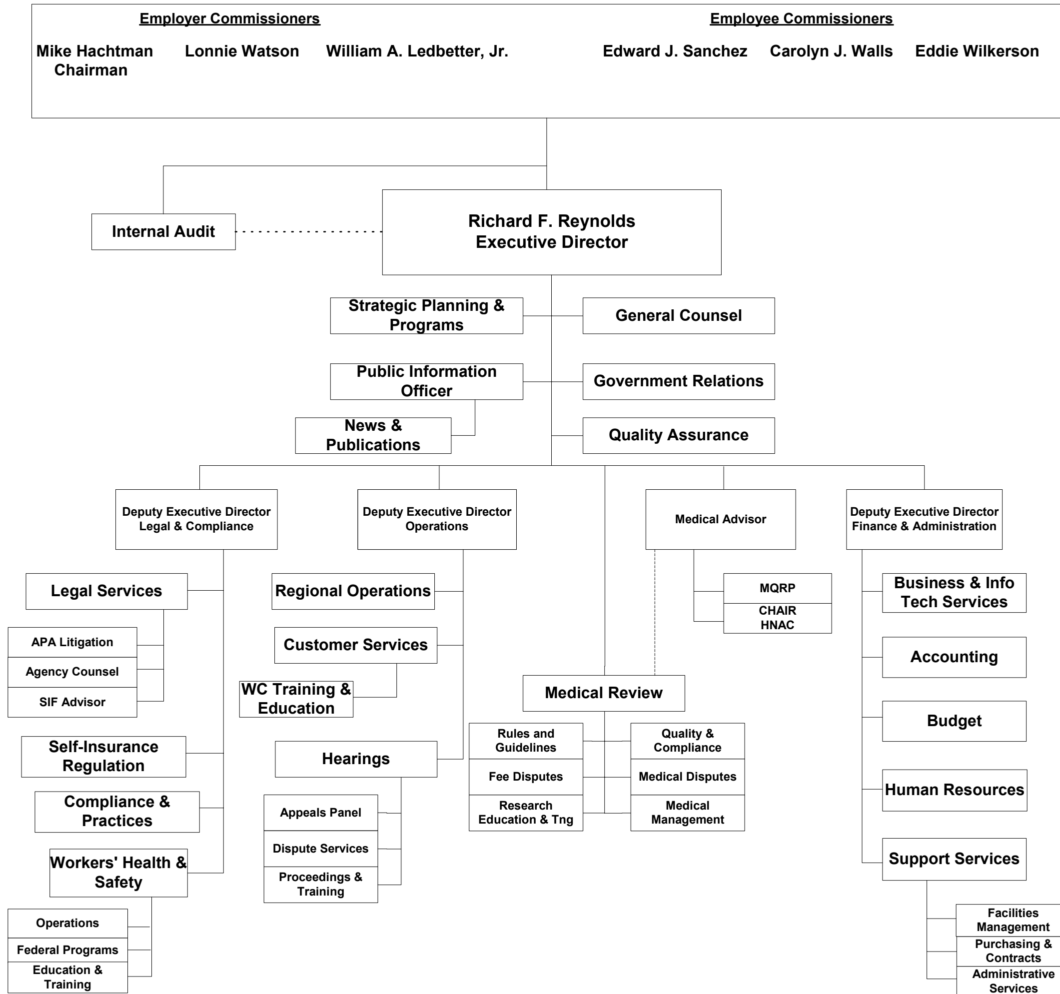
TEXAS WORKERS' COMPENSATION COMMISSION

ORGANIZATIONAL CHART



Executive Director
June 30, 2004

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APPENDIX C

FIVE – YEAR PROJECTIONS FOR OUTCOME MEASURES

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FIVE-YEAR PROJECTIONS FOR OUTCOME MEASURES

Outcome Measure	2005	2006	2007	2008	2009
Average Medical Cost per Texas Workers' Compensation Case	$4,035	$4,075	$3,768	$3,466	$3,813
Average Number of Days for the Required Initial Benefit Payment to be Issued after Benefits Begin to Accrue	8.8	8.6	8.4	8.2	8.0
Percentage of Notices of Injury Received by the Insurance Carrier On or Before the Benefit Eligibility Date	90%	90%	90%	90%	90%
Percentage of First Benefit Payment Timely Made by Insurance Carriers	82%	84%	86%	88%	90%
Percentage of Documents Received and Maintained Electronically by the Commission	72%	76%	77%	79%	81%
Percentage of Injury Records Created in Three Days or Less	97%	97%	97%	97%	97%
Percentage of Market Share of Certified Self-Insurance to the Total Workers' Compensation Insurance Market	10.00%	10.00%	10.00%	10.00%	10.00%
Percentage of Benefit Dispute Cases Resolved by the Commission's Informal Dispute Resolution System	83%	83%	83%	83%	83%
Percentage of Medical Benefit Dispute Cases Resolved By Initial Administrative Decision	85%	85%	85%	90%	90%
Percentage of Benefit Dispute Cases Resolved by the Commission's Formal Dispute Resolution System (Beginning With Contested Case Proceedings)	17%	17%	17%	17%	17%
Percentage of Benefit Dispute Cases In Which Unrepresented Parties Received Ombudsman Services for Benefit Review Conferences	54%	55%	55%	55%	55%
Percentage of Benefit Dispute Cases In Which Unrepresented Parties Received Ombudsman Services for Contested Case Hearings	42%	42%	42%	42%	42%
Average Number of Days to Resolve Benefit Dispute	57	57	57	57	57
Percent of Appealed Medical Fee Disputes Resolved Prior to a Formal Hearing at SOAH	75%	75%	75%	75%	75%
Statewide Incidence Rate of Injuries and Illnesses per 100 Full-time Employees	4.8	4.8	4.8	4.8	4.8
Percentage Change in the Injury Rate for Employers Provided Consultations and Inspection Services	-30%	-30%	-30%	-30%	-30%
Total Payments Made Out of the Subsequent Injury Fund For Lifetime Income Benefits and Reimbursements to Insurance Carriers	$2,977,415	$2,726,179	$2,947,231	$3,256,920	$3,702,925

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APPENDIX D

FY 2006-2007 PERFORMANCE MEASURE DEFINITIONS

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PERFORMANCE MEASURE DEFINITIONS

GOAL 1: To ensure the cost effective delivery of appropriate benefits

OBJECTIVE 1.1: To ensure appropriate payment of income benefits and health care for injured employees and fair and reasonable reimbursement for health care providers through 2009 to allow for appropriate return to work

Outcome Measure:

1.1.1 Average Medical Cost per Texas Workers' Compensation Case

Short Definition: This measure indicates the average medical cost associated with a workers' compensation case. The measure includes all medical payments made in connection with workplace injuries.

Each individual "TWCC number" represents a case. If the "TWCC number" is missing, each individual combination of claimant SSN and date of injury will represent a case.

Cases are associated with a particular reporting period according to the date of injury. Each reporting period accounts for the cases with dates of injury occurring during the time period, which precedes the reporting period by two years.

Purpose/Importance: The purpose of this measure is to monitor the average medical cost per workers' compensation case in which there are medical payments.

Source/Collection of Data: Data are maintained in the Medical Billing Database and other agency automated systems.

Method of Calculation: Medical payments made during a two-year period (date of injury plus two years) are combined to calculate the total medical payments per case. The total medical payments made for all of the cases are then divided by the total number of cases to obtain the average medical cost per case.

Data Limitations: Data limitations include the accuracy and completeness of the information received by TWCC from carriers and their third party administrators and data maturity issues.

Calculation Type: Non-cumulative

New Measure: No

Desired Performance: Lower than target

STRATEGY 1.1.1: Establish and maintain rules, guidelines, and programs (e.g., doctor monitoring, healthcare delivery networks, general education on medical rules and processes, and approved doctors list/designated doctors list (ADL/DDL) training and certification) that ensure appropriate utilization of medical services and the quality of medical providers

Output Measures:

1.1.1.1 Number of Quality of Care Reviews of Health Care Providers Completed

Short Definition: This measure indicates the number of quality of care reviews completed on health care providers during the reporting period. A quality of care review is performed under the direction of the Medical Advisor and is defined as a review of clinical evaluations, recommendations, treatment decisions, and clinical outcomes relating to health care. Quality of Care reviews are conducted on health care providers who provide care or evaluations in the workers' compensation system (other than in a peer-review or utilization review capacity). A review uses random or non-random sample methodology or census and may be directed towards a specific entity or the system as a whole. Completion of a review is the date the final report is issued. Reviews are performed according to standards approved by the TWCC Medical Advisor.

Purpose: The Commission is charged with monitoring the quality of healthcare in the workers' compensation system. This measure reflects one of the principle methods by which the Commission fulfills this requirement.

Data Source: Information is entered and maintained in a database.

Methodology: This measure is calculated by adding the number of final reports issued during the reporting period for all quality of care reviews conducted on health care providers.

Data Limitations: None.

Calculation Type: Cumulative

New Measure: No

Desired Performance: Higher than target

1.1.1.2 Number of Quality of Care Reviews of Insurance Carriers Completed

Short Definition: This measure indicates the number of quality of care reviews completed relating to insurance carrier duties during the reporting period. A quality of care review is performed under the direction of the Medical Advisor and is defined as a review of approvals, denials and other opinions, decisions, or practices relating to health care proposed or provided to injured employees and clinical outcomes relating to health care.

Quality of Care reviews can be conducted on insurance carriers or on individual providers working at the direction of or in the employ of a carrier(s). A review uses random or non-random sample methodology or census and may be directed towards a specific entity or the system as a whole. Completion of a review is the date the final report is issued. Reviews are performed according to standards approved by the TWCC Medical Advisor.

Purpose: The Commission is charged with monitoring the quality of healthcare in the workers' compensation system. This measure reflects one of the principle methods by which the Commission fulfills this requirement.

Data Source: Information is entered and maintained in a database.

Methodology: This measure is calculated by adding the number of final reports issued during the reporting period for all quality of care reviews conducted on insurance carriers.

Data Limitations: None

Calculation Type: Cumulative

New Measure: No

Desired Performance: Higher than target

1.1.1.3 Number of System Participants Who Received Medical Benefit Training

Short Definition: This measure identifies the number of verified system participants that receive medical benefit training. Types of training include seminars, hard copy training publications, and

web-based training providing up-to-date information regarding medical issues in workers' compensation such as preauthorization, impairment rating, and medical dispute resolution, etc.

Purpose/Importance: The purpose of this measure is to identify the number of system participants who receive training on medical issues. It is assumed that people who have current information and understanding of processes will have fewer problems and questions.

Source/Collection of Data: Data are maintained in agency automated systems, manual logs of publications sold, and paper attendance roster documents.

Method of Calculation: This measure is manually calculated by summing the number of certificates issued to and confirmations/evaluations received from system participants that have received medical benefit web-based training or purchased a hard copy training publication, and the number of system participants that attended a seminar during the reporting period.

A certificate is only issued to system participants who have completed the entire web-based training, and a confirmation/evaluation is only received from system participants who have taken web-based training or purchased a hard copy training publication.

Data Limitations: None

Calculation Type: Cumulative

New Measure: No

Desired Performance: Higher than target

1.1.1.4 Number of Electronic Medical Benefit Products and Services Distributed

Short Definition: This measure identifies the number of Medical Benefit products and services files opened on the Commission's website.

Purpose/Importance: The purpose of this measure is to identify the public demand for medical benefit products and services located on the Commission's website.

Source/Collection of Data: This data is obtained from the logs generated by the web server.

Method of Calculation: This measure is calculated by summing the number of times the medical benefit products and services files are opened on the Commission website. Files opened in which a confirmation is received are excluded from this measure.

Data Limitations: The count of the number of times medical benefits files are opened cannot accurately reflect the extent of public use of the information once it is distributed; however, it is assumed that people who have current information and understanding of processes will have fewer problems and questions.

Calculation Type: Cumulative

New Measure: Yes

Desired Performance: Higher than target

1.1.1.5 Number of Persons Receiving Return-to-Work Training Products and Services

Short Definition: This measure identifies the number of persons receiving return-to-work training products and services provided by the Commission. Return-to-work training provides education and information to employers and others regarding effective tools for managing disability associated with work-related illness or injuries. The training products and services include presentations, seminars, web-based training, publications and on-site visits to system participants.

Purpose/Importance: The purpose of this measure is to identify the number of persons receiving return-to-work training products and services that will aid in returning people to the workforce who have been injured on the job.

Source/Collection of Data: This data is maintained in agency automated databases and paper documents.

Method of Calculation: This measure is manually calculated by summing the number of persons that received return-to-work training products and services during the reporting period. An agency Internet report identifies the number of persons that received web-based training products and services based on the number of user sessions/downloads to the return-to-work training products and services available on the Commission's website. These numbers are added to the number of persons that: 1) attended seminars; 2) received hard copy publications; and 3) were assisted through on-site visits.

Data Limitations: User sessions/downloads to return-to-work publications are assumed to be one person receiving training products and services.

Calculation Type: Cumulative

New Measure: No

Desired Performance: Higher than target

Efficiency Measures:

1.1.1.1 Average Number of Days to Complete Quality of Care Reviews of Health Care Providers

Short Definition: This measure is defined as the average number of days to complete a quality of care review of a health care provider under output measure 1.1.1.1.

Purpose/Importance: This indicates the efficiency of the quality of care review process by measuring the length of time for a quality of care review of a health care provider to be completed.

Source/Collection of Data: Information is entered and maintained in a database.

Method of Calculation: This measure is calculated by dividing total days by reviews completed. The numerator is the total number of days to complete all reviews whose final report was issued during the reporting period. Total days for a review includes the time between the start of the record review and the issuance of the final report. The denominator is the number of reviews completed during the reporting period.

Data Limitations: None

Calculation Type: Non-cumulative

New Measure: No

Desired Performance: Lower than target

1.1.1.2 Average Number of Participants per Return-to-Work Seminar

Short Definition: This measure identifies the average number of participants per return-to-work seminar.

Purpose/Importance: The purpose of this measure is to monitor the effectiveness and efficiency of providing return-to-work information to system participants through seminars.

Source/Collection of Data: Data are maintained on paper documents.

Method of Calculation: This measure is calculated by dividing the total number of return-to-work seminar participants by the total number of seminars conducted during the reporting period.

The numerator is calculated by summing the number of return-to-work seminar participants that attended seminars.

The denominator is calculated by summing the total number of return-to-work seminars conducted during the reporting period.

Data Limitations: None

Calculation Type: Non-cumulative

New Measure: No

Desired Performance: Higher than target

OBJECTIVE 1.2: To monitor compliance with applicable statutes and rules and identify fraudulent activity in the workers' compensation system through 2009

Outcome Measures:

1.2.1 Average Number of Days for the Required Initial Benefit Payment to be Issued after Benefits Begin to Accrue

Short Definition: This measure indicates the average number of days from the eighth day of disability (i.e., the benefit eligibility/accrual date) to the date the required initial temporary income benefit (TIBs) payment is issued to injured workers.

Purpose/Importance: This measure provides an indication of the length of time for the initial temporary income benefit payments to be issued once a worker is eligible for temporary income benefits.

Source/Collection of Data: The information used in this calculation is received by the TWCC either via paper TWCC-1 or TWCC-21 form or electronically from the EDI I48 or A49. Paper documents submitted by the carriers are data entered by TWCC staff. EDI information is submitted electronically by the carriers and TWCC only transfers the data electronically to the COMPASS system.

Method of Calculation: The numerator is calculated by adding the number of days from the eighth day of disability to the date the required initial temporary income benefit payment is issued. The denominator is the total number of eligible indemnity claims.

Twelve months of data, based on the date of injury, are used in the calculation. The data is lagged one month from the reporting month.

Data Limitations: TWCC does not capture the accrual date. A1from field captured through EDI A49 or the TWCC-21, which is the first day of the benefit period, is used as a proxy accrual date. This measure is dependent on the provision of accurate data being submitted by insurance carriers.

Calculation Type: Non-cumulative

New Measure: No

Desired Performance: Lower than target

1.2.2 Percentage of Notices of Injury Received by the Insurance Carrier On or Before the Benefit Eligibility Date

Short Definition: This measure indicates the percentage of injury notices provided timely to insurance carriers. Ideally, benefits are to be delivered to the injured worker within seven days of the eighth day of disability (the benefit eligibility date). Insurance carriers are allowed fifteen days from the notice of injury to initiate payment or dispute benefits.

Purpose/Importance: The purpose of this measure is to indicate the timely filing of injury notices with the insurance carrier.

Source/Collection of Data: The information used in the calculation is received by the Commission either via paper TWCC-1 or TWCC-21 forms or electronically from the EDI 148 or A49. Paper documents submitted by the carriers are data entered by Commission staff. EDI information is submitted electronically by the carriers and the Commission only transfers the data electronically to the Commission's automated system. Data are maintained in agency automated systems.

Method of Calculation: The numerator is calculated by adding the number of indemnity claims where notice of injury was received by the carrier on or before the benefit eligibility date. The denominator is the total number of eligible indemnity claims. The eligibility date is the eighth day of disability as provided to the agency by the carrier.

Twelve months of data are used in the calculation. The data is lagged one month from the reporting period.

Data Limitations: The Commission does not capture the date on which benefits begin to accrue or the eighth day of disability. The Commission uses the "A1from" field captured through EDI A49 or the TWCC-21, which is the first day of the benefit period, as a proxy accrual date. This measure is dependent on the provision of accurate data being submitted by insurance carriers.

Calculation Type: Non-cumulative

New Measure: No

Desired Performance: Higher than target

1.2.3 Percentage of First Benefit Payment Timely Made by Insurance Carriers

Short Definition: This measure indicates the timely initiation of temporary income benefit payments to injured workers by insurance carriers. Insurance carriers are allowed fifteen days from the notice of injury to initiate payment or dispute benefits. Benefits are to be delivered to the injured worker within seven days of the eighth day of disability (the benefit eligibility date).

Purpose/Importance: The purpose of this measure is to indicate whether the insurance carriers timely initiated temporary income benefit payments.

Source/Collection of Data: The information used in the calculation is received by the Commission either via paper TWCC-1 or TWCC-21 forms or electronically from the EDI 148 or A49. Paper documents submitted by the carriers are data entered or imaged by Commission staff. EDI information is submitted electronically by the carriers and the Commission only transfers the data electronically to the Commission's automated system. Data are maintained in agency automated systems.

Method of Calculation: The numerator is calculated by adding the number of initial temporary income benefits payments made timely. The denominator is the total number of eligible paid indemnity claims in the period.

Twelve months of data are used in the calculation. The data is lagged one month from the reporting period.

Data Limitations: The Commission does not capture the date that benefits begin to accrue or the eighth day of disability. The Commission uses the "A1from" field captured through EDI A49 or the TWCC-21, which is the first day of the benefit period, as a proxy accrual date. This measure is dependent on the provision of accurate data being submitted by insurance carriers.

Calculation Type: Non-cumulative

New Measure: No

Desired Performance: Higher than target

STRATEGY 1.2.1: Monitor and enforce compliance of healthcare providers, insurance carriers, employees, employers, attorneys, and other participants with the statute and rules through audits, fraud investigations, and administrative violation referral reviews and take appropriate enforcement action.

Output Measures:

1.2.1.1 Number of Fraud Investigations Completed

Short Definition: The measure shows the number of administrative and criminal workers' compensation fraud investigations completed. A completed investigation is defined as the time at which the investigative process, after extensive investigation, supports a finding that prosecution is probable, or administrative enforcement action is taken or enforcement action (administrative or criminal) is deemed not warranted based on facts or available evidence. Individual investigations may be pursued through various prosecuting authorities.

Purpose/Importance: The Commission is charged with monitoring system participants for compliance with the Texas Labor Code and Administrative Rules. This measure indicates the number of fraud investigations completed.

Source/Collection of Data: Information is entered and maintained in the violation tracking system.

Method of Calculation: This measure is calculated by adding the number of completed fraud investigations as defined per violation code in the Texas Labor Code, Subtitle A; Texas Penal Code; Insurance Code, and US Criminal Code.

Data Limitations: None

Calculation Type: Cumulative

New Measure: No

Desired Performance: Higher than target

1.2.1.2 Number of Criminal Cases Referred to Prosecuting Authorities

Short Definition: This measure indicates the number of fraud cases referred to criminal prosecuting authorities. A referral is defined as a case presented to a prosecuting authority. Regardless of the number of counts a prosecuting authority may present to the Grand Jury, the referral will be counted as one criminal case referred. A prosecuting authority is defined as a person who institutes an official criminal prosecution before a court, regardless of jurisdiction.

Purpose/Importance: The purpose of this measure is to address the extent to which the outcome of a fraud investigation resulted in a referral to prosecutors for criminal prosecution.

Source/Collection of Data: Information is entered and maintained in the violation tracking system.

Method of Calculation: This measure is calculated by adding all of the fraud cases referred to criminal prosecuting authorities. Fraud is defined per violation code in the Texas Labor Code, Subtitle A; Texas Penal Code; Insurance Code, and US Criminal Code.

Data Limitations: None

Calculation Type: Cumulative

New Measure: No

Desired Performance: Higher than target

1.2.1.3 Number of Administrative Violation Referral Reviews Completed

Short Definition: This measure indicates the number of administrative violation referral reviews completed. An administrative violation review is defined as a case review of a specific allegation of a violation of the statute or rules received from internal or external sources. Excluded from this measure are reviews completed as part of audits or fraud investigations. A completed review is defined as when enforcement action is taken or when enforcement action is deemed not warranted based on facts or available evidence.

Purpose/Importance: The Commission is charged with monitoring system participants for compliance with the statute and rules. The Commission receives referrals of alleged violations by system participants. This measure indicates the number of these administrative referral reviews completed.

Source/Collection of Data: Information is entered and maintained in the violation tracking system.

Method of Calculation: This measure is calculated by adding the number of administrative violation reviews completed in the reporting period.

Data Limitations: None

Calculation Type: Cumulative

New Measure: No

Desired Performance: Higher than target

1.2.1.4 Number of Compliance Audits Completed

Short Definition: This measure indicates the number of compliance audits conducted involving workers' compensation records and claim files. A compliance audit is defined as a review of the compliance of one or more duties specified by statute or rule. A review uses random or non-random sample methodology or census and may be directed towards a specific entity or the system as a whole. Completion of an audit is the date the final report is issued.

Purpose/Importance: The Commission is charged with monitoring and reviewing the records of insurance carriers, employers, health care providers, and other system participants. This measure provides the number of audits completed involving these system participants.

Source/Collection of Data: Information is entered and maintained in an audit database.

Method of Calculation: This measure is calculated by adding the number of compliance audits conducted with a final report issued during the reporting period.

Data Limitations: This measure reflects audit activity funded through this strategy and the Medical Cost Containment strategy.

Calculation Type: Cumulative

New Measure: No

Desired Performance: Higher than target

Efficiency Measures:

1.2.1.1 Average Number of Days to Complete a Fraud Investigation

Short Definition: This measure indicates the efficiency of the fraud investigation process.

Purpose/Importance: The purpose of this measure is to measure the length of time for a fraud investigation to be completed.

Source/Collection of Data: Information is entered and maintained in the violation tracking system.

Method of Calculation: The numerator adds the total number of days from receipt of fraud allegations to the conclusion of investigations. The denominator is the output measure representing the total "Number of Fraud Investigations Completed" during the reporting period.

Data Limitations: None

Calculation Type: Non-cumulative

New Measure: No

Desired Performance: Lower than target

1.2.1.2 Average Number of Days to Complete a Compliance Audit

Short Definition: This measure indicates the efficiency of the compliance audit process.

Purpose/Importance: The purpose of this measure is to indicate the length of time for a compliance audit to be completed.

Source/Collection of Data: Information is entered and maintained in an audit database.

Method of Calculation: The numerator is calculated by totaling the number of days between the start of the record reviews to issuance of the final audit reports. The denominator is the "Number of Compliance Audits Completed" during the reporting period.

Data Limitations: This measure reflects audit activity funded through this strategy and the Medical Cost Containment strategy.

Calculation Type: Non-cumulative

New Measure: No

Desired Performance: Lower than target

1.2.1.3 Average Number of Days to Complete an Administrative Violation Referral Review

Short Definition: This measure indicates the efficiency of the administrative violation referral review process.

Purpose/Importance: The purpose of this measure is to indicate the length of time for an administrative violation referral review to be completed.

Source/Collection of Data: Information is entered and maintained in the violation tracking system.

Method of Calculation: The numerator is calculated by adding the number of days from receipt of the administrative violation referral to the conclusion of the review for each referral. The denominator is the total "Number of Administrative Violation Referral Reviews Completed" during the reporting period.

Data Limitations: None

Calculation Type: Non-cumulative

New Measure: No

Desired Performance: Lower than target

Explanatory Measures:

1.2.1.1 Number of Convictions Resulting from Criminal Cases Filed with Prosecuting Authorities

Short Definition: This measure shows the number of convictions resulting from criminal cases filed with prosecuting authorities. A prosecuting authority is defined as a person who institutes an official criminal prosecution before a court, regardless of jurisdiction.

Purpose/Importance: The purpose of this measure is to report the number of convictions as a result of criminal cases filed with prosecuting authorities.

Source/Collection of Data: Information is entered and maintained in the violation tracking system.

Method of Calculation: The measure is calculated by adding the number of reported convictions resulting from criminal cases.

Data Limitations: The agency is not always informed in a timely manner of action taken by the prosecuting authority after the referral. The date the Commission becomes aware of a conviction is entered into the automated tracking system as the conviction date.

Calculation Type: Cumulative

New Measure: No

Desired Performance: Higher than target

1.2.1.2 Total Number of Violation Notices Issued

Short Definition: This measure indicates the total number of violation notices issued by the Commission's division of Compliance and Practices for administrative violations, excluding violation notices issued resulting from fraud investigations.

Purpose/Importance: The purpose of this measure is to address the extent to which the outcome of administrative violation referral reviews (including referrals resulting from data mining) and compliance audits resulted in the issuance of a notice of administrative violation due to non-compliance with the Texas Labor Code and Administrative Rules.

Source/Collection of Data: Information is entered and maintained in the violation tracking system.

Method of Calculation: This measure is calculated by adding the number of violation notices issued during the reporting month. The number of violation notices withdrawn during the reporting month is subtracted from the number of violation notices issued for the reporting month irrespective of the month in which they were originally issued. Therefore, it may be possible for a negative number to be reported as the number of violation notices issued for the month.

Data Limitations: None

Calculation Type: Cumulative

New Measure: No

Desired Performance: Higher than target

1.2.1.3 Number of Administrative Remedies Resulting from Fraud Investigations

Short Definition: This measure indicates the total number of violation notices and warnings issued by the Commission's division of Compliance and Practices resulting from fraud investigations.

Purpose/Importance: The purpose of this measure is to address the extent to which the outcome of administrative fraud investigations resulted in the issuance of a notice of administrative violation or warning due to non-compliance with the Texas Labor Code and Administrative Rules.

Source/Collection of Data: Information is entered and maintained in the violation tracking system.

Method of Calculation: This measure is calculated by adding the number of violation notices and warnings issued resulting from fraud investigations during the reporting month. The number of violation notices withdrawn during the reporting month is subtracted from the number of violation notices issued for the reporting month irrespective of the month in which they were originally issued. Therefore, it may be possible for a negative number to be reported as the number of violation notices issued for the month.

Data Limitations: None

Calculation Type: Cumulative

New Measure: Yes

Desired Performance: Higher than target

OBJECTIVE 1.3: Improve efficiency of communication processes in the workers' compensation system by 2009

Outcome Measures:

1.3.1 Percentage of Documents Received and Maintained Electronically by the Commission

Short Definition: This measure reflects the percent of high volume forms that are eligible for electronic submission, excluding medical payments that are received by the Commission electronically.

Purpose/Importance: The purpose of the measure is to monitor the agency's efforts in maintaining injury information electronically rather than on paper. This is consistent with direction provided by the Legislature.

Source/Collection of Data: Documents are received from insurance carriers, employers, employees, health care providers, and other participants in the workers' compensation system. Data are maintained in agency automated systems.

Method of Calculation: The numerator is the number of eligible documents received or maintained electronically. The denominator is the total number of high volume documents eligible for electronic transmission (148, A49, TWCC-1, 5, 20, 21, 32, 45, 60, 69, 81-84, and 152).

Eligible documents are identified based upon the agency's ability to receive the records electronically. For projection purposes, the documents eligible for electronic transmission are the following: TWCC-1 (initial report of injury), TWCC-21 (subsequent report of injury), TWCC-32 (Request for Designated Doctor), TWCC-45 (Request for a Benefit Review Conference), TWCC-60 (Medical Dispute Resolution Request), TWCC-69 (Report of Medical Evaluation), TWCC-5, TWCC-20, and TWCC-81-84 (insurance coverage documents), and TWCC-152 (attorney fee application).

Data Limitations: Data is limited by parties that do not report injury information electronically, and therefore, can not be counted in the measure.

Calculation Type: Non-cumulative

New Measure: No

Desired Performance: Higher than target

1.3.2 Percentage of Injury Records Created in Three Days or Less

Short Definition: This measure reflects the percent of injury records created in three days or less. This measure includes all injury reports resulting in one day or greater of lost time, occupational diseases and fatalities.

Purpose/Importance: This measure represents the percent of all injury records that are created in three days or less. The measure is an indicator of customer service on the part of the Commission and of workers' compensation system performance. Researchers examining the efficiency and effectiveness of workers' compensation systems often use measures such as this to serve as one indicator of the system's ability to pay benefits timely. An injury must be reported and a claim created before benefits are paid.

Source/Collection of Data: Reports of injury are received from insurance carriers, employees, and health care providers.

The date of the receipt of the form is determined by the date stamp affixed to the forms by the Texas Workers' Compensation Commission (TWCC) central office mail room or by each TWCC field office. The date received generated by facsimiles will be used in place of date stamps. Records submitted via Electronic Data Interchange (EDI) will have the date received electronically recorded by the TWCC automated data system. Data are maintained in agency automated systems.

Method of Calculation: The numerator is the total number of injury records created within 3 business days. The denominator is the total number of injury records created during the reporting period.

Data Limitations: None

Calculation Type: Non-cumulative

New Measure: No

Desired Performance: Higher than target

STRATEGY 1.3.1: Develop and implement processes to receive, provide and maintain information in an electronic format

Output Measures:

1.3.1.1 Number of Documents Received and Maintained Electronically by the Commission

Short Definition: This measure reflects the number of high volume forms, excluding medical payments, that are received by the Commission electronically.

Purpose/Importance: The purpose of the measure is to monitor the agency's efforts in maintaining injury information electronically rather than on paper.

Source/Collection of Data: Documents are received from insurance carriers, employers, employees and healthcare providers, and other participants in the workers' compensation system. Data are maintained in agency automated systems.

Method of Calculation: This measure is calculated by adding all high volume documents received or maintained electronically. For projection purposes, the documents eligible for electronic transmission are the following: TWCC-1 (initial report of injury), TWCC-21 (subsequent report of injury), TWCC-32 (Request for Designated Doctor), TWCC-45 (Request for a Benefit Review Conference), TWCC-60 (Medical Dispute Resolution Request), TWCC-69 (Report of Medical Evaluation), TWCC-5, TWCC-20, and TWCC-81-84 (insurance coverage documents), and TWCC-152 (attorney fee application).

Data Limitations: Data is limited by external parties that do not report injury information electronically, therefore can not be counted in the measure.

Calculation Type: Cumulative

New Measure: No

Desired Performance: Higher than target

1.3.1.2 Number of Injury Records Created

Short Definition: This measure includes all injury records created based on a report of injury resulting in one day or greater of lost time, occupational diseases and fatalities.

Purpose/Importance: The purpose of this measure is to reflect the number of injuries/illnesses reported to the Commission during a reporting period.

Source/Collection of Data: Reports of injury are received from insurance carriers, employees, and healthcare providers. This measure applies only to injuries which occurred on or after January 1, 1991, for which claims were established in the current year. Data are maintained in agency automated systems.

Method of Calculation: The measure is calculated by adding the total number of income indemnity injury records created and the total number of reportable injury records created during the reporting period. An income indemnity injury record is created for cases in which the injury resulted in: eight or more days of absence from work and/or benefit payments are being paid or may be payable; occupational diseases; and fatalities. A reportable injury record is created for cases in which the injury resulted in one day or greater lost time but does not fit the criteria for an income indemnity injury record.

Data Limitations: This measure does not necessarily reflect the number of injuries occurring in a given year. The measure represents records created based on reports of injury, and an injury may be reported in a different year from the year of injury.

Calculation Type: Cumulative

New Measure: No

Desired Performance: Lower than target

1.3.1.3 Number of Injury Records Created for Income/Indemnity Injuries

Short Definition: This measure is the total number of injury records created or converted where eight or more days absence from work has accumulated and/or benefit payments are being paid or may be payable.

Purpose/Importance: The purpose of this measure is to reflect the number of injuries/illnesses created/converted during a reporting period.

Source/Collection of Data: Reports of injury are received from insurance carriers, employees, and healthcare providers. This measure applies only to injuries, which occurred on or after January 1, 1991. Data are maintained in agency automated systems.

Method of Calculation: This measure is calculated by adding the number of records created/converted during the reporting period in which the injury has resulted in or is anticipated to result in eight or more days absence from work, an occupational disease, or a fatality.

Data Limitations: None

Calculation Type: Cumulative

New Measure: No

Desired Performance: Lower than target

Efficiency Measure:

1.3.1.1 Average Number of Days to Create Injury Records

Short Definition: This measure calculates the average number of days to create injury records.

Purpose/Importance: This measure represents the average number of elapsed business days between receipt date of TWCC forms that create an injury record and the date the injury record is created. The measure is an indicator of customer service and workers' compensation system performance.

Source/Collection of Data: Reports of injury are received from insurance carriers, employees, and healthcare providers.

This measure includes all injury reports resulting in one day or greater of lost time, occupational diseases and fatalities. This measure applies only to injuries, which occurred on or after January 1, 1991, for which claims were established in the current year. The date of the receipt of the form is determined by the date stamp affixed to the forms by the Texas Workers' Compensation Commission (TWCC) central office mail room or by each TWCC field office. The date received generated by facsimiles will be used in place of date stamps. Records submitted via Electronic Data Interchange (EDI) will have the date received electronically recorded by the TWCC automated data system. Data are maintained in agency automated systems.

Method of Calculation: The numerator is the total number of days to create injury records. The denominator is the total number of injury records created.

Data Limitations: None

Calculation Type: Non-cumulative

New Measure: No

Desired Performance: Lower than target

Explanatory Measure:

1.3.1.1 Estimated Percentage of Employers Reported Participating in the Workers' Compensation System

Short Definition: This measure is a reflection of the percentage of employers participating in the state's workers' compensation system. Participating employers are those who have a current workers' compensation insurance policy in effect during the reporting period. This includes coverage by commercial insurance, self-insured governmental entities and certified self-insured employers.

Purpose/Importance: The purpose of this measure is to determine the percentage of employers participating in the worker's compensation system. Since most Texas employers are not required to carry workers' compensation insurance, the percent of employers choosing to participate in the workers' compensation system serves as a reflection of system performance.

Source/Collection of Data: All employers are required to file a form with the Commission indicating whether the employer has workers' compensation coverage or not. Data based on those forms are maintained in agency automated systems. The total number of employer locations is received from the Texas Workforce Commission.

Method of Calculation: The numerator is the total number of employers with an active workers' compensation insurance policy on record with the Commission. The denominator is the total number of employer locations based on the reports obtained by the Commission from the Texas Workforce Commission.

Data Limitations: The data is limited by the accuracy and completeness of data filed by employers regarding workers' compensation coverage.

Calculation Type: Non-cumulative

New Measure: No

Desired Performance: If the public policy preference is for employers to have workers' compensation insurance coverage, performance higher than the projection is desired.

OBJECTIVE 1.4: To certify and regulate large private employers that qualify to self-insure

Outcome Measure:

1.4.1 Percentage of Market Share of Certified Self-Insurance to the Total Workers' Compensation Insurance Market

Short Definition: This measure indicates certified self-insured employers' market share of the total workers' compensation insurance market.

Purpose/Importance: This measures serves as a reflection of changes in the workers' compensation insurance market. The portion of the market share represented by certified self-insured is related to the cost and availability of workers' compensation insurance in the commercial market. Self-insurance provides an alternative to purchasing commercial insurance for qualifying companies, and the program acts to moderate insurance rates in a competitive insurance market.

Source/Collection of Data: Data on estimated manual premiums for certified self-insurers is maintained by the Commission in spreadsheets. Data reflecting the total workers' compensation insurance market is maintained and reported by the Texas Department of Insurance in its *Quarterly Legislative Report on Market Conditions*.

Method of Calculation: The numerator is the total amount of statutorily estimated manual premium as maintained by the Commission for active certified self-insurers. The denominator is the direct written premiums for the voluntary workers' compensation market as published quarterly by the Texas Department of Insurance.

Data Limitations: The measure excludes public self-insured entities from the amount used to represent the total workers' compensation insurance market. Data for those entities is not collected and maintained regarding the estimated premiums attributable to them.

Calculation Type: Non-cumulative

New Measure: No

Desired Performance: Lower than target. If workers' compensation insurance costs are regarded as high, the percentage may be greater than target. If workers' compensation insurance costs are low, the percentage may be lower than target.

STRATEGY 1.4.1: Ensure that certified self-insuring employers meet statutory financial, claims administration, and safety requirements through an ongoing process of qualifying, renewing, and revoking certification

Output Measures:

1.4.1.1 Number of Companies in the Certified Self-Insurance Program

Short Definition: This measure indicates the number of companies regulated by the Commission's division of Self-Insurance Regulation. The number of companies represents active, as well as withdrawn or inactive certified self-insurers.

Purpose/Importance: The measure is an indication of the volume of companies requiring ongoing regulation. All companies that have been a certified self-insurer and still have remaining liabilities

to satisfy are included in the measure. Due to the nature of workers' compensation, regulation of payments, including medical, can last fifty years or more before a certified self-insurer's obligations are satisfied.

Source/Collection of Data: The Commission's division of Self-Insurance Regulation maintains the data in spreadsheets.

Method of Calculation: This measure is calculated by adding all of the companies regulated by the Commission's division of Self-Insurance Regulation. The total number of companies reported each month is the year-to-date total.

Data Limitations: In the self-insurance program, certificates of authority are issued at the parent level of the applicant's corporate structure in order to minimize unnecessary duplication of effort and to streamline the application and renewal process. Depending upon an applicant's corporate structure, a certificate of authority may cover one company or a parent with many subsidiaries.

Calculation Type: Cumulative

New Measure: No

Desired Performance: Lower than target. If workers' compensation insurance costs are regarded as high, the number of companies in the program may be greater than target. However, because the pay-out of claims are regulated after a company withdraws, the number of companies in the self-insurance program does not automatically decrease as a result of withdrawals from the program.

1.4.1.2 Number of Self-Insurance Applicants or Renewals Certified

Short Definition: The measure represents the number of self-insurance applicants or renewals certified during the reporting period.

Purpose/Importance: The measure reports certification activity for initial and renewal applicants.

Source/Collection of Data: The Commission's division of Self-Insurance Regulation maintains the data in spreadsheets.

Method of Calculation: This measure is calculated by adding the number of certificates issued to certified self-insurers during the reporting period.

Data Limitations: The measure reports only certification activity and does not reflect work related to applicants that withdraw or are rejected.

Calculation Type: Cumulative

New Measure: No

Desired Performance: Lower than target. If workers' compensation insurance costs are regarded as high, the number of companies certified may be greater than target. If workers' compensation insurance costs are low, the number may be lower than target.

Efficiency Measure:

1.4.1.1 Average Cost per Company in the Certified Self-Insurance Program

Short Definition: This measure indicates the average cost per company regulated in the self-insurance program. Direct costs and all indirect costs applicable to the program are included in the total cost.

Purpose/Importance: The measure provides an average cost to regulate a company in the program. It is important to note that all costs for the self-insurance program are billed to and are paid by the companies that participate in the self-insurance program through the Self-Insurance Regulatory Fee. The proceeds of the Regulatory Fee are deposited with the Comptrollers' office as un-appropriated funds.

Source/Collection of Data: The costs included in the Regulatory Fee are based upon all direct and indirect costs associated with the program in order for the state to fully recover any costs expended on this program. Indirect costs include a proportionate program share of TWCC indirect administrative costs and matching payroll and retirement costs such as OASDI/Medicare, state retirement contribution, state insurance contribution, Benefit Replacement Pay, and salary increases.

For consistency purposes, the same methodology used to determine the Regulatory Fee is used to determine costs for reporting this average cost measure. Cost figures used in determining the average cost are based on accounting system reports and analysis work papers, which includes allocations, ratios, and summarization of source documents, to accumulate and report these costs.

Method of Calculation: The numerator is the total cost associated with administering the self-insurance program. The denominator is the number of companies regulated by the Certified Self-Insurance program. The number used for the denominator is the same as the number reported for the output measure "Number of Companies in the Certified Self-Insurance Program."

Data Limitations: None

Calculation Type: Non-cumulative

New Measure: No

Desired Performance: Lower than target

Explanatory Measure:

1.4.1.1 Total Self-Insurance Regulatory Fee Paid By Certified Self-Insurers for the Prior Calendar Year

Short Definition: This measure is the amount of Self-Insurance Regulatory Fee paid by Certified Self-Insurers for the calendar year ended in the current fiscal year.

Purpose/Importance: This measure reflects the Regulatory Fee payments made for the prior completed calendar year. All costs for the Self-Insurance program are billed to and are paid by the companies that participate in the self-insurance program through the Self-Insurance Regulatory Fee.

Source/Collection of Data: Regulatory Fee amounts are based on the budgetary calculation of the Regulatory Fee and division accounting system reports.

Method of Calculation: This measure is calculated by adding the Self-Insurance Regulatory Fee paid by each certified self-insurer for the reporting period.

Data Limitations: The Self-Insurance Regulatory Fee is determined on a calendar year basis and the payments for that period are reported on that basis. This measure will be calculated only once a year when the calendar year calculations/payments are complete.

Calculation Type: Cumulative

New Measure: No

Desired Performance: Lower than target.

GOAL 2: To minimize and resolve disputes

OBJECTIVE 2.1: Resolve 99% of benefit and medical benefit disputes in the Commission's system through 2009

Outcome Measures:

2.1.1 Percentage of Benefit Dispute Cases Resolved by the Commission's Informal Dispute Resolution System

Short Definition: The measure reflects the percentage of benefit dispute cases resolved by the Commission's informal dispute resolution system.

A case is considered resolved when the dispute will not advance to the formal system of dispute resolution. Cases considered "resolved prior to a BRC" include cases in which: the parties reach an agreement; or, due to the dispute, a designated doctor appointment is set. Cases are considered "resolved at a BRC" when the parties: reach an agreement, or do not pursue the dispute within 90 days of ending a BRC session.

Purpose/Importance: The purpose of this measure is to monitor the Commission's effectiveness in resolving benefit dispute cases in the informal dispute resolution system (through the Benefit Review Conference (BRC)).

Benefit dispute cases are identified by Commission staff in communication with parties or by a party filing a "request for a BRC." Each case may consist of up to 6 issues. Benefit issues include issues such as coverage, compensability, average weekly wage, disability, impairment rating, maximum medical improvement, and legal expenses associated with a case.

Source/Collection of Data: Data are maintained in agency automated applications.

Method of Calculation: The numerator is calculated by adding the output measure representing the number of benefit dispute cases resolved prior to a BRC plus the output measure representing the number of benefit dispute cases concluded in BRCs, subtracting the output measure, number of benefit dispute cases concluded in contested case hearings. The denominator is the total number of benefit dispute cases concluded during the reporting period. The total number of benefit dispute cases concluded includes: Number of Benefit Dispute Cases Resolved Prior to a BRC plus the Number of Benefit Dispute Cases Concluded in BRCs.

Data Limitations: Due to the lag time between receipt and resolution of a dispute, it is not clear from this measure whether the number of disputes is increasing or decreasing for the reporting period. Disputes denied by the Commission because the parties are not ready to proceed and disputes withdrawn before agreement is reached or a determination is made to proceed to BRC are not included in this measure.

Calculation Type: Non-cumulative

New Measure: Yes

Desired Performance: Higher than target

2.1.2 Percentage of Medical Benefit Dispute Cases Resolved By Initial Administrative Decision

Short Definition: This measure represents the percentage of medical benefit disputes resolved by initial administrative review.

The types of medical benefit dispute cases are: preauthorization of medical treatment, retrospective review of necessity of treatment, and reasonableness of fees charged.

Medical benefit dispute cases are resolved by initial administrative review when the dispute is reviewed by a medical dispute resolution officer (MDRO) or an independent review organization (IRO) and a decision is made to (1) issue an order; (2) issue a finding with no order; (3) issue a dismissal; (4) withdraw the dispute; or (5) issue a finding with refund, and the decision is not appealed to the State Office of Administrative Hearings (SOAH).

If the decision is appealed, but resolution is gained prior to the Commission filing the appeal with the SOAH, the case is counted as resolved by initial administrative decision. Disputes identified as non-jurisdictional are not included in this measure.

Purpose/Importance: The purpose of this measure is to monitor the agency's effectiveness in resolving medical disputes by initial administrative decision, which is the first level of medical dispute resolution.

Source/Collection of Data: Data are maintained in agency automated systems.

Method of Calculation: The numerator is calculated by subtracting the number of medical benefit dispute cases that are appealed from the total number of medical benefit dispute cases concluded during the reporting period. The denominator is the total number of medical benefit dispute cases concluded during the reporting period. Cases concluded are defined as disputes in which a decision has been made.

Data Limitations: None

Calculation Type: Non-cumulative

New Measure: No

Desired Performance: Higher than target

2.1.3 Percentage of Benefit Dispute Cases Resolved by the Commission's Formal Dispute Resolution System (Beginning With Contested Case Proceedings)

Short Definition: This measure reflects the percent of benefit dispute cases resolved in the formal portion of the Commission's administrative dispute resolution process.

This measure involves benefit dispute cases resolved at Contested Case Hearings (CCHs) and through appeals panel decisions. Benefit dispute cases are identified by Commission staff in communication with parties or by a party filing a "request for a BRC." Each case may consist of up to 6 issues. Benefit issues include issues such as coverage, compensability, average weekly wage, disability, impairment rating, maximum medical improvement, disputes over recommendations for spinal surgery, and legal expenses associated with a case.

A case is considered resolved formally when the dispute is not appealed for judicial review.

Purpose/Importance: The purpose of this measure is to monitor the agency's effectiveness in resolving dispute cases relating to benefit issues in the formal administrative dispute resolution system.

Source/Collection of Data: Data are maintained in agency automated applications.

Method of Calculation: The numerator is calculated in the following way: The number of benefit dispute cases resolved at CCH plus the number of benefit dispute cases resolved at Appeal. The number of benefit dispute cases resolved at CCH is calculated as the number of benefit dispute cases concluded in CCH minus the number of benefit dispute cases concluded at Appeal. The number of benefit dispute cases resolved at Appeal is calculated as the number of benefit dispute cases concluded at Appeal minus the number of requests for judicial review.

The denominator (Total Number of Benefit Dispute Cases Concluded) is calculated in the following way: [the number of benefit dispute cases resolved prior to a Benefit Review Conference (BRC) plus the number of benefit dispute cases concluded in BRCs].

Data Limitations: Due to the lag time between receipt and resolution of a dispute, it is not clear from this measure whether the number of disputes is increasing or decreasing for the reporting period. Disputes denied by the Commission because the parties are not ready to proceed and disputes withdrawn before agreement is reached or a determination is made to proceed to BRC are not included in this measure.

Calculation Type: Non-cumulative

New Measure: Yes

Desired Performance: Lower than target

2.1.4 Percentage of Benefit Dispute Cases In Which Unrepresented Parties Received Ombudsman Services for Benefit Review Conferences

Short Definition: The measure reflects the percentage of compensation benefit cases in which unrepresented parties received ombudsman services for benefit review conferences. An ombudsman may provide assistance to unrepresented injured workers or unrepresented employers before a BRC, at a BRC, or both.

Purpose/Importance: The purpose of this measure is to monitor the level of ombudsman assistance provided prior to or at a BRC.

Source/Collection of Data: Data are maintained in agency automated applications.

Method of Calculation: The numerator is calculated by adding the number of concluded BRCs with ombudsman assistance. The denominator is the Number of Benefit Dispute Cases Concluded in BRCs.

Data Limitations: None

Calculation Type: Non-cumulative

New Measure: No

Desired Performance: Higher than target

2.1.5 Percentage of Benefit Dispute Cases In Which Unrepresented Parties Received Ombudsman Services for Contested Case Hearings

Short Definition: The measure reflects the percent of compensation benefit dispute cases in which unrepresented parties received ombudsman services for a contested case hearing. An ombudsman may provide assistance to unrepresented injured employees or unrepresented employers before a CCH, at a CCH, or both before and at a CCH.

Purpose/Importance: The purpose of this measure is to monitor the level of ombudsman assistance provided prior to a Contest Case Hearing (CCH) or at a CCH.

Source/Collection of Data: Data are maintained in automated applications.

Method of Calculation: The numerator is calculated by adding the number of concluded CCHs with ombudsman assistance. The denominator is the total Number of Benefit Dispute Cases Concluded in CCHs.

Data Limitations: None

Calculation Type: Non-cumulative

New Measure: No

Desired Performance: Higher than target

2.1.6 Average Number of Days to Resolve Benefit Disputes

Short Definition: This measure shows the average time to conclude disputes through the Commission's dispute resolution processes (pre-Benefit Review Conference, Benefit Review Conference, Contested Case Hearing and Appeal).

Purpose/Importance: Disputes are resolved at various levels, some are quickly resolved and some may go through the highest levels of resolution. This measure gives an accurate indication of the average time to resolve all disputes regardless of the level reached.

Source/Collection of Data: Data are maintained in agency automated applications.

Method of Calculation: The numerator is calculated by adding the days between the first notification of a dispute and the conclusion of the highest level of resolution for each dispute. The final conclusion date may be: a) the date the dispute resolution officer resolves the dispute; b) the date the parties last met if the dispute is withdrawn or the parties reach an agreement; or c) the date the decision and order is mailed to the parties. The highest level of dispute resolution is determined by the point at which no further appeal was pursued to conclusion. The denominator is the total number of benefit dispute cases concluded during the reporting period. The total number of benefit dispute cases concluded includes: Number of Benefit Dispute Cases Resolved Prior to a BRC plus the Number of Benefit Dispute Cases Concluded in BRCs.

Data Limitations: Disputes denied by the Commission because the parties are not ready to proceed and disputes withdrawn before agreement is reached or a determination is made to proceed to BRC are not included in this measure.

Calculation Type: Non-cumulative

New Measure: Yes

Desired Performance: Lower than target

2.1.7 Percent of Appealed Medical Fee Disputes Resolved Prior to a Formal Hearing at SOAH

Short Definition: This measure reflects the percent of appealed medical fee cases resolved prior to a formal hearing at the State Office of Administrative Hearings (SOAH).

Purpose/Importance: The purpose of this measure is to monitor the agency's effectiveness in resolving appealed medical fee dispute cases prior to a formal hearing at SOAH, thus saving parties time and possibly money.

Source/Collection of Data: Data are maintained in agency automated systems.

Method of Calculation: The numerator is calculated by adding the number of appealed medical fee dispute cases resolved prior to a formal hearing. This number is identified on a DRIS report (DR-770). Appealed medical fee dispute cases resolved prior to a formal SOAH hearing include cases which are dismissed or withdrawn, or in which there is an (1) agreement, or (2) settlement.

The denominator is calculated by adding the number of appealed medical fee dispute cases concluded during the reporting period. These numbers are identified on a DRIS report (DR-770). Appealed cases concluded include cases which are dismissed or withdrawn, or there is an (1) agreement, (2) settlement, or (3) decision issued.

Data Limitations: If an appealed medical fee dispute case is resolved by agreement or settlement, or is withdrawn or dismissed at or after a formal hearing, it will be included in the numerator until codes can be added to differentiate between appeals resolved prior to or at a formal hearing.

Calculation Type: Non-cumulative

New Measure: No

Desired Performance: Higher than target

STRATEGY 2.1.1: Provide injured workers, employers, and insurance carriers with information about their rights and responsibilities; minimize and resolve benefit disputes as informally as possible by talking with the participants and conducting compensation benefit review conferences

Output Measures:

2.1.1.1 Number of Benefit Dispute Cases Resolved Prior to a Benefit Review Conference (BRC)

Short Definition: This measure reflects the number of cases resolved prior to a benefit review conference (BRC). Benefit dispute cases are identified by Commission staff in communication with parties or by a party filing a "request for a BRC."

Cases considered "resolved prior to a BRC" include cases in which: the parties reach an agreement; or a designated doctor appointment is set.

Purpose/Importance: This measure reflects the number of benefit disputes resolved at the first level of dispute resolution.

Source/Collection of Data: Dispute cases are identified and are resolved by the Customer Assistance staff or Dispute Resolution staff within 19 days of receiving the dispute or for which a BRC was set to be held, but was resolved prior to holding the proceeding. Data are entered into and reported from agency automated applications.

Method of Calculation: The measure is calculated by adding the number of benefit dispute cases resolved prior to a BRC whereby the parties reach an agreement, or an appointment is set for a designated doctor.

Data Limitations: Disputes denied by the Commission because the parties are not ready to proceed and disputes withdrawn before agreement is reached or a determination is made to proceed to BRC are not included in this measure.

Calculation Type: Cumulative

New Measure: Yes

Desired Performance: Higher than target

2.1.1.2 Number of Compensation Benefit Dispute Cases Concluded in Benefit Review Conference

Short Definition: This measure reflects the number of benefit dispute cases concluded in a benefit review conference (BRC) whereby the dispute is resolved or is referred to the next level of dispute resolution. Disputes are considered resolved when the parties: withdraw the dispute; reach an agreement; or do not pursue the dispute within 90 days of ending.

Purpose/Importance: The measure indicates the number of BRCs that are actually held and concluded for the purpose of resolving benefit disputes that have been identified but not resolved by more informal means.

Source/Collection of Data: Data are reported in the agency automated applications.

Method of Calculation: The measure is calculated by adding the number of benefit dispute cases resolved at BRC and the number of cases referred to the next level of dispute resolution.

Data Limitations: None

Calculation Type: Cumulative

New Measure: No

Desired Performance: Lower than target

Efficiency Measure:

2.1.1.1 Average Number of Days From the Request for Benefit Review Conference to the Conclusion of the Benefit Review Conference

Short Definition: This measure reflects the average number of days from the request for a BRC to its conclusion. A BRC is considered concluded when either resolution results or a report refers the case to the next level of dispute resolution (CCH). Cases are considered "resolved at a BRC" when the parties: withdraw the dispute; reach an agreement; or do not pursue the dispute within 90 days of ending a BRC session.

Purpose/Importance: The purpose of this measure is to monitor the efficiency of the BRC process.

Source/Collection of Data: Data are maintained in agency automated applications.

Method of Calculation: The numerator is calculated by adding the total number of days from the BRC request date to the date the BRC is concluded. The denominator is the Number of Benefit Dispute Cases Concluded in BRCs.

Data Limitations: None

Calculation Type: Non-cumulative

New Measure: No

Desired Performance: Lower than target

Explanatory Measure:

2.1.1.1 Number of Benefit Dispute Cases Received by the Commission

Short Definition: This is a measure of the number of benefit dispute cases received during a reporting period.

Benefit dispute cases are identified by the Commission staff in communication with parties or by a party filing a "request for a BRC." Each case may consist of up to 6 issues. Benefit issues include issues such as coverage, compensability, average weekly wage, disability, impairment rating, maximum medical improvement, disputes over recommendations for spinal surgery, and legal expenses associated with a case.

Purpose/Importance: This measure reflects whether the volume of benefit disputes is increasing, decreasing, or remaining constant.

Source/Collection of Data: The data are maintained in agency automated applications.

Method of Calculation: The measure is calculated by adding the number of benefit dispute cases received and identified in the Dispute Resolution Information System during the reporting period.

Data Limitations: None

Calculation Type: Cumulative

New Measure: No

Desired Performance: Lower than target

STRATEGY 2.1.2: Minimize and resolve medical benefit disputes, before being appealed to the State Office of Administrative Hearings, by talking with participants and conduct medical dispute resolution reviews (including reviews by Independent Review Organizations)

Output Measure:

2.1.2.1 Number of Medical Benefit Dispute Cases Resolved By Initial Administrative Decision

Short Definition: This measure represents the number of medical benefit disputes resolved by initial administrative decision.

The types of medical benefit dispute cases are preauthorization of medical treatment, retrospective review of necessity of treatment and/or reasonableness of fees charged.

Medical benefit dispute cases are resolved by initial administrative decision when the dispute is reviewed by a medical dispute resolution officer (MDRO) or an independent review organization (IRO) and a decision is made to (1) issue an order; (2) issue a finding with no order; (3) issue a dismissal; (4) withdraw the dispute; or (5) issue a finding with refund, and the decision is not appealed to the State Office of Administrative Hearings (SOAH).

If a decision has been issued and one of the parties appeals to the Commission, but resolution is gained prior to the Commission filing the appeal with the SOAH, the case is counted in this measure. Non-jurisdictional disputes are not included in this measure.

Purpose/Importance: The purpose of this measure is to monitor the agency's effectiveness in resolving medical disputes by initial administrative decision, which is the lowest possible level.

Source/Collection of Data: Data are maintained in agency automated systems.

Method of Calculation: The number is calculated by subtracting the number of medical benefit dispute cases that are appealed from the number of medical benefit dispute cases concluded during the reporting period. Cases concluded are defined as disputes in which a decision has been made. A concluded case may go through further processing after an initial administrative decision if either of the parties appeals the decision.

Data Limitations: Statutorily, a party has 20 days to appeal an initial administrative decision. If the decision is made 20 days prior to the end of the reporting period, the appeal may not be included in the calculation of the number during the current reporting period, and thus may be included in the calculation of the number during the next reporting period.

Calculation Type: Cumulative

New Measure: No

Desired Performance: Higher than target

Efficiency Measure:

2.1.2.1 Average Number of Days To Conclude Medical Dispute Cases By Initial Administrative Decision

Short Definition: This measure indicates the efficiency of the medical benefit dispute resolution process.

Medical benefit dispute cases include issues such as preauthorization of medical treatment and retrospective review of necessity of treatment which are reviewed by an independent review organization (IRO) and/or reasonableness of fees charged which are reviewed by a medical dispute resolution officer (MDRO).

A case is considered concluded by initial administrative decision when the dispute is reviewed by an MDRO or IRO and a determination made to (1) issue an order, (2) issue a finding with no order, (3) issue a dismissal, (4) withdraw the dispute, (5) issue a finding with refund, or (6) close as non-jurisdictional.

Purpose/Importance: The purpose of this measure is to indicate the length of time for a medical dispute to be concluded by initial administrative decision.

Source/Collection of Data: Data are maintained in agency automated systems.

Method of Calculation: The numerator is calculated by adding the cumulative number of the days from receipt of a dispute to closure of the dispute for all cases concluded within the reporting period. The denominator is calculated by adding the total number of disputes concluded during the reporting period.

The numerator for the measure does not include the hospital fee disputes that were filed due to the invalidation of the 1992 Acute Care Inpatient Fee Guideline.

Disputes that are received and determined to be incomplete requests or are determined to be outside the jurisdiction of the Medical Dispute Resolution process prior to forwarding to a MDRO or an IRO are not included in this measure.

Data Limitations: This measure calculates one average for three types of disputes. Different reporting and completion requirements apply to each type of dispute. For preauthorization disputes, the respondent has seven days to respond to the request for medical dispute resolution. For medical fee and retrospective medical necessity disputes, the respondent has 14 days to respond to the request for medical dispute resolution. For preauthorization disputes, which require review by an IRO, the IRO should issue a final decision within 20 days of receipt of the IRO fee. For retrospective medical necessity disputes, which require review by an IRO, the IRO should issue a final decision within 30 days of receipt of the IRO fee. For medical fee disputes, after the respondent provides a response to the initial request, both parties are then provided with an additional 14 days to submit all documentation necessary to resolve the fee issues.

Calculation Type: Non-cumulative.

New Measure: No

Desired Performance: Lower than target

Explanatory Measure:

2.1.2.1 Number of Medical Dispute Cases Received by the Commission

Short Definition: This is a measure of the number of medical dispute cases received during a reporting period. A medical dispute case is considered received when a written request is entered into the Commission's Medical Dispute Resolution Information System.

Types of medical benefit dispute cases are: preauthorization of medical treatment, and retrospective review of necessity of treatment and/or reasonableness of fees charged.

Purpose/Importance: This measure provides a reflection of changing trends in the volume of medical dispute cases received by the Commission. It indicates the number of the requests for medical dispute resolution services received during a reporting period.

Source/Collection of Data: The data are maintained in the Medical Dispute Resolution Information System.

Method of Calculation: The measure is calculated by adding the total number of medical dispute cases received for all medical dispute types during the reporting period. Disputes identified as non-jurisdictional and disputes being processed through an alternate dispute resolution medical process for low cost disputes are also included in this measure.

Data Limitations: None

Calculation Type: Cumulative

New Measure: No

Desired Performance: Lower than target

STRATEGY 2.1.3: Conduct benefit contested case hearings, conduct reviews when participants appeal decisions made by benefit contested case hearings officers, and provide arbitration

Output Measure:

2.1.3.1 Number of Compensation Benefit Dispute Cases Concluded in Contested Case Hearings

Short Definition: The measure is the number of benefit contested case hearings (CCHs) held and concluded whereby a decision is rendered.

Purpose/Importance: The measure indicates the number of CCHs that are actually held and concluded because a benefit dispute has not been resolved by more informal means.

Source/Collection of Data: Data is reported in the agency automated applications.

Method of Calculation: The measure is calculated by adding the number of CCHs held and concluded in the reporting period.

Data Limitations: None

Calculation Type: Cumulative

New Measure: No

Desired Performance: Lower than target

Efficiency Measure:

2.1.3.1 Average Number of Days From the Request for a Contested Case Hearing to the Distribution of the Decision

Short Definition: The measure reflects the average number of days from the request for a CCH to the distribution of the decision.

Purpose/Importance: The purpose of this measure is to monitor the efficiency of the Contested Case Hearing (CCH) process.

Source/Collection of Data: Data are maintained in agency automated applications.

Method of Calculation: The numerator is calculated by adding the total number of days between the CCH request date to the date the CCH decision is distributed. The denominator is Number of Benefit Dispute Cases Concluded in CCHs.

Data Limitations: None

Calculation Type: Non-cumulative

New Measure: No

Desired Performance: Lower than target

Explanatory Measure:

2.1.3.1 Number of Appeals Panel Decisions Filed for Judicial Review

Short Definition: The measure is the number of appeals panel decision cases appealed to court for judicial review.

Purpose/Importance: The purpose of this measure is to report the number of benefit dispute cases, which are not resolved by any of the Commission's benefit dispute resolution procedures.

Source/Collection of Data: Data is maintained in a PC database.

Method of Calculation: The measure is calculated by adding the number of appeals panel decision cases appealed to court for judicial review and which are reported to the Commission.

Data Limitations: This measure captures only the appeals for which the Commission receives notification from the appealing party through service of process. A party may not seek judicial review unless the party has provided written notice of the suit to the Commission as required by statute; however, there may be some number of appeals to district court for which the Commission does not receive notification.

Calculation Type: Cumulative

New Measure: No

Desired Performance: Lower than target

STRATEGY 2.1.4: Process medical disputes that are appealed under the Administrative Procedure Act

Output Measure:

2.1.4.1 Number of Appealed Medical Fee Disputes Resolved Prior to a Formal Hearing at SOAH

Short Definition: This measure indicates the number of appealed medical fee dispute cases resolved prior to a formal hearing at SOAH.

This number is the numerator in the calculation method of the measure "Percent of Appeals Resolved Prior to a Formal Hearing at SOAH."

Purpose/Importance: The purpose of this measure is to identify the number of appealed medical fee dispute cases resolved, due in part to mediation efforts, before proceeding on to a formal hearing at SOAH.

Source/Collection of Data: Data are maintained in agency automated systems.

Method of Calculation: The measure is calculated by adding the number of appealed medical fee dispute cases resolved prior to a formal hearing. This number is identified on a DRIS report (DR-770). Appealed medical fee dispute cases resolved prior to a formal SOAH hearing include medical fee disputes which are dismissed or withdrawn, or there is an (1) agreement, or (2) settlement.

Data Limitations: If an appealed medical fee dispute case is resolved as agreement, settlement, withdrawn, or dismissed during a formal hearing, it will be included in this measure until codes can be added to reflect appeals resolved prior to or during a formal hearing, if applicable.

Calculation Type: Cumulative

New Measure: No

Desired Performance: Higher than target

Efficiency Measure:

2.1.4.1 Average Number of Days Saved through Resolution of Medical Fee Disputes Prior to Formal Hearing at SOAH

Short Definition: This measure identifies the average number of days saved by resolving appealed medical fee dispute cases prior to a formal hearing at the State Office of Administrative Hearings (SOAH).

Appealed medical dispute cases resolved prior to a formal SOAH hearing include cases which are dismissed or withdrawn, or there is an (1) agreement, or (2) settlement.

Appealed medical dispute cases resolved at a formal SOAH hearing include cases in which there is a SOAH decision issued.

Purpose/Importance: The purpose of this measure is to identify the efficiency resulting from continuing efforts to mediate and resolve appealed medical fee disputes prior to a formal SOAH hearing.

Source/Collection of Data: Data are maintained in agency automated systems.

Method of Calculation: The measure is calculated by subtracting the average number of days to resolve an appealed medical fee dispute case prior to a formal SOAH hearing from the average number of days from filing an appeal to receiving a SOAH decision after a formal hearing.

Minuend: The sum of the number of days from the date the dispute is appealed to the date a SOAH decision is issued during the reporting period divided by the sum of the number of appealed medical fee disputes in which a SOAH decision is issued during the reporting period.

Subtrahend: The sum of the number of days from the date the dispute is appealed to the date the case was settled, an agreement was reached, withdrawn or dismissed during the reporting period divided by the sum of the number of appealed medical fee disputes that were settled, an agreement was reached, withdrawn or dismissed during the reporting period.

Data Limitations: If an appealed medical fee dispute case is resolved as agreement, settlement, withdrawn, or dismissed during a formal hearing, it will be included in the average days to resolve an appealed medical fee dispute prior to a formal SOAH hearing until codes can be added to differentiate between appeals resolved prior to or at a formal hearing.

Calculation Type: Non-cumulative

New Measure: No

Desired Performance: Higher than target

GOAL 3: To promote safe and healthy workplaces

OBJECTIVE. 3.1: To contribute to keeping the Texas overall incidence rate of injuries and illnesses below the national incidence rate through 2009

Outcome Measures:

3.1.1 Statewide Incidence Rate of Injuries and Illnesses per 100 Full-time Employees

Short Definition: This measure reflects the injury and illness rate for the state of Texas as developed by the U. S. Bureau of Labor Statistics.

Purpose/Importance: This measure, in conjunction with the National Incidence Rate of Injuries and Illnesses, provides a comparison of the Texas injury and illness rate to the National injury and illness rate.

Source/Collection of Data: Data comes from the Annual Survey of Occupational Injuries and Illnesses, which uses a stratified sample of private sector establishments by industry and size class to develop reliable estimates of occupational injury and illness rates in Texas. This is determined by using OSHA (Occupational Safety & Health Administration) standards for record-keeping and injury reporting. Data is collected by TWCC and is entered into terminals which are linked to the Bureau Of Labor Statistics. Rates are developed by the Bureau of Labor Statistics on a calendar year basis. The incidence rate is based on the preceding calendar year.

Method of Calculation: The measure is calculated as (N/EH)x200,000. The numerator is the total number of recordable injuries and illnesses ("N") in the year. The denominator is the total number of hours ("EH") worked by all employees in the year. The multiplier (200,000) expresses the ratio as a rate equivalent to 100 full-time employees working 40 hour weeks 50 weeks per year, or 200,000 hours.

Data Limitations: Data is dependent on the Bureau of Labor Statistics, since BLS produces all calculations based on surveyed data collected by TWCC. The performance reported on a fiscal year basis is the most recently reported incidence rate. Because the incidence rate is calculated on a calendar year basis and almost one year after the close of the calendar year, the reported performance is almost two years old (e.g., CY 2004 performance will be reported in FY 2006). Because of changes to OSHA record keeping for data collected for CY 2002 (and subsequent years), and the BLS switch from Standard Industrial Classification (SIC) codes to North American Industry Classification System (NAICS) for data collected for CY 2003 (and subsequent years), the injury rates reported in FY 2006-FY 2007 and subsequent biennia cannot be directly compared to any year prior to FY 2005.

Calculation Type: Non-cumulative

New Measure: No

Desired Performance: Lower than target

3.1.2 Percentage Change in the Injury Rate for Employers Provided Consultations and Inspection Services

Short Definition: This measure represents the percentage the injury rate changed in the twelve month period following the provision of a service or regulatory action when compared to the twelve month period prior to the service or regulatory action. Injury rates include injuries and job related illnesses with one or more lost workdays, and are collected for both twelve month periods for comparison.

Purpose/Importance: This measure shows the progress of employers in reducing injuries by comparing the average injury rate for the twelve months prior to the time employers receive services to the average injury rate for the twelve months following the service.

Source/Collection of Data: Data is documented on various worksheets and maintained in automated applications.

Method of Calculation: The calculation of this measure is a two step process. The first step involves calculating the injury rates before and after the intervention. The percent change between the two rates is calculated in step two.

Injury Rate: The injury rate is calculated by the formula (injuries / employees) *100. The numerator is the number of injuries and job related illnesses with one or more lost workdays reported by an employer during a twelve month period. The denominator is the highest number of workers

employed by the employer during any month during a 12-month period. Multiplying the final ratio by 100 serves to express the rate as a percent of employees.

Percentage change in the injury rate: The percentage change is calculated by the formula:

[(post-intervention injury rate - pre-intervention injury rate) / pre-intervention injury rate] * 100. The numerator is the difference between the post-intervention injury rate and the pre-intervention injury rate. The denominator is the pre-injury rate. Multiplying the final ratio by 100 serves to express the rate change as a percent.

Data Limitations: None

Calculation Type: Non-cumulative

New Measure: No

Desired Performance: Lower than target

STRATEGY 3.1.1: Develop and provide health and safety services (e.g., needs analyses, education, consultations, investigations and inspections) to employers, employees, academic institutions, and other entities in the Texas workplace

Output Measures:

3.1.1.1 Number of Inspections, Consultations, and Investigations Provided to Employers

Short Definition: This measure shows the number of inspections, consultations, and investigations provided to employers.

Purpose/Importance: These services or regulatory actions are provided through programs such as the OSHCON, Hazardous Employer, Rejected Risk, and Accident Prevention Services (policyholder inspections), and any similar programs operated through additional federal grants.

Source/Collection of Data: Data is maintained on automated applications.

Method of Calculation: The measure is calculated by adding the number of inspections, consultations, and investigations accomplished.

Data Limitations: None

Calculation Type: Cumulative

New Measure: No

Desired Performance: Higher than target

3.1.1.2 Number of Notifications Sent to Employers Meeting Minimum Criteria for Classification as Hazardous

Short Definition: The measure is the number of notifications sent to employers meeting minimum criteria for classification as hazardous.

Purpose/Importance: This measure provides the number of notifications sent to employers stating that they meet the criteria to be identified as hazardous employers, as established by the Texas Labor Code, Section 411.041 and Commission Rules.

Source/Collection of Data: Data is obtained from Commission data and Texas Workforce Commission data. Case files are maintained which contain the notification letters. A PC database contains the date the notifications were mailed.

Method of Calculation: The measure is calculated by adding the number of notifications mailed during the reporting period.

Data Limitations: None

Calculation Type: Cumulative

New Measure: No

Desired Performance: Higher than target

3.1.1.3 Number of Texas Employers Receiving Safety Educational Products/Services

Short Definition: This measure is the total number of Texas employers receiving safety education and training products and services and the number of academic institutions incorporating safety and health educational programs into their curriculum. Safety products include hard copies of publications; informational brochures; and verified viewing of videotapes and DVDs. Safety services include on-site needs assessments, participation in seminars, workshops, and training events. Educational curriculum includes health and safety print materials, television programs produced, lesson plans, and student activities and programs.

Purpose/Importance: The measure reports the number of Texas employers and educational institutions receiving safety and health products and services.

Source/Collection of Data: Data is maintained on PC automated systems and on paper documents.

Method of Calculation: The measure is calculated by adding the number of the Texas employers and academic institutions receiving products and services. For the purposes of this measure, employer counts are unique (i.e., any employer who receives more than one product or service is counted only once).

Data Limitations: None

Calculation Type: Cumulative

New Measure: No

Desired Performance: Higher than target

3.1.1.4 Number of Texas Employees Receiving Safety Educational Products/Services

Short Definition: This measure is the total number of Texas employees receiving safety education and training products and services. Safety products include hard copies of publications; informational brochures; and verified viewing of videotapes and DVDs. Safety services include on-site needs assessments, and participation in seminars, workshops, and training events.

Purpose/Importance: The measure reports the number of Texas employees receiving safety and health products and services.

Source/Collection of Data: Data is maintained on PC automated systems and on paper documents.

Method of Calculation: The measure is calculated by adding the number of Texas employees that receive informational publications, and brochures, and those who view videotapes as reported by employers requesting those publications, brochures and videos. Added to this is the number of Texas employees participating in on-site needs assessments, seminars, workshops, and training events.

Data Limitations: None

Calculation Type: Cumulative

New Measure: No

Desired Performance: Higher than target

3.1.1.5 Number of Electronic Safety and Health Publications Distributed

Short Definition: This measure is the total number of safety publications distributed electronically to customers via the TWCC web site and emails. Safety publications include training programs,

sample written programs, fact sheets, workplace programs, checklists, activity booklets, electronic newsletters, and other safety and health related materials.

Purpose/Importance: The measure reports the number of electronic safety related materials opened by the public.

Source/Collection of Data: Data on safety publications is obtained from logs generated by the web server. Data on email newsletters is obtained from Mailloop activity logs that track email distribution. Electronic publications sent as email attachments by Resource Center staff are logged in electronic files.

Method of Calculation: This measure is calculated by summing the number of times the safety and health publication files are opened from the Health and Safety Publications section on the TWCC Internet site, the number of email newsletters distributed, and the number of publications sent as email attachments.

Data Limitations: The count of the number of times electronic publications are opened or distributed cannot accurately reflect the extent of public use of the information once it is distributed.

Calculation Type: Cumulative

New Measure: Yes

Desired Performance: Higher than target

Efficiency Measure:

3.1.1.1 Average Cost per Consultation/Inspection/Investigation

Short Definition: This measure shows the average cost for providing consultations, inspections and investigations. Direct costs and all indirect costs applicable to the programs are included in the total.

Purpose/Importance: The measure provides the average costs of consultations, inspections, and investigations. These services or regulatory actions are provided through programs such as the OSHCON, Hazardous Employer, Rejected Risk, and Accident Prevention Services (policyholder inspections), and any similar programs operated through additional federal grants.

Source/Collection of Data: The costs associated with providing consultation, inspection, and investigation services are based upon all direct and indirect costs associated with providing those services. Direct costs include the total cost of supporting the program to perform its functions. Indirect costs are a proportionate share of TWCC indirect administrative costs. The number of consultations, inspections, and investigations are totaled.

Method of Calculation: The measure is calculated by dividing the total costs by the total number of consultations, inspections, and investigations. The denominator for this measure is the output measure representing the Number of Consultations, Inspections, and Investigations.

Data Limitations: Because they are specifically appropriated in the OSHCON grant, fringe benefit costs, such as OASDI/Medicare, state retirement contributions, benefit replacement pay, salary increases, and medical benefits are included in the indirect costs for the OSHCON program. The same costs for the other programs are not included.

Calculation Type: Non-cumulative

New Measure: No

Desired Performance: Lower than target

Explanatory Measures:

3.1.1.1 Number of Health and Safety Related Hotline Reports Received

Short Definition: This measure is the number of hotline reports received during the reporting period which involve health and safety issues. The measure includes reports of violations of health and safety laws and related questions.

Purpose/Importance: The measure provides the number of health and safety related calls; correspondence and emails received by the Safety Violations Hotline program, which is established by the Texas Labor Code, Section 411.081.

Source/Collection of Data: Data is obtained from a daily log, which is manually maintained, then entered into an automated system.

Method of Calculation: Calculation is the sum of the telephone calls, emails, and correspondence received during the time frame.

Data Limitations: None

Calculation Type: Cumulative

New Measure: No

Desired Performance: Lower than target

3.1.1.2 Nationwide Incidence Rate of Injuries and Illnesses per 100 Full-Time Employees

Short Definition: This measure reflects the national injury and illness rate as developed by the U. S. Bureau of Labor Statistics.

Purpose/Importance: This measure, in conjunction with the Texas Incidence Rate of Injuries and Illnesses, provides a comparison of the Texas injuries and illnesses rate to the National injuries and illnesses rate.

Source/Collection of Data: Data comes from the Annual Survey of Occupational Injuries and Illnesses, which uses a stratified sample of private sector establishments by industry and size class to develop reliable estimates of occupational injury and illness rates. This is determined by using OSHA (Occupational Safety & Health Administration) standards for record-keeping and injury reporting. Data is collected by Bureau of Labor Statistics. The rate is reported on a calendar year basis and is based on the preceding calendar year.

Method of Calculation: The measure is calculated as (N/EH)x200,000. The numerator is the total number of recordable injuries and illnesses ("N") in the year. The denominator is the total number of hours ("EH") worked by all employees in the year. The multiplier (200,000) expresses the ratio as a rate equivalent to 100 full-time employees working 40 hour weeks 50 weeks per year, or 200,000 hours.

Data Limitations: Data is dependent on the Bureau of Labor Statistics, since BLS produces all calculations based on surveyed data collected nationally. The performance reported on a fiscal year basis is the most recently reported incidence rate. Because the incidence rate is calculated on a calendar year basis and almost one year after the close of the calendar year, the reported performance is almost two years old (e.g., CY 2004 performance will be reported in FY 2006). Because of changes to OSHA record keeping for data collected for CY 2002 (and subsequent years), and the BLS switch from Standard Industrial Classification (SIC) codes to North American Industry Classification System (NAICS) for data collected for CY 2003 (and subsequent years), the injury rates reported in FY 2006-FY 2007 and subsequent biennia cannot be directly compared to any year prior to FY 2005.

Calculation Type: Non-cumulative

New Measure: No

Desired Performance: Lower than target

GOAL 4: To effectively manage the responsibilities and funds of the Subsequent Injury Fund.

OBJECTIVE 4.1: To ensure proper financial administration of and appropriate payment of benefits to injured employees and reimbursements to insurance carriers through the Subsequent Injury Fund.

Outcome Measure:

4.1.1 Total Payments Made Out of the Subsequent Injury Fund For Lifetime Income Benefits and Reimbursements to Insurance Carriers

Short Definition: This measure represents Subsequent Injury Fund (SIF) payments to injured workers eligible for lifetime income benefits (LIBs) and reimbursements to insurance carriers for benefits that have been paid but have been determined to be reimbursable by the SIF.

Purpose/Importance: This measure reflects the obligations of the SIF in making payments to injured workers and to insurance carriers and in monitoring the SIF's financial status to meet those obligations.

Source/Collection of Data: SIF data is collected and maintained in the Commission's accounting system.

Method of Calculation: The measure is calculated by summing the payments made by the SIF: 1) to injured workers for LIBs, and 2) to insurance carriers for benefits that have determined to be reimbursable by the SIF administrator in accordance with the TWCC Act and Rules.

Data Limitations: Requests for reimbursement for benefits that have been paid as a result of a Commission order or decision that has been reversed or modified are paid the quarter following the quarter in which the requests were received. All requests for reimbursement for benefits paid as a result of multiple employment or pharmaceuticals for the first seven days after an injury are reimbursed in the fiscal year following the year in which the requests were received by the SIF. The measure does not include payments made from the SIF for (1) reimbursing death benefits prematurely paid to the SIF by insurance carriers, and (2) developing regional workers' compensation healthcare networks.

Calculation Type: Cumulative

New Measure: Yes

Desired Performance: Lower than target

STRATEGY 4.1.1: Pay authorized benefits timely and appropriately to injured employees who meet the statutory criteria for lifetime income benefits (LIBs) due to a second work-related injury and reimburse insurance carriers for eligible: (1) overpayment of benefits; (2) multiple employment benefits; and (3) pharmaceutical benefits.

Output Measures:

4.1.1.1 Number of Injured Workers Receiving Lifetime Income Benefit (LIBs) Payments Through the SIF

Short Definition: This measure tracks the number of injured workers who meet the eligibility requirements set by statute for lifetime income benefits and are receiving payment of those benefits through the Subsequent Injury Fund.

Purpose/Importance: The purpose of this measure is to identify the long-term obligations of the SIF because these benefits must be paid for the life of the injured worker. SIF is statutorily obligated to pay LIBs to injured workers who sustain a subsequent compensable injury that, with the effects of a previous injury, results in eligibility of LIBs.

Source/Collection of Data: SIF data is collected and maintained in the Commission's accounting system.

Method of Calculation: The measure is calculated by summing the number of injured workers receiving LIBs payments from the SIF during the reporting period.

Data Limitations: Attorneys, spouses, or children receiving a portion of a LIBs payment are not included in the measure.

Calculation Type: Non-cumulative

New Measure: Yes

Desired Performance: Lower than target

4.1.1.2 Number of Requests for Reimbursement for Overpayment of Benefits Processed

Short Definition: This measure tracks the number of determinations made by the SIF on completed requests received from insurance carriers for reimbursement of benefits that they have paid as a result of a Commission order or decision that has been reversed or modified by a subsequent order or decision by the Commission or a court.

Purpose/Importance: The SIF is statutorily obligated to reimburse insurance carriers who have paid benefits based on a Commission order or decision that is ultimately reversed or modified by a subsequent order or decision.

Source/Collection of Data: SIF data is collected and maintained in the SIF database.

Method of Calculation: The measure is calculated by summing the number of reimbursement requests reviewed for which a determination is issued during the reporting period.

Data Limitations: Incomplete requests for reimbursement are not included in this measure.

Calculation Type: Cumulative

New Measure: Yes

Desired Performance: Lower than target

4.1.1.3 Number of Requests Filed for Reimbursement of Multiple Employment Benefits Paid

Short Definition: The measure reflects the number of requests the SIF receives from insurance carriers for the reimbursement of benefits paid to injured workers who held multiple jobs prior to their injury.

Purpose/Importance: Reimbursement of the portion of income benefits paid by insurance carriers to injured workers for lost income from a job other than the one at which the injury occurred was added to the SIF's obligations during the 77th Legislative Session. This measure assists in tracking the frequency with which the SIF is asked to reimburse for multiple employment benefits and in identifying trends in that type of reimbursement.

Source/Collection of Data: SIF data is collected and maintained in the SIF database.

Method of Calculation: The measure is calculated by summing the number of complete requests filed by insurance carriers for reimbursement of benefits paid to injured workers who held multiple jobs prior to an injury and received benefits based on the lost income of the multiple jobs.

Data Limitations: Requests for reimbursement of multiple employment benefits are reimbursed annually in the fiscal year following the year in which the requests were received.

Calculation Type: Cumulative

New Measure: Yes

Desired Performance: Lower than target

Efficiency Measure:

4.1.1.1 Average Days from Close of Quarter to Payment of Requests for Reimbursement that are Approved

Short Definition: The measure reflects the average length of time required to review and make determinations on requests for reimbursement to insurance carriers for income benefits that were paid.

Purpose/Importance: The measure shows how long an insurance carrier waits after the close of a quarter to be reimbursed for overpaid benefits.

Source/Collection of Data: SIF data is collected and maintained in the Commission's accounting system and in the SIF administrator's database.

Method of Calculation: The measure is calculated for all reimbursement requests approved by the SIF administrator based on requests filed in the preceding quarter(s). The measure is calculated by dividing the total number of days from the start of a quarter to the paid date for each approved reimbursement request by the total number of reimbursement requests approved in that quarter.

For reimbursements of benefits based on overpayment of benefits due to reversed or modified orders/decisions, the number of days for each approved request is calculated as the difference between the paid date shown on the accounting reports and the first day of each quarter.

For reimbursements of multiple employment and pharmaceutical benefits paid for the first seven days after an injury, the number of days for each approved request is calculated as the difference between the paid date shown on the accounting reports and the first day of the fiscal year.

Data Limitations: Reimbursements in each quarter are based on requests filed by insurance carriers in previous quarter(s). Multiple employment and pharmaceutical reimbursements are made annually; therefore, activity relating to that type of reimbursement will only be reflected in the first quarter of each fiscal year. This measure does not include reimbursed death benefits or settlements.

Calculation Type: Non-cumulative

New Measure: Yes

Desired Performance: Lower than target

APPENDIX E

TEXAS WORKERS' COMPENSATION COMMISSION

WORKFORCE PLAN

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WORKFORCE PLAN

AGENCY OVERVIEW

The Texas Workers' Compensation Commission was established April 1, 1990 as part of a broad effort to reform the state's workers' compensation system. Continuation of the Commission is dependent upon passage of Sunset legislation in 2005. Recognizing that numerous changes will likely be discussed and may be adopted through the legislative process, the agency's workforce plan has been developed based on an assumption that a workforce with the identified skills will continue to be needed, whether as part of the agency as configured or as part of other possible configurations or another agency(ies).

The Commission has adopted as its mission to:

- provide a regulatory framework to facilitate timely, appropriate and cost-effective delivery of benefits and quality health care so that workers can return to productive roles in the workforce; and
- assist employers in the provision of safe workplaces.

The Commission's legal authority and general duties are described in Chapter 402 of the Texas Workers' Compensation Act of the Texas Labor Code, Title 5, Subtitle A. The Commission's primary responsibilities in the workers' compensation system are prioritized as follows:

- Administer a benefit delivery system to ensure employees with job-related injuries and illnesses receive fair and appropriate benefits in a timely and cost effective manner;
- Ensure appropriate health care for injured employees with fair and reasonable reimbursement for health care providers;
- Provide customers with information about their rights and responsibilities;
- Ensure compliance with the Texas Workers' Compensation Act and Commission rules;
- Minimize and resolve disputes at the agency level, as soon as possible, without having to go to court;
- Certify and regulate large private employers that qualify to self-insure;
- Promote safe and healthy workplaces; and
- Manage the responsibilities and funds of the Subsequent Injury Fund.

Agency Goals and Objectives

In accordance with the agency's statutory requirements, the Commission works toward accomplishing four primary goals.

- ensuring the cost effective delivery of appropriate benefits;
- minimizing and resolving disputes;
- promoting safe and healthy workplaces; and
- effectively managing the responsibilities and funds of the Subsequent Injury Fund.

The Commission has developed the following objectives to direct the agency's efforts in reaching its goals.

- To ensure appropriate payment of income benefits and health care for injured employees and fair and reasonable reimbursement for health

care providers through 2009 to allow for appropriate return to work

- To monitor compliance with applicable statutes and rules and identify fraudulent activity in the workers' compensation system through 2009

- Improve efficiency of communication processes in the workers' compensation system by 2009

- To certify and regulate large private employers that qualify to self-insure

- Resolve 99% of benefit and medical benefit disputes in the Commission's system through 2009

- To contribute to keeping the Texas overall incidence rate of injuries and illnesses below the national incidence rate through 2009

- To ensure proper financial administration of and appropriate payment of benefits to injured employees and reimbursements to insurance carriers through the Subsequent Injury Fund

Commission Organizational Structure

The Commission is governed by a part-time, six member policy-making board. Three Commissioners represent wage earners and three Commissioners represent employers. The executive director is the executive officer and administrative head of the agency. The executive director exercises all rights, powers, and duties imposed or conferred by law on the Commission except for rulemaking and other rights, powers, and duties specifically reserved by statute for members of the Commission. Three deputy executive directors are responsible for overseeing the particular areas of agency operations. The executive director, the deputy executive directors, and the directors for each of the functional areas of the Commission are currently located in Austin, with the exception of four regional directors who are responsible for managing the operations of the Commission's twenty-four field offices.

The Commission's central office is located in Austin and provides technical support for the agency by developing rules, regulations and operational procedures; responding to requests for information under the Public Information Act; monitoring system participants; conducting research and analysis on system data; and reporting performance to internal and external customers. The central office also provides administrative support such as developing and maintaining information systems, human resources, budget, and facility management. Also located in Austin is the agency's record center, which provides safe storage and maintenance of Commission claim records.

The Commission has twenty-four field offices, divided into four regions, strategically located across Texas. In addition to dispute resolution efforts conducted in all of the field offices, the Commission has additional facilities in Uvalde and Mt. Pleasant for the sole purpose of holding dispute proceedings. Field office locations are determined by claim activity and demand for services in the geographic area.

Anticipated Changes in Customer Demands and Commission Organizational Structure

Since employers and employees are among the Commission's primary service populations, changes in the state's population and workforce directly affect the number of individuals who can potentially require or request services from the Commission. To forecast changing demands for the services provided by the Commission and the necessity of changing the services or the manner in which they are provided, the Commission considers data regarding: forecasted changes in the state's population and economy; analyses of workers' compensation injury statistics; demands expressed by system participants; and how technology will effect the delivery of services in the future.

Population Trends:

- Texas will be among the top three fastest growing states in the U.S. and that by 2010, the population will be approximately 24.2 million.[43]
- Total employment in Texas is projected to increase by over 1.8 million jobs between 2000 and 2010, rising to nearly 13 million.[44]
- Elderly population is expected to increase by twenty-two percent between 2000 and 2010.[45]
- Potential shortage of skilled labor as key positions employees are able to retire, taking with them critical knowledge and skills.[46]
- Hispanics will become the majority ethnic group in the state between 2026 and 2035.[47]
    - even though Texas experienced an all time low in the number of total occupational fatalities in 2002, Hispanic workers' representation in the overall number of fatalities increased from thirty-one percent in 2001 to thirty-five percent in 2002.[48]
- Texas is one of few states to see a rise in the number of adults who have not graduated from high school.[49]

Economic Trends:

- Texas' poverty rate in 2003 was 15.6 percent overall – three points higher than the U.S. rate.[50]
- Low wages in many of the growth sectors of Texas' economy contribute to the state's large working poor population.
- Poverty rates are significantly higher for the large and growing Hispanic population.

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[43] Gattis, D. (December 2002). "Jobs in the 21st Century," *Texas Labor Market Review* published by the Labor Market Information Department of the Texas Workforce Commission.
[44] Ibid. Gattis.
[45] Ibid. Gattis.
[46] Ibid. TWC, "The Texas Economy: An Age of Global Economic Opportunity," p. 38.
[47] Miller, J. (October 2002) "The Hispanic Republic of Texas: It's coming. Soon," *National Review*. Retrieved March 18, 2004 http://www.findarticles.com/cf_dls/m1282/19_54/92049012/print.jhtml. p. 11.
[48] Texas Workers' Compensation Commission (2001-2002). Bureau of Labor Statistics Census of Fatal Occupational Injuries.
[49] Taylor, L. (January/February 2003). "Region Lags Nation in Educational Attainment," Federal Reserve Bank of Dallas, *Southwest Economy*. Retrieved on 3/19/2004 http://dallasfed.org/research/swe0301a.html p. 2.
[50] Center for Public Policy Priorities. (2003). "Texas Poverty Fact Sheet," Retrieved March 19, 2004 http://www.cppp.org/products/fastfacts/poverty.html p.1.

- Workforce trends reveal a shift to occupations that require a higher level of skill and education.
- Many low-skilled and low-educated workers obtain employment in high hazard occupations in construction, manufacturing, and agriculture industries, thus increasing their likelihood of being injured or killed on the job.
- Some of the occupations projected to be the fastest growing between now and 2010 are: computer software engineers, computer support specialists, network administrators, database administrators, desktop publishers, health service occupations, teachers, and customer service representatives, particularly in the technology field.

Customer Demands:

- Despite the state's workforce growth, the number of workplace injuries has declined over the last several years. That decline has contributed to maintaining fairly constant workload demands in areas such as benefit dispute resolution.
- There is a rising public expectation for easy access to information at any time, especially through the use of the internet.
- The Commission forecasts an increased need to provide services in several formats; for example, in other languages, in formats that do not require reading proficiency, and/or that are ADA compliant.
- System participants have increased the demand for improvements in how many injured employees return to work and in how quickly those employees return to work.

Effect of Technology on Commission's Future Service Delivery and Structure. As the Commission's automated claim system is redesigned through the Business Process Improvement project and moves toward an "e-claim" system, the Commission will become less dependent on paper documents to conduct its business, and the organization and structure of the agency may also change. Once electronic claim files are created, it will become much easier to provide assistance to the Commission's customers via web-delivered services or by phone from anywhere in the state. In order to implement systems dependent on electronic records, it will be essential that staff responsible for handling and maintaining mail and paper records are trained and provided with access to assistance in the use of new document management equipment and technology (i.e., scanners, indexing tools, etc).

Although the initial response from customers using video- and tele-conferencing for dispute resolution proceedings has not all been positive, resource demands may require conducting more and more of those dispute resolution proceedings in a setting other than a face-to-face interaction. With the availability of technology to create and distribute electronic records and to bring parties in different locations together, conducting dispute proceedings and other Commission services will likely change over the next five years. The Commission is currently exploring additional opportunities to utilize tele-conferencing to conduct dispute proceedings.

Although the Commission's existing goals and strategies are not anticipated to change dramatically in the foreseeable future, strategies related to new functions

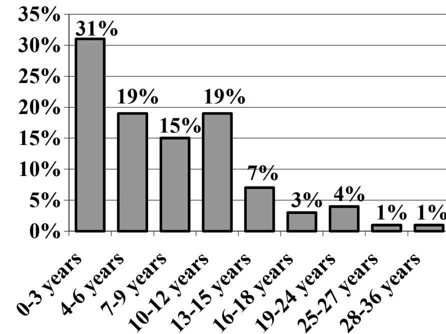
may be added and reprioritization of existing strategies may be necessary. Efforts to educate and assist employers with providing safe workplaces will continue to be critical in preventing significant increases in the number of workplace injuries. Additionally, the increasing size of the state's workforce and changing customer expectations will certainly require identification and implementation of alternative service delivery options. The increased attention to and priority being given to controlling medical costs and timely returning injured employees to work may require the redistribution or the addition of new resources to perform functions not currently performed by the agency.

Current Workforce Profile

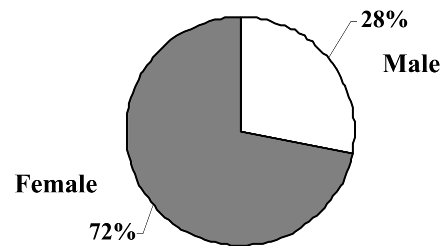
The Commission is authorized to have 1,042 full-time equivalents (FTEs). Approximately fifty-five percent of the staff is located in the agency's central office located in Austin, and the other forty-five percent is located in field offices throughout the state.

The following charts profile the agency's workforce as of August 31, 2003 and include both full-time and part-time employees.

Workforce Tenure



Workforce By Gender

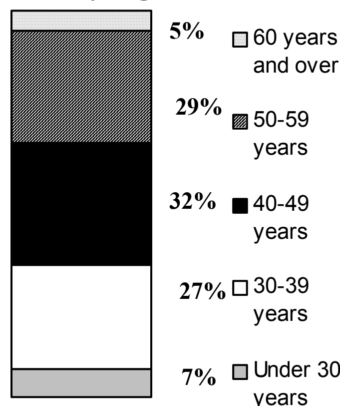


Commission Equal Employment Opportunity Statistics

Job Category	Total Positions	Black: Agency	Black: Civilian Labor Force %	Hispanic: Agency	Hispanic: Civilian Labor Force %	Female: Agency	Female: Civilian Labor Force %
Fiscal Year 2003 — Minority Workforce Percentages							
Official/Administrators	20	5%	7%	10%	12%	40%	32%
Professional	495	10%	9%	27%	11%	61%	47%
Technician	42	10%	14%	31%	19%	38%	39%
Protective Services	0	0%	18%	0%	22%	0%	21%
Para-Professional	103	20%	18%	45%	31%	94%	56%
Administrative Support	300	22%	20%	47%	26%	89%	80%
Skilled Craft	0	0%	10%	0%	30%	0%	10%
Service/Maintenance	3	0%	18%	100%	44%	0%	25%

Source: Equal Employment Opportunity Commission's National Employment Summary EEO-4 2000 and EEO-1 2001; http://tchr.state.tx.us/wkfrc.htm

Distribution of Workforce By Age



The average salary of Commission staff is approximately $34,337 per year. Based on FY 2002 data from the State Auditor's Office, the Commission's average salary level is fairly consistent with the average statewide salary; however, it is significantly below the average salary of employees working at other Article VIII-Regulatory agencies ($40,042).

Employee Turnover and Retirement Eligibility. As for any organization, the Commission must account for staff turnover in its planning efforts. After experiencing turnover rates of 19% or more for several years, the Commission has seen a reduction in the turnover rate for the past couple of years. In FY 2003, the Commission's turnover rate was 14.8%. Although the Commission's rate was below the statewide rate (including intra-agency transfers) of 18.7%, the Commission was fortunate, because of its statutorily-defined source of funding, that it was not subject to the 7% funding reduction that required many agencies to institute reductions in force in FY 2003. The Commission recognizes that the lower turnover rates in recent years may merely be the result of the economic downturn. Maintaining a work environment that values employees and provides opportunities for advancement is essential in order to retain a qualified and skilled workforce.

As is being seen throughout state government and in the workforce in general, the Commission is experiencing increased numbers of employees becoming eligible for and taking retirement. Retirement is now a significant component of the agency's turnover. The combination of natural retirements and the 25% retirement bonus incentive enacted by the 78th Legislature resulted in the loss of 43 Commission employees due to retirement in FY 2003, and another ten have retired in FY 2004 as of May 1, 2004. Based on analysis of the Commission's workforce, it appears that somewhere in the neighborhood of 141 current employees could become eligible for retirement between FY 2005 and FY 2009, which is approximately 14% of the agency's workforce. Sixty-four percent of the possible retirees are people in positions classified as "professional," most of which require training and experience with workers' compensation and Commission practices and procedures. Furthermore, the loss of management skills could be tremendous. Twenty-six percent (36 people) of the persons eligible are in positions with management and supervisory responsibilities, and one-third of the agency's executive management structure will be eligible for retirement within the next five years.

To prepare for future turnover, whether due to retirements or otherwise, the Commission has taken a number of actions to mitigate the loss of experience and expertise. A succession planning

program was initiated in the Spring, 2004 to begin providing junior staff with planning and leadership training and project experience that will prepare them for possible management positions in the future. The six-month program consists of classroom training, skills assessments, project assignment, and a mentoring component.

Several vacant positions have been filled by employees who have retired from the agency, which allows for the retention of valuable expertise but continues the risk of losing that expertise in the foreseeable future. The need to ensure that processes and job functions are documented and that cross-training occurs for all agency functions has become increasingly critical.

Contract Workforce. The Commission typically only uses independent contractors, temporary workers supplied by staffing companies, contract company workers and consultants where the Commission does not have necessary skill sets or expertise and when additional resources are needed for a limited time. For example, in FY 2003 and FY 2004, the following types of employees have been hired under contract:

- Registered nurses and doctors to perform reviews of medical cases to determine appropriateness of health care being provided;
- Support personnel to process high volume of medical dispute cases received;
- Programming and other technical personnel with necessary skills to develop and implement new infrastructure and automated systems through the Commission's Business Process Improvement project; and
- Support staff to assist in collecting data for annual survey of employers regarding workplace injuries through a federal grant

Mission Critical Workforce Skills:

- Customer service skills to assist participants in understanding workers' compensation requirements and processes
- Ability to use and perform basic functions on a personal computer
- Ability to interpret and implement state and federal statutes
- Communication skills to explain Commission policy and purpose to diverse customer groups simply and effectively
- Mediation and dispute resolution skills for resolving contested issues between parties in the workers' compensation system, including conducting dispute resolution proceedings if necessary
- Investigative skills to identify or confirm alleged non-compliance and fraudulent activity
- Safety and health skills needed by agency safety professionals doing training, inspections, and consultation activities
- Technical skills necessary to develop and maintain the Commission's existing and new automated systems
- Management skills, including the provision of leadership to staff

Future Workforce Profile

Although key functions currently performed by the Commission are not expected to be eliminated over the next several years, new functions may be added and the manner in which functions are performed and the resources dedicated to functions may change significantly.

The introduction of new technology, through the full implementation of the Business Process Improvement Project and the development of call center(s) to handle customer assistance by phone, should allow for resources to be redeployed from historically labor-intensive processes to more direct service delivery and more sophisticated methods of system monitoring. Approximately thirty percent of the current workforce is classified in the "administrative support" EEO job category. The redeployment will require either training existing employees in new skill sets or reclassifying and redefining vacant positions based on the skills now needed.

As the Commission incorporates a responsibility for returning injured workers to the workforce as safely and quickly as possible, new or enhanced functions will likely be performed by agency staff. For instance, if the disability management model currently being considered by the Commission that changes the manner in which health care is provided and how claims are managed is adopted, staff will begin collecting and reporting on new information and monitoring for outcomes that are not currently tracked. Additionally, new training and certification standards may be needed for doctors practicing within the disability management paradigm.

Two new processes for handling disputes over medical issues are expected to be implemented within the next year. The first process establishes an avenue to resolve situations in which medical care is not being provided because there is an indication from the insurance carrier that no further medical care is needed for that injury or part of the injury. These prospective medical care issues are currently brought to the Commission for resolution, but a consistent methodology has not existed for handling them. Since these issues are currently being brought to Commission staff for assistance, the significant increase in workload is not expected. However, since these differences of opinion by the insurance carrier and the health care provider may result in the issuance of an interlocutory order to provide the medical care, there may be a need for additional medical expertise to assist in monitoring those decisions.

The other new process to be implemented in the near future is an alternate medical dispute resolution process for disputes of retrospective medical necessity that involve care costing less than the cost of a review by an Independent Review Organization (IRO). The Commission was provided with statutory authority during the 78th Legislature to establish such an alternative medical dispute resolution process. The volume of medical disputes that are not raised through the current medical dispute resolution process because the IRO fee is cost prohibitive is unknown; however, the volume of new disputes being brought the Commission for resolution under this new process may be significant. Although the process as proposed enlists the expertise of health care providers selected by the Commission to perform the reviews of the submitted medical documentation and to make the determinations, additional resources to process and track the disputes may be needed.

Necessary Future Workforce Skills:

- Customer service skills to assist participants in understanding workers' compensation requirements and processes

- Writing skills for the development of various types of public communications in clear and simple language – Commission interpretation of state and federal statutes and rules; explanation of new or modified Commission policies; guidance on how to participate in the workers' compensation system; highlighting performance in the workers' compensation system, whether that of the Commission or other system participants
- Mediation and dispute resolution skills for resolving contested issues between parties in the workers' compensation system, including conducting dispute resolution proceedings if necessary
- Strategic planning skills as workflows transition from paper-intensive formats to web-based and other technology supported self-delivery formats
- Data analysis for issue identification; possible incentives for "good performers" in the system; development of public information reflecting overall system performance
- Spanish proficiency for educators, trainers, and consultants
- Return-to-work program experience and expertise to educate system participants, including Commission staff, on the benefit of early return-to-work and to assist with the development of effective return-to-work programs in public and private business settings
- Medical expertise to review questions of appropriateness of care being provided and/or requested and other medical questions
- Professional occupational safety and health skills to conduct inspections, consultations, investigations, and training.
- Legal expertise to support the Commission's need for legal guidance on medical, compliance, application of technology, and litigation questions
- Technical skills for the development of self-service applications and computer–based training, both for internal and external system participants
- Managing and providing leadership to staff, as well as developing future leaders

The Commission believes that to appropriately perform the functions required to meet the stated goals and objectives of the agency, the actual overall staffing level needs to increase. Efforts are being made to increase the "occupancy rate" for the FTEs currently authorized for the agency. As the initial step in that effort, Commission staff has undertaken a review of current staffing allocations among program areas to determine whether resources need to be redistributed and where additional FTEs need to be dedicated in order to meet the agency's goals and responsibilities. Additional funding, possibly including additional FTEs, will be requested in the future to continue the medical quality review functions currently being performed under funding through a grant from the Texas Mutual Insurance Company.

Gap Analysis

Areas in which the Commission anticipates having imbalances between the staffing and/or skills presently available and those needed in the future include:

- The number of staff currently responsible for data entry functions will exceed the need for those functions as the Business Process Improvement project progresses and more services are provided via electronic means.

- Additional staff with medical expertise is needed to perform medical file reviews and to communicate with system participants regarding medical issues. Over the last couple of years, the Commission has experienced an increase in the number of medical disputes being filed, requests for guidance on the application Medicare policies, and increased roles in the review and monitoring of the medical delivery. Additionally, as part of a grant from the Texas Mutual Insurance Company, the Commission has been able to contract for additional medical resources to perform duties associated with conducting quality of care reviews of health care providers. It is the Commission's desire to continue the same level of performance that has been established after the grant has ended. Although an analysis of the compensation rates for employees with nursing experience in other agencies showed comparable compensation rates to those offered by the Commission, attracting and retaining these skills sets has proven to be a challenge.

- More Spanish speakers for critical functions such as safety consultations and inspections; training, education, and public information efforts; and customer service.

- Difficulty attracting safety officers with the training and experience necessary for the job functions.

- Increased need for staff performing return to work training, public information development, and monitoring functions.

- Increased demand for staff able to develop training regarding the use of technology. As the Commission increases its use of technologies to deliver services and perform functions that were previously performed through human interaction, the demand for training on the use of technologies will increase and need to be coupled with training on the statutes, rules, policies, and procedures.

- Increased demand for access to legal expertise on medical and compliance issues; issues regarding the use of technology for service delivery; and litigation.

- Insufficient pool of staff with project, contract, and human resource management skills.

- Replacement of leadership skills as agency turnover and retirements deplete the available pool of staff with experience and expertise in the workers' compensation program areas.

Strategies for Addressing Identified Gaps

Commission management has developed the following goals and strategies for addressing the shortages in staffing levels

and skills required for the agency's future workforce.

GAP 1: The number of staff currently responsible for data entry functions will exceed the need for those functions as the Business Process Improvement project progresses and more services are provided via electronic means.

Goal: As efficiencies are realized through the Business Process Improvement Project, identify and reallocate resources to service delivery functions that have been prioritized by management, such as alternate medical dispute resolution, new responsibilities associated with a disability management model for claims administration, and return to work educational efforts.

Strategy: Retrain data entry staff in the use of document management technology.

Strategy: Once efficiencies have been realized, reallocate some of the data entry positions into key functions requiring additional resources.

Strategy: Conduct job classification and compensation reviews and make appropriate modifications as staff gain new skills and take on increased responsibilities.

GAP 2: Additional staff with medical expertise is needed to perform medical file reviews and to communicate with system participants regarding medical issues.

Goal: Obtain access to a sufficient number of staff with medical expertise to continue the present level of quality of care reviews of health care providers; to be integrally involved in the development of rules, policies, and public information regarding medical issues; and to perform oversight functions relating to medical issues.

Strategy: Conduct cost-benefit analysis of attracting and retaining additional employees with medical expertise to conduct quality of care reviews and other medical functions versus outsourcing those functions.

Strategy: Identify whether state employees with medical expertise may be affected by the consolidation of health and human services agencies, and if so, establish methods for recruiting from that pool of possible job seekers.

Strategy: Allow critical positions requiring medical expertise to work flexible and/or reduced work schedules where possible.

Strategy: Conduct job classification and compensation reviews and make appropriate modifications to attract and retain nurses who competently perform their required functions.

Strategy: Obtain the services of another health care provider, either through hiring or contracting, to assist with establishing policy direction and performing monitoring functions.

GAP 3: There is an increased need for more Spanish speakers for critical functions such as safety consultations and inspections; training, education, and public information efforts; and customer service.

Goal: Attract and retain the level of staffing with Spanish language skills to meet the needs of our customer populations.

Strategy: Encourage Commission employees and managers to work toward becoming conversant in Spanish through education by taking advantage of the tuition reimbursement program and flexible work schedules.

Strategy: Develop a recruitment strategy for attracting bilingual applicants for Commission positions, specifically positions in field offices, Customer Services, and Workers' Health and Safety.

Strategy: Determine whether implementation of a call center allows for increased access to Spanish speakers who are performing customer service functions.

Strategy: Explore the possibility of providing for increased compensation for Spanish speakers in positions that are difficult to fill and/or particular areas of the state if those positions have been designated as requiring a Spanish speaker.

GAP 4: Difficulty attracting safety officers with the training and experience necessary for the job functions.

Goal: Increase pool of qualified applicants for safety officer positions.

Strategy: Develop an apprenticeship/internship program for safety professionals.

Strategy: Modify the required experience provisions for health and safety professional positions to allow for a larger pool of candidates for those positions.

Strategy: Encourage educational institutions to develop and offer safety curriculum.

GAP 5: Increased need for staff performing return-to-work training, public information development, and monitoring functions.

Goal: Reduce the time that employees in Texas are off work due to work-related injuries.

Strategy: Add staff positions for developing public information regarding the benefits of prompt return-to-work after an injury; providing on-site education and assistance to employers wanting to develop return-to-work programs; and monitoring the effect of Commission policies and rules on return to work outcomes.

GAP 6: Increased demand for staff able to develop training regarding the use of technology.

Goal: Ensure that new automated system users have sufficient instructional materials and resources to access necessary information and perform functions appropriate for their

roles in the workers' compensation system.

Strategy: Develop written procedures and training modules to clearly establish workflow and processing instructions for staff and external customers using new technology tools and applications.

GAP 7: Increased demand for access to legal expertise on medical and compliance issues; issues regarding the use of technology for service delivery; and litigation.

Goal: Ensure sufficient legal support for the performance of mission-critical functions.

Strategy: Identify how other agencies that have implemented automated service delivery systems have obtained legal training on issues such as confidentiality, user verification, litigation documentation, etc. Work with the Legal workgroup of the State Agency Coordinating Council to determine whether any cost effective opportunities exist for accessing legal continuing education regarding the use of new technologies for all state agencies.

Strategy: Add staff with the types of legal expertise identified as necessary to perform mission-critical functions.

GAP 8: Insufficient pool of staff with project, contract, and human resource management skills.

Goal: Develop existing staff with workers' compensation expertise knowledge and technical expertise to perform roles such as project lead and contract manager.

Strategy: Provide for new staff development opportunities to develop and enhance the skills of staff in areas such as project, contract and human resource management.

GAP 9: Replacement of leadership skills as agency turnover and retirements deplete the available pool of staff with experience and expertise in the workers' compensation and the workplace safety program areas.

Goal: Identify and prepare staff who possess the leadership skills necessary to fill roles as managers, supervisors, and team leads.

Strategy: Develop methods for cross-training staff within and between program areas, including the support functions.

Strategy: Continue succession planning program to develop future leaders by systematically providing cross-training and career development opportunities to enable employees to prepare for positions with a set of skill requirements including leadership, management, strategic planning, budgeting, etc.

Conclusion

Human resource planning will be one of the Commission's most significant challenges during the next several years. The ability to identify changing skill requirements, make adjustments in the allocation of resources, and prepare the agency's workforce for those changes is essential for the agency to successfully fulfill its mission.