Texas State Government Effectiveness and Efficiency

Selected Issues and Recommendations

SUBMITTED TO THE 81ST TEXAS LEGISLATURE JANUARY 2009

PREPARED BY LEGISLATIVE BUDGET BOARD STAFF

TEXAS STATE GOVERNMENT EFFECTIVENESS AND EFFICIENCY

SELECTED ISSUES AND RECOMMENDATIONS

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January 2009

Honorable Governor of Texas
Honorable Members of the Eighty-first Legislature

Ladies and Gentlemen:

The Legislative Budget Board staff report *Texas State Govemment Effectiveness and EfSlciency: Selected Issues and Recommendations* contains 73 analyses on the effectiveness and efficiency of Texas state government. The report has been prepared in compliance with the provisions of Section 322 of the Texas Government Code.

The evaluation and audit processes established under the provisions of Section 322 are valuable tools to help the Texas Legislature identify and implement changes that improve state agency effectiveness and efficiency. The results of these evaluations and audits, coupled with ongoing reviews of each agency's progress towards the achievement of established performance targets contained in the General Appropriations Act, facilitate the accomplishment of state goals and objectives.

The 73 analyses contained in the *Texas State Govemment Effectivenessand Efficiency: Selected Issues and Recommendations* report are organized by functional area. Each analysis is designed to provide the reader with an understanding of the salient findings, concerns, and recommendations (if warranted) related to the issue or program that has been reviewed by Legislative Budget Board staff. When appropriate, the five-year fiscal impact of any recommendation(s) is discussed, and information is provided as to whether the recommendation(s) has been included in the introduced 2010–11 General Appropriations Bill.

The staff of the Legislative Budget Board appreciates the cooperation and assistance state agencies provided during the preparation of this report.

Respectfully submitted,

John O'Brien
Director

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ELIMINATE PAPER WARRANTS BY USING DIRECT DEPOSIT OR ELECTRONIC PAY CARDS FOR STATE PAYMENTS

Texas has used direct deposit of funds as an alternative to paper warrants since 1981. Still, in fiscal year 2008, over 7.0 million warrants were issued to vendors, employees, annuitants, and other recipients. During this period, 50 percent of all vendor payments and 13 percent of payroll and annuity payments were paid by warrant. While direct deposit rates have increased in the last few years, the state could realize additional benefits from making payments electronically.

Previous Texas Legislatures have addressed this issue. Legislation requiring employees and vendors to receive payment via direct deposit was enacted in the 1990s. However, this mandate was repealed in 1999 based on claims that it caused a hardship for state employees and small businesses unable to open a bank account and establish a relationship with a financial institution. Since then, state agencies have successfully implemented programs to increase payments made via direct deposit or electronic pay card.

An alternative to paper warrants and direct deposit, such as an electronic pay card, would allow businesses and individuals who do not have back accounts or sophisticated accounting systems to receive an electronic payment. Instead of transferring funds to a bank account, payment would be deposited in an electronic pay card or debit card. The pay card would replace the warrant and could either be cashed like a warrant or used as a debit card. Requiring state employees, vendors, and other recipients of state-issued checks to receive payment from the state via direct deposit or electronic pay cards could decrease administrative costs and increase efficiencies.

FACTS AND FINDINGS

- The Comptroller of Public Accounts estimates that each warrant converted to a direct deposit saves $1.80 in computer service time and handling.
- Since 1995, the Texas Health and Human Services Commission has provided food stamp and welfare recipients with benefits through a debit card. The Texas Health and Human Services Commission reports this change helped streamline program administration, reduce the illegal sale of food stamps, and provide a secure and convenient way for program recipients to receive benefits.
- The Texas Workforce Commission and the Office of the Attorney General are using electronic pay cards to disburse benefits to unemployment insurance and child support recipients.

CONCERN

- Processing paper payments (i.e., checks, warrants, etc.) involves a substantial amount of paper, postage, storage, processing time, and personnel cost that can be reduced if direct deposit or an electronic pay card were used as payment.

RECOMMENDATION

- **Recommendation 1:** Amend Texas Government Code, Section 403.016, to require the Comptroller of Public Accounts to pay all vendors, employees, annuitants, and other recipients of state-issued payments via direct deposit or electronic pay card.

DISCUSSION

The Comptroller of Public Accounts (CPA) is responsible for processing payments of state funds to state employees, annuitants, and state agency and institution of higher education vendors. The only exceptions are the Texas Workforce Commission's (TWC) unemployment insurance payments and the Texas Health and Human Services Commission's (HHSC) Temporary Assistance for Needy Families (TANF) and food stamps benefits. Both agencies generate their own payments for these purposes. **Figure 1** shows the number of warrants that Texas issued to vendors, employees, annuitants, and child-support recipients in fiscal years 2007 and 2008.

FIGURE 1
NUMBER OF WARRANTS ISSUED BY TEXAS, FISCAL YEARS 2007 AND 2008

PAYROLL AND ANNUITY PAYMENTS	VENDOR PAYMENTS	CHILD SUPPORT PAYMENTS	TOTAL
871,627	2.4 million	5.0 million	8.3 million
916,919	2.2 million	4.0 million	7.0 million

SOURCE: Comptroller of Public Accounts.

CPA issued approximately 8.3 million warrants in fiscal year 2007, representing 68 percent of all payments issued by

CPA. The total number of payments issued by warrant decreased by 1.3 million in fiscal year 2008.

Each agency is responsible for authorizing CPA's Payee/ Payment Services (PPS) to distribute its warrants in a specific manner. Some agencies located in Austin retrieve warrants at CPA, while other Austin area agencies contract with CPA's Texas Procurement and Support Services (TPASS) to deliver the warrants to them. Agencies outside of the Austin area typically authorize PPS to mail the warrants to the agency.

CPA offers vendors several free services to help them reconcile state payments to their accounting records. One service is the State-to-Vendor Payment Information website. Using a personal identification number, vendors can see their warrant or direct deposit payments for the current and past three fiscal years. Vendors receiving direct deposit payments can also sign up to receive an Advance Payment Notification (APN) which contains information on how much money will be deposited and when it will arrive. The vendor can choose to receive the APN via email or FAX. **Figure 2** shows an example of an APN.

Both the State-to-Vendor Payment Information website and APN include the invoice number and invoice description fields that agencies enter in the state's Uniform Statewide Accounting System (USAS). The website provides the paying agency's name and contact information.

FIGURE 2
EXAMPLE OF AN AUTOMATED PAYMENT NOTIFICATION, FISCAL YEAR 2008

DO NOT REPLY TO THIS MESSAGE. This message has been generated by an automated system. Confidentiality Statement: The Advance Payment Notification you have received may contain confidential and privileged information. Any unauthorized review, use, disclosure or distribution is strictly prohibited. If you are not the intended recipient, please destroy all copies of the original notification.

IMPORTANT

The Texas Comptroller of Public Accounts has processed direct deposit payment(s) that are scheduled to post to your account on the first business day after the date of this notice. Before expending funds, please verify the availability of funds with your financial institution.

Direct Deposit Notification -TIN: 17426950000- Mail Code: 020

Payment #: 4003071

Total Payment Amt: $312.38 Total Interest Included: $00

Agency: 529 HEALTH AND HUMAN SERVICES COMMISSION

Doc No: 20389198 $175.99 0.00

Inv No: 02LQ0398

TABLE TOP

Doc No: 20389198 $136.39 0.00

Inv No: 02LQ0398

TABLE BASE

Payment #: 4003072

Total Payment Amt: $149.59 Total Interest Included: $00

Agency: 529 HEALTH AND HUMAN SERVICES COMMISSION

Doc No: 20389199 $149.59 0.00

Inv No: 02LQ0390

1-DRAWER FILE CABINET

SOURCE: Comptroller of Public Accounts.

According to CPA, some vendors have had problems reconciling direct deposits they received from state agencies. The majority of these complaints occur when paying agencies do not enter all of the information that vendors need to reconcile their payments. As shown in **Figure 2**, vendors can receive information for every transaction line item if agencies post the data to USAS correctly. The information on the APN and payment web applications is pulled directly from USAS. It is up to each agency to ensure that they provide detailed information in USAS to allow vendors to reconcile payments.

CPA also works with the largest vendors (determined by the number of warrants received) to determine what information is needed from agencies to reconcile their payments efficiently and receive their payments by direct deposit. CPA then works with the agencies that pay those vendors to convert the payments to direct deposit. CPA staff is available to help agencies work with any vendors to convert payments to direct deposit.

PAST STATE EFFORTS TO ENCOURAGE DIRECT DEPOSIT

Previous Texas Legislatures have addressed the issue of converting warrants to direct deposit. The enactment of legislation by the Seventy-second Legislature, 1991, mandated that state employees receive payment through direct deposit. However, the mandate allowed broad exceptions that rendered the mandate ineffective. The law required CPA to issue a warrant to pay a person unless the person properly notified the comptroller that receiving the payment via direct deposit would be impractical, would be more costly than receiving the payment by warrant, or that the person was unable to establish a bank account. This requirement essentially made it optional for state employees to receive payment via direct deposit.

Six years after the direct deposit mandate for state employees, legislation enacted by the Seventy-fifth Legislature, 1997, required vendors to accept direct deposit beginning in 1998. However, the requirement for vendors did not allow the same exceptions granted to employees. The only way a vendor could opt out from direct deposit was if they did not have a bank account. This mandate and the one for state employees were repealed by the enactment of legislation by the Seventy-sixth Legislature, 1999, based on claims that it caused a hardship for small businesses without accounting systems sophisticated enough to process direct deposits.

STATE INITIATIVES FOR ELECTRONIC PAY CARDS

Despite repealing this requirement, the state continued to consider new ways to reduce the number of paper warrants issued. An electronic benefits task force was created in 1995 when HHSC launched the electronic benefits transfer (EBT) program for food stamps and TANF recipients. Legislation enacted by the Seventy-fifth Legislature, Regular Session, 1997, directed the task force to determine what other state programs could benefit from the conversion of a warrant to an electronic funds transfer, and the cost-effectiveness of such an expansion. It directed the Office of the Attorney General (OAG) and TWC to perform a cost-benefit analysis of providing benefits electronically. The analysis led to electronic pay cards being used by each agency to pay recipients their unemployment and child support benefits.

FOOD STAMPS AND TANF PAYMENTS

The EBT program for food stamps and TANF recipients began in October 1994. The program provides benefits to over 2 million food stamp and welfare recipients on the Lone Star card, an electronic debit card, and replaced millions of warrants and food stamp coupons. Recipients can access their benefits by using their Lone Star card at participating retail locations, including U.S. post offices. They scan their card to pay for a purchase in the same manner a debit or credit card is used. Benefit recipients must choose a personal identification number that is entered at the point of sale to protect against unauthorized use of the card or in case it is lost or stolen. No purchase is necessary if the TANF recipient wants to withdraw funds from the debit card at a participating retail location, but some stores may set a limit on how much cash can be withdrawn at one time. The Texas EBT program is one of the largest in the nation.

The Health and Human Services Commission (HHSC) maintains that this move from a paper process to an electronic process helped streamline program administration, reduce the illegal sale of food stamps, and provide a safe and convenient way to receive benefits. Retailers also benefited from the transition to the debit card because they immediately receive payment of food purchases made with the card.

CHILD SUPPORT PAYMENTS

The Office of the Attorney General's Child Support Division (CSD) collects and disburses child support payments to more than one million families. In fiscal year 2007, CSD collected over $2.3 billion in child support payments. OAG now allows child support recipients to choose a warrant, direct deposit, or payment card (Texas Debit Card) as their method

of payment. According to CPA, while almost 5 million warrants were issued to child support recipients in fiscal year 2007, almost 78 percent of recipients received payments electronically. The OAG estimates that it has saved $13.7 million by converting paper warrants to electronic payment since fiscal year 2005.

The Texas Debit Card was introduced in April 2006 as a safer and more convenient way to receive child support payments than warrants or direct deposit. The card is issued by a vendor, loaded with the amount of funds due to the recipient, and may be used by the recipient anywhere Visa is accepted. Just like cashing a paper check, the card can be taken to the participating banks to withdraw the entire amount of funds. Other benefits of the debit card as reported by OAG include:

- a bank account is not necessary;
- no check cashing fees;
- no lost or stolen checks;
- no waiting for checks to come in the mail; and
- no waiting for deposits to clear the bank.

UNEMPLOYMENT BENEFITS

Since June 2007, all unemployment compensation beneficiaries receive their benefits from TWC on an electronic pay card (UI debit card) issued by Chase Bank. The debit card is accepted anywhere that Visa cards are accepted. Like a paper check, the UI debit card can be taken to a Chase bank or a Visa bank teller service for one free cash withdrawal, or smaller unlimited withdrawals can be made when making purchases with the UI debit card at a retailer. Chase supplements the customer service aspect of the UI debit card system by handling banking issues such as transaction disputes through Chase Customer Service. Each debit card lists a toll-free number for Chase Customer Service for the claimant, and Chase is now offering access to online statements. In November 2008, TWC will also be making available online UI benefit statements.

Sometimes vendors charge to provide pay card services. However, Chase does not charge TWC, the state, or beneficiaries for the debit card or the transfer of benefits payments to the cards. As is typically the case with retailers who accept credit cards, the retailers must pay a service charge to the credit card company to allow the use of their card for purchases. The vendor negotiating the contract with TWC earns fees from retailers when unemployment beneficiaries make purchases through the vendor provided pay card.

After transitioning to the UI debit card, TWC was able to eliminate costs incurred for warrant mailings such as postage, warrant paper, security envelopes, and some labor costs. During fiscal year 2008, 410,324 individuals were paid unemployment benefits by debit card at an estimated annual savings of $1.4 million to the agency in mailing and printing costs. Overall, TWC has made a successful transition to the UI debit card but reports that it is working on plans to provide a direct deposit option in response to claimants' requests.

INDEMNITY PAYMENTS

Senate Bill 908, Eightieth Legislature, 2007, included a provision that required direct deposit of indemnity payments for those state employees receiving their salary through the same means. The Sunset Advisory Commission (Sunset) made this recommendation as an efficiency and cost savings measure in its review of the State Office of Risk Management (SORM). The Sunset report states that such a move would save SORM and injured state employees time, effort, and money. SORM implemented the recommendation in February 2008 and has increased its direct deposit rate of indemnity payments to 20.7 percent in fiscal year 2008 from 7.5 percent in fiscal year 2007. As of August 2008, 31,979 indemnity payments had been paid for fiscal year 2008.

Some key findings from Sunset include:

- Paying workers' compensation indemnity benefits by check wastes taxpayer dollars.
- CPA makes most payments to state employees by direct deposit.
- The workers' compensation program operated by the Texas Department of Transportation pays most indemnity benefits through direct deposit.
- Direct deposit delivers workers' compensation benefits faster and reduces hardships for employees.

Although the Sunset report estimated a $75,000 savings from converting indemnity checks to electronic payment for those state employees with direct deposit, as of the beginning of fiscal year 2009, SORM has not quantified any savings. Furthermore, SORM states that paying injured workers through direct deposit has not reduced administrative costs for the agency. As a workers' compensation carrier, SORM is required to mail an explanation of benefits (EOB) form to

the claimant notifying them of the type of indemnity benefit and the period for which payment is made. For paper warrants, the EOB is mailed with the warrant; for direct deposits, the date of the transaction is noted on the EOB and is mailed alone. The same amount of administrative time is required because now direct deposit must be verified before the EOB is mailed; whereas before, receipt of the warrant provided SORM verification of the payment processing.

SORM also reports that some additional administrative duties are also now required for canceling or recalling payments. While this is also not a significant percentage of the payments process, a common occurrence is an adjuster learning that an injured worker has returned to work and is not due the entire payment processed. As a carrier, SORM is required to make indemnity payments by specific deadlines, and because of the two business day turn-around to process payments through CPA, the processing must begin a few days in advance. When information is received that a full payment is not due, a paper warrant can be cancelled, preventing the overpayment of state funds. The equivalent recall of direct deposits requires a different process, including attention to whether funding in the individual's account will be sufficient for a return of the payment.

While the transition to direct deposit has been difficult for SORM, it is important to note that the rules SORM must comply with as a compensation carrier are unique and do not apply to vendors, state employees, or child-support recipients.

CURRENT STATE EFFORTS TO REDUCE THE NUMBER OF WARRANTS

Several efforts to educate vendors and employees about the benefits of electronic funds transfer have been underway. The e-Payment Promotions staff at CPA are dedicated to educating state employees and vendors about the benefits of direct deposit. The following are examples of efforts to promote direct deposit payments:

- Direct Deposit Focus Group—This group, led by CPA staff, includes state agencies and vendors who are scheduled to meet quarterly to discuss ideas that can lead to greater participation in direct deposit payments for vendors.
- Direct Deposit Brochures—TxDOT, in collaboration with CPA, designed and mailed a brochure with paper warrants, an envelope-size version of the direct deposit form that state employees who prefer direct deposit must fill out.
- Direct Deposit Web Page—CPA has a website with information and updates about direct deposit payments for employees, state agencies, and vendors interested in learning more about the benefits of this type of electronic payment.
- Direct Deposit Mail-Out—Every May, CPA sends direct deposit brochures with warrants to individuals who have not yet elected to receive payment through direct deposit. This brochure provides information on the benefits of direct deposit and explains the process of receiving payment electronically.
- Payee Direct Contact—CPA staff contact employees and vendors who receive warrants every year to inform them of the direct deposit option. According to CPA, on average, there were 286 payees contacted per month in fiscal year 2008. CPA reports that it converted 2,721 payees to direct deposit in fiscal year 2008, a 79.4 percent success rate.

While these efforts have improved direct deposit rates and reduced warrants, they do not include the option to replace warrants with an electronic pay card.

ELIMINATE WARRANTS ISSUED BY THE STATE

While the state's rate of employee participation in direct deposit is at 87 percent, as of October 2008, and 50 percent of bill payments to vendors are paid via direct deposit, there are benefits to be realized from eliminating warrants. In addition to direct deposit, the development of secure, no-cost electronic pay cards can help reduce state costs and provide an easy way for vendors, employees, and others to receive state payments. As evidenced by several state agencies serving low-income clients, electronic pay cards have reduced costs, streamlined payment processes, and still provide a secure way of delivering funds.

Recommendation 1 would amend Section 403.016 of Texas Government Code to allow vendors, state employees, annuitants and all other recipients of state-issued checks to choose between direct deposit or an electronic pay card to receive payment of state funds. The CPA would consider the most conducive and cost effective strategy for implementing this mandate, including entering into a contract with a vendor to provide debit card services. Full implementation of Recommendation 1 would be required by the end of the 2010–11 biennium.

Figure 3 shows a summary of state laws related to the direct deposit of wages compiled by the National Conference of

FIGURE 3
STATE LAWS RELATED TO DIRECT DEPOSIT OF PAYCHECKS, 2006

STATE	PROVISIONS
Alabama	May be mandatory at employers' discretion.
Kentucky	Employer may make direct deposit mandatory, but employer must bear the cost of any monthly service charges. (Section 337.010) State employees may request, in writing, that they be paid via electronic fund transfer. The state treasurer may decline, if the financial institution designated by the employee cannot receive electronic funds transfers. (Section 41.165)
Louisiana	Mandatory direct deposit at employer's discretion permitted.
Maine	Employer may make direct deposit mandatory provided deposit is readily convertible to cash, (i.e., the bank is in close proximity and there are no withdrawal restrictions).
Mississippi	Employer may require direct deposit, provided employee is permitted to choose the financial institution. (Reg. E, Section 205. 1 0)
Missouri	May be mandatory, at employer's discretion; wages must be paid as often as semi-monthly. (Section 290–080)
North Carolina	Employer may make direct deposit mandatory provided the policy is uniform and nondiscriminatory. (N.C. Admin. Code T. 13, Section 12.0309)
Ohio	Employer may make direct deposit mandatory.
South Carolina	Payment by direct deposit may be mandatory if: the wages are deposited in a South Carolina financial institution; the employee is furnished with a statement of earnings and withholdings; and the employee is entitled to at least one withdrawal for each deposit, free of any service charge. (Section 41–10-40)
South Dakota	May be mandatory, at employer's discretion, provided employee incurs no special or extra costs as a result.
Tennessee	Direct deposit constitutes payment in lawful money, and employers may make it mandatory, since employers have the right to choose the form of payment and the form of lawful money.

SOURCE: National Conference of State Legislatures.

State Legislatures in 2006 regarding direct deposit of wages. The figure shows that eleven states allow direct deposit to be mandatory at an employers' discretion. However, no mention of electronic pay cards is made. All other states require that the employee consent to direct deposit. Legislative Budget Board staff research did not find any states that require vendors to receive payment electronically.

FISCAL IMPACT OF THE RECOMMENDATION

The recommendation would not have a direct impact on General Revenue Funds appropriated in the 2010–11 biennium. The recommendation would reduce CPA administrative costs but the extent to which cannot be determined until full implementation is achieved in fiscal year 2011. Additionally, state agencies would also be expected to see savings as evidenced by HHSC, OAG, and TWC.

The introduced 2010–11 General Appropriations Bill does not reflect any adjustments as a result of this recommendation.

LIMIT THE STATE'S ROLE IN ADMINISTERING LOCAL FIRE FIGHTER PENSION PLANS

The two primary functions of the Office of the Fire Fighters' Pension Commissioner are to offer assistance and education to the 121 fire fighter pension plans under the Texas Local Fire Fighters' Retirement Program and to administer the statewide Texas Emergency Services Retirement System for 182 volunteer fire fighter departments. The functions of the Texas Local Fire Fighters' Retirement program are duplicative to other entities like the Pension Review Board and the Texas Association of Public Employee Retirement Systems, and many of the functions can be completed independently by the local pension plans.

The state is statutorily liable for the actuarial soundness/financial stability of the Texas Emergency Services Retirement System, but other local pension plans are not afforded this benefit and are liable for their own financial stability. These plans are administered and funded at the local level. By discontinuing the functions of the Texas Local Fire Fighters' Retirement Program and establishing the Texas Emergency Services Retirement System as an independent entity outside of the Texas Legislature's appropriation process, the state could save approximately $1.1 million in General Revenue Funds each biennium.

CONCERNS

- The Office of the Fire Fighters' Pension Commissioner's duties related to the Texas Local Fire Fighters' Retirement Act are no longer needed.
- The state is currently liable for the actuarial soundness of the Texas Emergency Services Retirement System and is responsible for providing assistance for the administration of the fund.

RECOMMENDATIONS

- **Recommendation 1:** Amend Vernon's Annotated Texas Civil Statute Article 6243e.3 to discontinue the agency's functions under the Texas Local Fire Fighters' Retirement Act.
- **Recommendation 2:** Amend Texas Government Code, Sections 865.010 and 865.011, to discontinue the agency and commissioner's functions under the Texas Emergency Services Retirement System and establish the fund as a separate entity outside of the Texas Legislature's appropriation process.
- **Recommendation 3:** Amend Texas Government Code, Section 865.015, to eliminate the state's required contribution necessary to make the Texas Emergency Services Retirement System actuarially sound each year.
- **Recommendation 4:** Include a contingency rider in the 2010–11 General Appropriations Bill to eliminate all appropriations and riders related to the Office of the Fire Fighters' Pension Commissioner.

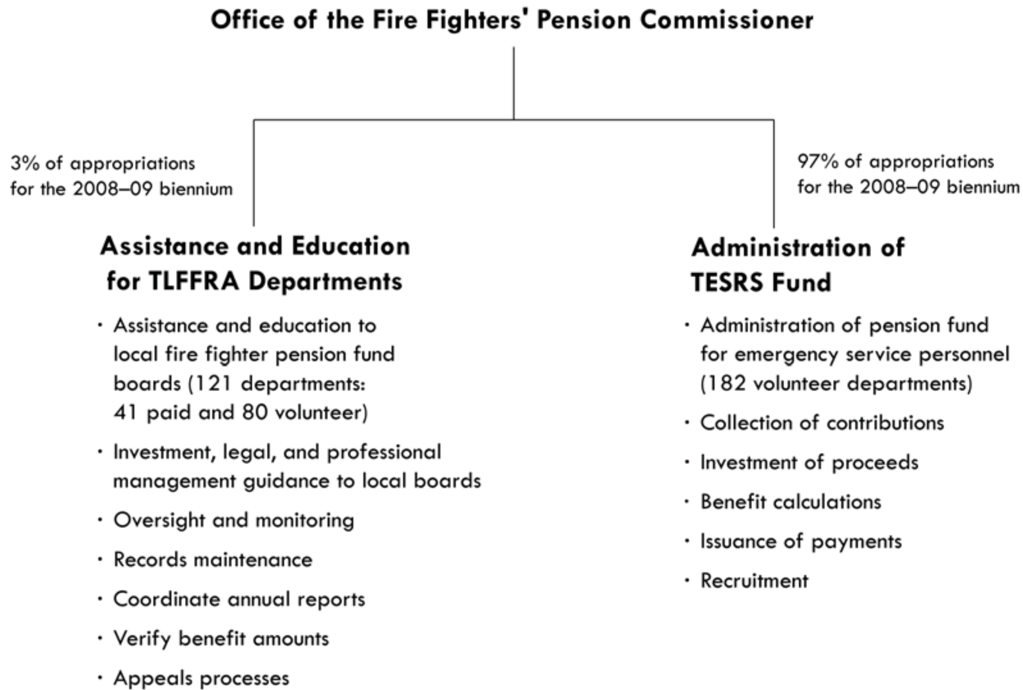
DISCUSSION

A survey conducted by the Texas Forest Service in fiscal year 2008 found that there were 1,800 fire departments in Texas. Of these departments, 81 percent were volunteer departments, 14 percent were a combination of paid and volunteer departments, and 5 percent were full-time paid departments. In fiscal year 2008, the Office of the Fire Fighters' Pension Commissioner served 303 fire fighter departments, or 17 percent of Texas fire fighter departments.

The Texas Legislature created the Office of the Fire Fighters' Pension Commissioner (FFPC) in 1937 to protect pensions of local volunteer and paid fire department personnel and their families. The Firemen's Relief and Retirement Fund Act established a framework for paid and volunteer departments to provide a pension system for their fire fighters, although today not all fire fighter departments offer a pension plan. When FFPC was first created, its sole responsibility was to oversee the distribution of state funding to local paid and volunteer fire fighter departments.

In 1977, the Legislature enacted the statewide Texas Emergency Services Retirement Act, establishing a statewide pension fund that pools the assets of volunteer fire departments. The administration of this statewide pension fund became the responsibility of the FFPC as well. Today, FFPC's two functions are to provide assistance and education to departments who participate in the Texas Local Fire Fighters' Retirement Program (TLFFRA) and administer the Texas Emergency Services Retirement System (TESRS). **Figure 4** shows the two major functions of FFPC.

FIGURE 4
FFPC FUNCTIONS, FISCAL YEAR 2008



Note: TLFFRA (Texas Local Fire Fighters' Retirement Program); TESRS (Texas Emergency Services Retirement System).
Source: Legislative Budget Board.

TEXAS LOCAL FIRE FIGHTERS' RETIREMENT ACT

In fiscal year 2008, 121 departments received assistance and educational services from the TLFFRA program. Not all local pension systems of paid and volunteer fire departments are a part of the TLFFRA program. The role of the TLFFRA program has changed over the years. Between 1942 and 1988, FFPC was responsible for overseeing the distribution of state funding to local departments under TLFFRA. The Legislature initially appropriated $300,000 annually to fund pension systems of local fire departments operating under TLFFRA. The appropriated amount was decreased two times in the 1980s before being eliminated in 1988. In 1999, the Legislature amended the act allowing local departments to use its pension fund assets to pay for administrative costs and costs related to board member duties.

The Legislature no longer appropriates funds to local fire department pension systems under TLFFRA, but assists 41 paid and 80 volunteer local fire fighter departments that administer their own local pension fund by providing education and guidance. Of the legislative appropriations to FFPC in the 2008–09 biennium, 3 percent, or $287,500, was allotted to the TLFFRA program. FFPC provides support to TLFFRA departments, which includes:

- oversight and monitoring—interpretation of governing statutes;
- records administration—storage, annual review, benefit calculations;
- appeals process—appeal of last resort in cases of benefit determination discrepancies; and
- education—annual conference and continuing education on investment management and pension fund administration.

In December of 2006, the combined assets for all TLFFRA department pension funds exceeded $1.2 billion. The board of each TLFFRA department is responsible for the administration of the plan's assets and hiring of staff to support the board. Similar to other local public pension funds, the boards of the TLFFRA paid fire departments administer their pension funds through the plan's assets, city contributions derived from local tax revenues, and employee contributions. Pension systems under TLFFRA receive support from city governments and city management, which must be represented on the board of trustees of paid funds. According to the Pension Review Board, in fiscal year 2007, 36 out of 41 paid fire fighter pension plans under TLFFRA

were actuarially sound, meaning the amount of all contributions was sufficient to cover the plans' liabilities.

The other 80 TLFFRA plans are for volunteer departments, and the majority of these are pay-as-you-go plans in which the city pays benefit expenses as they arise through local tax revenues. According to the 2000 Sunset Staff Report, volunteer fire fighter pension funds are much smaller than paid fire fighter funds and require less assistance from FFPC because with few or no assets, many do not administer a pension fund and therefore do not need actuarial advice.

As local fire fighter pension plans have become more self-sufficient in managing and funding their pension plans, the services provided by the TLFFRA program are no longer necessary. Also, the availability of other resources for local public pension plans eliminates the need for the services provided by the TLFFRA program. Other public pension plans of political subdivisions are funded and supported at the local level and do not receive assistance from the state. Local fire fighter pension plans that receive services from the TLFFRA program can obtain similar services from other sources.

OVERSIGHT AND MONITORING

The Pension Review Board (PRB), the state agency that oversees Texas public retirement systems including fire fighter pension systems, examines state legislation for potential effects on Texas public retirement systems and interprets governing statutes. All public pension plans are required to report to the PRB, including the TLFFRA fire fighter plans. In fiscal year 2008, the PRB added more staff and expanded the scope of their mission. PRB provides technical assistance for pension board trustees and administrators. Municipal attorneys or legislative counsels are also available to interpret local laws for pension plans.

RECORDS ADMINISTRATION

Typically, local pension board members or contracted administrators maintain pension plan records, review benefit and refund applications, and calculate benefits. If a plan contracts for any of these services, the contract is paid from the local pension plan's assets.

APPEALS PROCESS

Public pension plans members typically appeal benefit decisions to their board. The process usually involves filing an appeal in writing to the board within a specified period and supplying additional information related to the appeal. The board decides on a hearing time and the board's decision is the final non-judicial determination. Appeals may be taken to the state district court of the county. Between 1991 and 2008, FFPC processed 24 appeals indicating a low demand for this service.

EDUCATION

Education resources that are similar to the TLFFRA program include:

- The PRB offers regional seminars and an annual conference for board members and pension plan administrators. Both TLFFRA volunteer and paid departments have attended PRB seminars and conferences.
- The Texas Association of Public Employee Retirement Systems (TEXPERS) also offers education for public pension/retirement plans. Many fire fighter pension plans are members of TEXPERS.
- Fire fighter departments may also be part of the Texas State Association of Fire Fighters (TSAFF) and the State Firemen's and Fire Marshal's Association of Texas (SFFMA). In 2006, 29 percent of TLFFRA departments attended the annual TLFFRA conference; and in 2007, 34 percent of the departments attended the annual conference, indicating a low demand for these conferences.

Figure 5 shows that local fire fighter pension plans can receive similar services to what the TLFFRA program provides from other sources.

According to the 2000 Sunset Staff Report, most other states do not have a separate state agency to assist local fire fighter departments with administering their fund, and less than 7 percent of local fire fighter departments in Texas receive assistance through the TLFFRA program. The Office of the Fire Fighters' Pension Commissioner's (FFPC) duties related to the Texas Local Fire Fighters' Retirement Act are no longer necessary. Firefighter pension plans are receiving the same services through PRB and TEXPERS, making the FFPC's function duplicative. Recommendation 1 would amend Vernon's Annotated Texas Civil Statute Article 6243e.3 to discontinue the agency's duties under the Texas Local Fire Fighters' Retirement Act.

TEXAS EMERGENCY SERVICES RETIREMENT SYSTEM

The statewide Texas Emergency Services Retirement System (TESRS) was established in 1977 through the statewide Texas Emergency Services Retirement Act to operate a pension system that would provide retirement, death,

FIGURE 5
SOURCES THAT PROVIDE SIMILAR SERVICES TO THE TLFFRA PROGRAM, FISCAL YEAR 2008

	SERVICES PROVIDED BY THE TLFFRA PROGRAM			
ALTERNATIVE SOURCES FOR SIMILAR SERVICES	OVERSIGHT AND MONITORING	RECORDS MANAGEMENT	APPEALS PROCESS	EDUCATION
Pension Review Board	X			X
Texas Association of Public Employee Retirement Systems				X
Fire Fighter Associations (TSAFF & SFFMA)				X
Municipal/local resources		X	X	

Source: Legislative Budget Board.

disability, and survivor benefits to volunteer fire fighters. FFPC contracts with investment managers, attorneys, actuaries, accountants, and consultants to fulfill the agency's duties. There are also 4.5 full-time-equivalent (FTE) state employees who work specifically with the TESRS fund. In fiscal year 2008, 182 fire and EMS departments participated in the TESRS fund, representing over 8,000 members and their beneficiaries. FFPC's management duties related to the TESRS fund include:

- Collect contributions from participating departments: As of August 2008, participating departments and governmental entities contribute an average of $36.40 per member per month.
- Manage Fund Investments: A nine-member state board of trustees oversees the TESRS fund. Legislation enacted by the Seventy-ninth Legislature, Regular Session, 2005, provided the TESRS board with more authority to make plan design changes to improve the retirement plan solvency.
- Calculate Benefits: FFPC issues payments to retirees and their beneficiaries and maintain records for active members. Members of the TESRS fund are volunteers and do not have a salary; therefore, benefits are based on years of service and amount of department contributions.

In fiscal year 2007, TESRS paid $2.5 million in retirement benefits, representing 92 percent of the system's total expenses. According to the TESRS 2007 investment policy, benefits are funded by contributions from the participating departments, investment returns, and contributions from the state.

The state supports TESRS by appropriating General Revenue Funds for the administration of the fund. Ninety-seven percent of 2008–09 General Revenue Fund appropriations to the FFPC were dedicated to the fulfillment of duties related to the statewide TESRS pension fund.

As needed, the state contributes to the TESRS fund to make it actuarially sound. Legislation enacted by the Sixty-fifth Legislature, Regular Session, 1977, required the state to contribute a sum necessary to make the statewide TESRS fund actuarially sound, and this contribution may not exceed one-third of the total of all contributions made by fire department governing boards in one year. For example, if the contributions made by participating fire departments totaled $3 million, the maximum contribution that the state could have made for the same year would be $1 million.

The 2002 Actuarial Valuation found that the statewide TESRS fund was actuarially unsound and the state would need to contribute approximately $651,000 per year for the next 30 years to make the fund actuarially sound. In 2004, the valuation report found that the TESRS fund was actuarially unsound with unfunded liabilities over $13.4 million.

Before 1998, the TESRS plan's administrative costs were fully funded with General Revenue Funds. In fiscal year 2007, the TESRS fund investment earnings funded approximately 79 percent of the TESRS administrative costs. According to FFPC, administrative funding demands compounded the actuarial problems of the statewide TESRS fund.

Legislation enacted during the Seventy-ninth Legislative Session, 2005, addressed pension-funding issues by giving the TESRS Board of Trustees the authority to make benefit plan changes. Benefit plan changes made included the elimination of partial vesting for less than 10 years of service, reduced benefits, and increased contribution rates. Also during this session, for the first time, the agency requested the statutorily mandated funding from the Legislature to

make the fund actuarially sound. According to FFPC, the TESRS Board of Trustees plans to request the appropriate maximum annual contribution as required by state law in each future biennium.

Figure 6 shows the agency's exceptional item requests for the statutorily required state's portion of the contributions during the Seventy-ninth, Eightieth, and Eighty-first Legislative Sessions.

FIGURE 6
FFPC EXCEPTIONAL ITEM REQUESTS FOR THE STATUTORILY REQUIRED STATE CONTRIBUTION, FISCAL YEARS 2006 TO 2010

LEGISLATIVE SESSION	AMOUNT OF EXCEPTIONAL ITEM REQUEST (EIR)	LEGISLATIVE APPROPRIATIONS IN RESPONSE TO EIR
Seventy-ninth Regular Session	$2 million for state contributions for 2003–2005	$1.4 million
Eightieth Session	$267,385	$8.8 million
Eighty-first Session	$1.7 million	To be determined

SOURCE: Legislative Budget Board.

In response to the FFPC's exceptional item request during the Eightieth Legislature, 2007, the Legislature appropriated $8.8 million in General Revenue Funds to FFPC. This amount was estimated to be the present value needed to make the fund actuarially sound for fiscal year 2008. The funds were transferred directly into the TESRS pension fund and invested based on the board's allocations.

As a result of the $8.8 million appropriated to the TESRS plan by the Eightieth Legislature, 2007, the August 2008 actuarial valuation reports that with the expected contributions from each participating department and approximately $425,000 each year from the state for the system's administrative costs, the system has adequate funding.

However, the actuarial valuation also reported that as a result of the economic downturn the system experienced a significant decrease in its assets the two months following the August 31, 2008, valuation date. According to the report, the system would have inadequate contribution arrangements without the maximum annual contributions from the state due to the system's decrease in assets.

OTHER VOLUNTEER FIRE FIGHTER PENSION FUNDS

There are approximately 1,450 volunteer fire departments in Texas. Data on the departments that offer a pension plan for their volunteers is limited to those that are affiliated with the FFPC and those that are independent and report to the PRB. In July 2008, the PRB oversaw 11 volunteer fire fighter pension plans that were not affiliated with FFPC. All of these plans were closed paying benefits (CPB) plans, meaning the plan has no active members, and the city or local authority is paying the remaining benefits to retirees from local revenue. The other known volunteer fire fighter pension plans in Texas are those that participate in the TLFFRA program, and the majority of these pension plans are pay-as-you-go plans in which the city pays benefit expenses as they arise through local taxes.

Other states have pension plans for volunteer fire fighters, and these plans are referred to as Length of Service Awards or a Relief Fund. These pension plans are a way to reward volunteer fire fighters for their community service. A state's involvement in volunteer pension plans is usually limited to enacting legislation that authorizes the establishment of local pension plans for volunteer fire fighters and contributing a small percentage of various tax premiums to the plan. Typically, volunteer fire fighter pension plans are administered locally. Minnesota found that local control of local pension plans might produce increased community involvement, personal service, and civic pride. Most volunteer fire fighter pension plans in other states receive annual contributions from their respective municipalities for each qualifying volunteer, and legislative assistance is typically not provided. In some cases, the volunteer fire fighters contribute to the pension plan but the community or department usually pays for the whole program. In Wyoming, the volunteer fire fighter pension plan is funded by a tax on fire insurance premiums and member contributions of $12.50 per month, which can be paid by the participating fire fighter or by the municipality if approved by the governing board. Arkansas, Georgia, Kansas, Minnesota, Montana, Oklahoma, New Hampshire, North Carolina, and South Carolina also fund their pension plans through member contributions and/or fire tax premiums.

ESTABLISHING THE TESRS FUND AS AN INDEPENDENT ENTITY

In 2000, the Sunset Advisory Commission staff recommended that TESRS be abolished because it was found that the TESRS fund had matured and no longer needed the agency's help to successfully operate. The Sunset Advisory Commission

staff also found that removing TESRS from the state's appropriation process and removing state support would bring its operation more in line with typical pension administration. The establishment of an administrative budget from assets held in the fund would provide greater accountability for the board of trustees. Some other benefits to TESRS becoming an independent entity include:

- a greater flexibility to handle investments, purchases, and personnel without the restrictions attached to appropriated funds, such as employee caps and salary limitations; and
- a greater opportunity to spend funds for recruitment of volunteer fire fighter departments that are not part of the TESRS fund.

The state is currently liable for the actuarial soundness of the Texas Emergency Services Retirement System and is responsible for providing assistance for the administration of the fund. Other local public pension systems function independently and are not in the appropriations process, and other volunteer fire fighter pension plans in Texas and in other states are administered and financially supported on the local level.

Recommendation 2 would amend Texas Government Code, Sections 865.010 and 865.011, to discontinue the FFPC's functions under the Texas Emergency Services Retirement System and establish the fund as a separate entity outside of the state's appropriation process. This would bring its operation more in line with typical pension administration and provide greater accountability for the board of trustees. Removing the TESRS fund from the appropriation process would also eliminate some of the state restrictions on how funds are spent.

Recommendation 3 would amend Texas Government Code, Section 865.015, to eliminate the state's required contribution necessary to make the Texas Emergency Services Retirement System actuarially sound each year. This would remove the state's liability for the TESRS fund now and in the future.

Recommendation 4 would include a contingency rider to the 2010–11 General Appropriations Bill eliminating all appropriations, FTEs, and riders related to the Office of the Fire Fighters' Pension Commissioner.

FISCAL IMPACT OF THE RECOMMENDATIONS

Based on 2010–11 budget recommendations, Recommendations 1 through 4 would save approximately $1.1 million in General Revenue Funds and avoid costs in the future by no longer supporting the financial solvency of the TESRS fund. **Figure 7** shows the total fiscal impact of Recommendations 1 through 4.

FIGURE 7
FIVE-YEAR FISCAL IMPACT, FISCAL YEARS 2010 TO 2014

FISCAL YEAR	PROBABLE SAVINGS IN GENERAL REVENUE FUNDS	PROBABLE REDUCTION OF FULL-TIME EQUIVALENTS
2010	$539,373	8.5
2011	$539,373	8.5
2012	$539,373	8.5
2013	$539,373	8.5
2014	$539,373	8.5

SOURCE: Legislative Budget Board.

The introduced 2010–11 General Appropriations Bill does not include any adjustments as a result of these recommendations.

OPTIMIZE THE TEXAS COMMISSION ON THE ARTS' CULTURAL ENDOWMENT FUND

The Texas Legislature established the Cultural Endowment Fund in 1993 to provide a sustaining source of funding for the Texas Commission on the Arts; however, a lack of consistent legislative funding and contributions from private donors has limited the fund's growth. The fund does not provide for the majority of the agency's appropriation needs as intended. There have been no legislative appropriations to the fund for the last four fiscal years and no private donations in the last two fiscal years, eroding its future value through its inability to grow at the rate of inflation. There are two options for optimizing the Cultural Endowment Fund: (1) use legislative appropriations to encourage private contributions to the fund, or (2) transfer the fund's balance to the Texas Commission on the Arts operating fund for a one-time revenue gain of approximately $9.8 million.

FACT AND FINDING

- The Seventy-third Legislature, 1993, established the Cultural Endowment Fund outside the Treasury to provide a permanent and sustaining source of financial support for the Commission on the Arts and to eliminate the need for future appropriations of General Revenue Funds. The fundraising goal was set at $200 million by 2005, a level estimated as necessary to support annual agency appropriations of $9.3 million.

CONCERNS

- The Cultural Endowment Fund has not reached its target of $200 million, ending fiscal year 2008 with a balance of $9.8 million. The fund has not accomplished its purpose of providing a sustainable source of financial support for the agency.
- A stable long-term revenue stream to build the Cultural Endowment Fund was never identified, and initial legislative appropriations and private donations to the Cultural Endowment Fund totaled approximately $13 million, which limited its growth.
- No legislative appropriations have been made to the Cultural Endowment Fund in the last two biennia, and no private contributions have been made in the last two years. There is no source of funds to build the fund's principal balance because Texas Government Code requires interest and income to be removed from the Cultural Endowment Fund and deposited in the agency's operating fund annually. This requirement erodes the fund's future value and prevents it from growing at the rate of inflation.

RECOMMENDATIONS

Optimizing the Cultural Endowment Fund involves a choice between two mutually exclusive options:

- **Option 1:** Amend Chapter 444 of the Texas Government Code to create an incentive to encourage private donations to the Cultural Endowment Fund by providing General Revenue Funds to the Fund based on the amount of private funds deposited in the Cultural Endowment Fund, and indexing the growth of the corpus of the Fund to the Consumer Price Index. Include a provision that if the Fund has not increased private donation deposits by $5 million by fiscal year 2014, the Fund's balance would be transferred to the Commission on the Arts' operating fund. Include a contingency rider in the 2010–11 General Appropriations Bill to appropriate General Revenue Funds to the Cultural Endowment Fund.
- **Option 2:** Amend Chapter 444 of the Texas Government Code to dissolve the Cultural Endowment Fund and transfer the fund balance to the Commission on the Arts' operating fund. Include a contingency rider in the 2010–11 General Appropriations Bill to amend the agency's method of finance to replace General Revenue Funds with General Revenue–Dedicated Funds from the agency's operating fund.

DISCUSSION

The Texas Legislature established the Texas Commission on the Arts (TCA) in 1965 to enable the receipt of funding from the National Endowment for the Arts (NEA). To qualify for federal arts-related funds, Texas must have a designated state arts agency. TCA's mission is to develop a receptive climate for the arts in Texas, a function it achieves by processing, distributing, and monitoring grants to non-profit organizations and schools; promoting the arts and cultural tourism; and raising public and private funds to support the arts.

During the Eightieth Legislature, 2007, the Texas Sunset Advisory Commission (SAC) reviewed TCA and found the state benefits from public arts funding through economic stimulation and tourism generated by the arts, and concluded that the agency achieves its mission. However, the SAC analyzed administrative operations and recommended the agency adopt rules pertaining to private donations and the grant approval process. The Legislature elected to continue the agency for six years.

GRANTS AWARDED

In fiscal year 2007, TCA awarded 1,481 grants and distributed a total of $3.1 million. The average grant award was $2,965. The agency awards grants to non-profit organizations, local arts agencies, local governments, universities, and public schools to support arts organizations, arts education, and cultural tourism. The agency offers many specific types of grants, but the primary grant categories in terms of funds distributed are core support grants, project grants, and cultural tourism grants.

SOURCES OF FUNDING

TCA has received financial support from a variety of funding sources. The five primary arts funding sources are: General Revenue Funds; General Revenue–Dedicated Funds; Federal Funds; interagency contracts; and Appropriated Receipts, which include private donations and sale of TCA merchandise. **Figure 8** shows the total amounts appropriated to TCA from fiscal years 2006 to 2009.

General Revenue Fund appropriations typically comprise the majority of TCA's funding; however, that changed during the 2008–09 biennium due to a method of finance exchange. More General Revenue–Dedicated Funds were appropriated to use fund balances in the agency's operating account.

General Revenue–Dedicated Funds appropriated to the agency come from several sources that are deposited in the agency's operating account (Arts Operating Account). These sources include:

- **Interest and earnings from the Cultural Endowment Fund (CEF):** Legislation enacted by the Seventy-third Legislature, 1993, established the CEF. The CEF's purpose was to serve as a permanent and sustaining source of support for the agency, capable of generating enough interest to fund agency operations and eliminate the need for future appropriations of General Revenue Funds. The fund exists outside the state Treasury, and the Legislature may not appropriate funds directly from the CEF. The fund's fiscal year 2007 ending balance was $9.8 million. The fund earned $522,000 in interest that year and a fair value adjustment increased its value by $1.4 million.
- **Sales from the State of the Arts specialty license plate:** The Seventy-third Legislature also established the State of the Arts license plate, which has raised more than $4 million in revenue to date. Plate sales in fiscal years 2006 and 2007 were approximately $400,000 each year.
- **Restricted private donations:** Private donors may contribute to the fund but the donations are typically minimal. The agency does not dedicate staff or resources toward raising these funds.

Of these sources that deposit into the operating fund, interest and earnings from the CEF provide the largest amount of funding. The other funding sources make limited

FIGURE 8
TEXAS COMMISSION ON THE ARTS APPROPRIATIONS, FISCAL YEARS 2006 TO 2009

METHOD OF FINANCE	2006	2007	2008	2009
General Revenue Funds	$2,364,127	$2,353,415	$159,750	$1,154,405
General Revenue–Dedicated Funds (Arts Operating Account)	609,040	593,745	2,932,397	1,627,600
Federal Funds	791,200	791,200	863,500	863,500
Interagency Contracts	970,000	970,000	980,000	980,000
Appropriated Receipts	331,905	331,905	530,405	530,405
TOTAL	**$5,066,272**	**$5,040,265**	**$5,466,052**	**$5,155,910**

NOTE: A method of finance exchange was used in fiscal year 2008, which resulted in a greater amount of funding from General Revenue–Dedicated Funds and a reduction in General Revenue Funds.
SOURCE: Legislative Budget Board.

contributions to the operating fund now and are unlikely to contribute more in the future. Future prospects from license plate sales are limited; TCA expects sales of the plate to decrease to $250,000 in fiscal year 2008. Because the agency does not expend resources to raise private funds, donations depend on the public's willingness to contribute. The agency's fundraising efforts are limited because donors often prefer to donate directly to the arts organization of their choice rather than a state agency, and efforts to increase private fundraising compete directly with the arts entities the agency exists to support. The agency expended a total of $455,264 from the arts operating account in fiscal year 2007.

Texas receives Federal Funds from NEA through a Partnership Agreement, which includes formula-driven and competitive grant awards. States must apply to receive NEA funding and provide a plan for expending funds received that designates or establishes a single state agency as the administrator of the state plan. States must meet NEA standards in three areas: (1) planning; (2) reporting; and (3) evaluation. The agency expended $865,500 in Federal Funds during fiscal year 2007.

TCA receives funds from interagency contracts with two agencies. In fiscal year 2007, the agency received $980,000 which included $310,000 from the Texas Education Agency for arts education grants, and $670,000 from Texas Department of Transportation for cultural tourism grants and marketing efforts to promote cultural tourism destinations in Texas.

The remaining amount of TCA's appropriation is comprised of Appropriated Receipts which include all funds available to the agency outside the General Appropriations Act. These include private donations and the sale of merchandise, such as mugs, t-shirts, and caps. The agency expects most of its appropriated receipts to be from restricted grants, and believes the prospect for merchandise sales is small. The agency expended $166,235 in fiscal year 2007 from Appropriated Receipts.

STATUS OF THE CULTURAL ENDOWMENT FUND

Like many states that initially created endowment funds to replace some or all of their appropriations of General Revenue Funds, Texas' fund does not provide the majority of the agency's financial support. Analysis completed by the SAC before the Eightieth Legislative Session identified several problems with the CEF and recommended that it be dissolved.

TCA was expected to raise $200 million for the CEF by 2005. This amount would generate enough earnings and interest to support annual agency appropriations of $9.3 million, which is almost twice the agency's current annual appropriation. To reach the target value, the CEF would have had to grow by more than $15 million annually for 12 years. The current value of the CEF is $9.8 million. In its Strategic Plan for Fiscal Years 2009–2013, TCA estimated its annual appropriation need between $5 million and $5.5 million to ensure continued programming. The CEF generates interest, but not enough on an annual basis to provide consistent support for the agency's operations. The CEF generated more than $1 million in interest per year during fiscal years 2004–2006. That amount decreased to $522,000 during fiscal year 2007, and the fund lost $300,000 in fiscal year 2008.

There are several reasons the CEF has not grown as intended. First, a long-term revenue stream to build the CEF was never identified. The Legislature considered dedicating revenue from several sources including gas, cigarette, or hotel occupancy taxes, but none was selected. Second, legislative appropriations and private donations to the CEF were insufficient to meet the $15 million annual goal. The Legislature initially appropriated $2.2 million to the CEF, and total legislative appropriations as of fiscal year 2009 have been $10.9 million. At the CEF's creation, the agency was given the authority to accept private donations for the operating fund and the CEF. The agency has reported raising a total of $1.8 million in private donations since the CEF's creation.

In addition to not growing as initially projected, the CEF's principal no longer has a means of growth which is eroding its future value. The Legislature has not contributed to the CEF for the past two biennia. The appropriations ceased due to the existence of a budget shortfall in fiscal years 2003 and 2004 and have not resumed. Private donations to the CEF occurred in tandem with government appropriations. Fiscal year 2006 was the last year private funds were donated to the Cultural Endowment Fund, and that year, donations totaled approximately $600. Interest earnings are not a source of CEF growth. Texas Government Code requires interest and earnings to be removed from the CEF and deposited in the agency's operating fund annually. The Legislature funded its 2004–05 biennial appropriation to the CEF using interest earnings, but interest earnings are not typically used to build the corpus of the CEF. If the lack of contributions to the

CEF persists, the fund's value will not grow at the rate of inflation.

OPTIONS TO OPTIMIZE THE CULTURAL ENDOWMENT FUND

The Legislature can either attempt to increase private contributions to the CEF to enable it to serve its intended purpose of reducing or eliminating the need for future appropriations of General Revenue Funds, or dissolve the CEF for a one-time revenue gain of approximately $9.8 million.

Option 1 would build the CEF in two ways. First, it would amend Chapter 444 of the Texas Government Code to provide General Revenue Funds to the CEF based on the level of private contributions made to the CEF. State appropriations could leverage private donations through a one-to-one matching system, in which legislative appropriations would be based on private donations deposited in the CEF. It is difficult to predict the level of private donations that would result, how quickly the CEF would grow, and the point at which the agency would require less General Revenue Funds. However, historical evidence suggests that when the Legislature made direct appropriations to the CEF, private donors also contributed, and when legislative appropriations ceased, private contributions ceased. To mitigate risks of the approach, the maximum amount of General Revenue Funds that would be appropriated to the CEF could be capped. This option would require a contingency rider in the 2010–11 General Appropriations Bill to appropriate General Revenue to the CEF. Another option would be to provide General Revenue Funds to the agency's operating fund based on private donations to the CEF.

If the matching strategy does not generate at least $5 million in private contributions to the CEF by fiscal year 2014, the option would include a provision to transfer the CEF balance to the Commission on the Arts' operating fund. If the approach is effective in building the CEF to a level that can support TCA's appropriation need, future General Revenue appropriations can be reduced or eliminated.

The second part of the option would index the growth of the corpus of the CEF to the Consumer Price Index (CPI). The agency would retain the annual income and interest earnings needed for the corpus to grow at the rate of inflation, and the remaining income and interest would be transferred to the agency's operating fund. For example, if the CEF's value was $9.8 million and the rate of inflation for the year was 2 percent, the CEF's corpus would need to grow by $196,000 in order to keep pace with inflation. If the CEF earned 5 percent interest and income that year ($490,000), the recommendation would allow the CEF to retain $196,000, and the remaining $294,000 would be transferred to the operating fund.

Option 2 would amend Chapter 444 of the Texas Government Code to dissolve the CEF, resulting in a one-time revenue gain of $9.8 million that would be transferred to TCA's operating account to ensure its use for the arts. This option would also require a contingency rider to the General Appropriations Bill that would amend the agency's method of finance to increase the share of General Revenue–Dedicated Funds appropriated and decrease the share of General Revenue Funds appropriated.

FISCAL IMPACT OF THE OPTIONS

Option 1 would result in a cost in General Revenue Funds of $1,459,100 for fiscal year 2010 and $1,481,225 in fiscal year 2011 to match private contributions with General Revenue Funds and because some of the CEF's interest and income would remain in the Fund as a result of indexing the corpus of the Fund to the CPI. In addition, the loss of General Revenue Funds in the short-term is expected to result in a long-term savings in General Revenue Funds by building the CEF.

Figure 9 shows the five-year fiscal impact of the option. This approach assumes $1.25 million in private donations and $1.25 million in legislative appropriations are made to the CEF, and that the fund earns 5 percent income and interest each year for five years. The probable loss in General Revenue Funds was calculated based on the legislative appropriations made and the amount of interest that would be retained in the CEF for the corpus to grow at the rate of inflation. This approach assumes total appropriations to TCA would remain constant from the 2008–09 biennium. However, if the

FIGURE 9
FIVE-YEAR FISCAL IMPACT, FISCAL YEARS 2010 TO 2014

FISCAL YEAR	PROBABLE SAVINGS/(COST) IN GENERAL REVENUE FUNDS
2010	($1,459,100)
2011	($1,481,225)
2012	($1,586,344)
2013	($1,692,401)
2014	($1,764,521)

SOURCE: Legislative Budget Board.

Legislature were to increase the appropriation, there would be additional costs in General Revenue Funds.

Option 2 would result in a one-time fiscal gain of $9.8 million in General Revenue–Dedicated Funds, and a net fiscal impact of $9.3 million for fiscal year 2010 and a loss of $490,000 for fiscal year 2011 because the option would forgo future CEF interest earnings. The fiscal impact is shown in **Figure 10**. This option would require the Legislature to continue to appropriate the majority of the agency's funding in General Revenue Funds for the future but the actual amount appropriated would be larger than that appropriated now due to the loss of the CEF's interest.

FIGURE 10
FIVE-YEAR FISCAL IMPACT, FISCAL YEARS 2010 TO 2014

FISCAL YEAR	PROBABLE SAVINGS/(COST) IN GENERAL REVENUE FUNDS	PROBABLE GAIN/LOSS) IN GENERAL REVENUE–DEDICATED FUNDS	PROBABLE NET FISCAL IMPACT
2010	($490,000)	$9,800,000	$9,310,000
2011	($490,000)	$0	($490,000)
2012	($490,000)	$0	($490,000)
2013	($490,000)	$0	($490,000)
2014	($490,000)	$0	($490,000)

Note: This assumes a 5 percent rate of interest for the CEF.
Source: Legislative Budget Board.

The introduced 2010–11 General Appropriations Bill does not include these recommendations.

OPTIMIZE THE USE OF STATE PARKING FACILITIES

The Texas Facilities Commission maintains 17,267 parking spaces in 46 lots and garages in the central Austin area, 85 percent of the agency's total parking capacity statewide. Sixty-two percent of this parking capacity is located within the Capitol Complex corridor and in downtown Austin, areas of limited parking options for non-state employees commuting to work and school. Daily usage rates for state parking lots and garages in central Austin range from less than 10 percent to 95 percent, averaging 68 percent. Given a 32 percent average vacancy level, optimizing the use of the state's parking facilities would increase revenue and improve the management and maintenance efficiency of this major set of state assets.

Many of the state's parking lots and garages are located on prime real estate in the Capitol Complex corridor. The state's primary administrative offices, housing 24 percent of the state's workforce, are located in Travis County. While the Texas Facilities Commission manages 5.4 million square feet of office space in Austin, 37 percent of total occupied office space in the area is leased from private building owners. Rising lease rates and large amounts of lease inventory expiring between 2010 and 2016 will significantly increase yearly lease costs for the state. Reviewing underused parking facilities in the Austin area for opportunities for increased capacity or conversion to alternative purposes could help the state avoid such costs.

CONCERNS

- ♦ More than 5,500 parking spaces in state-owned facilities remain unused in the Austin area on a daily basis, costing the state directly in maintenance and management expenses and indirectly in potential lost revenue from maximization of the assets. The Texas Facilities Commission spent $1 million on operations and utility expenses for state parking facilities during fiscal year 2007.
- ♦ State parking facilities are underused, with 83 percent maintaining an average use rate of less than 90 percent and 33 percent maintaining average vacancy rates of more than 50 percent. This excess capacity represents both a direct cost to the state and a loss of potential revenue.
- ♦ The Texas Facilities Commission reports that state facility ownership costs in the Austin area are 8 percent lower than applicable lease costs. Rising lease rates and the expiration of 39 percent of active leases from 2010 to 2016 puts the state at risk for significantly increased lease costs.

RECOMMENDATIONS

- ♦ **Recommendation 1:** Amend Texas Government Code, Chapter 2165, to direct the Texas Facilities Commission to lease excess parking spaces in state-owned lots and garages to private citizens.
- ♦ **Recommendation 2:** Include a contingency rider in the 2010–11 General Appropriations Bill that would provide the appropriate administrative resources to administer leasing operations within state parking facilities. The rider would appropriate $120,715 in General Revenue Funds to the Texas Facilities Commission and increase the agency's full-time-equivalent position cap by one position.
- ♦ **Recommendation 3:** Amend Texas Government Code, Chapter 2165, to direct the Texas Facilities Commission to lease underused parking lots and garages to institutions of higher education, private businesses, or local governments.
- ♦ **Recommendation 4:** Include a rider in the 2010–11 General Appropriations Bill that would direct the Texas Facilities Commission to report on the available capacity and use of state-owned parking lots and garages under its authority and on opportunities to redevelop severely underused facilities for other purposes.

DISCUSSION

The state of Texas owns, manages, and maintains a building inventory of more than 56 million square feet, valued at $2.4 billion. The largest property-owning agencies include the Texas Department of Criminal Justice, the Texas Health and Human Services Commission, the Texas Department of Transportation, the Texas Facilities Commission, and the Texas Parks and Wildlife Department. However, the Texas Facilities Commission (TFC) manages the majority of state-

owned space in Travis County, where the state's administrative offices and agency headquarters are located.

TFC maintains 4.7 million square feet of usable space in 42 buildings in the Austin city limits, primarily general office space located in the area immediately surrounding the state capitol building. To support the 17,610 state employees working in these buildings, the agency also manages 46 distinct parking facilities, lots and garages, in Austin containing 17,267 parking spaces. Sixty-two percent of these spaces are located in the Capitol Complex and the downtown business district. TFC also manages more than 3,000 parking spaces in 12 parking lots and garages located outside the Austin area.

While these numbers seem to indicate that the state's parking facilities operate at maximum capacity, that is not the case. Many factors contribute to reduced demand among state employees for parking spaces. For example, according to the U.S. Department of Transportation, 21 percent of Texans commute to work by means other than driving alone in a personal vehicle, immediately reducing parking demand by state employees by 3,698 full-time-equivalent positions (FTEs). Other factors reducing parking demand include employees taking sick leave or vacation time, working telecommuting schedules from home, attending offsite meetings, and conducting work outside of their office.

These factors significantly reduce the demand for state parking by agency employees. A 2008 study by Legislative Budget Board (LBB) staff concluded that state-owned parking facilities achieve an average usage rate of 68 percent, leaving 32 percent of available parking spaces vacant at any given time. Vacancy rates at individual parking facilities in the study ranged from a low of 5 percent to a high of 92 percent, with one-third failing to achieve a usage rate of at least 50 percent.

More efficient management and use of these assets could generate additional revenue for the state. By leasing individual excess parking spaces, leasing entire underused parking facilities, and evaluating severely underused facilities for potential conversion to a more effective purpose, the state would realize additional recurring non-tax revenue streams and offset maintenance, utility, and building costs. Implementation of these recommendations first requires the TFC to conduct a thorough use analysis of each parking facility in its inventory and calculate individual use rates based on current need. Such a study is established in Recommendation 4.

OPTIMIZING CAPACITY WITH NON-TRADITIONAL DEMAND

The state has an opportunity to realize a new stream of revenue by leasing unused individual parking spaces in state-owned parking lots and garages in the Capitol Complex and downtown areas of Austin. Commercial parking in the central Austin business district has been reduced due to the recent redevelopment of private parking facilities into office buildings and condominium towers. Much of the remaining parking available is divided into monthly contract parking and daily rate pay parking. Contract parking on the northern edge of downtown Austin, in the blocks adjacent to the Capitol, can range from $110 to $165 per month. Daily pay parking rates are typically capped between $7 and $10 per day, with hourly rates starting around $3 for the first hour.

The north side of the Capitol Complex is bordered by The University of Texas' Austin campus, which faces parking shortages for students, staff, faculty, and visitors. In addition to an extensive inventory of existing garages, the university is finishing construction on a multi-story parking facility along the northwestern edge of the campus on San Antonio Street, which will add 315 new spaces to an existing facility. The university also operates a multi-story parking garage one block east of the Capitol Complex at 17th Street and Lavaca next to an administrative building in the same block.

By leasing excess parking spaces in state-owned parking lots and garages, the state would generate a new non-tax stream of revenue that could offset much of the maintenance and operational costs of the facilities while also improving citizen access to business, government, and educational opportunities in downtown Austin. Garages currently operating at less than 90 percent capacity, including 10 of the 12 garages included in the LBB survey, would be ideal for leasing individual spaces. Facilities achieving capacities above 90 percent are not ideal because they lack sufficient flexibility to accommodate visitors to state facilities and possible mid-term and seasonal growth in state employee numbers. The specific garages and lots included in such a program would be determined by the detailed parking use study completed by the TFC included in Recommendation 4.

The potential revenue generated by Recommendation 1 is dependent on two factors: (1) a final determination of excess parking capacity, to be calculated by the TFC; and (2) the actual demand for parking in the area at the time the program is instituted. While neither of these variables is precisely known, enough data is available to estimate the amount of revenue that could be generated by individual parking space

leasing activities. Parking fees at The University of Texas, Austin campus, range from $9 to $14 per month for surface lot passes and from $43 to $79 per month for garage access, and contract parking in downtown Austin can range from $110 to $165 per month.

Based on these rates, lease rates for contract parking in state parking facilities could range from $25 to $75 per month, depending on specific demand and availability. The 2008 LBB staff study of parking capacity indicates there are approximately 3,200 excess spaces available for lease in state garages in the downtown Austin area. If 40 percent of these spaces were leased by private individuals at an average rate of $50 per month, the state would receive an additional $771,000 in General Revenue Funds per year, or $1.5 million per biennium. This amount of revenue would have paid for 94 percent of the total costs associated with TFC's full parking facilities inventory, including maintenance projects, custodial services, and utility costs, during the 2006–07 biennium. At the upper range, the state could generate $4.6 million per biennium by leasing 80 percent of the available excess spaces at an average rate of $75 per month. **Figure 11** shows the potential yearly revenue projections for various rates based on the percentage of available excess parking spaces leased.

FIGURE 11
YEARLY REVENUE PROJECTIONS FOR PARKING LEASE PROGRAM

MONTHLY LEASE RATE	LEASING 40% OF EXCESS SPACES	LEASING 60% OF EXCESS SPACES	LEASING 80% OF EXCESS SPACES
$25	$385,488	$578,232	$770,976
$35	$539,683	$809,524	$1,079,366
$50	$770,976	$1,156,464	$1,541,951
$75	$1,156,464	$1,734,695	$2,312,927

SOURCE: Legislative Budget Board.

Recommendation 2 provides for the resources necessary to manage a program charged with leasing excess individual parking spaces within state facilities through a rider in the 2010–11 General Appropriations Bill. In addition to related appropriations, the rider would increase the TFC full-time-equivalent position cap by one position to staff the new operations. This rider would be contingent on the enactment of legislation amending Texas Government Code, Chapter 2165.

FULL FACILITY LEASE OPTIONS

Significantly underused facilities, those with usage rates below 50 percent, should be considered for more extreme leasing models. For such facilities it may be more efficient to lease the entire facility to a single business, university, or local government entity rather than attempt to lease a majority of the excess spaces to individuals. By implementing Recommendation 3, the state could recover the cost of maintaining parking facilities through a flat-rate payment structure and receive a percentage of revenue collected by the lessee for use of the facility by individuals.

While approximately one-third of the state's current parking facilities might meet the classification requirements set above, not all would be suitable for full facility leases. Garages and lots identified for lease would need to be located within close walking distance of large businesses, universities, or local governmental entities, such as hospitals and city offices, that have limited or insufficient parking. An ideal situation would also require other immediately adjacent state parking with adequate excess capacity to absorb state employees displaced by the lease of a full facility. TFC state parking garages B and G, located along San Jacinto Avenue between 16th and 17th Streets, are a prime example of the convergence of these requirements. LBB staff found the usage rates of garages B and G to be 30 percent and 27 percent, respectively. The garages are immediately across the street from multiple state parking facilities, with average vacancy rates ranging from 20 percent to 45 percent, adequate to accommodate the current state employee use experienced by garages B and G. Finally, both facilities are located two blocks from The University of Texas, Austin campus, which is currently attempting to address limited parking options for its students, staff, faculty, and visitors.

During fiscal year 2007, TFC spent $92,797 in utility, custodial, and maintenance costs for garages B and G. Conservative estimates indicate that the state could generate $180,000 in General Revenue Funds annually by leasing garages B and G to The University of Texas at Austin through a 5- to 10-year split structure contract based on a set yearly lease rate and supplemental profit-sharing agreement. That amount of revenue is more than enough to cover the maintenance costs of the facilities while retaining the properties in the state inventory as they continue to appreciate. Lease contract terms could be set at appropriate lengths to allow the state to continually re-evaluate the advantages of the lease operation and potentially return the facilities to use as state employee parking or convert the

properties to another state use as described in the next recommendation.

The University of Texas, Austin campus, is not the only potential party interested in leasing state garage facilities. There are several large hospital complexes and private enterprises within walking distance of the Capitol Complex, and the city of Austin has recently expressed interest in acquiring and operating existing parking facilities in the downtown business district.

PROPERTY REDEVELOPMENT OPPORTUNITIES

While the state maintains a significant inventory of state-owned office space in Travis County through TFC, 6.1 million square feet, TFC also leases 2.8 million square feet of office space from private building owners in Austin for state agencies. The 79 active leases comprising this space cost $31.2 million per year in All Funds. In making these regular lease payments, the state is paying the cost of building owners' profit margins, elevated utility and maintenance expenses, and property taxes, fees that would not be assessed, or could be minimized, if the properties were state-owned facilities.

By redeveloping severely underused parking facilities in the Capitol Complex to other uses, such as the construction of new state-owned office buildings, the state would both improve the efficiency of major state real estate assets and reduce the long-term cost of leasing millions of square feet of space per year. Recommendation 4 applies to parking facilities with usage rates below 30 percent. These facilities should be targeted for examination, with those falling below 10 percent classified as ideal sites for redevelopment. For example, a recent LBB study found TFC parking lot 8, located along 15th Street in the middle of the Capitol Complex, to have an observable usage rate of less than 10 percent. The lot is located in the same block as the state's child care center. Both of these properties were also recommended for redevelopment to high-rise office buildings during a 2004 evaluation conducted by the General Land Office.

A new state office building the approximate size of the William B. Travis Building, 450,000 square feet, could be constructed in the block currently occupied by TFC parking lot 8 and the child care facility for less than $90 million. With the additional space created by such a building, more than 1,700 state employees could be transitioned out of leased facilities, saving $3.7 million per year in All Funds. While there would be upfront costs associated with the construction of a new office building and the related bond issuances, the project could begin generating savings for the state before the end of the indebtedness period. Factoring in the resulting savings from reduced lease needs, construction costs, and financing expenses, the construction of a new office building as described above would cost $50.1 million over the life of the bond issuance, a savings of $38.0 million from the initial construction cost. After fully paying off the associated debt, the state could see savings in excess of $5.6 million per year. **Figure 12** shows an example of the costs and savings associated with such a project over the 20-year life of a bond obligation.

FIGURE 12
ESTIMATED COST OF STATE BUILDING PROJECT, 20-YEAR PROJECTION

FISCAL YEAR	LEASE SAVINGS (IN MILLIONS)	DEBT SERVICE (IN MILLIONS)	TOTAL COST (IN MILLIONS)
1	$0.0	$2.8	$2.8
2	0.0	9.1	9.1
3	(3.9)	8.9	5.0
4	(4.0)	8.6	4.7
5	(4.1)	8.4	4.3
6	(4.1)	8.2	4.0
7	(4.2)	7.9	3.7
8	(4.3)	7.7	3.4
9	(4.4)	7.4	3.0
10	(4.5)	7.2	2.7
11	(4.6)	7.0	2.4
12	(4.7)	6.7	2.0
13	(4.8)	6.5	1.7
14	(4.9)	6.2	1.4
15	(5.0)	6.0	1.0
16	(5.1)	5.7	0.7
17	(5.2)	5.5	0.3
18	(5.3)	5.3	0.0
19	(5.4)	5.0	(0.4)
20	(5.5)	4.8	(0.7)
21	(5.6)	4.5	(1.1)
TOTAL	**($89.3)**	**$139.4**	**$50.1**

SOURCE: Legislative Budget Board.

The example shown in **Figure 12** is based on a conservative yearly lease cost adjustment of 2 percent per year. Actual yearly increases in lease costs above 2 percent would accelerate the rate of savings of such a project and decrease the over all cost to the state. For example, a yearly lease cost increase of 4 percent would decrease the total cost of the building project

to $32.7 million, or $1.6 million per year over a 21-year total project length. Actual realized savings would depend on multiple variables, including the number of employees relocated from leased space, the size and capacity of a newly constructed building, and the timing of construction and financing costs.

Recommendation 4 also sets the requirement for TFC to establish baseline usage rates for state-owned parking facilities under their management. The establishment of base usage rates for each facility is necessary to determine the most appropriate application of the various recommendations listed above, and must be completed prior to the implementation of any activities related to Recommendations 1, 2 , or 3.

FISCAL IMPACT OF THE RECOMMENDATIONS

These recommendations would generate an estimated net gain of $1.8 million in General Revenue Funds during the 2010–11 biennium. The exact amount of new revenue is dependent on the number of facilities ultimately determined to be underused and included in leasing operations and the mix of recommendations applied to those facilities, and could be greater than estimated here. **Figure 13** shows probable yearly revenue resulting from a conservative implementation of these recommendations.

FIGURE 13
FIVE-YEAR FISCAL IMPACT OF OPTIMIZING THE USE OF STATE PARKING FACILITIES

FISCAL YEAR	PROBABLE SAVINGS/(COST) IN GENERAL REVENUE FUNDS	PROBABLE GAIN/(LOSS) IN GENERAL REVENUE FUNDS	PROBABLE ADDITION/ (REDUCTION) OF FULL-TIME EQUIVALENTS
2010	($62,933)	$951,385	1
2011	($57,781)	$951,385	1
2012	($57,897)	$951,385	1
2013	($57,897)	$951,385	1
2014	($57,897)	$951,385	1

SOURCE: Legislative Budget Board.

Recommendation 1 proposes leasing individual parking spaces in state lots and garages with excess capacity to private citizens working or attending school in the area. Implementing this recommendation across 40 percent of the excess spaces available in Capitol Complex facilities at $50 per month would generate an estimated $1.5 million in General Revenue Funds during the 2010–11 biennium. TFC would require an additional full-time employee, at a total cost of $63,000 in the first year, to implement a parking lease program as described in Recommendation 1. Recommendation 2 provides these resources. Program staff would report to the director of the Facilities Leasing Division at the Texas Facilities Commission.

Recommendation 3 proposes leasing entire parking facilities for use by private businesses, universities, or local governments. Limited implementation of this recommendation as defined in the example provided above, leasing TFC garages B and G, would generate an estimated $360,000 in General Revenue Funds during the 2010–11 biennium. This recommendation could be implemented with existing agency resources at no additional cost to the budget.

Recommendation 4 requires the TFC to conduct a study of parking facility usage rates and report opportunities to redevelop severely underused facilities. This recommendation can be implemented with existing agency resources and has no direct fiscal impact during the 2010–11 biennium.

The introduced 2010–11 General Appropriations Bill contains rider language to implement Recommendation 4 but does not address Recommendations 1, 2, or 3.

IMPROVE ACCOUNTABILITY FOR THE TEXAS EMERGING TECHNOLOGY FUND

Through a collaboration of private sector, higher education, and regional economic development entities, the Emerging Technology Fund promotes technology-related research and commercialization. Created by the Seventy-ninth Legislature, Regular Session, 2005, and managed by the Office of the Governor, the Emerging Technology Fund is comparable in its objectives and investment capacity to technology innovation agencies in other states. This level of economic development potential should be accompanied by a higher degree of accountability.

FACTS AND FINDINGS

- Out of the initial $200 million Emerging Technology Fund appropriation, the Office of the Governor made 46 awards totaling $85.3 million during the 2006–07 biennium. The pace of grant allocations increased in fiscal year 2008, when the agency made 33 awards totaling $51.8 million.
- Technology development agencies in four states with programs and funding similar to the Texas Emerging Technology Fund are required by law to submit annual reports. The reports contain performance metrics such as companies and jobs created, as well as private investment and matching grants leveraged. Also, some provide information about significant commercialization or research outcomes realized by funded organizations.
- Under Emerging Technology Fund contracts, the Office of the Governor can take an equity position in companies receiving commercialization program awards. These arrangements have the potential to generate significant rates of return for the state. On the other hand, there is no guarantee that repayment of awards will occur because start-up companies often fail before they bring new products or processes to market.
- Similar to the growth pattern of Emerging Technology Fund awards overall, the number of companies in which the Office of the Governor can take an equity position grew from 30 to 54 during fiscal year 2008.

CONCERNS

- State law does not require the Office of the Governor to produce an annual report that shows the Emerging Technology Fund's actual performance. This accountability measure is standard among similar technology development agencies in other states.
- The state's growing investment in early stage technology companies and the high risk, high return nature of Emerging Technology Fund equity arrangements warrants additional disclosure to the public identifying the companies in which the Office of the Governor can take an equity position and each company's Emerging Technology Fund award amount.

RECOMMENDATION

- **Recommendation 1:** Amend Section 490, Texas Government Code, to require the Office of the Governor to submit an Emerging Technology Fund annual report to the Legislature that includes performance metrics, such as companies receiving private investment, total private investment received, and total federal grants received. The report should describe the planned and actual outcomes resulting from technology commercialization and research for the prior two fiscal years and disclose those companies in which the Office of the Governor can take an equity position. Annual reports should also show the amount of awards provided to each company, institution of higher education, and non-profit organization.

DISCUSSION

The Emerging Technology Fund (ETF) supports research and commercialization projects that enhance Texas' competitive standing in advanced technology. According to the fund's enabling statute, its purpose is to facilitate commercialization, increase the number of high-quality jobs in Texas, and expand higher education technology research capabilities. The Department of Economic Development and Tourism within the Office of the Governor (agency) manages the ETF.

The agency began providing ETF awards in fiscal year 2006. For the 2006–07 biennium, the agency expended $94.7 million from the original $200 million appropriation. The agency estimates expenditures of $203.5 million for the 2008–09 biennium. The General Appropriations Act limits ETF-related annual administrative expenditures to $600,000.

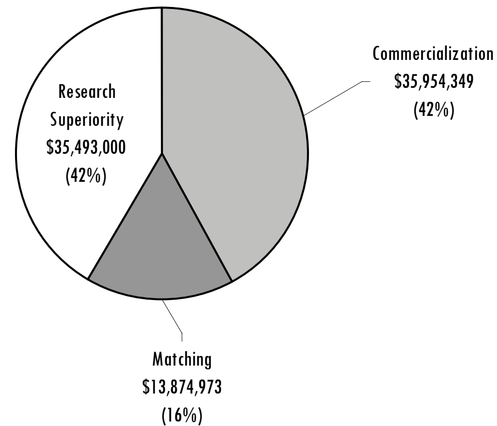
The ETF consists of three programs.

- The commercialization program finances early stage ventures focused on bringing high technology products or processes to market. Awards under this program have funded commercialization projects to improve treatment of infectious disease and reduce the cost of electricity.
- Through the research matching program, institutions of higher education and companies receive state funding to acquire federal research and commercialization grants. For example, a $975,000 grant to Carbon Nanotubes will help it market an innovative fuel cell product. The federal National Institute of Standards and Technology provided an equivalent grant.
- The third program, research superiority, offers grants that allow higher education-private sector partnerships to develop research centers and attract prominent scientists. For example, a $2.5 million ETF grant to the University of Texas Health Science Center at Houston led to the recruitment of a leading researcher in nanotechnology.

Figure 14 shows ETF grant allocations by program. During the 2006–07 biennium, the agency provided $36.1 million in commercialization awards, $13.9 million in research matching, and $35.5 million in research superiority grants, for a total of $85.5 million. These award levels represent program allocations of 42 percent, 16 percent, and 42 percent, respectively. State law in effect for the 2006–07 biennium required an allocation of 50 percent, 25 percent, and 25 percent. The same statute, however, permitted the Governor to allocate awards in a different manner with prior approval from the Lieutenant Governor and Speaker of the House of Representatives. Approval was granted for this purpose in the 2006–07 biennium.

Legislation enacted by the Eightieth Legislature, 2007, altered the allocation pattern to 50 percent, 16.7 percent, and 33.3 percent for commercialization, research matching, and research superiority, respectively. It also retained the Governor's authority, with prior approval from legislative leadership, to adjust these allocations.

FIGURE 14
EMERGING TECHNOLOGY FUND ALLOCATIONS BY PROGRAM, 2006–07 BIENNIUM



SOURCES: Legislative Budget Board; Office of the Governor.

REVIEW OF AWARD APPLICATIONS

Applications for commercialization awards are reviewed by Regional Centers for Innovation and Commercialization (RCIC), the Life Science Center, the ETF Advisory Committee, and the Office of the Governor, as well as the state's government leaders: the Governor, Lieutenant Governor, and Speaker of the House of Representatives. The seven RCICs are non-profit organizations established through collaborations of economic development, higher education, and private sector entities. In addition to reviewing applications from within their regions, RCICs provide support services for early stage companies. Each RCIC is sponsored by a local economic development agency or institution of higher education. A statewide Life Science Center, based in Houston, processes applications related to bioscience technology.

After an RCIC or the Life Science Center endorses an application, it is submitted to a 17-member advisory committee. Members of the advisory committee are appointed by the Governor and must be business or higher education leaders. Once a proposal is approved by the advisory committee, the Governor's staff conducts a nine-step due diligence analysis. The analysis includes assessment of the applicant's financial condition and whether its proposed milestones are reasonable. If a proposal clears the due diligence stage, it is forwarded to the Governor, Lieutenant

Governor, and Speaker of the House of Representatives for final approval.

Applications for research matching and research superiority are submitted directly to the Office of the Governor. At that point, applications undergo a due diligence review, and if approved, are reviewed by the ETF advisory committee and the state government leaders. Applicants for matching grants must already have obtained an equal or greater federal grant amount and must represent a consortium of higher education and private sector entities. Research superiority grants must be matched by higher education contributions and meet other criteria related to improving the state's applied science standing.

CONTRACT COMPLIANCE MONITORING

The agency negotiates agreements with companies receiving commercialization awards. Agreements establish the conditions under which disbursements will be made. Conditions include achievement of milestones by specific dates and maintaining primary business operations in Texas. The first disbursement occurs soon after an agreement is signed; the final one takes place four to six months later.

Each year of the agreement all entities must submit compliance reports to the agency indicating milestone achievement status. The agency compares the grantee's actual progress to its milestone contract terms. If the grantee is making its best effort to achieve milestones on time, the agency will deem the entity in compliance with its contract. In general, the same monitoring process is followed in all three programs.

OTHER STATES' TECHNOLOGY DEVELOPMENT PROGRAMS

Texas is among several states providing financing and other services for technology development. The Massachusetts Technology Development Corporation (MTDC), created in 1979, is the oldest state entity offering this assistance. The MTDC began as a state grant program and evolved into a non-profit that helps finance early stage companies. Like some newer programs, the MTDC takes an equity position in start-up companies and, as a result, can fund new ventures with its investment returns.

Figure 15 shows information about technology development programs and agencies in four states with funding comparable to the Texas ETF. All of these programs have been operating since 2001 and each received annual appropriations or total funding in fiscal years 2007, 2008, or 2009 greater than $60 million.

Programs administered by the agencies in Ohio, Pennsylvania, New Jersey, and Kansas support early stage companies involved in commercialization and higher education or private sector research. The Ohio Third Frontier Project and the Kansas Bioscience Authority provide funding to recruit

FIGURE 15
COMPARISON OF MAJOR STATE TECHNOLOGY DEVELOPMENT PROGRAMS

FUND ELEMENTS	OHIO	PENNSYLVANIA	NEW JERSEY	KANSAS	TEXAS
Technology Development Programs	Third Frontier Project	Ben Franklin Technology Programs	Edison Innovation Fund	Bioscience Programs	**Emerging Technology Fund**
Agency Responsible	Ohio Third Frontier Commission	Ben Franklin Technology Development Authority	New Jersey Economic Development Authority	Kansas Bioscience Authority	**Governor's Office**
Year Program/Fund Created	2002	2001	2006	2004	**2005**
State Funding/Total Financing Provided	$117 million fiscal year 2008	$61 million fiscal year 2007	$154 million fiscal year 2007	$71 million fiscal year 2009	**$203 million 2008–09 biennium**
Annual Report Required	Yes	Yes	Yes	Yes	**No**
Annual Report Performance Measures/Information	Private Investment Leveraged Companies Created Jobs Created Results Information	Private Investment Leveraged Jobs Created Matching Grants Leveraged	Public/Private Investment Jobs Created Results Information	Capital Investment Jobs Created Results Information	**Not Applicable**

Sources: Legislative Budget Board; Ohio Third Frontier Commission; Ben Franklin Technology Development Authority; New Jersey Economic Development Authority; Kansas Bioscience Authority.

prominent researchers. The Pennsylvania and Ohio agencies provide loans and grants to private investment funds that capitalize start-up companies. Agencies in New Jersey and Kansas can take equity positions in companies they fund.

Laws in the four states listed in **Figure 15** governing each of the agencies responsible for the emerging technology programs in those states require them to submit annual reports. The reports contain performance metrics that show the number of companies and jobs created, and private investment and outside grants leveraged by agency grants. Also, annual reports for three of the states' agencies highlight the projected or actual outcomes associated with program awards. For example, the Ohio Third Frontier annual report discusses important new products that grantees either have or will bring to market. This information allows taxpayers to understand the extent to which these programs benefit their state.

REQUIRE ANNUAL REPORTS AND EQUITY POSITION DISCLOSURE

Texas state law does not require the Office of the Governor to submit an ETF annual report. This omission is problematic for two reasons. First, the fund's investment capacity aligns with several large-scale state technology development programs. Second, cumulative ETF award levels have grown significantly since 2005, totaling $137.2 million by the end of fiscal year 2008. Thus, the fund has reached a size that warrants more public accountability.

Recommendation 1 would amend Section 490, Texas Government Code, to require the Office of the Governor to submit an annual report to the Legislature on the status of the Emerging Technology Fund. The annual ETF report would include performance metrics, such as companies receiving private investment, total private investment received, and total federal grants received. In addition to that, it would describe the planned and actual outcomes resulting from technology commercialization and research for the prior two fiscal years.

Agreements related to the commercialization program contain provisions that allow the Office of the Governor to take an equity position in companies receiving awards. The purpose of these arrangements is to provide the state a return on its investment and give companies a financial incentive to obtain private equity financing as quickly as possible.

An equity position occurs when a company obtains private financing. The Governor's Office can claim investment shares based on the private investors' valuation of the company. Under ETF agreements, the state gains when a company either sells shares on the open market or is bought out by another firm. Rates of return under these agreements have the potential to be very high. According to the Office of the Governor, Cardio-Spectra generated a 47 percent return within 18 months of its ETF award notification as a result of Volcano Corporation purchasing the company.

ETF investments in early stage companies also carry a high level of risk. According to a Copley News Service article, up to 40 percent of early stage biotechnology companies fail to repay their initial loans. As of September 2008, one company that received ETF money has failed. Nanocoolers received a $3 million award in March 2007. The company shut down in November 2007 without repayment of its award. According to the Office of the Governor, technical hurdles prevented Nanocoolers from successfully creating a marketable product, leading to the company's dissolution.

As the fund's cumulative award total grows, the likelihood of company closures without repayment of ETF awards will increase. The ETF currently has a rapidly growing cumulative award total. During fiscal year 2008, the cumulative award total increased by approximately 60 percent.

It is important that the Legislature and the public understand the high-risk, high-return nature of ETF investments, and that the state can take an equity position in companies receiving awards. The fund's growing investment stake makes the need for such an understanding even greater. Currently, however, there is no statutory requirement for the Office of the Governor to disclose that the state may take an equity position, or the risks associated with exercising this right, to either the Legislature or the public. Implementation of Recommendation 1 would address this concern by requiring ETF annual reports to disclose those companies in which the Office of the Governor can take an equity position. The disclosure would indicate that returns resulting from acquiring shares in companies financed by the ETF can be much higher than conventional equity investments, but that some companies may never repay their awards. Annual reports would also show the amount of awards provided to each company, plus institutions of higher education and non-profit organizations.

FISCAL IMPACT OF THE RECOMMENDATION

Preparation and distribution of an ETF annual report as proposed by Recommendation 1 would not significantly increase expenditures for the Office of the Governor. The

agency can collect performance-related information from existing sources. The cost of producing and distributing ETF annual reports could be minimized by printing and mailing them at the same time as other reports required of the agency.

The introduced 2010–11 General Appropriations Bill does not include any adjustments as a result of these recommendations.

ESTABLISH A STATEWIDE CONTRACT FOR COMPUTER-ASSISTED LEGAL RESEARCH SERVICES

Computer-assisted legal research services provide electronic access to comprehensive legal, business, and media sources. Although numerous state agencies in Texas purchase legal research services from two primary vendors, the state lacks a consolidated statewide contract.

Legal and judicial agencies in Texas have negotiated independent contracts that offer more favorable rates than market standards for these services. Other states have implemented consolidated contracts for use by all state agencies that have resulted in reduced subscription rates for computer-assisted legal research services. A consolidated statewide contract would allow Texas to negotiate discounts based on the combined user volume of multiple state agencies. Therefore, a statewide contract for these services based on volume pricing would allow the state to receive optimal pricing and terms for the provision of computer-assisted legal research services. The Comptroller of Public Accounts plans to review this service for a potential statewide contract in fiscal year 2009.

CONCERNS

- ♦ In Texas, 145 state agencies and institutions of higher education purchase legal research products from two primary vendors and many agencies independently contract with these vendors for computer-assisted legal research services. These contracts cause the total quantity of legal research services purchased by the state to appear smaller than is actually the case, thus reducing or eliminating discounts available based on user volume.

- ♦ The rates Texas agencies pay for computer-assisted legal research services vary from $12 to $109 per user each month, even though they are receiving similar services.

RECOMMENDATION

- ♦ **Recommendation 1:** The Comptroller of Public Accounts should complete its planned analysis of the feasibility of a statewide contract for computer-assisted legal research services and consult with the Office of Court Administration, State Law Library, and Office of the Attorney General in completing this evaluation.

DISCUSSION

Computer-assisted legal research (CALR) services provide federal and state statutes, court cases and documents, regulations, journal articles, legal references, and citation services through electronic media, primarily the internet and research software. Many of these services also include access to non-legal academic journals and other forms of media, including newspapers. CALR services allow a user to search a wide array of legal resources by providing case synopses and a history of legal documents.

The two primary providers of CALR services to state agencies in Texas are LexisNexis (Lexis) and Westlaw (West). Both Lexis and West provide case laws, state and federal statutes, citations, treaties, and numerous other legal documents. However, the analytical features and breadth of information provided varies between the two CALR services. **Figure 16** shows a comparison of the two primary providers of CALR services used by state agencies.

From fiscal years 2005 to 2007, a total of 145 state entities (agencies and institutions of higher education) purchased

FIGURE 16
COMPARISON OF LEXISNEXIS (LEXIS) AND WESTLAW (WEST) CALR SERVICES

LEXIS	WEST
• Lexis first became available to legal practitioners in 1973.	• Became available to legal practitioners in 1975.
• Nexis was created in 1979 to provide news and business information.	• Has developed searchable databases and access to non-legal media services and reports.
• Consists of over 5 billion documents from more than 40,000 sources.	• More than 30,000 legal, financial, and business news databases are available through the Internet.
• Provides risk assessment services, products to complete compliance assessments, and business management tools.	• Provides citation and continuing legal education services and tools to help monitor financial markets and litigation trends.

Source: Legislative Budget Board.

legal research products from Lexis and West. During this period, 141 state entities purchased products from West or its subsidiaries, while 115 state entities purchased products from Lexis and its subsidiaries. From fiscal years 2005 to 2007, 111 state agencies purchased products from both Lexis and West. This total includes legislative agencies and judicial entities. **Figure 17** shows fiscal year 2007 state agency expenditures to West and its auxiliary companies, totaling $5.3 million, and expenditures on products from Lexis and its auxiliary companies, totaling almost $1.8 million. All state agencies spent a combined $7.1 million on products from West and Lexis in fiscal year 2007. During the past three fiscal years, state agencies have paid a total of $19.9 million to West, Lexis, and their subsidiaries for all legal research products, including CALR services.

Agencies spent approximately $4.1 million specifically for CALR services from Lexis and West during the past three fiscal years. This is second only to print materials in services purchased from these two vendors, accounting for 20 percent of all payments made from fiscal years 2005 to 2007.

TEXAS STATE AGENCIES CONTRACTING FOR CALR SERVICES

The Judicial Committee on Information Technology (JCIT), through the Office of Court Administration (OCA), has negotiated contracts with both Lexis and West that all judicial entities statewide may use. The State Law Library, as the entity responsible for assisting courts with legal research needs, has responsibility for these contracts. **Figure 18** shows the rates received by state judicial entities that choose to use the Lexis contract, which is divided into limited access and full access based on the number of databases a user accesses.

Prices for West services vary between $30 and $200 per month for court users and each plan allows three passwords per judge and their staff. Plans for use of materials by non-court users also vary between $30 and $200 per month based on the online services used; however, these prices are per user.

Although all judicial entities in Texas could subscribe to West and Lexis through the State Law Library's contracts, many do not. Some courts have independently negotiated contracts with Lexis and West outside of the centrally administered contract option. The Tenth Court of Appeals paid a flat rate of $350 per month for unlimited access to select West databases by all employees during fiscal year 2007. Nine employees at the Tenth Court of Appeals used West during fiscal year 2007; therefore, the monthly user fee was $38.89.

Texas has not negotiated a statewide contract with Lexis or West that applies to all state agencies, although many agencies have individually negotiated contracts with the companies. The Office of the Attorney General (OAG) negotiated a contract with Lexis for a flat rate of $10,950 per month. The OAG contract allows 801 to 900 users unlimited access to a

FIGURE 17
STATE AGENCY LEGAL RESEARCH EXPENDITURES, FISCAL YEARS 2005 TO 2007

FISCAL YEAR	ALL WESTLAW PURCHASES (IN MILLIONS)	CALR SERVICES PURCHASED FROM WESTLAW* (IN MILLIONS)	ALL LEXISNEXIS PURCHASES (IN MILLIONS)	CALR SERVICES PURCHASED FROM LEXISNEXIS* (IN MILLIONS)	TOTAL ALL PURCHASES (IN MILLIONS)	TOTAL CALR PURCHASES* (IN MILLIONS)
2005	$4.57	$0.69	$1.61	$0.56	$6.18	$1.25
2006	$4.99	$0.73	$1.70	$0.57	$6.68	$1.30
2007	$5.30	$0.81	$1.80	$0.68	$7.10	$1.49
TOTAL	**$14.86**	**$2.23**	**$5.10**	**$1.81**	**$19.96**	**$4.04**

*Estimated.
SOURCE: Legislative Budget Board.

FIGURE 18
JUDICIAL ENTITY RATES FOR LEXIS SERVICES, 2009

ENTITY	LIMITED ACCESS*	FULL ACCESS*
Judges, Judicial Training Centers, OCA, Staff Attorneys	$23 per ID holder, per month	$38 per ID holder, per month
Library Staff, Prosecutors, Public Defenders	$58 per ID holder, per month	$73 per ID holder, per month

*Texas Factual Discovery (SP00TX) may be added to either plan for $15 per ID holder, per month.
SOURCE: Office of Court Administration.

subset of CALR databases, at unit costs between $12.17 and $13.67 per user per month.

Other agencies such as the Public Utility Commission have negotiated contracts at a fixed-monthly rate that do not specify the number of users authorized. Alternatively, the Texas Education Agency has a contract based on usage rather than a flat rate. **Figure 19** shows a sampling of the average monthly rates per user and type of contracts various state agencies have negotiated with Lexis and West.

CALR CONTRACTING IN OTHER STATES

Other states have successfully negotiated statewide contracts with both Lexis and West from which all state agencies are eligible or required to purchase. These contracts include various rate structures that accommodate the legal research needs of a variety of state agencies. **Figure 20** shows an overview of these contracts.

In 1993, the Florida Department of Legal Affairs negotiated a state term contract for CALR services that allowed trial courts to receive reduced subscription rates for legal services, while the appellate courts negotiated their own contract. During fiscal year 2001, the Florida Office of State Courts Administrator (OSCA) negotiated a contract with West for both trial and appellate courts that reduced per password rates by approximately 75 percent.

FIGURE 19
SAMPLING OF AGENCY RATES PER USER AND CONTRACT TYPE FOR CALR SERVICES

AGENCY	CALR PROVIDER	2005 AVERAGE PRICE/USER	2006 AVERAGE PRICE/USER	2007 AVERAGE PRICE/USER	TYPE OF CONTRACT
OAG	LexisNexis	$12.17	$12.17	$12.17	Fixed monthly rate/801–900 users
TCEQ	LexisNexis	$22.01	$28.39	$27.58	Fixed monthly rate/125 users
Sixth Court of Appeals	LexisNexis	$32.00	$34.00	$36.00	State Law Library Contract
Texas Supreme Court	Westlaw	$39.20	$40.05	$40.89	Fixed monthly rate/unlimited users
TEA	Westlaw	$77.88	$59.78	$78.83	Based on usage, no flat rate
PUC	Westlaw	$100.01	$107.06	$109.21	Fixed monthly rate/unspecified users

NOTE: OAG = Office of the Attorney General; TCEQ = Texas Commission on environmental Quality; TEA = Texas Education Agency; PUC = Public Utility Commission.
SOURCE: Legislative Budget Board.

FIGURE 20
OVERVIEW OF STATEWIDE CONTRACTS WITH LEXISNEXIS (LEXIS) AND WESTLAW (WEST)

STATE	CALR SERVICE PROVIDER	CONTRACT ADMINISTRATOR	RATE STRUCTURE(S)
Florida	Lexis	Department of Management Services	Rates for most government entities are on a per user per month basis. Select databases are provided at transactional billing rates and an annual flat rate.
Florida	West	Department of Management Services	Rates are based on a per user per month basis.
New Jersey	Lexis	Department of the Treasury	Fixed price, flat-rate tiered structure provided for most databases; some databases are available at a per transaction rate.
New Jersey	West	Department of the Treasury	A per transaction fee is charged for access to all materials.
Washington	Lexis	Office of State Procurement	One price schedule applies to the Administrative Office of the Courts. A five-tiered schedule applies to all other agencies.
New York	West	Office of General Services	One plan allows hourly or transactional billing; a second option is based on a tiered structure; a third option allows a three-month trial period. The agreement is based on combined usage.
South Carolina	West	Division of the State Chief Information Officer	Seven plans are available. Options include selecting hourly or transactional billing; a flat monthly rate; and negotiating a Special Offer Amendment.

SOURCE: Legislative Budget Board.

In 2002, the Florida Office of Program Policy Analysis and Government Accountability (OPPAGA) recommended that the Office of State Courts Administrator and the Departments of State and Legal Affairs collaborate with DMS to develop subscription options for use by all Florida state agencies with West and Lexis. Additionally, OPPAGA recommended that DMS make legal research subscription rate information available online so that state agencies could choose which company to use and verify charges when billed by the vendors. The Department of Management Services (DMS) negotiated the first statewide contract in Florida with both West and Lexis during 2003 that set a ceiling for subscription rates applicable to all state agencies. All state agencies are required to use these contracts for CALR services. A standard vendor number has been assigned to the state of Florida, and each agency individually purchases from West or Lexis. State agencies are billed directly for their purchases and are individually responsible for verifying and paying the bill. The statewide contract includes a provision requiring the CALR vendors to pay Florida a one percent transaction fee, which is used to finance the state's online procurement system.

The New Jersey Administrative Office of the Courts (AOC) initiated a contract with West that provided CALR services to municipal court judges at no cost in exchange for providing all court documents free of charge to West. Interested judges created an account with AOC and were assigned a password that allowed them to access West services from any location. Additionally, the New Jersey Department of the Treasury negotiated a statewide contract with both Lexis and West in 2005 that was available to all state agencies and cooperative purchasing partners. The Lexis contract allowed unlimited access to certain databases and materials at a fixed price, flat-rate tiered structure. Access to materials not included in the contract were available at a per transaction price. The West contract was based on a per transaction fee to all materials. Both contracts expired during June 2008 but have currently been renewed under the original contract terms until December 2008.

The Office of State Procurement in Washington negotiated a contract with Lexis for use by all state agencies, political subdivisions, qualified non-profit organizations, and certain institutions of higher education. This contract went into effect during September 2005 and includes two price schedules. The first applies to courts and the Administrative Office of the Courts (AOC) and allows up to 1,250 users. The second option is a five-tiered schedule (based on number of users) and applies to all entities in the Washington State Purchasing Cooperative. The contract also includes a provision in which Lexis agrees that the rates set forth in the contract are comparable to or better than rates offered to other governmental entities of a similar size. Additionally, Lexis is obligated to provide rates that are more favorable to the State of Washington if, during the term of the contract, Lexis reaches an agreement with another governmental entity of a similar size in which better rates are offered.

The Office of General Services in New York negotiated a contract with West that became effective during September 2002. The state contract may be used by all state agencies and departments, political subdivisions, and entities authorized to use New York State centralized contracts. Special discounts are included for faculty and students at state educational institutions. The contract is based on a combined usage subscription agreement with three plans currently available. The first plan allows users to choose an hourly or transactional billing option when using West and sets the hourly and transactional price for accessing various West services. A second plan provides a tiered structure based on the number of users. Each user is assigned a password and a flat monthly fee is charged for the use of certain databases. The monthly charge per user ranges from $70 to $181 depending on the number of State of New York users. The contract also allows for a three-month trial period available to users that have not previously subscribed to West. The trial provides unlimited access for as many as ten users per agency at $250 per user. West is required to aggregate the usage of all eligible New York employees and determine the cumulative charge for the month. Each entity is billed individually and state agencies forward invoices to the Office of the State Comptroller, which is responsible for making payments.

The Division of the State Chief Information Officer in South Carolina negotiated a Master Service Agreement with West in 2002 that is open to all state agencies. The contract allowed any state agency choosing to use the statewide contract to cancel an existing subscription to West or West CD-ROM library. Each agency that contracted with West using the statewide contract was billed individually for their usage at the rates negotiated in the contract. Seven plans are available under the contract. One plan allows the user to select either an hourly or a transactional billing option and specifies transmission charges for a variety of documents and databases. Two plans are applicable to state agencies with a maximum of 14 West users and charge a flat monthly rate. Three additional plans are available for state agencies with a minimum of two passwords and apply a flat monthly rate.

The final option under South Carolina's contract allows state agencies with more than 14 users to negotiate a Special Offer Amendment specific to that agency.

MAXIMIZING TEXAS' PURCHASING POWER

Other state's experiences show that statewide contracts can be negotiated with Lexis and West that employ a state government's bulk purchasing power. Additionally, the services in these contracts are structured in a variety of ways to meet the needs of numerous governmental entities. The potential to reduce the cost of CALR services based on volume pricing is further demonstrated by the favorable prices OAG receives compared to other Texas agencies, as well as the variety of prices charged per user across agencies. State agencies could keep the savings from lower rates negotiated in a statewide contract and apply them to other administrative uses.

CPA has indicated that they plan to consider the creation of a statewide contract for CALR services during fiscal year 2009. Recommendation 1 suggests that CPA pursue the creation of a statewide contract for CALR services with assistance from the OCA, State Law Library, and OAG. CPA is now required to study and negotiate statewide contracts and therefore can absorb the cost of any work necessary to implement a statewide contract for CALR services. Section 2155.064, Texas Government Code, requires CPA to attempt to benefit from bulk purchasing. Additionally, Section 2155.072, Texas Government Code, requires CPA to study a minimum of one service annually that state agencies purchase to determine whether a regional or statewide contract for the service would benefit the state.

A consolidated state contract would include the CALR needs of all agencies and entities in the judicial, legislative, and executive branches of state government. Where possible the contract should attempt to meet the needs of institutions of higher education as well. CPA should consult with the OAG, OCA, and State Law Library to develop and negotiate a statewide contract for CALR services. This consultation will ensure that appropriate subscription options are created to meet the legal research needs of all impacted parties. Additionally, these three agencies have experience negotiating favorable contracts for CALR services and working with Lexis and West as they provide court documents to both these businesses. Upon implementation of a statewide contract, CPA should take appropriate steps enabling state entities to ensure the charges they receive for usage of CALR services.

FISCAL IMPACT OF THE RECOMMENDATION

The recommendation in this report has no direct fiscal impact on appropriations of General Revenue Funds during the 2010–11 biennium. The implementation of a statewide contract for CALR services would result in reduced costs to user agencies for procured computer-assisted legal research services; however, any savings realized would be left as agency appropriations and redirected to other administrative and program costs.

IMPROVE ENERGY CONSERVATION IN STATE FACILITIES BY USING SEASONAL THERMOSTAT SETTINGS

Utility expenses have risen during the past several biennia while an aging infrastructure has decreased the efficiency of climate control equipment in Texas state facilities. During the Eightieth Legislature, 2007, the Texas Facilities Commission received $2.8 million in supplemental appropriations to meet utility costs incurred by agencies in state-owned facilities during the 2006–07 biennium. This was an increase of 17 percent above appropriations made for utilities in 2006–07. An office environment's temperature is directly linked to employee comfort and productivity; therefore, adjusting thermostats by several degrees could reduce heating and cooling costs and increase state employee productivity. Improving energy conservation is a simple measure the state could implement to become more energy efficient, cost effective, and environmentally friendly.

To ensure that energy conservation measures are used to help offset costs associated with growing energy demands, thermostats in state facilities should be set on a seasonal basis in accordance with industry standards for energy consumption and employee comfort.

FACTS AND FINDINGS

- ♦ Texas state agencies and institutions of higher education spend $218 million for electricity and $55 million on natural gas and liquefied petroleum annually. From fiscal years 2002 to 2007, electricity expenditures for state agencies increased by 31 percent and gas utility expenditures increased by 42 percent.
- ♦ The U.S. Department of Energy and the Texas Comptroller of Public Accounts recommend that thermostats be set at 78°F during warmer months and 68°F during cooler months and lowered when a building is unoccupied.
- ♦ The Texas Facilities Commission's tenant manual requires thermostats be set at 74°F, +/- 2°F. This setting applies to the 71 facilities that the Texas Facilities Commission manages.
- ♦ Establishing a baseline of energy consumption is necessary to assess energy efficiency measures and effectively manage energy usage.

CONCERNS

- ♦ State agencies are not required to consider energy conservation standards when determining thermostat settings for state office buildings. Since 2005, only four of the 26 agencies that reported temperature settings in their Energy Conservation Plans met standards recommended by the U.S. Department of Energy.
- ♦ There is no state standard to track energy consumption and expenditures, making it difficult to compare energy conservation and efficiency efforts among agencies and determine whether agencies are achieving quantifiable savings. Many state agencies housed in buildings managed by the Texas Facilities Commission report they do not have access to detailed information regarding their energy usage and expenditures.

RECOMMENDATIONS

- ♦ **Recommendation 1:** Amend Texas Government Code, Chapter 2165, to require a state agency or institution of higher education in charge and control of a state building to adjust thermostat settings to achieve occupant comfort within industry standards for energy conservation.
- ♦ **Recommendation 2:** Amend Texas Health and Safety Code, Chapter 388, to require each state agency or institution of higher education in charge and control of a state building to report to the State Energy Conservation Office on efforts to adjust thermostat settings based on industry standards for energy conservation and thermal comfort. (This recommendation amends a current reporting requirement and does not create a new report.)
- ♦ **Recommendation 3:** Amend Texas Government Code, Chapter 447, to require the State Energy Conservation Office to develop and maintain a database of statewide energy consumption and expenditures.

DISCUSSION

Texas is currently the fifth largest user of energy in the world, consuming 12 percent of all energy in the U.S. This consumption is a result of the state's petrochemical and refining activities, the size of the population, and the number of vehicles in the state. Texas leads the nation in both the production and consumption of energy and maintains per capita residential energy use that is higher than the national average.

As **Figure 21** shows, the commercial price of natural gas in Texas, which is commonly used for heating, increased 159 percent from calendar years 1995 to 2005. The commercial price of electricity in Texas, used for both cooling and heating, increased 34 percent during the same period.

ENERGY EXPENDITURES BY STATE AGENCIES

State entities (agencies and institutions of higher education) spend $218 million on electricity and $55 million on natural gas and liquefied petroleum annually. From fiscal years 2002 to 2007, 68 percent of utility expenditures resulted from electricity consumption while gas consumption comprised 22 percent of all utility expenditures. The remaining 10 percent supports the use of water and thermal energy. **Figure 22** shows state entity expenditures for electricity increasing during this period. From fiscal years 2002 to 2008, state entity expenditures for electricity increased by 31 percent, and natural gas expenditures increased by 42 percent. The Comptroller of Public Accounts estimates that the state spends $50 million annually on unnecessary utilities.

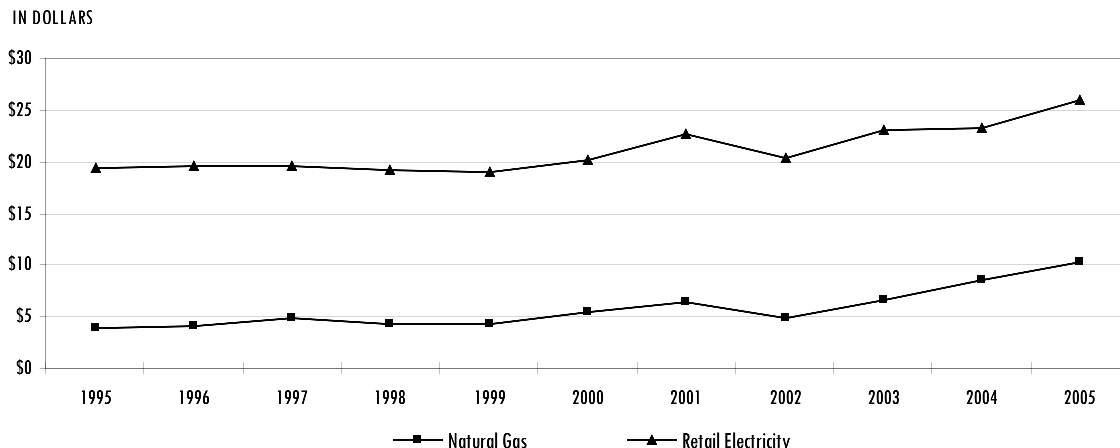
The Texas Facilities Commission (TFC) manages the procurement of utilities for 71 state-owned buildings that consist of over 10 million square feet and certain grounds. **Figure 23** shows the cost of electricity and gas used to heat, cool, and light these facilities. During fiscal year 2007, this cost was $17.3 million. The agency was appropriated $16.6 million in General Revenue Funds for utility expenditures during fiscal year 2007, and an additional $2.8 million was provided as a supplemental appropriation by the Eightieth Legislature, 2007.

ACHIEVE ENERGY CONSERVATION THROUGH HEATING AND COOLING TEMPERATURE CONTROLS

Energy conservation occurs when energy use is reduced through the avoidance of excessive or wasteful consumption and is a result of behavior modifications. Lowering the demand for energy or modifying the level of its timing or use, such as by turning out a light in an unused room, are methods of achieving energy conservation. Energy efficiency is a subcategory of energy conservation and occurs when less energy is used to achieve the same outcome. Energy efficiency is generally technology-based, such as using compact fluorescent light bulbs instead of traditional light bulbs.

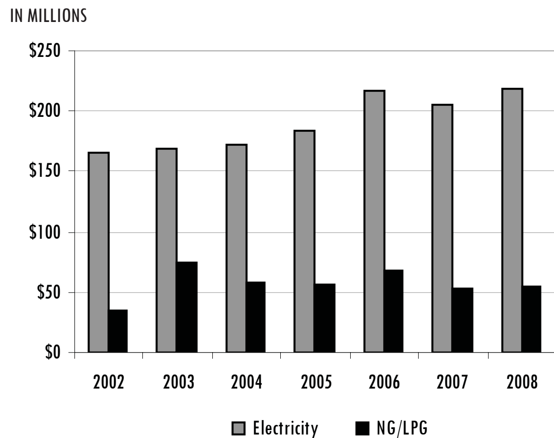
According to ENERGY STAR, a collaborative program between the U.S. Environmental Protection Agency and the U.S. Department of Energy (DOE), energy efficiency results in immediate savings, making it the most cost-effective step a business can take to become more environmentally sensitive. ENERGY STAR lists heating and cooling systems that operate at a full load when unnecessary and the use of personal heaters or fans by employees as two of the most common areas businesses can address to create energy savings.

FIGURE 21
COMMERCIAL SECTOR ENERGY PRICE ESTIMATES IN TEXAS, CALENDAR YEARS 1995 TO 2005



SOURCE: U.S. Energy Information Administration.

FIGURE 22
STATE ENTITY EXPENDITURES ON ELECTRICITY AND NATURAL GAS/LIQUID PROPANE GAS, FISCAL YEARS 2002 TO 2008



NOTE: The General Land Office was not included in natural gas/liquid propane gas expenditures because it purchased large quantities of natural gas for purposes other than direct consumption.
SOURCE: Texas Comptroller of Public Accounts.

ENERGY STAR notes that office buildings often run heating and cooling systems 24 hours a day, but reducing system use for one out of every 12 hours results in energy savings of approximately 8 percent. The U.S. Department of Energy's Federal Energy Management Program (FEMP) has indicated that programmable temperature controls often do not correspond to building occupancy schedules. Adjusting control schedules to better match occupancy schedules can result in fuel savings and associated reductions in total costs. FEMP contends that lowering a thermostat setting 10 degrees for an average of eight hours each day results in a 10 percent decrease in annual fuel consumption.

DOE and the Texas Comptroller of Public Accounts (CPA) recommend that thermostats be set to 68˚F during operating hours during cooler months and lowered when a building is primarily unoccupied. According to DOE, reducing a thermostat by 10˚F to 15˚F for an eight-hour period can reduce a household heating bill by 5 to 15 percent annually. DOE and CPA also recommend thermostats be set to 78˚F in warmer months during occupied hours. FEMP has determined that fuel consumption is reduced by 3 percent for every degree a thermostat is decreased.

ACHIEVE COMFORT THROUGH HEATING AND COOLING TEMPERATURE CONTROLS

Thermal comfort refers to the level of satisfaction a person has with their surrounding environment. Many factors can contribute to a person's level of thermal comfort, including air and radiant temperature, relative humidity, speed of air, solar heat, individual metabolic rates, and attire. The American Society of Heating, Refrigerating and Air-Conditioning Engineers (ASHRAE) has established internationally accepted standards for indoor air quality. ASHRAE Standard 55-2004 relates solely to thermal comfort and can be applied to any building type. Standard 55-2004 is based on norms that are comfortable to 80 percent of occupants. The recommended temperatures under Standard 55-2004 are between 68˚F and 78˚F during cooler months and 74˚F and 82˚F during warmer months, depending on factors such humidity levels. These standards are also the basis for the US Green Building Council's Leadership in Energy and Environmental Design (LEED) program.

The Occupational Safety and Health Administration (OSHA) in the U.S. Department of Labor acknowledges that office temperature is a matter of human comfort. OSHA does not specifically regulate office temperatures; however, OSHA does recommend that temperature controls between 68˚F and 76˚F be maintained.

FIGURE 23
TEXAS FACILITIES COMMISSION UTILITY EXPENSES, FISCAL YEARS 2004 TO 2008

FISCAL YEAR	ELECTRICITY (IN MILLIONS)	GAS NATURAL/LIQUID PROPANE (IN MILLIONS)	TOTAL (IN MILLIONS)	APPROPRIATIONS* (IN MILLIONS)
2004	$12.9	$1.6	$14.4	$12.9
2005	$14.3	$1.9	$16.2	$12.9
2006	$15.4	$2.3	$17.7	$16.6
2007	$15.3	$2.0	$17.3	$19.4
2008	$15.5	$2.3	$17.8	$19.2
TOTAL	**$73.3**	**$10.0**	**$83.4**	**$80.9**

*For all utilities (including water and thermal energy).
SOURCE: Legislative Budget Board.

CONSERVATION EFFORTS IN OTHER STATES

Illinois implemented a pilot program during the winter of 2005 in which thermostats in state facilities were lowered from 72˚F to 68˚F during the day. Thermostats were additionally lowered to 55˚F during the evening and off-hours. Facilities such as prisons and military barracks maintained a temperature of 68˚F at all times, and facilities housing vulnerable populations and with temperature-sensitive operations were not affected by any of the changes. The settings were applied from November 1, 2005 to April 15, 2006 and resulted in $4.8 million in savings. During November 2006, the Governor of Illinois implemented a permanent energy efficiency initiative that reduced daytime thermostat settings in state facilities to 68˚F in winter and increased them from 74˚F to 78˚F during summer months and as high as 80˚F during unoccupied periods. The Illinois Department of Central Management Services reported that the temperature adjustments decreased natural gas consumption by 2.2 million therms (1 therm is equal to 100,000 BTU), reduced carbon monoxide emissions by nine tons, and lessened nitrous oxide emissions by a total of 11 tons for 2005 and 2006.

In 2005, the Governor of Minnesota issued an executive order requiring all state agencies to set heating temperatures between 60˚F and 70˚F, depending on the purpose of the space, and 55˚F for all unoccupied and vacated spaces. The Governor required cooling temperatures to be set between 76˚F and 78˚F for all occupied spaces and that thermostats be set to 85˚F or turned off during nights and weekends. Certain computer, research, and special care facilities were exempt from these requirements. The Minnesota Department of Administration and the Department of Commerce reported that during 2006 state agencies subject to the Executive Order saved approximately $1.25 million in energy costs and reduced energy consumption by 4.8 percent.

CURRENT THERMOSTAT SETTINGS IN BUILDINGS OCCUPIED BY TEXAS STATE AGENCIES

The Governor issued Executive Order RP 49 in October 2005 requiring all state agencies and institutions of higher education to submit Energy Conservation Plans and Reports on a quarterly basis to the Office of the Governor and the Legislative Budget Board (LBB). Since the order was issued, LBB has received reports from 82 state entities. **Figure 24** shows the thermostat settings of the 26 entities that included this information in their reports. A wide range of settings were reported; however, only four entities reported thermostat settings in accordance with recommended settings by DOE. An additional four entities reported thermostat settings that align with DOE recommendations only during winter months, and four entities indicated they adjust thermostat settings during periods when buildings are unoccupied. All temperature settings reported are in the ranges recommended for achieving thermal comfort. The lowest reported setting during summer months was 72˚F and the highest was 78˚F. During winter months, the lowest reported setting was 68˚F while the highest was 75˚F.

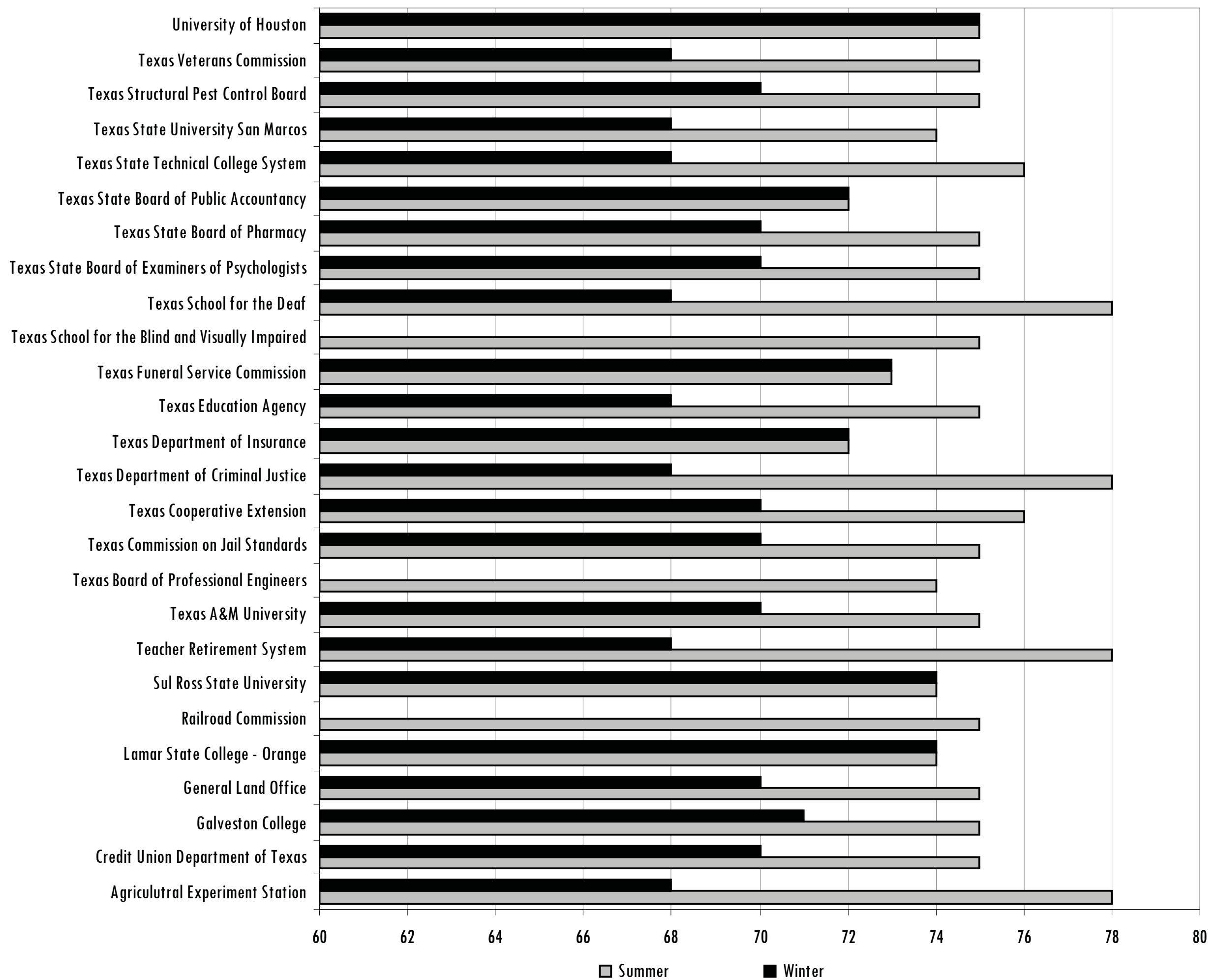
The Tenant Manual issued by TFC requires thermostats to be set at 74˚F, +/- 2ºF. This setting applies to the 71 facilities TFC manages. Many of TFC's tenant agencies report they do not have access to facility utility bills and related reports and they have limited opportunities to alter energy consumption through measures such as adjusting thermostats.

ADJUSTING THERMOSTAT SETTING TO ACHIEVE ENERGY CONSERVATION AND THERMAL COMFORT IN TEXAS

State entities are required by statute to reduce electric consumption by 5 percent annually from fiscal years 2007 to 2012. Recommendation 1 amends Chapter 2165, Texas Government Code, to require each state agency or institution of higher education that has control over a state building to establish thermostat settings that conform to national industry standards and best practices. These standards should include thermal comfort standards as recommended by ASHRAE that are within energy conservation standards set by DOE. Additionally, specific thermostat settings should be established for the hours in which a building is unoccupied, as recommended by DOE. State entities could determine which settings best address the thermal comfort of employees and a building's occupied hours through measures such as an employee survey. The statutory requirement would exempt certain facilities that have temperature sensitive operations such as some law enforcement agencies, computer or laboratory facilities, or buildings in which populations live or are served on a 24-hour basis. This recommendation would contribute to agency efforts to reduce electricity consumption under the current statutory requirement.

State entities are also statutorily required to annually report efforts to, and progress in, reducing electric consumption to the State Energy Conservation Office (SECO). Recommendation 2 amends Chapter 388 of the Texas Health and Safety Code to require each state agency or institution of higher education that has control over a state building to include in their report to SECO efforts to adjust thermostat settings. This section of the report should include, at a

FIGURE 24
STATE AGENCY TEMPERATURE SETTINGS BY SEASON



Source: Legislative Budget Board.

minimum, the seasonal specific thermostat settings of their buildings and any attempts to alter settings at non-peak or off hours.

Despite statutory requirements for entities to reduce and report on efforts to decrease electric consumption, it is difficult to determine whether an entity is achieving a real savings of 5 percent. Each entity tracks energy usage and expenditures using individual methods and data sources. SECO, through an outsourced contract, is developing a statewide energy database that will capture the utility usage and expenditures of all state agencies. The database will be accessible to agencies through the Internet and allow a baseline of energy consumption to be established for each agency. All information on a utility bill including physical location, consumption, rates, and actual cost will be included in the database, which will also contain building specific information such as square footage. A two-year history of utility bills will be available through the database when it becomes operational during the 2008–09 winter, and all utility bills going forward will be included. The database will serve as the state's primary energy management tool, and interested parties will be able to use it to observe trends in state and agency energy expenditures and consumption.

The database will allow for a common information technology platform from which agency energy usage and expenditures can be tracked. Therefore, the database will allow interested parties to determine the actual energy consumption and reduction of state agencies. State agencies that share building space with other agencies will also be able to determine their individual energy consumption and expenditures using this database. The building specific information will allow

formulas considering an agency's square footage to determine agency specific information.

Savings should be measured in reductions in energy consumption. Because the price of energy is volatile, it is possible that reductions in energy consumption could occur while energy expenditures would remain steady or increase. However, reductions in consumption result in monetary savings through cost avoidance, even if an increase in the price of energy does not result in a lower electricity bill.

Recommendation 3 amends Chapter 447 of the Texas Government Code to codify the requirement for the creation and maintenance of the energy database. This statewide energy database would include energy consumption and expenditure data for each state agency and include square footage information regarding the total area occupied by each state agency per building to allow each agency to determine their individual utility consumption and expenditures. The database would also be made available to agencies that are considered tenants of the Texas Facilities Commission. This will allow these agencies to access information regarding their expenditure and usage history so that they may better implement energy conservation efforts within their daily operations.

FISCAL IMPACT OF THE RECOMMENDATIONS

The recommendations have no direct fiscal impact on General Revenue Fund appropriations during the 2010–11 biennium. It is possible that the recommendations would result in reduced costs to state entities for utility expenditures; however, the savings would be retained by entities and redirected to other administrative and program costs. Additionally, savings resulting from adjustments made to thermostat settings would reduce requests from entities for emergency or supplemental appropriations to cover utility expenditures.

The introduced 2010–11 General Appropriations Bill does not include these recommendations.

STATE PRESERVATION BOARD FUNDING

The State Preservation Board is responsible for managing various historical and cultural facilities in Austin, which includes the management of the Bob Bullock Texas State History Museum. Legislative appropriations, as well as three funds outside the state Treasury and their related operating accounts provide funding for specific agency functions. The Capitol Fund, which has the highest balance of the three funds, pays for building and grounds improvements and maintenance, acquisition and preservation of historic artifacts, and visitor education.

FACTS AND FINDINGS

- During the 2006–07 biennium, the Capitol Fund's total revenue equaled $5.4 million; it included $3.9 million, or 73 percent, from fees, leases, commissions, business proceeds, and interest earnings; and $1.5 million, or 27 percent, from private donations. Capitol Fund expenditures totaled $1.5 million that biennium. Due to the fund's net gain of $3.9 million, its balance increased to $12.3 million at the end of fiscal year 2007.
- The State Preservation Board projects that the Capitol Fund balance will increase to $15.1 million by the end of the 2010–11 biennium. This projection is based on estimated revenue levels similar to the 2008–09 biennium and anticipated expenditures of $2.1 million.
- The Legislature could eliminate appropriations for the 2010-11 biennium to the State Preservation Board's Strategy A.2.1, Manage Education Program, given that projected Capitol Fund revenues will exceed fund-related expenditures by $1.4 million and because the strategy's estimated base level funding is $1.2 million.
- Eliminating General Revenue appropriations to Strategy A.2.1, and instead using Capitol Fund revenues for visitor education is consistent with state law which allows the fund to pay for any functions currently supported by legislative appropriations, including education. Both this strategy and the Capitol Fund support visitor education services. Therefore, allocating only the fund's revenue for this purpose would eliminate duplicative funding.

DISCUSSION

The State Preservation Board's (SPB) mission is to restore, preserve, and maintain the state Capitol, the 1857 General Land Office Building, the Governor's Mansion, and their grounds. The agency also manages the Bob Bullock Texas State History Museum. The agency uses appropriations of General Revenue Funds and several other sources of funding to meets it statutory obligations. During the 2006–07 biennium, the agency received $45.5 million in total revenue—$24.5 million, or 54 percent, from appropriations, and $21.0 million, or 46 percent, from three funds held outside of the state Treasury: the Museum Fund, Capitol Renewal Fund, and Capitol Fund and their related operating accounts.

The Museum Fund acts as a reserve account by supplementing revenue earned by the Bob Bullock Texas State History Museum. As shown in **Figure 25**, the museum had losses of $399,223 and $551,888 in fiscal years 2006 and 2007, respectively. SPB partially offset these losses by shifting $180,949 in fiscal year 2006, and $200,275 in fiscal year 2007 from the Museum Fund to the Texas State History Museum Fund operating account.

Before fiscal year 2006, the Museum Fund's balance increased as a result of interest earnings, private donations, and the museum's net income. Since then, the museum's increasing losses, stemming from declining revenue and rising expenses, caused the agency to rely more heavily on the Museum Fund to cover operating expenses. As a result, the Museum Fund's balance decreased from $881,836 to $679,853 in fiscal year 2007.

The Capitol Renewal Fund finances major repairs, replacement of fixtures and equipment, and restoration of historic property. For example, in fiscal year 2007, the fund paid for replacing light fixtures and carpeting. The fiscal year 2006 beginning fund balance developed from prior year interest earnings revenue, incoming transfers from the Capitol Fund, Pease Mansion sale proceeds, and appropriations of General Revenue Funds. As **Figure 26** shows, the projects mentioned previously and other

FIGURE 25
TEXAS STATE HISTORY MUSEUM OPERATING ACCOUNT AND THE MUSEUM FUND, FISCAL YEARS 2006 AND 2007

TEXAS STATE HISTORY MUSEUM OPERATING ACCOUNT		
FINANCIALS	2006	2007
Revenue	$5,576,887	$5,551,432
Expenses		
Personnel	$2,671,480	$2,600,237
Repairs and Maintenance	$220,189	$211,456
Rental/Leases	$774,066	$1,097,863
All Other	$2,310,376	$2,193,763
Total Expenses	$5,976,110	$6,103,320
Net Gain/(Loss)	($399,223)	($551,888)
Museum Fund Net Transfer In	$180,949	$200,275

MUSEUM FUND		
FINANCIALS	2006	2007
Revenue	$32,947	$34,761
Expenditures	$1,509	$36,469
Beginning Fund Balance	$1,031,347	$881,836
Net Gain/(Loss)	$31,438	($1708)
Museum Operating Account Net Transfer Out	($180,949)	($200,275)
Ending Fund Balance	$881,836	$679,853

Source: State Preservation Board.

FIGURE 26
CAPITOL RENEWAL FUND, FISCAL YEARS 2006 AND 2007

FINANCIALS	2006	2007
Revenue	$540,675	$601,931
Expenses		
Capitol Outlay	$709,867	$929,964
All Other	$124,690	$384,527
Total Expenses	$834,557	$1,314,491
Beginning Fund Balance	$12,321,170	$12,027,288
Net Gain/(Loss)	($293,883)	($712,560)
Ending Fund Balance	$12,027,288	$11,314,727

Source: State Preservation Board.

expenditures reduced the fund's balance from $12 million in fiscal year 2006 to $11.3 million in fiscal year 2007.

The Capitol Fund receives revenue from two gift shops, a visitor parking garage, fees from parking meters, automated teller machine use, commissions from the extension cafeteria, and leases for the press area, and cellular carrier space. Additional income is provided by donations and interest earnings. The agency uses the fund to pay for education, property maintenance and improvements, historic preservation, and costs associated with revenue sources such as the cafeteria.

As shown in **Figure 27**, Capitol Fund revenues totaled $3.1 million in fiscal year 2006 and $2.3 million in fiscal year 2007. Private donations of $1.3 million accounted for the higher fiscal year 2006 amount. Higher fee and lease revenue in fiscal year 2007 resulted from additional cafeteria and parking-related income associated with the legislative session. Expenditures in those years also increased due to greater facility improvement and maintenance workload.

Transfers of visitor parking garage and gift shop proceeds represent another source of revenue to the Capitol Fund. These transfers occur only when the agency determines that the two enterprises have generated adequate annual surpluses. As shown in **Figure 27**, gift shop revenues justified transfers of $500,000 and $600,000 in fiscal years 2006 and 2007, respectively. In fiscal year 2007, however, the agency discontinued its practice of transferring $200,000 each year from the visitor parking garage because the prior year's net proceeds had fallen to approximately $79,000.

Despite fluctuations in Capitol Fund revenues and expenditures, fund balances increased during the 2006–07 biennium. The fund's balance increased from $8.4 million to $12.3 million, or $3.9 million, during that biennium. This growth is consistent with the fiscal year 2005 fund balance increase of $1.7 million.

Figure 28 shows projected Capitol Fund revenue and expenditures for the 2010–11 biennium. Total revenue is projected to exceed planned expenditures by $490,000 and $900,000 in fiscal years 2010 and 2001, respectively—creating a biennial net gain of $1.4 million. As in prior biennia, the fiscal year 2011 gain is higher due to legislative session-related revenue.

FIGURE 27
CAPITOL FUND, FISCAL YEARS 2006 AND 2007

	FISCAL YEAR 2006	FISCAL YEAR 2007	2006–07 BIENNIUM TOTAL
REVENUES			
Interest Earnings	$421,425	$611,139	$1,032,564
Commissions, Leases, and Fees	672,484	910,981	1,583,465
Gift Shops – Transfers In	500,000	600,000	1,100,000
Visitor Parking Garage – Transfers In	200,000	0	200,000
Private Donations	1,343,212	136,413	1,479,625
Total Revenues	**$3,137,121**	**$2,258,533**	**$5,395,654**
EXPENDITURES			
Capital Outlay	$83,679	$1,028,982	$1,112,661
All Other	66,865	309,389	376,254
Total Expenditures	**$150,544**	**$1,338,371**	**$1,488,915**
Beginning Fund Balance	$8,392,553	$11,379,130	$8,392,553
Net Gain/(Loss)	2,986,577	920,162	3,906,739
ENDING FUND BALANCE	**$11,379,130**	**$12,299,292**	**$12,299,292**

Source: State Preservation Board.

FIGURE 28
CAPITOL FUND PROJECTED REVENUES, EXPENDITURES, AND FUND BALANCE, FISCAL YEARS 2010 AND 2011

	FISCAL YEAR 2010	FISCAL YEAR 2011	2010–11 BIENNIUM TOTAL
REVENUES			
Interest Earnings	$400,000	$500,000	$900,000
Commissions, Leases, and Fees	731,800	950,600	1,682,400
Gift Shops – Transfers In	0	500,000	500,000
Private Donations	168,200	249,400	417,600
Total Revenues	**$1,300,000**	**$2,200,000**	**$3,500,000**
EXPENDITURES			
Education	$170,000	$180,000	$350,000
All Other	640,000	1,120,000	1,760,000
Total Expenditures	**$810,000**	**$1,300,000**	**$2,110,000**
Beginning Fund Balance	$13,682,435	$14,172,435	$13,682,435
Net Gain/(Loss)	490,000	900,000	1,390,000
ENDING FUND BALANCE	**$14,172,435**	**$15,072,435**	**$15,072,435**
ADDITIONAL INFORMATION			
Non-Donation Revenue	$1,131,800	$1,950,600	$3,082,400

Source: State Preservation Board.

This financial analysis suggests that the agency could allocate enough Capitol Fund revenue for visitor education to make appropriations for this purpose unnecessary. The base level 2010–11 funding for Strategy A.2.1, Manage Education Program, is estimated to be $1.2 million. Appropriations for the strategy could be replaced with Capitol Fund allocations in the same amount, given the fund's projected revenues and net gain for the 2010–11 biennium. The strategy finances personnel-related and other operating expenditures; while the fund pays for non-personnel items, such as visitor center exhibits.

State law permits the agency to use Capitol Fund revenues for education, with the exception of private donations. This revenue source must be allocated according to the donors' wishes. Also, the agency's 2009–13 strategic plan indicates that the Capitol Fund should be used for visitor education, as well as acquisition and preservation of historical artifacts, and to benefit the buildings the agency manages.

Currently, both the Capitol Fund and Strategy A.2.1 provide funding for visitor education. Using Capitol Fund revenue in lieu of legislative appropriations would consolidate allocations for visitor education and eliminate the current funding duplication. It would also result in annual savings of $1.2 million in General Revenue Funds for the 2010–11 biennium.

STRENGTHEN THE SOLVENCY OF THE COMPENSATION TO VICTIMS OF CRIME FUND

The Compensation to Victims of Crime Fund provides funding for the victims' compensation program administered by the Office of the Attorney General and for a variety of victims' services programs administered by multiple Texas state agencies. This fund is a constitutionally dedicated account, and according to statute, it must be used for compensation to crime victims before any of the fund may be appropriated for other victims' services programs. Only excess funds beyond amounts needed for compensation payments may be appropriated for other victims' services programs. For the fund to be deemed solvent, it must have enough money to pay approved victim compensation claims each year. At current revenue and expenditure projections, the fund will remain solvent. However, in recent years the fund has been in danger of insolvency.

A combination of factors led to the increased use of revenues in the Compensation to Victims of Crime Fund, including greater demand for compensation payments, increased appropriations to the Victims Assistance grant program at the Office of the Attorney General, and increased appropriations to other state agencies for victim services. By increasing the revenues to and reducing specific expenditures from the Compensation to Victims of Crime Fund, an additional $13.3 million would be available for victim compensation payments in the 2010–11 biennium and the long-term solvency of the fund would be improved. This report is an update to one published in the 2007 edition of the *Texas State Government Effectiveness and Efficiency Report.*

CONCERNS

- No statutory guidance exists regarding the maintenance of a minimum fund balance for victim compensation in the Compensation to Victims of Crime Fund, making depletion of the fund more likely.
- The appropriation of excess funds to various victim assistance programs reduces the amount available for compensation payments in future years.
- The fund balance of the Compensation to Victims of Crime Auxiliary Fund, into which unclaimed restitution paid by probationers is deposited, has grown an average of $1.8 million per year from fiscal years 2003 to 2008. Typically, less than $22,000 per year in claims are made to the fund. The unused balance could be used to fund victim compensation.

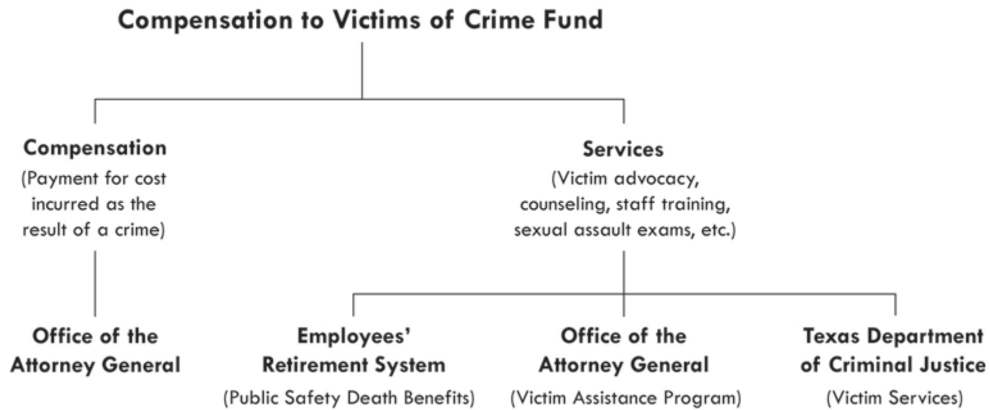
RECOMMENDATIONS

- **Recommendation 1:** Amend the Texas Code of Criminal Procedure, Section 56.541, to create a reserve in the Compensation to Victims of Crime Fund equal to 5 percent of the funds obligated under the Texas Code of Criminal Procedure, Section 56.541(a)(2). This reserve would not be available for appropriations.
- **Recommendation 2:** Make a one-time appropriation to the Office of the Attorney General of $10 million from the Compensation to Victims of Crime Auxiliary Fund to be used for victim compensation.
- **Recommendation 3:** Amend the Texas Code of Criminal Procedure, Chapter 56, to permit a periodic transfer of 50 percent of the balance exceeding $5 million in the Compensation to Victims of Crime Auxiliary Fund to the Compensation to Victims of Crime Fund.
- **Recommendation 4:** Include a contingency rider to appropriate $3.3 million transferred from the Compensation to Victims of Crime Auxiliary Fund to the Compensation to Victims of Crime Fund for victim compensation.

DISCUSSION

The primary function of the Compensation to Victims of Crime (CVC) Fund is to provide victim compensation, which is payment to a victim of violent crime for costs incurred as a result of the crime. These costs include medical expenses, lost wages, funeral expenses, attorney fees, and several other types of costs. The Texas Code of Criminal Procedure, Section 56.54(e), prohibits the use of General Revenue Funds for compensation payments. The CVC Fund is a General Revenue–Dedicated Fund established by the Texas Constitution, Article I, Section 31. Statute permits excess funds to be appropriated for victim services and defines excess funds as funds beyond the amounts needed for compensation payments in a given year. **Figure 29** shows the agencies and program functions that receive CVC funding.

FIGURE 29
PROGRAM FUNCTIONS SUPPORTED BY THE CVC FUND



Source: Legislative Budget Board.

The Sixty-sixth Legislature, 1979, passed the Crime Victims' Compensation Act. For the 2008–09 biennium, the state of Texas, through the Victim Compensation Program, is projected to expend $119.2 million on behalf of crime victims from the CVC Fund. The Victim Compensation Program administered by the Office of the Attorney General (OAG) is the payer of last resort to crime victims. Victims who exhaust other means, such as insurance, can apply for payment for specific out-of-pocket expenses. Covered benefits for victim compensation include hospital care and other medical expenses, counseling, loss of wages or support, funeral and burial expenses, relocation, attorney fees, dependent care, crime scene clean-up, travel, bereavement leave, emergency awards, and catastrophic injuries.

The Victim Compensation Program is an entitlement program that offers compensation to cover specific expenses previously listed. To receive this compensation, a person must meet the following eligibility criteria:

- be a U.S. resident if the crime occurs in Texas, or a Texas resident who becomes a victim in a state or country without compensation;
- report the crime to law enforcement within a reasonable period; and
- apply for compensation within three years of the date of the crime.

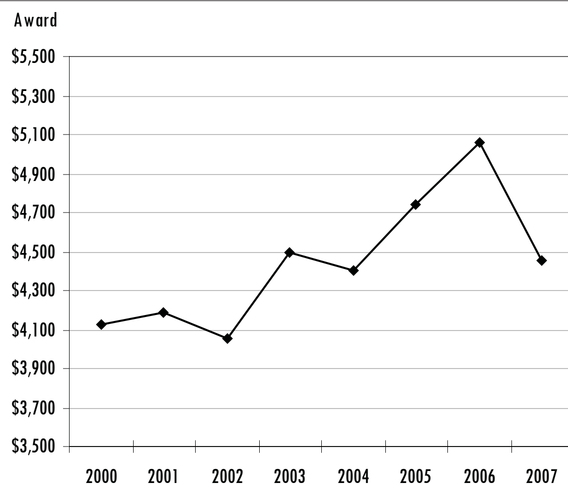
Persons who may qualify for compensation include the victim, a dependent, an immediate family member who requires counseling, or an authorized individual acting on behalf of the victim. During fiscal year 2007, the OAG reviewed 25,458 victim applications for eligibility; of those, 6,106 were denied, resulting in a 76 percent application approval rate.

MAXIMUM VICTIM AWARD AND PAYMENT TRENDS

The Texas Code of Criminal Procedure, Section 56.42, sets the state's maximum victim compensation award at $50,000, plus an additional amount of $75,000 for catastrophic injury resulting in permanent disability. Texas' maximum award is higher than most other states. The average maximum award of all 50 states is $25,600, and the median maximum award is $25,000.

Though Texas' maximum victim award is $50,000, the annual average total victim compensation payments are less than $5,000. **Figure 30** shows the average victim compensation awards from fiscal years 2000 to 2007.

FIGURE 30
TEXAS' AVERAGE AWARD FROM THE VICTIM COMPENSATION PROGRAM, FISCAL YEARS 2000 TO 2007



Sources: Legislative Budget Board; Office of the Attorney General.

As **Figure 31** shows, over 75 percent of victim awards were $5,000 or less for fiscal years 2000 to 2006.

FIGURE 31
VICTIM COMPENSATION AWARDS TOTALS, FISCAL YEARS 2000 TO 2006

DOLLARS PAID RANGE	NUMBER OF VICTIM AWARDS WITHIN THE PAYMENT RANGE	PERCENTAGE OF VICTIM AWARDS WITHIN DOLLAR RANGE
$1–$5,000	49,065	75.2%
$5,001–$10,000	6,736	10.3%
$10,001–$20,000	4,588	7.0%
$20,001–$30,000	1,854	2.8%
$30,001–$40,000	883	1.4%
$40,001–$50,000	1,898	2.9%
$50,001–$75,000	137	0.2%
$75,001–$100,000	43	0.1%
$100,001–$125,000	11	0.0%
$125,001–$150,000	3	0.0%
TOTAL VICTIM AWARDS	**65,218**	**100.0%**

Note: The data provided by the Office of the Attorney General includes payments for fiscal years 2000 to 2006. Any payments made to victims outside that timeframe are excluded.
SOURCE: Office of the Attorney General.

REVENUE SOURCES FOR THE CVC FUND

The CVC Fund receives revenue from a variety of sources. These are the major revenue sources for the fund:

- Consolidated Court Cost–As laid out in the Texas Local Government Code, Section 133.102(a), the CVC Fund receives 37.6 percent of revenues from the Consolidated Court Cost. The court costs total $40 for Class C Misdemeanors, $83 for Class A and B Misdemeanors, and $133 for felonies.

- Restitution–Restitution provides reimbursement from offenders to victims for costs incurred as a result of the crime and is ordered by a judge. If a victim also receives payment from the compensation program, he or she is required to submit any restitution payments to the CVC Fund. OAG works with local prosecutors to provide information about victim compensation payments prior to a judgment, so that restitution payments by the offender may be included in the judgment and can reimburse the fund up to the amount of a compensation award.

- Restitution Installment Fee–For offenders needing to pay restitution in installments, a one-time fee of $12 may be charged. Half of this amount is deposited to the CVC Fund. This fee was created by legislation enacted by the Seventy-ninth Legislature, Regular Session, 2005.

- Federal VOCA Grant–The federal Victims of Crime Act (VOCA), enacted in 1984, allows the collection of fines, fees, and forfeitures for federal convictions. VOCA has awarded grants to the state's compensation program since 1986. These grants are made on the basis of a formula that gives each state 60 percent of the state's fund paid to victims two years prior. The VOCA grant received by the OAG can only be used for compensation payments.

- Parole Administrative Fee–This fee is an $8 administrative fee paid each month by all parolees on active supervision for crimes occurring after September 1, 1993.

- Donations–Jurors receive information about the CVC Fund and have the option to donate their daily reimbursements to the fund.

- Subrogation–When a court awards money to a crime victim in a settlement or a civil suit, the OAG shall ask that the victim or claimant reimburse the fund for the amount paid on behalf of the victim, up to the amount of the civil award.

Figure 32 shows the amount each of these revenue sources provided to the CVC Fund from fiscal years 2004 to 2008.

CAUSES OF POTENTIAL INSOLVENCY

At current expenditure levels, OAG projects the CVC Fund will remain solvent at least through the end of fiscal year 2015. Despite the improved outlook for the fund, preventing insolvency will require careful attention to expenditures. Several factors have contributed to the fund's depletion.

The first factor contributing to depletion of the CVC Fund is that the demand for compensation payments under the compensation program increased dramatically. Compensation payment expenditures from the CVC Fund increased 89 percent in the past 10 years, from $33.6 million in fiscal year 2000, to a budgeted $63.5 million in fiscal year 2009. OAG attributes this increase in part to better communication with victim service providers, who in turn better educate victims about their options. For the 2008–09 biennium, estimated expenditures for the Victim Compensation Program from the CVC Fund total $119.2

FIGURE 32
MAJOR REVENUES TO COMPENSATION TO VICTIMS OF CRIME FUND
FISCAL YEARS 2004 TO 2008

REVENUE SOURCE	REVENUE CODE	2004	2005	2006	2007	2008
Consolidated Court Cost	3713	$76,882,164	$78,919,506	$77,904,317	$78,649,239	$79,180,819
Restitution	3734	1,019,533	1,061,706	1,158,280	1,222,331	1,162,264
Restitution Installment Fee	3801	0	0	30	244	3,281
Federal VOCA Grant	3700	28,319,354	39,341,339	23,731,211	13,622,000	17,893,879
Parole Supervision Fee	3727	2,505,539	2,932,635	3,217,040	3,502,034	4,032,689
Donations	3740	192,837	191,342	218,565	204,489	238,061
Subrogation	3805	473,872	668,260	697,304	733,206	688,502
TOTAL REVENUE		**$109,393,299**	**$123,114,788**	**$106,926,747**	**$97,933,543**	**$103,199,495**

SOURCES: Legislative Budget Board; Comptroller of Public Accounts.

million. These estimated expenditures represent 61 percent of the total CVC Fund expenditures for the biennium.

The second factor contributing to the depletion of the CVC Fund is the increased expenditures from the fund for victim services programs. These programs occur at multiple state agencies. The victim services program receiving the largest share of CVC Funds is the Victim Assistance Program, a grant-based victim services program at the OAG, where expenditures have increased 896 percent from fiscal years 2000 to 2009. OAG's Victim Assistance Program began in the 1998–99 biennium; its purpose is to grant funds to victim services providers. During the 1998–99 biennium, $1 million was expended for Court Appointed Special Advocates (CASA), which was the only provider to receive grant funding. These expenditures represented 1 percent of the total CVC Fund expenditures for the biennium. Over the next four biennia, grant funding to victim services providers substantially increased. For the 2008–09 biennium, estimated expenditures for the Victim Assistance Program from the CVC Fund total $66.4 million. These estimated expenditures represent 34 percent of the total CVC Fund expenditures for the biennium. It is worth noting that expenditures from the CVC Fund for OAG's Victim Assistance Program have remained flat since the 2002–03 biennium, while victim services funding to other state agencies has been reduced or eliminated.

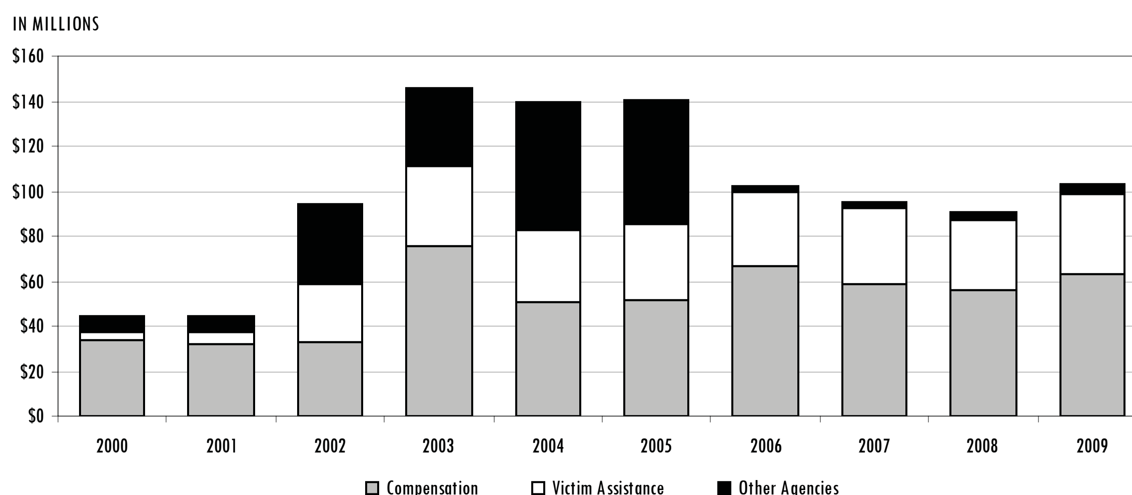
In addition to OAG, several other agencies have historically received CVC funding for victim services. Appropriations from the CVC Fund to state agencies other than the OAG to pay for victim services programs increased over a 10-year period but then decreased due to concerns about insolvency. During the 1998–99 biennium, $3.8 million was expended by other state agencies, which represented 6 percent of the total CVC Fund expenditures. During the 2004–05 biennium, CVC Fund expenditures by other state agencies totaled $111.5 million, which represented 40 percent of total fund expenditures during the biennium. To prevent the depletion of the fund, the Legislature reduced or eliminated CVC Fund appropriations to several state agencies during the 2006–07 biennium, and $5.7 million was expended during that time. The trend of reduced appropriations continued for the 2008–09 biennium, with $8.7 million in appropriations. These estimated expenditures represent 4 percent of the total CVC Fund expenditures for the biennium. When combining expenditures for victim services, the total estimated expenditure is $75.1 million for the 2008–09 biennium, or 38 percent of the fund's expenditures. **Figure 33** shows the major categories of expenditures for fiscal years 2000 to 2009.

Establishing a fund reserve policy and making optimal use of available funding sources could help ensure the continued solvency of the CVC Fund.

CVC FUND RESERVE POLICY

According to the Texas Code of Criminal Procedure, Section 56.541, victim compensation, which reimburses a victim for costs related to the crime, is the primary funding priority for the CVC Fund. Victim services is the secondary funding priority from the CVC Fund. Victim services funding has comprised an increasing amount of CVC Fund expenditures from fiscal years 1997 to 2008. Currently victim services funding from the CVC Fund is appropriated to OAG for its Victim Assistance Program; to ERS for public safety death benefits; and to the Texas Department of Criminal Justice (TDCJ) for its victim services division.

FIGURE 33
COMPENSATION TO VICTIMS OF CRIME FUND EXPENDITURES, FISCAL YEARS 2000 TO 2009



SOURCE: Legislative Budget Board.

Though three state agencies receive CVC funding for victim services programs for the 2008–09 biennium, in previous years more agencies received funding. During the 2004–05 biennium, nine programs at eight state agencies received CVC funds. **Figure 34** shows the money expended for victim services programs at all state agencies that historically and currently receive CVC Fund appropriations for this program function.

For the 2008–09 biennium, estimated CVC Fund expenditures at state agencies providing victim services total $75.1 million. Though victim services programs provide needed assistance to crime victims, all monies appropriated to these programs are funds that cannot be used for compensation payments. The amount expended from the fund on victim services is based on excess amounts that are not needed for compensation.

By current statute, most of the funds in the CVC Fund can be spent. There is no minimum balance requirement for the fund, with the exception of a $10 million catastrophic contingency for each biennium as required by the Texas Code of Criminal Procedure, Section 56.54(h). For many years the CVC Fund had a large fund balance. From fiscal years 1998 to 2008, the CVC Fund end-of-year balances ranged from $49.5 million to $269.5 million. **Figure 35** shows the end-of-year fund balances by fiscal year.

Since 1997, in compliance with the Texas Code of Criminal Procedure, Section 56.541, the Office of the Attorney General has been required to submit to the Governor, Lieutenant Governor, and the Speaker of the House a biennial certification by December 15 of each even-numbered year for the next biennium that includes the following information:

- projected deposits (revenues) to the fund, excluding donations and federal aid;
- projected funding obligations for victim compensation for the next biennium;
- reserving $10 million as a catastrophic contingency after compensation needs have been met; and
- projected unexpended balance at the end of the current fiscal year that will be available for victim services appropriations during the next biennium.

Based on the legislative appropriation requests for the 2010–11 biennium, approximately $109.4 million would be needed for compensation. After compensation, a $10 million catastrophic contingency is deducted from estimated end-of-fiscal-year balances

Victim services appropriations are made from the excess funds available in the CVC Fund. **Figure 36** shows an example of how certification of the CVC Fund works, based on the 2008–09 Biennial Certification submitted by the Attorney General in December 2006.

Prior to the current requirements of the Texas Code of Criminal Procedure, Section 56.541, from fiscal years 1998 to 2005, OAG was required to withhold 20 percent of the

FIGURE 34
VICTIM SERVICES EXPENDITURES, FISCAL YEARS 1998 TO 2009

VICTIM SERVICES PROGRAM	1998–99	2000–01	2002–03	2004–05	2006–07	2008–09
OAG VICTIM ASSISTANCE						
Victim Coordinator/Liaison	$0	$1,512,741	$4,827,523	$4,707,671	$4,890,745	$4,867,796
Statewide Victim Notification System	0	0	3,761,850	6,828,305	6,851,360	7,006,072
Sexual Assault and Crisis Prevention	0	853,592	12,050,287	13,789,311	13,599,688	13,749,731
Other Victim Assistance	0	0	23,557,728	21,164,764	20,999,307	21,046,375
Children's Advocacy Centers	0	2,748,749	7,997,068	7,998,006	7,997,740	7,998,006
CASA	1,000,000	3,000,000	4,122,795	5,969,737	6,012,733	6,000,000
Legal Services Grants	0	0	5,035,738	5,000,000	5,000,000	5,000,000
Sexual Assault Services (TAASA)	0	453,682	750,000	750,000	750,000	750,000
OAG VICTIM ASSISTANCE TOTAL	**$1,000,000**	**$8,568,764**	**$62,102,989**	**$66,207,794**	**$66,101,573**	**$66,417,980**
OTHER STATE AGENCIES						
SHSU (CVI)	$245,881	$1,054,235	$430,566	$555,534	$0	$0
TDCJ - BIPP	0	1,900,000	2,494,432	2,499,999	0	0
TDCJ - Victim Services	0	2,708,747	2,847,086	2,699,337	2,983,516	3,124,473
HHSC - Family Violence Shelters	3,600,000	8,600,000	30,725,641	34,693,696	0	0
DFPS - Foster Care/Adult Protection	0	0	31,965,418	65,565,418	0	0
ERS	0	0	0	3,291,976	2,750,000	5,527,500
OCA - Foster Care Courts	0	0	1,599,139	2,161,691	0	0
CPA	0	1,835	167	16,750	70	0
OTHER STATE AGENCIES TOTAL	**$3,845,881**	**$14,264,817**	**$70,062,449**	**$111,484,401**	**$5,733,586**	**$8,651,973**

SOURCE: Legislative Budget Board.

FIGURE 35
COMPENSATION TO VICTIMS OF CRIME FUND END-OF-FISCAL YEAR BALANCES, FISCAL YEARS 1998 TO 2008

FISCAL YEAR	FUND BALANCE (IN MILLIONS)	CHANGE (IN MILLIONS)	PERCENTAGE CHANGE
1998	$167.9	NA	NA
1999	$205.4	$37.5	22%
2000	$234.9	$29.5	14%
2001	$269.5	$34.6	15%
2002	$260.5	($8.9)	(3%)
2003	$191.7	($68.8)	(26%)
2004	$137.5	($54.3)	(28%)
2005	$84.5	($52.9)	(39%)
2006	$67.1	($17.5)	(21%)
2007	$57.7	($9.4)	(14%)
2008	$49.5	($8.2)	(14%)

SOURCES: Legislative Budget Board; Comptroller of Public Accounts.

funds obligated for victim compensation and the Crime Victims' Institute (the latter of which is no longer funded by CVC dollars). Due to the pressures put upon the CVC Fund from appropriations for the 2004–05 biennium, the Seventy-ninth Legislature, Regular Session, 2005, used a combination of reducing victim services appropriations from the CVC Fund and removing the 20 percent reserve to promote the solvency of the fund while maintaining some victim services expenditures.

Appropriations from the fund for victim services were reduced by $105.6 million during the 2006–07 biennium. The Seventy-ninth Legislature, Regular Session, 2005, enacted legislation that removed the 20 percent reserve. While these changes have allowed the state to fund the OAG's Victim Assistance Program at a level comparable to the 2002–03 and 2004–05 biennia, the funds expended for this program, or any victim service program, are funds that will not be available for victim compensation in future years. Having a small reserve would help reduce the risk of future insolvency and ensure that at least a modest amount of

FIGURE 36
EXAMPLE OF THE BIENNIAL CERTFICATION FOR THE COMPENSATION TO VICTIMS OF CRIME FUND

CATEGORY	ESTIMATED FISCAL YEAR 2010	ESTIMATED FISCAL YEAR 2011	ESTIMATED BIENNIUM
Revenues			
Excluding donations and federal aid	$86,693,000	$87,589,000	$174,282,000
Funds obligated			
Victim compensation	51,029,642	61,029,642	112,059,284
Estimated amount unexpended at the end of fiscal year 2009	0	0	$18,350,808
Less: Catastrophic Contingency	0	0	(10,000,000)
Total estimated to be unexpended at the end of fiscal year 2009	0	0	$8,350,808
Amount of excess funds anticipated in the Compensation to Victims of Crime (CVC) Fund			
Sum of Revenue and Previously Unexpended Funds			$182,632,808
Total funds anticipated to be obligated			(112,059,284)
CERTIFIED AMOUNT OF EXCESS FUNDS			**$70,573,524**

NOTE: Information in this figure is based on the 2010–11 certification submitted by the Attorney General in December 2008.
SOURCE: Office of the Attorney General.

money is available for victim compensation should the state face a biennium where there is not enough money to fund both victim compensation and victim services at the level of the preceding biennium.

Recommendation 1 would amend the Texas Code of Criminal Procedure, Section 56.541, to create a reserve in the Compensation to Victims of Crime Fund equal to 5 percent of the funds obligated for victim compensation under the Texas Code of Criminal Procedure, Section 56.541(a)(2). This reserve would not be available for appropriation and would be part of the biennial certification process for the CVC Fund that the OAG provides to the Legislature and the Governor. Without a minimal reserve mechanism in place, insolvency is more likely to occur after several years of high demand for both victim compensation and victim services funding. Based on the current fund balance and appropriations, this recommendation would reserve $5.5 million for the 2010–11 biennium.

CRIME VICTIMS' AUXILIARY FUND

The Crime Victims' Auxiliary Fund (General Revenue–Dedicated Funds) serves a function related to the CVC Fund. Restitution is a court-ordered payment made by offenders to a victim to reimburse the victim for costs incurred as a result of the crime. Local community supervision and corrections departments (CSCD), according to Texas Government Code, Section 76.013, must retain money paid by an offender for a period of five years and make a good-faith effort to locate the victim if the money goes unclaimed. After five years, the CSCD may retain 5 percent as a fee and then remit the remainder to the Comptroller of Public Accounts, where it is deposited into the Auxiliary Fund. After that occurs, a victim seeking the restitution must apply to the comptroller. As of the end of fiscal year 2008, the fund had a balance of $17 million.

Since fiscal year 2004, only a small amount of the funds have been claimed (less than $22,000 per year). **Figure 37** shows the amounts claimed, deposited, and end of fiscal year balances.

The Auxiliary Fund is under many of the same restrictions as the CVC Fund. The Auxiliary Fund is a General Revenue–Dedicated account established by the Texas Constitution, Article I, Section 31, which states that the Auxiliary Fund may only be expended for the purposes of victim compensation or services. As a constitutional fund, like the CVC Fund, the balance in the Auxiliary Fund is not available for certification of the General Appropriations Act.

Statute adds further restrictions to the Auxiliary Fund. The Texas Code of Criminal Procedure, Section 56.54(c), restricts the use of the Auxiliary Fund to victim compensation payments; one exception to this rule was added during the Eightieth Legislature, 2007, to permit the attorney general use of the Auxiliary Fund for the Address Confidentiality program, which began in fiscal year 2008.

FIGURE 37
COMPENSATION TO VICTIMS OF CRIME AUXILIARY FUND (494)
FISCAL YEARS 2004 TO 2008

FINANCIAL INFORMATION	2004	2005	2006	2007	2008
Beginning balance	$8,033,380	$9,358,759	$10,482,672	$12,309,486	$14,774,352
Restitution deposits	1,203,125	884,590	1,355,903	1,810,595	1,688,387
Warrants voided	1,359	0	214	0	0
Interest	124,660	239,817	470,697	667,593	678,752
Claims paid	(3,764)	(494)	0	(13,321)	(21,595)
Address confidentiality	0	0	0	0	(53,629)
ENDING BALANCE	**$9,358,759**	**$10,482,672**	**$12,309,486**	**$14,774,352**	**$17,066,249**

Sources: Comptroller of Public Accounts; Office of the Attorney General.

With a balance of $17 million and a minimal amount of victim claims per year, the Auxiliary Fund is not being optimized. Transferring a portion of the Auxiliary Fund to the CVC Fund each fiscal year would allow the Auxiliary Fund to be used for victim compensation payments.

Recommendation 2 would involve a one-time appropriation of $10 million from the CVC Auxiliary Fund to be used for compensation for fiscal year 2010, and Recommendation 3 would amend the Texas Code of Criminal Procedure, Chapter 56, to permit an ongoing transfer to the CVC Fund of 50 percent of the CVC Auxiliary Fund balance over $5 million. Although the Legislature has the ability to appropriate directly from the Auxiliary Fund for compensation, to prevent depletion of the fund, a more formal statutory policy is recommended for the ongoing transfer. Recommendation 4 would include a contingency rider to appropriate money transferred by statute as described in Recommendation 3. The $3.3 million transferred in fiscal year 2011 from the Compensation to Victims of Crime Auxiliary Fund to the Compensation to Victims of Crime Fund would be for victim compensation payments. **Figure 38** shows the step-by-step calculation for the fiscal impact of Recommendations 2, 3, and 4.

The recommendations provided in this report involve a combination of short- and long-term strategies. While the short-term strategies may assist in preventing insolvency of the Compensation to Victims of Crime Fund during the 2010–11 biennium, incorporating more long-term strategies would help ensure victims are able to receive needed compensation payments in future years.

FIGURE 38
IMPACT TO THE CVC AUXILIARY FUND IF RECOMMENDATIONS ARE IMPLEMENTED, FISCAL YEARS 2009 TO 2013

FINANCIAL INFORMATION	2009	2010	2011	2012	2013
Beginning balance	$17,066,249	$18,516,320	$10,052,923	$8,294,763	$7,415,683
Restitution deposits	1,388,516	1,388,516	1,388,516	1,388,516	1,388,516
Warrants voided	314	314	314	314	314
Interest	436,304	436,304	436,304	436,304	436,304
Claims paid	(23,185)	(30,000)	(30,000)	(30,000)	(30,000)
Address confidentiality	(351,879)	(258,531)	(258,531)	(258,531)	(258,531)
Ending balance (before transfer)	**$18,516,320**	**$20,052,923**	**$11,589,527**	**$9,831,367**	**$8,952,287**
One-time direct MOF appropriation	0	$10,000,000	0	0	0
CVC Fund ongoing transfer					
Balance over $5 million	0	0	6,589,527	4,831,367	3,952,287
Transfer of 50% of balance over $5 million	0	0	3,294,763	2,415,683	1,976,143
NEW ENDING BALANCES	**$18,516,320**	**$10,052,923**	**$8,294,763**	**$7,415,683**	**$6,976,143**

Sources: Legislative Budget Board; Comptroller of Public Accounts.

FISCAL IMPACT OF THE RECOMMENDATIONS

There is a $10 million fiscal impact on General Revenue–Dedicated Funds from these recommendations for the 2010–11 biennium. This impact is based on Recommendation 2. However, the fiscal impact does not reduce the amount of General Revenue Funds available for certification because the CVC Fund and the Crime Victims' Auxiliary Fund are constitutionally dedicated accounts.

Implementing Recommendation 1 would reserve $5.5 million within the CVC Fund during the 2010–11 biennium, which would not be available for appropriation. This recommendation would reserve $2.5 million in fiscal year 2010 and $3.0 million in fiscal year 2011.

Implementing Recommendation 2 would involve a one-time appropriation of $10 million in fiscal year 2010 from the Crime Victims' Auxiliary Fund for the purpose of victim compensation. The fiscal impact from Recommendation 2 constitutes a cost of $10 million to the Auxiliary Fund in fiscal year 2010.

Implementing Recommendations 3 and 4 would involve an ongoing transfer beginning in fiscal year 2011 equal to 50 percent of the Auxiliary Fund end-of-fiscal-year balance that exceeds $5 million. For fiscal year 2010, there is no fiscal impact for this recommendation. For fiscal year 2011, this recommendation constitutes a revenue gain to the CVC Fund of $3.3 million and a revenue loss of $3.3 million to the Auxiliary Fund.

Figure 39 shows the five–year fiscal impact of these recommendations.

FIGURE 39
FIVE-YEAR FISCAL IMPACT, FISCAL YEARS 2010 TO 2014

FISCAL YEAR	PROBABLE REVENUE GAIN/(LOSS) TO THE CVC FUND (GENERAL REVENUE–DEDICATED FUNDS)	PROBABLE SAVINGS/ (COST) TO THE CVC AUXILIARY FUND (GENERAL REVENUE–DEDICATED FUNDS)
2010	$0	($10,000,000)
2011	$3,294,763	($3,294,763)
2012	$2,415,683	($2,415,683)
2013	$1,976,143	($1,976,143)
2014	$1,756,373	($1,756,373)

Source: Legislative Budget Board.

The introduced 2010–11 General Appropriations Bill does not include any adjustments for Recommendations 1, 3, and 4, but it does include a $10 million strategy appropriation for Recommendation 2.

IMPROVE BENEFITS PROGRAMS AT THE STATE EMPLOYEES RETIREMENT SYSTEM

The Employees Retirement System of Texas manages a variety of complex state employee benefits programs including health, dental, life, and disability insurance, and a flexible spending account. The agency contracts with vendors to provide benefits to participants and is governed by a six-member board that oversees the structure of the benefits programs. The agency continually seeks opportunities to improve services and contain costs and may adjust some of its benefits program offerings with board approval.

The Employees Retirement System has a customer service center that answers calls from employees, retirees, dependents, and terminated employees about their benefits. State employees may also contact their employing agency's benefits coordinator for assistance. Each state agency selects one of its employees to act as the benefits coordinator, and that employee is the liaison between the Employees Retirement System and agency staff. The benefits coordinator enrolls employees in Employees Retirement System programs and provides employees information and assistance with benefit decisions. However, since benefits coordinators are not required to attend training or have any particular expertise in human resources or employee benefits, there is risk that employees may receive inaccurate information about their benefits. To improve customer service, the Employees Retirement System should provide a certification program to properly train benefits coordinators to ensure that they are providing employees with accurate information. The agency should also correspond electronically whenever possible and encourage participation in the flexible spending account, which would benefit members by reducing costs.

FACTS AND FINDINGS

- ♦ The Employees Retirement System managed over $2 billion in employee health benefits programs for 525,000 participants at 193 different state agencies, institutions of higher education, and others in fiscal year 2008.
- ♦ In fiscal years 2000 to 2009, state employees pledged $511.0 million to the flexible spending accounts program, TexFlex, which saved the state $31.7 million in Social Security and saved employees approximately $108.4 million in Federal Income Tax, Social Security, and Medicare tax.
- ♦ In fiscal year 2007, the health plan administrator generated 4.4 million explanation-of-benefits statements detailing healthcare services provided to participants; 3.9 million were mailed via U.S. mail and 0.5 million were made available online to members electronically.

CONCERNS

- ♦ Employees depend on the Employees Retirement System to provide them with confidential, accurate, and helpful information to make complicated benefits decisions. This service is provided by benefits coordinators at state agencies who may or may not have the necessary expertise to properly advise employees about their benefits.
- ♦ Some employees who are not enrolled in the state's flexible spending account program, TexFlex, consistently have out-of-pocket health expenses that would cost less if they were paid by employees with pre-tax dollars.
- ♦ Explanation-of-benefits—informational statements detailing healthcare services provided to health plan participants—are available online, yet the Employees Retirement System incurs an administrative cost to have the statements printed and mailed to each health plan participant after the participant receives services.

RECOMMENDATIONS

- ♦ **Recommendation 1:** Amend Texas Government Code, Chapter 815, to require the Employees Retirement System to develop a certification program for benefits coordinators and require agency staff who counsel employees on benefits decisions to be certified within one year of being selected as the agency benefits coordinator.
- ♦ **Recommendation 2:** Amend Texas Government Code, Chapter 815, to require the Employees Retirement System to report annually on December 1 to the agency's board, the Legislative Budget Board, and the Governor which agencies do not have certified benefits coordinator, and data about

the costs incurred by the agency to support employees at agencies without certified benefits coordinators.

- ♦ **Recommendation 3:** The Employees Retirement System should promote the state's flexible spending account program, TexFlex, to employees who are likely to benefit from this program and notify members who have accounts about unspent balances before the end of the fiscal year.
- ♦ **Recommendation 4:** The Employees Retirement System should distribute explanation-of-benefits statements electronically.

DISCUSSION

The Employees Retirement System (ERS) Group Benefits Program manages a variety of complex employee benefits programs including health, dental, life, and disability insurance, and a flexible spending account with a combined value of over $2 billion. In fiscal year 2008, there were 525,000 participants at 193 different state agencies, institutions of higher education, and others. Eighty-nine percent of health insurance participants are enrolled in the HealthSelect plan. HealthSelect is the self-funded managed care point-of-service plan administered by Blue Cross Blue Shield of Texas (BCBSTX). There are three areas in which ERS could improve services and contain costs: (1) ensuring participants receive accurate information about their benefits, (2) encouraging participation in the flexible spending account, TexFlex, for members who would benefits from the program, and (3) providing electronic explanation-of-benefits statements (EOBs) to health plan members.

BENEFITS COORDINATORS

ERS uses a variety of methods to communicate information to benefits plan recipients including mailings, the ERS website, benefits fairs, and ERS and agency staff. ERS has a customer service center staffed with approximately 25 full-time benefits specialists who answer calls from employees, retirees, dependents, and terminated employees about their benefits. ERS also relies on state agency benefits coordinators to assist employees with benefits decisions. A benefits coordinator is an employee at a state agency who is selected by the agency to serve as liaison between ERS and the agency and to provide employees with benefits information and assistance.

According to the Society for Human Resource Management, a professional association devoted to human resource management since 1948, full-time employee benefits coordinators should have two to four years experience with benefits administration, provide benefits orientation and enrollment, and administer various employee benefits programs, such as life, medical, dental, disability insurances, and pensions. Private employers require benefits coordinators to be qualified to manage the open enrollment process, ensure benefits programs meet employee needs, comply with legal requirements, process changes for current employees, and terminate employees from benefits programs. ERS benefits specialists working in the customer service center at ERS attend a six-week training class covering all aspects of the employee benefits program and must pass a proficiency test after each module of the training. ERS offers benefits coordinators an introductory training, specialized classes, and refresher courses, but all are voluntary.

Not all state agency benefits coordinators attend training or the annual benefits coordinators conference prior to annual open enrollment. Because benefits coordinators are neither required to attend training nor have any particular human resource or employee benefits expertise, there is increased risk that employees may receive and make benefit decisions with inaccurate information from benefits coordinators. According to ERS, plan members have complained about the quality and availability of benefits information.

Some state agencies have a full-time human resource professional acting as the benefits coordinator, while others do not. In fiscal year 2007, the ERS customer service center received over 400,000 calls; 46 percent of calls were handled by the interactive voice response system and the other 54 percent were completed by an ERS benefits specialist. ERS categorizes the majority of calls handled by a benefits specialist as "general customer service." The average cost for processing a call is $3.78, which includes staff salaries, facilities, technology, and the 800-number toll charges. The total cost for the call center in fiscal year 2007 was $1.6 million.

In the first eight months of fiscal year 2008, ERS customer service staff answered 109,746 calls. **Figure 40** shows the 12 state agencies or caller types with the greatest number of calls in the first 8 months of fiscal year 2008. Retired and terminated employees are the most frequent caller types because ERS customer service is their only point of contact. Generally, the state agencies with the most employees are also generating the most calls. Of the calls received in the first eight months of fiscal year 2008, 48 percent came from employees at agencies with benefits coordinators.

FIGURE 40
CALLS TO EMPLOYEES RETIREMENT SYSTEM CUSTOMER SERVICE CENTER, FISCAL YEAR 2008, SEPTEMBER 2007 TO APRIL 2008

EMPLOYEE TYPE	NUMBER OF CALLS IN THE FIRST 8 MONTHS OF 2008	PERCENTAGE OF TOTAL CALLS	NUMBER OF EMPLOYEES/ GROUP MEMBER	CALLS PER 100 EMPLOYEES/ GROUP MEMBER
Retired	26,088	23.8%	71,937	36
Terminated	19,266	17.6%	NA	–
Texas Department of Criminal Justice	9,670	8.8%	37,441	26
Department of Aging and Disability Services	6,766	6.2%	14,923	45
Health and Human Services Commission	6,219	5.7%	9,793	64
Department of State Health Services	5,315	4.8%	11,850	45
Department of Family Protective Services	4,960	4.5%	10,379	48
Texas Department of Transportation	3,936	3.6%	14,148	28
Department of Public Safety	2,792	2.5%	8,033	35
COBRA recipient	2,307	2.1%	1,540	150
Department of Assistive and Rehabilitative Services	1,680	1.5%	3,106	54
Texas Youth Commission	1,594	1.5%	4,113	39

SOURCES: Legislative Budget Board; Employees Retirement System.

Figure 41 shows the top 25 agencies with the most calls per employee in the first eight months fiscal year 2008. Of the agencies with the most calls per employee, 5 are considered large agencies having more than 1,000 employees, 4 are medium agencies having between 100 and 999 employees, and the remaining 16 are small agencies with fewer than 100 employees. Texas Government Code, Chapter 670, limits the number of human resource professionals a state agency with 500 or more employees may employ to one human resources employee for every 85 agency staff members. It is common for agencies with fewer than 85 employees to rely on general administrative staff at the agency to perform the human resources and benefits coordinator duties. As **Figure 41** shows, agencies with fewer than 85 employees often have more calls per employee.

ERS relies on benefits coordinators to assist state employees covered by ERS benefits. To ensure benefits coordinators are qualified, Recommendation 1 would amend the Texas Government Code, Chapter 815, to require the Employees Retirement System to develop a certification program for benefits coordinators. Recommendation 1 would also require agency staff who advise employees on benefits decisions be certified within one year of being selected as the agency benefits coordinator. ERS may charge state agencies for training benefits coordinators on a cost recovery basis. The amount ERS charges for the training would not exceed the cost of providing the training.

Recommendation 2 would amend Texas Government Code, Chapter 815, to require ERS to report annually on December 1 to the agency's board, the Legislative Budget Board, and the Governor which state agencies do not have a certified benefits coordinator and data about the costs incurred by the agency to support employees at agencies without certified benefits coordinators. The report should include, but is not limited to, information on the cost of handling calls from agencies without certified benefits coordinators, the number of exceptions ERS processed for agencies with uncertified benefits coordinators, complaints from employees at agencies without certified benefits coordinators, and options to serve employees at small agencies or agencies without dedicated benefits staff. The information will be helpful in evaluating the need for improvements to how ERS provides benefits information to state employees.

FLEXIBLE SPENDING ACCOUNT

TexFlex is the state's flexible spending account program (FSA). FSAs allows employees to contribute to an account through salary deduction and then withdraw the funds to pay certain medical and dependent care expenses. The Internal Revenue Service defines which expenses are FSA reimbursable. The employee and the state save money when an employee contributes to TexFlex. The salary deposited in the FSA is not subject to the Federal Insurance Contributions Act (FICA) which includes Social Security and Medicare tax or the employee portion of Federal Income Tax (FIT), thus

FIGURE 41
TOP 25 AGENCIES WITH THE MOST CALLS PER EMPLOYEE, FISCAL YEAR 2008, SEPTEMBER 2007 TO APRIL 2008

STATE AGENCY	NUMBER OF CALLS	NUMBER OF AGENCY EMPLOYEES	CALLS PER EMPLOYEE
Health Professions Council	6	2	3.00
Texas Office of Public Utility Counsel	24	15	1.60
Texas Board of Professional Engineers	27	30	0.90
Texas Commission on Fire Protection	26	32	0.81
Texas Ethics Commission	24	34	0.71
Texas Board of Architectural Examiners	16	24	0.67
Texas Board of Professional Land Surveying	3	5	0.60
Health and Human Services Commission	6,219	9,793	0.64
Texas Residential Construction Commission	29	48	0.60
Legislative Reference Library of Texas	14	26	0.54
Court of Appeals - Fourth District	19	34	0.56
Department of Assistive and Rehabilitative Services	1,680	3,106	0.54
Texas Veterans Commission	157	315	0.50
Texas Alcoholic Beverage Commission	307	628	0.49
Department of Family Protective Services	4,960	10,379	0.48
Texas Racing Commission	32	68	0.47
Texas Board of Law Examiners	10	21	0.48
Fire Fighters Pension Commission	3	7	0.43
Texas State Securities Board	40	88	0.45
Department of Aging and Disability Services	6,766	14,923	0.45
Court of Appeals - Third District	14	32	0.44
Department of State Health Services	5,315	11,850	0.45
Board of Tax Professional Examiners	2	4	0.50
Texas Water Development Board	122	283	0.43
Texas Secretary of State	99	233	0.42

Sources: Legislative Budget Board; Employees Retirement System.

providing employees who choose to contribute to TexFlex a tax savings. FIT is based on a percentage of an employee's annual earnings and FICA is comprised of 6.2 percent for Social Security and 1.45 percent for Medicare. The state must also pay matching FICA taxes for each employee.

TexFlex has two types of accounts: a Health Care Reimbursement Account (HCRA) or a Dependent Care Reimbursement Account (DCRA). The HCRA allows employees to set aside pre-tax income to pay themselves back for eligible healthcare expenses, such as eyeglasses, dental bills, prescription and over-the-counter drugs, and copays for themselves and their dependents. The DCRA allows employees to set aside pre-tax income to pay for eligible dependent care expenses like a child's day care or after-school care.

As of September 2008, there were approximately 46,000 participants enrolled in the TexFlex program and $81 million in planned contributions for the fiscal year, a slight increase in enrollment and contributions from fiscal year 2008. In fiscal years 2000 to 2009, state employees pledged $511.0 million to TexFlex, which saved the state $31.7 million in FICA and saved employees approximately $108.4 million in FIT and FICA.

Employees increase their available income when they contribute to TexFlex. **Figure 42** compares the income of two employees who earn the same monthly salary, but one

FIGURE 42
EXAMPLE OF THE EFFECT OF A $1,000 ANNUAL TEXFLEX CONTRIBUTION ON EMPLOYEE SALARY

EARNINGS AND DEDUCTIONS	EMPLOYEE A CONTRIBUTES TO TEXFLEX	EMPLOYEE B DOES NOT CONTRIBUTE TO TEXFLEX
Monthly Gross Salary	$3,000.00	$3,000.00
TexFlex	(83.33)	0.00
FIT	(301.75)	(314.25)
FICA	(223.12)	(229.50)
Retirement	(180.00)	(180.00)
Monthly Net	2,211.80	2,276.25
Gross Annual Salary Plus Available TexFlex	27,541.56	27,315.00
ANNUAL TAX SAVINGS	**$226.56**	**$0.00**

Source: Legislative Budget Board.

contributes to TexFlex to pay his or her medical costs and the other does not. At the end of the year, the employee who contributed to TexFlex saved $226.56 in taxes. Some employees who are not enrolled in TexFlex have out-of-pocket health expenses that would be lower if they were paid with pre-tax dollars. In fiscal year 2007, only 21.6 percent of active health plan members who had more than $1,000 in out-of-pocket medical expenses were enrolled in TexFlex.

Participation in flexible spending accounts may be low because employees must choose the amount they would like to set aside at the beginning of the fiscal year and must spend the entire amount during the fiscal year, or they lose the money. Once an employee designates a contribution amount during open enrollment at the beginning of each year, the employee is not allowed to change the amount or drop out of the plan during the year. Federal law requires that the employee forfeit any unspent funds in the account at the end of the year. In fiscal year 2005, ERS adopted a grace period which allows participants to spend their TexFlex balance on eligible expenses and claim reimbursement from their funds contributed in the prior fiscal year from September 1 through November 15 of the new fiscal year. Participants then have from November 15 through December 31 to submit all prior fiscal year claims. In fiscal year 2007, there was almost $1 million in unspent funds. Currently, ERS uses unspent TexFlex contributions to pay the administrative costs associated with the TexFlex program and the agency adjusts participants' fees in the following year.

Recommendation 3 directs ERS to promote TexFlex to state employees who are likely to benefit from a flexible spending account and notify participants who have accounts with unspent balances. Through the health plan administrator, ERS can determine which health plan members consistently have medical and pharmacy costs that could be paid with TexFlex contributions. If ERS could increase the number of employees contributing to TexFlex from 46,000 to 50,000 employees and the average contribution rate of each new participant was $1,000, Recommendation 3 could save approximately $0.3 million in FICA payments each year.

EXPLANATION OF BENEFITS

An EOB is provided to group benefit plan members after they receive health care services. EOBs are distributed to HealthSelect members to inform them of their healthcare costs and coverage. EOBs lists the services the patient received, the amount billed, covered and paid for each service, and any amount the patient may owe the healthcare provider.

EOBs are mailed to the member unless the member logs in to the BCBSTX website and changes his or her user preference to: "I would like to view and print my medical paper statements (EOBs) online instead of receiving statements via U.S. mail." Once members choose to receive EOBs online, they will go to the website and view or print their EOBs as needed. Members may choose to stop paper EOBs and later decide to restart paper EOBs by adjusting their user preferences. Every ERS plan member can use the information on his or her subscriber card to create an account on the BCBSTX website to access health plan information and a variety of services.

In fiscal year 2007, the HealthSelect plan administrator generated 4.4 million EOBs; 3.9 million were mailed via U.S. Mail and 0.5 million were made available online to members who choose to view or print their EOBs on the BCBSTX website. ERS is not able to estimate the specific

cost associated with mailing EOBs because it is part of the contract for administrative services with BCBSTX.

Other public health plans in Texas use electronic correspondence to communicate with members. With the exception of correctional officers at the Texas Department of Criminal Justice, most state employees access a computer and the Internet at work; therefore, most could readily access the BCBSTX website and view or print their EOBs. ERS could reduce the number of printed and mailed statements if the default for receiving the EOB were electronic instead of paper. Recommendation 4 directs ERS to make the default for how members receive their EOBs to online through the BCBSTX website instead of by U.S. Mail unless a participant requests EOBs by mail. This change would increase efficiency and reduce costs. Any savings would help reduce future cost increases in plan administration.

FISCAL IMPACT OF THE RECOMMENDATIONS

These recommendations would not have a direct fiscal impact to the state. Recommendations 1 and 2 would result in improved customer service for plan participants. Recommendations 3 and 4 could result in a small savings. Recommendation 4 is currently part of the administrative contract with the health plan third-party administrator, BCBSTX. Reducing the number of EOBs will reduce the plan's administrative costs, but will not create immediate savings for ERS.

The introduced 2010–11 General Appropriations Bill does not include any adjustments as a result of these recommendations.

REDUCE HEALTHCARE COSTS AND CONSEQUENCES OF OBESITY AMONG STATE EMPLOYEES

Despite evidence that demonstrates the effectiveness of the web-based weight management programs available through the state health plan, program awareness, participation, and use of these wellness resources is low. Web-based weight management programs that provide individualized feedback result in three times greater weight loss than information-only weight management programs. A 5 percent weight loss can result in cost savings to a healthcare system of more than $400 per patient per year.

Most state employees who are members of the Employees Retirement System have access to a web-based weight management program that provides individualized feedback. The First Care Plan is the only plan in the Employees Retirement System Group Benefits Program that will not offer a weight management program in fiscal year 2009. Individualized weight management plans are developed through the completion of a health risk assessment or health questionnaire. Health risk assessments are not only important for creating individualized weight management plans, but can also serve as an information source for summarizing the health of the state employee population. Increasing state employee awareness and participation in the weight management programs offered through the state health plan could reduce state healthcare costs, increase employee productivity, and increase the availability of population-based data on the state employee population.

CONCERNS

- ♦ While there is no data on how many overweight or obese state employees there are, in 2007, 66 percent of adults in Texas were classified as being overweight or obese; however, in fiscal year 2007, less than 1 percent of HealthSelect Plan members and their dependents participated in the HealthSelect weight management program or completed the online health risk assessment.
- ♦ There is limited population-based health data on the number of overweight and obese state employees. This type of data, which health risk assessments collect, would help decision makers assess population needs, evaluate the effectiveness of interventions, and improve existing programs.
- ♦ According to the Employees Retirement System, some state employees are not aware of the role that the agency plays and the resources that they offer through the state health plans. This lack of awareness contributes to low participation rates in benefits including the weight management program.

RECOMMENDATIONS

- ♦ **Recommendation 1:** Amend Texas Government Code, Chapter 664 (State Employees Health Fitness and Education Act of 1983), to require state agencies, except for institutions of higher education, to provide state employees four hours of leave time per year as an incentive for completing a health risk assessment. Institutions of higher education as defined in Texas Education Code, Section 61.003, are exempt from this requirement, but may provide employees four hours of leave time per year at their own discretion as an incentive for completing a health risk assessment.
- ♦ **Recommendation 2:** Include a rider in the 2010–11 General Appropriations Bill requiring the Employees Retirement System to purchase access to an online health risk assessment for state employees that do not already have access to one.
- ♦ **Recommendation 3:** Amend Texas Insurance Code, Section 1551.061, to require the Employees Retirement System to submit a population-based summary of the health risk assessment results and an evaluation of the state health plan's weight management programs to the Governor and the Legislative Budget Board.
- ♦ **Recommendation 4:** The Employees Retirement System should draft a notice for all agency executive directors to endorse and distribute to their employees. The content should include the function of a health risk assessment and an overview of each of the weight management programs and other wellness resources available through the Employees Retirement System Group Benefits Program.

DISCUSSION

The Employees Retirement System (ERS) administers health, life, and dental insurance for state employees, retirees, and their dependents through the Group Benefits Program. Of the state employees in the Group Benefit Program, 89.8 percent are covered by the HealthSelect Plan, while the remainder are covered by one of the Health Maintenance Organization (HMO) plans. In fiscal year 2009, three HMOs will be contracted as third-party administrators, and Blue Cross Blue Shield of Texas will be contracted as the third-party administrator for the HealthSelect Plan. As third-party administrators, Blue Cross Blue Shield of Texas and the three HMOs provide a health care provider network, pay claims, and assist with various communication and programmatic initiatives. Legislative appropriations and employee contributions fund the HMOs and HealthSelect Plan's initiatives. The state pays for 100 percent of the premiums for full-time state employees, while state employees make contributions for dependents and any additional optional coverage. **Figure 43** shows the administrative structure for the Group Benefit Program.

RISKS OF BEING OVERWEIGHT OR OBESE

Overweight and obesity are both labels for ranges of weight that are greater than what is generally considered healthy for a given height. These labels are most commonly measured by calculating the body mass index (BMI), which correlates with the amount of body fat for most adults. While BMI correlates with body fat for most people, BMI does not accurately reflect body fat amounts in all adults. For example, athletes may have a BMI that identifies them as overweight even though they do not have excess body fat. A healthy BMI range for the average adult is between 18.5 and 24.9. An adult with a BMI between 25 and 29.9 is classified as overweight, and an adult who has a BMI over 30 is classified as obese.

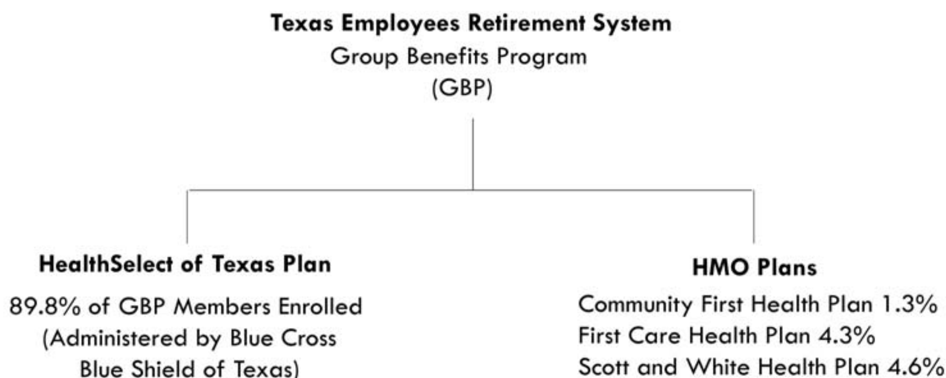
Data on the number of overweight and obese state employees is not available; however, in 2007 the U.S. Center for Disease Control and Prevention found that 66 percent of Texas adults were classified as being overweight or obese, exceeding the national prevalence of 63 percent. Applying this percentage to the individuals in the ERS Group Benefits Program would mean that 182,545 of these 276,584 individuals are overweight or obese. According to the Department of State Health Services Obesity Data Sheet, in 2007 Texas had the 12th highest prevalence of adult obesity in the U.S., with an average of 26.3 percent of the adult population categorized as obese. If current prevalence trends continue, it is estimated that 75 percent of Texas adults will be overweight or obese by the year 2040.

Texans who are overweight or obese have an increased risk for developing type II diabetes, cardiovascular disease, stroke, metabolic syndrome, osteoarthritis, gallbladder disease, asthma, sleep apnea, and certain cancers. In 2002, the University of California at Los Angeles (UCLA) and the RAND Corporation found that obesity posed a greater risk for health complications and increased health spending more than smoking or drinking, and obese individuals have 30 percent to 50 percent more chronic medical problems than those who smoke or drink heavily.

COST OF BEING OVERWEIGHT OR OBESE

The health risks associated with being overweight or obese directly affects employers through increased healthcare costs

FIGURE 43
ADMINISTRATIVE STRUCTURE FOR THE GROUP BENEFITS PROGRAM

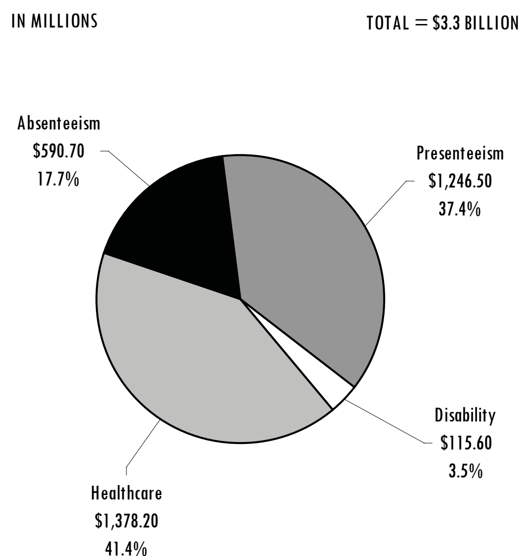


NOTE: Percentages do not add up due to rounding.
SOURCE: Employees Retirement System.

and indirectly through lost productivity. A 2002 study conducted by UCLA and the RAND Corporation found that obese individuals spend 36 percent more on annual medical needs and 77 percent more on medications than people of normal weight, and incur greater costs than smokers or problem drinkers. It is difficult to quantify the correlation between healthcare costs and being overweight or obese for the state employee population due to limited data.

Employers in Texas are indirectly affected by overweight and obesity through lost productivity when employees are sick, disabled, or simply not functioning up to standard at work. Absenteeism and presenteeism are two terms used to describe a loss of productivity by employees. Presenteeism refers to diminished on-the-job performance due to health-related problems. The Comptroller of Public Accounts (CPA) estimated that costs to Texas businesses due to obesity and obesity related illnesses totaled more than $3.3 billion in fiscal year 2005. **Figure 44** shows the distribution of estimated costs attributed to adult obesity in Texas.

FIGURE 44
DISTRIBUTION OF ESTIMATED COSTS ATTRIBUTED TO ADULT OBESITY IN TEXAS
FISCAL YEAR 2005



NOTE: Amounts may not total due to rounding.
SOURCE: Texas Comptroller of Public Accounts; U.S. Centers for Disease Control and Prevention.

If current trends continue, the CPA estimates that overweight and obesity-related illnesses could cost Texas businesses up to $15.8 billion annually by 2025.

HEALTH PROMOTION PROGRAMS

As healthcare costs continue to increase, employers in both the private and public sectors have made health promotion resources and services available to their employees.

Health promotion programs encourage employees to change their lifestyle and behaviors to move toward a state of optimal health; reduce health risks; and prevent and manage disease—all while optimizing the health productivity of an organization. These programs provide individuals with incentives, knowledge, and opportunities to make healthy choices. By August 2007, 36 states had enacted state legislation implementing or expanding health promotion and disease management programs as a way to contain healthcare costs.

Employer-based health promotion initiatives include, smoking cessation programs, health screenings, physical activity programs, and weight management programs. Weight management programs promote positive behavioral changes, such as increasing physical activity levels and integrating a balanced and healthy diet into one's life to maintain a healthy weight. Employers in the public and private sector have supported weight management programs as a way to reduce health care costs and increase productivity. Tennessee has a weight management program that focuses on healthy eating practices and exercise for state employees and their dependents. The program includes the use of weight loss teams to help participants commit to improving their eating habits and participation in an exercise program. On average, 76 percent of participants in the program lost weight, and the average weight loss per person was 7 pounds. Arkansas state employees are eligible for a $100 discount on the enrollment fee to participate in a multi-faceted weight loss program designed by the University of Arkansas for Medical Sciences. Program components include guidance for dietary change, behavior modification, and nutrition education. A 2001 article in the *American Journal of Health Promotion* showed that on average, health promotion programs produce a return on investment of $4.30 per dollar spent and is achieved through healthier workers, reduced insurance costs, and less absenteeism.

THE SCOTT AND WHITE AND COMMUNITY FIRST PLAN'S WEIGHT MANAGEMENT PROGRAM

Two of the three HMOs that contract with ERS offer members access to a weight management program or health risk assessment in fiscal year 2009. First Care Plan is the only plan that does not provide members with access to these benefits. The Scott and White Plan (S&W) and the

Community First Plan (CF) will offer a web-based weight management program called HealthMedia Balance (Balance WMP) in fiscal year 2009. S&W has offered this program since fiscal year 2005, but fiscal year 2009 will be the first time that CF plan members will have access to the web-based program. There is no cost associated with the Balance WMP to the state or to plan members, and participation is voluntary. In this program, participants take an online health risk assessment on a secure website, and responses from the assessment are used to create an automated, personalized weight management plan for each individual. Questions on the assessment are related to the participant's food choices, physical activity levels, and self-image. Responses to the health risk assessment are not shared with other entities besides the third-party administrator without an individual's consent. The Balance WMP focuses on maintaining a healthy diet, recognizing behavioral and social cues to eating, increasing physical activity, and promoting a positive self-image. Program participants have access to the following features:

- an opportunity to set up personal goals and action plans;
- unlimited access to interactive tools and resources designed to support weight loss and weight maintenance including an online library, cookbook, and various tools for making smart food choices;
- an opportunity to identify a support person who will be sent an e-mail message with information on how to encourage and support the participant in his or her weight management efforts; and
- e-mail reminders and prompts throughout the program.

Completion of the program occurs when an individual decides that they no longer want to continue using the resources available through the Balance WMP. For fiscal year 2007, the S&W plan was not able to provide an evaluation of the program or identify how many ERS members participated in the program. However, Kaiser Permanente, a nation-wide managed health care organization, has offered this program to its members since 2004, and has experienced positive results. In 2004 and 2005, Kaiser Permanente completed a study in which they compared the Balance WMP to other web solutions that did not provide participants with a personalized weight management program. The study found that a weight loss of 5 percent attained by participation in the Balance WMP resulted in cost savings from the perspective of the health care system of more than $400 per patient per year.

THE HEALTHSELECT WEIGHT MANAGEMENT PROGRAM

The HealthSelect weight management program (HealthSelect WMP) is also a voluntary program and was added at no cost to the state or to HealthSelect members. The HealthSelect WMP was started in fiscal year 2007 as an enhancement to the HealthSelect disease management and wellness programs. Similar to the Balance WMP, individuals take an online health risk assessment on a secure website and responses from the assessment are used to create an automated, personalized weight management plan. Questions on the HealthSelect assessment are related to nutrition, physical activity, smoking, and more specific information such as cholesterol levels, waist size, and blood pressure. Responses to the assessment are not shared with other entities besides the third party administrator without an individual's consent. The HealthSelect WMP is different than the Balance WMP because each participant receives guidance and support through telephonic lifestyle and motivational coaching. Also, the HealthSelect plan recruits participants to the program but an individual can start the program on their own as well. Potential participants in the HealthSelect WMP are identified by one or more of the following ways:

- A HealthSelect Plan member submits an on-line health risk assessment and is identified as a potential participant based on various trigger responses;
- A member starts the program on their own;
- A computer-based predictive modeling tool identifies potential participants based on trigger diagnoses such as metabolic syndrome;
- A member uses a certain prescription drug that is a trigger criteria for outreach; or
- A customer service advocate, case manager, disease management service, or a health care provider refers a member to the program.

Once a member has been identified as a potential participant, a Behavior Modification Coach (BMC) contacts the person by telephone and by mail. The BMC is a fully credentialed licensed professional counselor or licensed mastered social worker with experience in cognitive and behavior modification. Upon making contact with the person, the BMC then assesses their readiness to engage in the program and informs the person of the resources available from the

Personal Health Manager on the HealthSelect Plan website. The Personal Health Manager is a web-based health resource and information tool that includes interactive tools for wellness and information on disease prevention. The following wellness tools are available in the Personal Health Manager:

- Health Risk Assessment—Information obtained from the assessment is used to create a customized health plan for program participants.
- Custom Exercise Program—Creates an exercise plan customized to the member's desired workout schedule and level of physical fitness.
- Custom Meal Planner and Evaluator—Creates a customized nutrition plan for each member and integrates this plan with their exercise program.
- Life Skill Development Program—Creates a personal self improvement plan focusing on community and core values.
- Ask a Nurse, Dietician, Trainer, or BMC—Offers access to health professionals and BMCs that are fully credentialed with experience in cognitive and behavioral modification skills. This tool is a core component of the HealthSelect weight management Program.
- Message Board and Reminder System—Provides access to wellness and condition-specific information via secured messaging, alerts for screening tests, and reminders for medical appointments and medication refills.

Throughout the program, participants have access to a BMC. The BMC provides telephonic coaching and education including motivational interviewing, nutritional counseling, physical activity counseling, behavior therapy, and pharmaceutical therapy. The frequency of coaching contact is based upon the needs of each participant and on mutually agreed upon clinical and lifestyle management goals. Ultimately, the participant decides how often contact is made with a BMC and can contact their BMC directly for any questions or requests for support at any time. Successful completion of the program occurs when documented goals and guidelines are met, but the participant is never formally disenrolled in the program. Individuals can stop participating in the program whenever they choose to. The HealthSelect WMP was initiated as pilot program in 2006 and results showed that 72 percent of the participants lost an average of 11 pounds. A 2008 study on weight-loss maintenance from the Journal of the American Medical Association reinforced the quality of the HealthSelect WMP with findings that a combination of personal contact and web-based support are key to successful long-term weight management.

WEIGHT MANAGEMENT PROGRAM PARTICIPATION

Despite research and pilot program results that support the value of the Balance and HealthSelect WMPs, program participation is low. As noted before, for fiscal year 2007, S&W was not able to identify how many ERS members participated in the Balance WMP. Out of a total of 440,893 members enrolled in the HealthSelect Plan, only 598 had participated in the weight management program as of January 2008. This represents less than 1 percent of HealthSelect plan members.

Low participation may stem from:

- An underuse of the health risk assessment (HRA);
- Limited availability of population-based health data of state employees; and
- A lack of program awareness among state employees.

The HealthSelect Plan uses health risk assessment results to identify potential participants for their programs. Although the HRA is a useful and secure tool, in fiscal year 2007, only 1,703 individuals had completed the assessment, representing less than 1 percent of HealthSelect Plan members. If more individuals complete the assessment, more potential program participants could be identified.

Overall, the small percentage of ERS members completing a HRA limits the availability of population-based health data on overweight and obesity. Population-based health data provides broad demographic data and helps decision makers assess population needs, evaluate the effectiveness of interventions, and improve existing programs.

Other states and private entities encourage employees to complete an HRA by offering incentives. Arkansas provides a $20 monthly reduction in insurance premiums to state employees if they participate in a voluntary assessment. South Dakota state employees receive $50 incentive credited to a health risk and wellness account for completing an HRA.

Recommendation 1 would amend Texas Government Code, Chapter 664 of the State Employees Health Fitness and

Education Act of 1983, requiring state agencies, except for institutions of higher education, to provide general state employees four hours of leave time per year as an incentive for completing the Health Risk Assessment. Institutions of higher education, as defined in Texas Education Code, Section 61.003, are exempt from this requirement but may provide employees four hours of leave time per year at their own discretion as an incentive for completing a health risk assessment.

Texas Government Code, Chapter 664, the State Employee Health Fitness and Education Act of 1983, currently authorizes state agencies to provide 8 hours of leave each year to employees who receive a physical exam and complete a health risk assessment (HRA). If Recommendation 1 were implemented, incentives for state employees would include:

- 8 hours of leave per year completing a HRA and getting a physical as currently authorized by statute; or
- 4 hours of leave per year for completing a HRA only.

Recommendation 2 would require ERS to purchase access to an online health risk assessment for state employees that do not already have access one. Currently, the First Care Plan is the only plan that does not provide members with access to a HRA or weight management program. If more individuals complete a HRA, it could provide more population-based data for assessing population needs. Greater completion rates of an assessment will also help identify potential participants of the weight management programs.

Recommendation 3 would amend Texas Insurance Code, Section 1551.061, to require ERS to submit a population-based summary of state employee HRA results and an evaluation of all weight management programs to the Legislative Budget Board and the Governor. This evaluation summary should include but not be limited to the number of overweight and obese state employees based on HRA results and a summary of population-based outcomes related to participation in the weight management programs. The report should be submitted by December 1 of each even year of the biennium beginning in 2010.

PROGRAM AWARENESS

According to ERS, there is a lack of awareness of the role that ERS and the third-party administrators play in providing state employees, retirees, and their dependents with health, life, and dental insurance. Employees' awareness and perception of ERS affects the probability of an employee providing health information through an HRA and participating in one of the weight management programs.

ERS promotes health initiatives to employees and retirees through newsletters, mailers, flyers, benefit books, their website, health fairs, and during summer enrollment. ERS also works closely with each agency's benefit coordinator and has promoted health initiatives during conferences and through newsletters. In 2007, ERS formed a communications workgroup to develop a strategy to help state agency leaders encourage employees to participate in wellness programs and identified the lack of trust among group benefit members as a challenge. The communications workgroup has discussed the possibility of creating special communication initiatives for agency leaders to use with employees.

Governors and agency heads in other states have endorsed and encouraged employee commitments to health, helping to diffuse doubts and mistrust. According to the National Governor's Association, top management must visibly proclaim that health is a critical value and an organizational objective, for both the public and private sectors, while also explaining the steps it will take to address poor health and health risks.

Recommendation 4 directs ERS to compose a communication piece for all agency executive directors to sign and distribute to their employees. The content of the communication piece should include but not be limited to: the role of ERS and the third-party administrators, the function of the health risk assessment, and an overview of the weight management programs, and other available wellness resources offered through the Group Benefit Program.

This communication piece would inform employees of their respective executive director's support of health initiatives, such as the weight management program, and help to alleviate employees' concerns.

FISCAL IMPACT OF THE RECOMMENDATIONS

Recommendations 1, 2, 3, and 4 would not have a significant fiscal impact during the 2010–11 biennium.

It is assumed that Recommendation 1 would not result in any additional costs to the state; however, it would reduce the number of hours a participating employee works by four hours per year.

During the 2010–11 biennium, Recommendation 2 would cost ERS $88,000 for providing all state employees with

access to an online health risk assessment. This estimate is based on the number of state employees that do not have access to a health risk assessment and the cost per person for the HealthSelect Personal Health Manager tool, which includes an online health risk assessment. In fiscal year 2008, the HealthSelect Personal Health Manager tool cost $6.60 per person per year. In fiscal year 2008, there were 13,200 state employees that did not have access to a health risk assessment because they were enrolled in the First Care Plan or chose to opt out of the ERS Group Benefits Program. The cost to provide all state employees with access to an online health risk assessment feature would be paid from the current level of appropriations to ERS.

The introduced 2010–11 General Appropriations Bill includes a rider to implement Recommendation 2.

ESTABLISH PILL-SPLITTING PROGRAMS TO CONTAIN STATE EMPLOYEE HEALTH PLAN COSTS AND REDUCE OUT-OF-POCKET EXPENSES

"Pill splitting" is a strategy for containing prescription drug costs. With this strategy, a user of a qualified medication buys half as many pills at twice the dose. The user is responsible for cutting their pills in half to achieve the prescribed dose. This strategy is safe and effective with medications that split easily, meet pricing criteria, and have a low risk of toxicity. Depending on the pricing structure of the medication's doses, pill splitting can save money.

Prescription drug spending for Texas employee health plans exceeded $1.0 billion in All Funds for fiscal year 2006 and was estimated to be $1.1 billion for fiscal year 2007. Nationally, retail costs of prescription drugs increased an average of 7.5 percent per year from 1994 to 2006. By establishing voluntary pill-splitting programs, Texas can help to contain costs for state health plans and state employees.

CONCERN

- Texas is not taking full advantage of opportunities to reduce prescription drug costs for state health plans.

RECOMMENDATION

- **Recommendation 1:** Amend the Texas Insurance Code to require the Employees Retirement System, Teacher Retirement System, The University of Texas System Administration, and the Texas A&M University System Administrative and General Offices to each establish a voluntary pill-splitting program with a mandatory copay reduction incentive for member participation and require these agencies to each establish a list of medications appropriate for splitting.

DISCUSSION

"Pill splitting" is a strategy for containing prescription drug costs. Savings accumulate when, month after month, a user of a qualified medication buys half as many pills as normal at twice the dosage. The user obtains the prescribed dose by using a splitting device or knife to cut the pills in half.

According to the Henry J. Kaiser Family Foundation, retail prescription prices increased on average 7.5 percent a year between 1994 and 2005, rates almost triple that of the average annual inflation rate. According to Legislative Budget Board staff analysis, prescription drug spending for Texas employee health plans exceeded $1.0 billion in 2006 and was estimated to be $1.1 billion for 2007. The goal of an optional pill-splitting program is to save money at the state and individual level without compromising participants' health.

The costs of medications do not necessarily increase proportionately to the dosage. The cost of a medication often reflects packaging, advertising, and research and development. For instance, Employees Retirement System (ERS) paid an average of $3.32 per 100 mg tablet of Lamictal (an anticonvulsant) in fiscal year 2007. For the same year, ERS paid $3.94 per 200 mg tablet. The relative costs of Lamictal in the other state employee health plans were similar.

ELIGIBLE INDIVIDUALS AND MEDICATIONS

Only a relatively small number of medications are appropriate for a pill-splitting program. Medications less suited for splitting include those with the following characteristics:

- have some sort of external coating;
- are capsules, gels, or liquid;
- are extended-release formulations;
- are prepackaged (such as an oral contraceptive pill);
- are in a capsule form or asymmetrically shaped; or
- splitting the medication would alter its chemical stability.

It is also not practical to split medications that only come in a single dose or for which there is no per-dosage cost savings in a pill-splitting program.

Likewise, not all individuals are appropriate candidates for a pill-splitting program. Individuals who have limitations in vision or dexterity may find splitting pills a challenge. For such reasons program participants must consult with a doctor to obtain medications in appropriate doses and quantities.

EFFICACY AND SAFETY OF PILL-SPLITTING PROGRAMS

Efficacy and safety are important considerations for pill splitting. Even if individuals use a splitting device to divide

their pills, the resulting halves can vary in size by up to 15 percent. Therefore, medications whose long-term efficacy is unaffected by day-to-day fluctuations in dosage are best suited for splitting.

Drugs that are safe for splitting have a high therapeutic index. The therapeutic index is the ratio of the therapeutic and toxic quantities of the drug. A drug with a narrow index (such as seizure medications and blood thinners) is a drug that could be toxic within those day-to-day fluctuations. A drug with a high index will not have a toxic effect if the user takes slightly more than prescribed but will still be therapeutic if occasionally taken in doses slightly less than prescribed.

Statins, a type of medication used to lower cholesterol, have proven to have both savings and safety associated with splitting. In 2000, a one-year study involving over 2,000 patients at the Veterans Affairs Palo Alto Health Care System in California found that splitting three statin drugs saved over $138,000. Splitting medications had no adverse effect on any of the participants' cholesterol levels. Certain medications used for the treatment of migraines, sexual dysfunction, depression, and anxiety are also candidates for splitting.

PILL SPLITTING IN OTHER HEALTH PLANS

Though pill splitting has only recently become a more common cost-containment practice, doctors have long used it in pediatric and geriatric dosing. Moreover, it has been an informal cost-containment strategy in the retail world. A 2008 poll conducted by the Harvard School of Public Health and the Kaiser Family Foundation for National Public Radio found that approximately one-fifth of the respondents in Ohio and Florida had split their pills to save money.

Though the practice is not yet widespread, it has been successful in a number of notable contexts.

The University of Michigan offers a 50 percent copay reduction to those employees taking some statin drugs who are willing to split their medication. They instituted this program in 2006 after establishing through a randomized trial that patients were willing to split certain cholesterol-lowering drugs in exchange for a copay reduction, and that splitting their medications did not adversely affect their cholesterol levels. In its first full year, the pill-splitting program saved the University $195,000. The more than 500 employees who participated saved over $25,000 in drug copay costs.

Since January 2004, Navitus, Minnesota's pharmacy benefit manager (PBM), has promoted a voluntary pill-splitting program by offering eligible state employees a 50 percent copay reduction. Their formulary consists of 19 medications. In the year following the program's implementation, it had a participation rate of between 10 percent and 20 percent. It now has a pool of 200,000 members who split 37 percent of their eligible medications and realize out-of-pocket savings of $60,000 per quarter.

Medco, Texas' former PBM, launched a voluntary pill-splitting program in February 2006, though the Employees Retirement System did not participate. This pill-splitting program is available to Medco's retail customers and includes a "copay modification." This program consists of nine medications. According to Medco, they have a participation rate around 40 percent.

The Texas Health and Human Services Commission (HHSC) contracts with an agency for retrospective drug utilization reviews. This entails looking at paid claims to find patterns of inappropriate or unnecessary uses of some medications and advising the doctor on more efficient prescribing strategies. Pill splitting is one of the strategies used to maximize the cost/benefit ratio of drug therapy. For fiscal year 2007, pill splitting resulted in over $142,000 in General Revenue Fund savings in the Medicaid program.

With the exception of the HHSC retrospective drug utilization review, voluntary participation is common to all these pill-splitting programs. Copay reductions are also the norm for participation incentives, though health plans and PBMs also take other approaches. One PBM pays pharmacists a one-time fee if they get members to participate in the pill-splitting program. Other plans use a similar approach with physicians. Doctors in these plans have incentives to meet a list of measures including generic drug utilization, diabetic foot screenings, and pill splitting.

ESTABLISHMENT OF A PILL-SPLITTING PROGRAM

Through a review of studies and current programs in other states, Legislative Budget Board staff identified 31 medications that appropriate users could safely split to achieve savings, as shown in **Figure 45**.

Figure 46 shows in fiscal years 2006 and 2007 over 350,000 Texas state employees used medications that are suitable for a pill-splitting program.

FIGURE 45
MEDICATIONS SAFE AND COST-EFFECTIVE FOR A PILL-SPLITTING PROGRAM

CATEGORY	MEDICATIONS		
Antipsychotics	Abilify Zyprexa	Risperdal	Seroquel
Blood Pressure, Cholesterol, Hypertension	Aceon Crestor Zocor	Atacand Diovan Pravachol	Avapro Lipitor Norvasc
Depression, Anxiety	Lexapro Celexa	Paxil	Zoloft
Diabetes	Actos	Avandia	Januvia
Epilepsy	Lamictal	Topamax	
Parkinson's, Alzheimer's	Aricept	Mirapex	Razadyne
Migraine Headaches	Axert	Maxalt	Zomig
Others	Levitra	Synthroid	Viagra

Source: Legislative Budget Board.

FIGURE 46
TEXAS STATE EMPLOYEES USING MEDICATIONS SUITABLE FOR PILL SPLITTING, FISCAL YEARS 2006 AND 2007

	STATE EMPLOYEE USAGE	
PLAN	2006	2007
Employees Retirement System	163,818	130,442
University of Texas System	47,967	60,134
Teacher Retirement System Active Care	62,922	51,381
Teacher Retirement System Care	126,953	107,452
Texas A&M University System	14,625	11,669
TOTAL	**416,285**	**361,078**

Source: Legislative Budget Board.

Figure 47 shows state health plan expenditures for medications that are suitable for a pill-splitting program for fiscal years 2006 and 2007.

Because pill splitting can reduce prescription drug costs for both the state and its employees, Recommendation 1 would:

- direct the Employees Retirement System, Teacher Retirement System, The University of Texas System Administration, and Texas A&M University System Administrative and General Offices to establish a pill-splitting program with a copay reduction incentive for voluntary member participation; and
- direct each of these agencies to establish a list of medications appropriate for splitting.

This recommendation would require the state employee health plans to work with Texas' PBMs (Caremark and Medco) to develop a list of medications for a voluntary pill-splitting program. A reduced copay incentive should be included in the program to encourage eligible plan members to participate in the program.

FIGURE 47
STATE HEALTH PLAN COSTS FOR MEDICATIONS SUITABLE FOR PILL SPLITTING EXCLUDING MEMBER CONTRIBUTIONS, FISCAL YEARS 2006 AND 2007

	STATE HEALTH PLAN COSTS (IN MILLIONS)	
PLAN	2006	2007
Employees Retirement System	$52.8	$45.7
Teacher Retirement System Active Care	18.7	16.7
Teacher Retirement System Care	52.9	46.6
University of Texas System	16.4	17.9
Texas A&M University System	5.2	4.6
TOTAL	**$146.0**	**$131.6**

Source: Legislative Budget Board.

This recommendation would also require each agency to report to the Legislative Budget Board and the Governor on the plan design, medication formulary, participation, and cost savings relating to their pill-splitting program no later than December 1, 2010.

FISCAL IMPACT OF THE RECOMMENDATION

Recommendation 1 would save $789,879 in General Revenue Funds and General Revenue–Dedicated Funds for the 2010–11 biennium.

The fiscal impact in **Figure 48** considers the following factors:

- medications with more than 100 users would have a 7.5 percent participation rate for the first year and 15 percent each year thereafter. The 15 percent assumption was derived from Minnesota's experience with participation rates between 10 percent and 20 percent at the end of their program's first year; and
- medication strengths with fewer than 50 users, or a per pill cost of less than $1, would have no participants.

The costs for setting up and advertising these programs could be met with existing resources.

The fiscal impact estimates assumed that program participants purchased approximately 2.5 million fewer pills. The combined savings for state health plans and members would be over $2 million each year. The copay reduction incentive

would result in over $1 million in out-of-pocket savings for plan members. This estimate presumes a 50 percent copay reduction, though lesser reductions would still result in savings to state employees. Since a significant portion of both the UT and A&M health insurance expenditures fall outside the appropriations process, the savings to appropriated funds would be in addition to the savings to UT and A&M's non-appropriated funds.

Figure 49 shows estimated General Revenue Fund savings by agency, relying on the same assumptions.

The introduced 2010–11 General Appropriations Bill does not include any adjustments as a result of this recommendation.

FIGURE 48
FIVE-YEAR FISCAL IMPACT, FISCAL YEARS 2010 TO 2014

FISCAL YEAR	SAVINGS/(COST) IN GENERAL REVENUE FUNDS	SAVINGS/(COST) IN GENERAL REVENUE–DEDICATED FUNDS	SAVINGS/(COST) IN FEDERAL FUNDS	SAVINGS/(COST) IN OTHER FUNDS	TOTAL SAVINGS IN ALL FUNDS
2010	$238,217	$25,076	$83,585	$71,047	$417,925
2011	$476,435	$50,151	$167,170	$142,095	$833,639
2012	$476,435	$50,151	$167,170	$142,095	$833,639
2013	$476,435	$50,151	$167,170	$142,095	$833,639
2014	$476,435	$50,151	$167,170	$142,095	$833,639

Source: Legislative Budget Board.

FIGURE 49
GENERAL REVENUE FUND SAVINGS BY AGENCY, FISCAL YEARS 2010 TO 2014

FISCAL YEAR	EMPLOYEES RETIREMENT SYSTEM	UNIVERSITY OF TEXAS SYSTEM	TEACHER RETIREMENT SYSTEM ACTIVE CARE	TEACHER RETIREMENT SYSTEM CARE	TEXAS A&M UNIVERSITY SYSTEM
2010	$174,680	$67,911	$575,572	$95,397	$22,367
2011	$349,359	$135,822	$115,143	$190,794	$44,733
2012	$349,359	$135,822	$115,143	$190,794	$44,733
2013	$349,359	$135,822	$115,143	$190,794	$44,733
2014	$349,359	$135,822	$115,143	$190,794	$44,733

Source: Legislative Budget Board.

STUDY CONTRACTING WITH MEDICARE TO MAXIMIZE THE STATE'S PRESCRIPTION DRUG FUNDING

The Texas state systems providing health insurance/care to retirees (Texas A&M University System, The University of Texas System, Employees Retirement System, and Teacher Retirement System) use a Medicare subsidy to finance the costs of prescription drugs in their plans. The systems expect to receive about $115 million for fiscal year 2009 from this subsidy. While the subsidy is substantial, Medicare would pay more if the systems directly contracted with Medicare to provide prescription drugs to Medicare-eligible retirees. Therefore, Texas systems may not be maximizing this revenue stream.

If Texas systems were to work together in directly contracting with Medicare for the Medicare prescription drug subsidy, some of the administrative costs might be averted. However, because of the differences in how Texas systems' prescription drug programs are set up, in-depth analysis and planning would be needed to achieve such savings in administrative costs while maximizing revenues and minimizing negative impacts on retirees. By studying the feasibility of directly contracting with Medicare for prescription drug coverage in place of the current drug subsidy, Texas could eventually implement a plan that may increase revenues from Medicare by almost $33 million per year in All Funds after full implementation.

This report also updates information on clawback, Texas' reimbursement to Medicare for the cost of prescription drugs for Medicaid clients.

FACTS AND FINDINGS

- Texas state systems providing health insurance/care to retirees received approximately $92 million for fiscal year 2007, and anticipate receiving about $103 million for fiscal year 2008 from Medicare as a subsidy to pay for prescription drugs for Medicare-eligible retirees. The systems expect about $115 million for fiscal year 2009, $132 million for fiscal year 2010, and $150 million for fiscal year 2011.
- Agencies in two states that contract directly with Medicare receive more funding per retiree per month than they would if they received the Medicare subsidy. After administrative expenses, one state estimates receiving an additional $14.42 per participant per month, while another state estimates receiving an additional $24.20 per participant per month.
- Directly contracting with Medicare is more administratively cumbersome and takes about a year to implement. Another state required 30 to 40 full-time employees in their first two years of directly contracting with Medicare but now requires 7 to 10 full-time employees.

CONCERNS

- While the retiree drug subsidy from Medicare to the Texas systems is substantial, Medicare pays more when employers and retirement systems provide prescription drugs to retirees by directly contracting with Medicare. Therefore, Texas retirement systems are not maximizing this revenue stream. Texas could potentially increase revenues from Medicare by almost $33 million per year in All Funds. Because of timing, however, increased revenues might not be realized until after fiscal year 2011.
- If Texas systems were to work together in directly contracting with Medicare for the Medicare Part D prescription drug subsidy, some of the administrative costs might be averted. However, because of the differences in how Texas systems' prescription drug programs are set up, in-depth analysis and planning would be needed to achieve such savings in administrative costs while maximizing revenues and minimizing negative impacts on retirees.

RECOMMENDATIONS

- **Recommendation 1:** Include a rider in the 2010–11 General Appropriations Bill that would require the Teacher Retirement System to conduct an in-depth study to analyze the pros and cons of directly contracting with Medicare for prescription drug coverage in lieu of the 28-percent-retiree-drug subsidy. The Teacher Retirement System should provide the final report to the Legislative Budget Board and the Governor by March 31, 2010.
- **Recommendation 2:** Include a rider in the 2010–11 General Appropriations Bill that would require the Teacher Retirement System to begin applications and

negotiations with Medicare to become an Employer Group Waiver Plan sponsor during fiscal year 2011 if the study indicates that directly contracting with Medicare is cost effective and to notify the Legislative Budget Board and the Governor within 45 days of implementing the process.

- **Recommendation 3:** Include a rider in the 2010–11 General Appropriations Bill that requires the Employees Retirement System, the Texas A&M University System, and The University of Texas System to provide data and information to the Teacher Retirement System for the study on directly contracting with Medicare for prescription drug coverage. Based on the most cost-effective recommendations of the study, require these agencies to begin applications and negotiations with Medicare for each to become an Employer Group Waiver Plan sponsor during fiscal year 2011, or to develop a Memorandum of Understanding with the Teacher Retirement System to implement the recommendations of the study.

DISCUSSION

The Medicare Part D prescription drug program began on January 1, 2006. The program subsidizes prescription drugs for Medicare-eligible individuals who enroll in a prescription drug plan (PDP). Enrollment is voluntary, and plans vary by premium and copayment amounts, deductibles, covered medications, and other coverage options. The program is run on a calendar year basis.

In 2008, 56 PDPs were available through 22 organizations in Texas, with monthly premiums ranging from $12.10 to $97.50. The average premium in Texas in 2008 was $38.10. An additional 33 companies provided coverage through Medicare Advantage prescription drug plans. Coverage limits increase annually for inflation. For 2009, the basic plan has a $295 deductible; a 25 percent copayment for annual expenditures between $295 and $2,700; a coverage gap (100 percent copayment, also known as the "donut hole") for expenditures between $2,700 and $6,154; and a 5 percent copayment for prescription drug expenses over the $6,154 cost limit. **Figure 50** shows this standard benefit design for a person with prescription drug expenditures of $7,200 a year and a premium of $38.10 a month. By having Medicare Part D coverage, this person's out-of-pocket costs decrease to $4,859, a savings of $2,341 for the year.

MEDICARE CLAWBACK

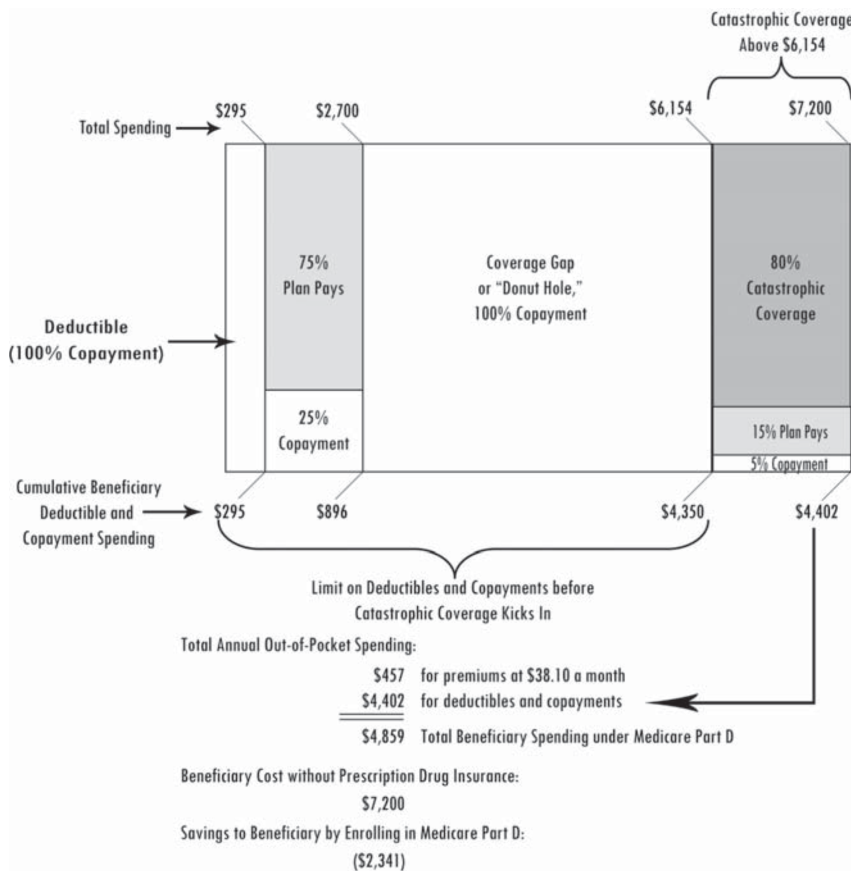
State budgets are primarily affected by the Medicare Part D program in two areas. First, the federal Medicaid program no longer pays for most prescription drugs for individuals on Medicaid that are also Medicare-eligible (called "dual eligible" individuals). Consequently, they are automatically enrolled in a Medicare Part D plan. As a result, Medicare directly pays for most of their prescription drugs. The original federal legislation excluded benzodiazepines, barbiturates, drugs for weight loss or weight gain, and a few other classes of drugs. With enactment of the federal Medicare Improvements for Patients and Providers Act of 2008, benzodiazepines and barbiturates will be Medicare Part D covered drugs beginning January 1, 2013.

States are required to pay Medicare for most of the costs that states previously incurred for the dual eligible individuals' prescription drugs. The amount states have to pay is officially called "phased down contributions," but is more commonly referred to as "clawback." The amount of clawback is estimated by the Centers for Medicare and Medicaid Services (CMS) based on each state's per capita prescription drug expenditures for this population in 2003 adjusted for national per capita inflation for prescription drugs, changes in the state's Federal Medical Assistance Percentage (FMAP), the number of dual eligibles, and with an annual reduction of the state share from 90 percent in 2006 to 75 percent by 2015.

Since the Medicare Part D prescription drug program began in January 2006, Texas' clawback payments for fiscal year 2006 only included January 2006 to August 2006, covering an average of 326,431 recipients per month. For fiscal year 2007, clawback payments were made for 335,160 recipients per month. Clawback payments for fiscal years 2006 to 2008 and estimates of Texas' clawback obligation for fiscal years 2009 to 2011 are shown in **Figure 51**.

In March 2006, Texas filed a complaint with the U.S. Supreme Court against Medicare, objecting to states being required to fund a benefit offered by the federal government. The complaint contends that "the federal government has usurped states' sovereign powers and violated the U.S. Constitution by mandating direct payments to the federal government to fund the new Medicare prescription drug program." In June 2006, the U.S. Supreme Court denied both the motion for a preliminary injunction against the operation of the clawback provision and the motion for leave to file a bill of complaint initiating an original action to challenge the constitutionality of the clawback provision. No

FIGURE 50
BENEFICIARY OUT-OF-POCKET COSTS UNDER STANDARD MEDICARE PART D BENEFIT FOR PERSON WITH $7,200 ANNUAL EXPENSES, 2009



SOURCE: Legislative Budget Board.

FIGURE 51
CLAWBACK AMOUNTS FOR TEXAS (IN MILLIONS) FISCAL YEARS 2006 TO 2011

2006	2007	2008	2009 (ESTIMATED)	2010 (PROJECTED)	2011 (PROJECTED)
$136.2	$289.2	$298.4	$317.4	$344.3	$363.7

NOTE: Clawback was levied for only eight months in fiscal year 2006.
SOURCE: Texas Health and Human Services Commission.

further action on this is expected. While states can refuse to make the clawback payment, CMS will reduce the Medicaid funds it would otherwise send to states by the clawback amount plus interest. Although the Governor vetoed appropriations specifically for the clawback, appropriations for Medicaid were used to pay it. The Health and Human Services Commission has included clawback payments in its 2010–11 Legislative Appropriations Request, with an exceptional item to cover cost increases.

STATE AS AN EMPLOYER

The second way that states are affected by the Medicare Part D program is as an employer that provides prescription drug coverage to Medicare-eligible retirees. Employers and employer-funded retirement systems have several options that allow them to receive Medicare Part D prescription drug funding for Medicare-eligible retirees.

TWENTY-EIGHT-PERCENT-RETIREE-DRUG SUBSIDY OPTION

The simplest option is the 28-percent-retiree-drug subsidy. Medicare pays employers 28 percent of the total cost of covered drugs for Medicare-eligible retirees who are not enrolled in a PDP, within per person cost limits. The *2008 Segal Medicare Part D Survey of Multiemployer Health Funds* by the Segal Group, Inc., a benefits, compensation, and human resources consulting group, found that 68 percent of their clients nationally were receiving the 28-percent-retiree-

drug subsidy in 2008. This rate of participation is down from 72 percent in 2007.

The Texas state systems providing health insurance/care to retirees—the Texas A&M University System (A&M), The University of Texas System (UT), the Employees Retirement System (ERS), and the Teacher Retirement System (TRS)—are using this option. **Figures 52 and 53** show estimated amounts of Medicare Part D funding to Texas systems for fiscal years 2006 to 2011. Appropriations for fiscal years 2006 to 2009 and requests for fiscal years 2010 to 2011 assume that the systems receive the 28-percent-retiree-drug subsidy. For UT, the General Revenue Fund share of the total health benefits pool is decreasing (from 40 percent in fiscal year 2000 to 28 percent in fiscal year 2007). This decrease means the savings of General Revenue Funds in fiscal year 2007 was approximately $2 million. Over all systems combined, the General Revenue Fund share is approximately 50 percent.

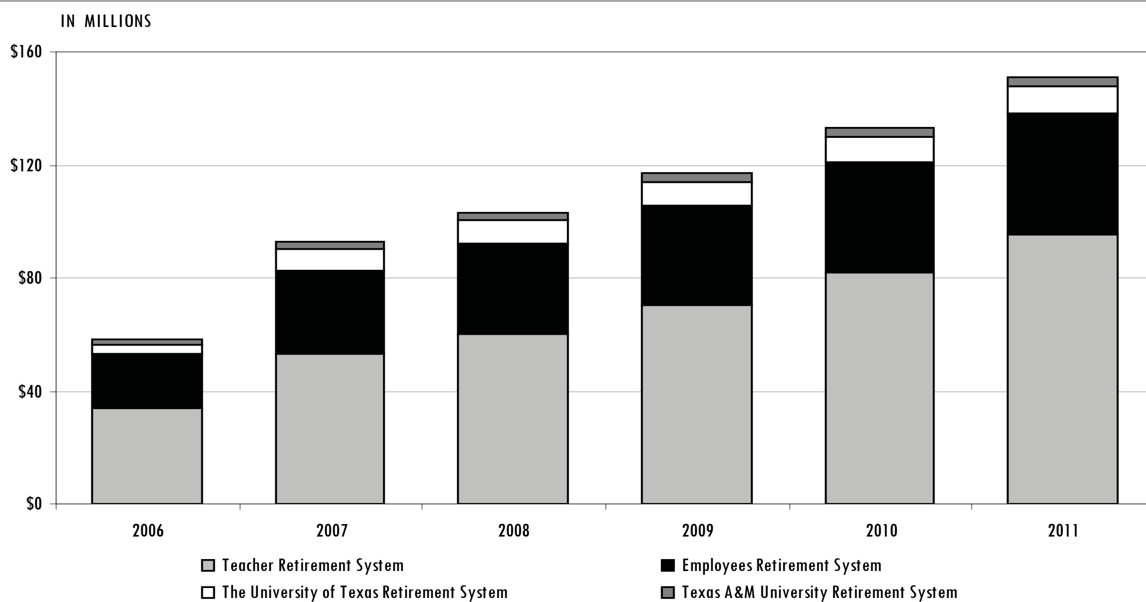
Data on prescription drugs used by Medicare-eligible retirees is sent to Medicare, and the Texas systems bill Medicare monthly, quarterly, or semi-annually. After verifying Medicare eligibility and performing other checks, Medicare sends the 28-percent-retiree-drug subsidy amount to the systems within a month. Accounts with Medicare are supposed to be reconciled within 15 months after the plan year ends, but reconciliation for 2006 occurred in spring

FIGURE 52
ESTIMATED SUBSIDY RECEIVED OR EXPECTED BY TEXAS SYSTEMS, FISCAL YEARS 2006 TO 2011

	SUBSIDY RECEIVED (IN MILLIONS)					
TEXAS SYSTEM	**2006**	**2007**	**2008**	**2009**	**2010**	**2011**
Texas A&M University System	$2.1	$3.3	$3.5	$3.7	$4.0	$4.2
The University of Texas System	3.5	7.1	7.4	7.5	8.5	9.5
Employees Retirement System	19.0	29.3	33.0	33.9	37.4	41.3
Teacher Retirement System	34.6	52.3	59.5	70.1	81.9	95.3
TOTAL	**$59.2**	**$92.1**	**$103.4**	**$115.3**	**$131.8**	**$150.4**

NOTES: The subsidy was provided for only eight months in fiscal year 2006. Information for the Employees Retirement System includes both state retiree and Higher Education Group Insurance benefits administered by the Employees Retirement System. Fiscal years 2006 and 2007 are amounts after final reconciliation with Medicare; other years are estimated based on expected increases in the number of Medicare-eligible retirees and in some prescription drug costs. Totals may not sum due to rounding.
SOURCE: Legislative Budget Board.

FIGURE 53
ESTIMATED 28-PERCENT-RETIREE-DRUG SUBSIDY BY TEXAS SYSTEM, FISCAL YEARS 2006 TO 2011



SOURCE: Legislative Budget Board.

2008. The 2007 reconciliation occurred at the end of November 2008.

Figure 54 shows information, by state system, on the number of retirees for which the 28-percent-retiree-drug subsidy was received in fiscal year 2007 and the amount of the 28-percent-retiree-drug subsidy per participant per month (pp/mo). Texas systems received the 28-percent-retiree-drug subsidy for 167,098 persons in 2007. They expect the number of Medicare-eligible retirees to grow between 4 percent and 6 percent per year over the next five years, with an increase to over 6 percent from fiscal year 2012 to fiscal year 2013 at TRS. Payments of the 28-percent-retiree-drug subsidy by Medicare to the Texas systems ranged from $42.93 pp/mo to $51.19 pp/mo, averaging $48.72.

FIGURE 54
PERSONS COVERED AND 28-PERCENT-RETIREE-DRUG SUBSIDY BY STATE SYSTEM, FISCAL YEAR 2007

TEXAS SYSTEM	NUMBER OF PERSONS COVERED	PER PERSON PER MONTH SUBSIDY
Texas A&M University System	6,766	$42.93
The University of Texas System	13,465	$46.25
Employees Retirement System	57,201	$44.98
Teacher Retirement System	89,666	$51.19
ALL STATE SYSTEMS	**167,098**	**$48.72**

SOURCE: Legislative Budget Board.

GROUP CONTRACT WITH PDP OPTION

Instead of the 28-percent-retiree-drug subsidy, employers may contract with a PDP on a group basis to have the PDP provide Medicare Part D prescription drugs to the employers' Medicare-eligible retirees. In this option, Medicare pays the PDP, but some of the cost reductions are passed along to the employer. The savings under this option should be larger than the 28-percent-retiree-drug subsidy. Many private employers have chosen this option because it is administratively simple. However, employers lose control over pharmaceutical benefits, and negotiations for prescription drugs for their other enrollees can be adversely impacted because of loss of purchasing power.

Administrators at the Texas state systems consulted with their pharmacy benefit managers (PBMs) and/or other PDPs to determine whether this was a cost-effective option. The state systems concluded that the additional revenues over the 28-percent-retiree-drug subsidy were mostly offset by the additional costs quoted by the PDPs. For example, the estimated revenue from the 28-percent-retiree-drug subsidy is about $45 pp/mo for ERS for fiscal year 2007. One PBM told ERS that they would be willing to administer a group contract with PDP program for $7 to $8 pp/mo. ERS estimated that Medicare would pay $52 to $53 pp/mo. Thus, ERS would expect a net reimbursement of $45 ($52.50–$7.50), which is about the same amount ERS currently receives. Slight variations in these assumptions could show a loss or a gain. The cost of any extra administrative complexity of having to have a separate program for Medicare-eligible retirees is not considered in this analysis. Conversely, competition among PDPs could lower quoted amounts for such a contract, making this option more attractive. Further, the pp/mo reimbursement from Medicare might be larger. Nonetheless, additional savings pp/mo under this option would likely be minimal.

DIRECT CONTRACT WITH MEDICARE OPTION

Alternatively, employers may contract with Medicare directly as an "Employer Group Waiver Plan" (EGWP). Few public entities have chosen this option. The option is administratively complex, with many new requirements and interactions with Medicare. Consequently, it takes about a year to implement. However, once it is implemented, revenues should be considerably higher than the 28-percent-retiree-drug subsidy.

A representative of the Oklahoma State and Education Employees Group Insurance Board, which operates a direct-contract EGWP, indicates that their Board's prescription drug coverage did not qualify for the 28-percent-retiree-drug subsidy in January 2006 when the Medicare prescription drug program was implemented. The agency modified their prescription drug coverage to become a direct-contract EGWP. In the first two years, 30 to 40 full-time staff were needed to implement the program. Currently, a staff of about nine administer the plan for approximately 38,000 members. Because their prescription drug offering is generous, with low copayments by members and a maximum out-of-pocket amount of $2,500 for preferred prescription drugs, few members reach the out-of-pocket level triggering Medicare catastrophic coverage. Consequently, Medicare payments are averaging only $53 pp/mo. Oklahoma staff advise against becoming a direct-contract EGWP for plans that are able to take advantage of the 28-percent-retiree-drug subsidy, especially for systems that have an out-of-pocket limit on prescription drugs that is less than the Medicare level for catastrophic coverage.

Conversely, two public retirement systems that developed direct-contract EGWPs had positive results. The Missouri Department of Transportation and Missouri State Highway Patrol Retirement System has 4,860 retirees that are Medicare-eligible, while the Pennsylvania Public School Employees Retirement System has 37,279 retirees that are Medicare-eligible.

Figure 55 provides information from an analysis by the systems' consultant comparing the amount of Medicare payments to these systems under the direct-contract EGWP with an estimate of what the 28-percent-retiree-drug subsidy would have been. It includes the actual and estimated operational cost pp/mo under these two options. It is estimated that the Missouri system is receiving $14.42 more pp/mo under their direct-contract EGWP than under the 28-percent-retiree-drug subsidy, after accounting for the higher operational cost under the direct-contract EGWP. Similarly, it is estimated that the Pennsylvania system is receiving $24.20 more pp/mo under their direct-contract EGWP than under the 28-percent-retiree-drug subsidy.

Administrators from Missouri and Pennsylvania contracted with a consultant to implement the direct-contract EGWP. The Missouri system had not had a prescription drug benefit for their retirees prior to implementing the direct-contract EGWP. The Pennsylvania system had a prescription drug benefit, so it worked with its PBM in developing the direct-contract EGWP. Neither of these retirement systems increased staffing to establish the direct-contract EGWP or to continue operations. Both systems began with the direct-contract EGWP in 2006, the first year of the Medicare Part D program, so they are in the third year of operations. Administrators from both states indicate that the direct-contract EGWP yields more net revenues than the estimated amounts for the 28-percent-retiree-drug subsidy and is a worthwhile approach. They conveyed that contracting out the operations of the plan was worth the additional cost to avoid the additional administrative hassle.

The results of applying the experience of the Missouri system, which yielded the lower net reimbursement of $14.42 pp/mo, to the number of Texas systems' Medicare-eligible retirees for fiscal years 2010 to 2011 is shown in **Figure 56**.

FIGURE 55
COMPARISON OF MEDICARE REIMBURSEMENTS AND ADMINISTRATIVE COSTS OF TWO PUBLIC RETIREMENT SYSTEMS UNDER EMPLOYER GROUP WAIVER PLAN AND 28-PERCENT-RETIREE-DRUG SUBSIDY

	MISSOURI DEPARTMENT OF TRANSPORTATION AND MISSOURI STATE HIGHWAY PATROL RETIREMENT SYSTEM			PENNSYLVANIA PUBLIC SCHOOL EMPLOYEES RETIREMENT SYSTEM		
Number of Medicare-eligible retirees →	4,860			37,279		
	EMPLOYER GROUP WAIVER PLAN	28-PERCENT-RETIREE-DRUG SUBSIDY	DIFFERENCE	EMPLOYER GROUP WAIVER PLAN	28-PERCENT-RETIREE-DRUG SUBSIDY	DIFFERENCE
Medicare Reimbursement pp/mo	$57.16	$38.74	$18.42	$65.77	$40.07	$25.70
Operational Cost pp/mo	(5.00)	(1.00)	(4.00)	(2.00)	(0.50)	(1.50)
NET REIMBURSEMENT PP/MO	**$52.16**	**$37.74**	**$14.42**	**$63.77**	**$39.57**	**$24.20**

NOTE: pp/mo is per participant per month.
SOURCE: Independent Pharmaceutical Consultants, Inc.

FIGURE 56
ESTIMATED NUMBER OF TEXAS STATE SYSTEMS' MEDICARE-ELIGIBLE RETIREES AND ESTIMATED ADDITIONAL REVENUES FROM DIRECTLY CONTRACTING WITH MEDICARE, FISCAL YEARS 2010 AND 2011

	NUMBER OF PARTICIPANTS		ADDITIONAL REVENUES (IN MILLIONS)		
TEXAS SYSTEM	2010	2011	2010	2011	2010–11 BIENNIUM
Texas A&M University System	7,671	7,998	$1.3	$1.3	$2.6
The University of Texas System	15,587	16,367	2.6	2.7	5.3
Employees Retirement System	66,275	68,926	10.9	11.3	22.2
Teacher Retirement System	105,021	110,482	17.3	18.2	35.5
TOTAL	**194,554**	**203,773**	**$32.0**	**$33.5**	**$65.5**

NOTES: Based on the Missouri Department of Transportation and Missouri State Highway Patrol Retirement System estimated increase of $14.42 per participant per month over the 28-percent-retiree-drug subsidy. Totals may not sum due to rounding.
SOURCE: Legislative Budget Board.

Assuming Texas systems' performance is at least as good as the Missouri performance, the Texas systems would receive $65.5 million more than receipts under the 28-percent-retiree-drug subsidy for the 2010–11 biennium, if the direct-contract EGWP were in place.

While these estimates show additional revenues, there are many unknowns. First, Texas systems' results may not be comparable to the Missouri or Pennsylvania experience. Also, the other states' figures may not have included all administrative costs, especially any added costs of their PBM for helping to administer the program. Furthermore, the Medicare program operates on a calendar year, which may create certain challenges for plans operating their health insurance coverage on a fiscal year basis.

Nonetheless, the optimal way to administer the program in Texas should be investigated. For example, some of the functions could possibly be contracted out to lower costs. Similarly, administrative costs may be minimized by having one direct-contract EGWP for all Texas state systems providing health insurance/care to retirees, rather than having one for each system. Since retiree healthcare, including prescription drug coverage, differs among the systems, an in-depth analysis of ways to overcome the challenges would be prudent.

FISCAL IMPACT OF THE RECOMMENDATIONS

Recommendation 1 directs TRS to conduct an in-depth study to look into these issues. TRS was selected because it has the largest population of Medicare-eligible retirees of all of the state's systems. The study should examine options for increasing the amount of Medicare funding for prescription drug coverage to the state's systems providing health insurance/care to retirees. It should analyze the pros and cons of directly contracting with Medicare, including likely additional administrative costs as well as additional revenues from Medicare. The study should also determine the most cost-effective model for the state to use and explore the possibility of other state systems using TRS as the sponsoring entity with Medicare. The final report is to be provided to the Legislative Budget Board and the Governor by March 31, 2010.

Recommendation 2 directs TRS to begin applications and negotiations with Medicare to become a direct-contract EGWP sponsor during fiscal year 2011, if the study indicates that directly contracting with Medicare is cost effective. TRS is to notify the Legislative Budget Board and the Governor within 45 days of implementing the process.

Recommendation 3 directs ERS, UT, and A&M to cooperate with TRS by providing data and information for the study. It further requires them to begin applications and negotiations with Medicare for each to become an Employer Group Waiver Plan sponsor during 2011, or to develop a Memorandum of Understanding with TRS to implement the recommendations of the study as soon as possible, if the study indicates that it is cost effective to do so.

The cost of the study should be absorbed by the agencies involved. Fiscal savings in General Revenue Funds and General Revenue–Dedicated Funds could accrue in later years if the study shows that directly contracting with Medicare for prescription drug coverage is cost effective.

The introduced 2010–11 General Appropriations Bill includes riders to implement the recommendations.

INCREASE EMPLOYEE PARTICIPATION IN THE TEXA$AVER PROGRAM

Having an adequate income during retirement is crucial for state of Texas employees permanently leaving the workforce. For many state employees, Social Security and pension benefits will provide part of their needed income during retirement. These benefits will not be enough for most state employees to comfortably retire on; like other Americans, state employees will also need to have some of their own savings. To help employees meet this need, state agencies and higher education institutions offer the Texa$aver Program, a deferred compensation program, consisting of a 401(k) plan and a 457 plan. Designing a strong deferred compensation program that includes relevant information and education about savings options is key to helping employees build a secure retirement.

FACTS AND FINDINGS

- As of October 2008, 27.1 percent of state employees contribute to the Texa$aver 401(k) plan (or 41,366 out of 152,514 who were eligible). Approximately 45 percent of 401(k) participants (or 18,425 out of 41,366) were new state employees who were auto-enrolled in the plan. For the same period, 3.7 percent of state and higher education employees participate in the Texa$aver 457 plan (or 10,498 out of 286,160 who were eligible).
- State employees tend to be risk adverse, choosing a plan fund with a lower rate of return with protection of principal. Within the Texa$aver Program, 15.3 percent of plan assets for the 401(k) plan are in the ING Stable Value Account and 16.9 percent are in the same fund for the 457 plan.

CONCERNS

- For most state employees the combination of pension and Social Security will not be enough to live on during retirement; to provide a secure retirement, most state employees must contribute to an optional savings program or account.
- Participation rates in the Texa$aver Program, an optional defined contribution program, are less than 28 percent. State employees are less likely to save in the Texa$aver Program and are less likely to have any other type of voluntary, non-pension retirement savings, which means they may not have adequate income during retirement.
- The cost of investing with the Texa$aver Program is difficult to determine for an individual participant, despite clearly published plan fees and fund expenses. Not understanding the full costs may prevent an employee from enrolling or cause an employee to invest in more expensive fund options, which will reduce savings available during retirement.
- Employee feedback indicates interest in different types of fund options. Two notable fund types absent from the Texas$aver Program are a socially responsible investment fund, which may be of interest to public employees, and an FDIC-insured fund option, which would reassure employees who have concerns about market volatility.
- House Bill 957 of the Eightieth Legislature, 2007, required the automatic enrollment of new state employees on or after January 1, 2008 in the Texa$aver 401(k) plan. This change applied only to new employees and enrolls them at 1 percent of salary, without further adjustment unless there is action by the employee. While automatic enrollment added 18,425 enrollees to the 401(k) plan as of October 2008, this default contribution rate is a low savings amount that is unlikely to yield adequate retirement savings for an individual employee.
- Employees have a strong interest in both an employer match for the Texa$aver Program and a Roth 401(k) option, yet neither feature is offered within the Texa$aver Program.

RECOMMENDATIONS

- **Recommendation 1:** The Employees Retirement System should disclose plan fees and investment fees in a reader-friendly format on quarterly Texa$aver statements so that plan participants can clearly understand the total cost of investing in the Texa$aver Program.
- **Recommendation 2:** The Employees Retirement System should add a Federal Deposit Insurance

Corporation-insured fund option and a Socially Responsible Investment Fund option to the Texa$aver Program.

- **Recommendation 3:** Amend Texas Government Code, Section 609.5025, to expand automatic enrollment in the Texa$aver 401(k) plan to all state agency employees. Add an auto-escalation feature to automatic enrollment to increase employee contributions by 1 percent each year until the contribution rate reaches 5 percent of an employee's salary; employees will have the option to decline enrollment and escalation.
- **Recommendation 4:** Amend Texas Government Code, Chapter 609, to permit an employer match for the Texa$aver 401(k) Plan contingent upon legislative approval, appropriations, and sufficient funding for the pension.
- **Recommendation 5:** Include a contingency rider in the 2010–11 General Appropriations Bill to appropriate funds to the Comptroller of Public Accounts for an employer match of $10 per month ($120 per year) for participants within the Texa$aver 401(k) plan.
- **Recommendation 6:** Amend Texas Government Code, Chapter 609, to require the Employees Retirement System, through its existing statutory and administrative authority, to add a Roth plan option to the Texa$aver Program for the 401(k) plan, and contingent upon federal legislation, to the 457 plan.
- **Recommendation 7:** The Employees Retirement System should expand educational offerings to state employees regarding the Texa$aver Program and general retirement savings.

DISCUSSION

Individual retirement savings through optional savings accounts or programs complete the retirement income sources many state and higher education employees will depend on during their retirement years. One option for state employees is a deferred compensation plan such as a 401(k). The State of Texas offers the Texa$aver Program to state agency and higher education employees. This program includes two plan options: a 401(k) plan, which is available to all state agency employees, and the 457 plan, which is available to all state agency and higher education institution employees. Texas is unusual in that it offers both a 401(k) and a 457; most state and local governments only offer a 457 plan.

The Texa$aver Program, which includes the 401(k) and 457 plans, is a defined contribution plan. This means the program is an employer-sponsored retirement plan where the employee contributes a portion of his or her salary into the plan, and the employee bears the investment risk.

For calendar year 2008, under federal rules, the 401(k) and 457 plans both permit a maximum of $15,500 contribution per year, based on federal limits. Employees contribute to the 401(k) plan by percentages of their salaries; with the 457 plan, employees contribute a specified dollar amount. Since the state offers both a 401(k) plan and a 457 plan, state agency employees could contribute up to $31,000 during calendar year 2008. **Figure 57** shows the average account balance, deferral amount, and number of accounts in the 401(k) and 457 plans as of December, 2007.

FIGURE 57
TEXA$AVER PROGRAM STATISTICS, DECEMBER 2007

PLAN STATISTIC	401(K)	457
Average account balance	$21,411	$16,966
Number of deferring participants with accounts	28,636	9,706
Average monthly deferral amount	$273.55	$347.90

Source: Employees Retirement System.

For the 401(k) plan, the Employees Retirement System (ERS) reports an average 6.34 percent monthly deferral rate as of December 31, 2007. The average annualized participant salary for the 401(k) plan as of December 2007 was $47,294.

Demographic information also helps illustrate who uses the Texa$aver Program. As **Figure 58** shows, a majority of Texa$aver Program participants are female and most participants are age 40 to 59.

The demographic and salary information for Texa$aver Program participants corresponds somewhat to the average state employee. According to Buck Consultants, the actuary hired by ERS, the average ERS member in fiscal year 2008 was 43.7 years old, earned $39,468 per year, and had 9.5 years of service with the state.

Long-term saving, such as for retirement, can be difficult. When the savings goal is decades away, the urgency of the

FIGURE 58
AGE AND GENDER STATISTICS OF TEXA$AVER PARTICIPANTS, DECEMBER 2007

	401(K)	457
GENDER		
Male	43.1%	48.7%
Female	56.8%	50.0%
AGE		
Under 30	4.1%	9.8%
30–39	20.4%	20.0%
40–49	33.3%	27.9%
50–59	30.6%	29.4%
60 +	11.6%	12.9%

NOTE: A small number of participants were not able to be identified by gender, so gender statistics do not sum to 100 percent.
SOURCES: Legislative Budget Board; Employees Retirement System.

circumstances that often motivates people to act is absent. This circumstance is demonstrated by the age demographics of Texa$aver Program participants. Employees from age 40 to 59, who are closer to retirement, form the majority of participation in both plans. While all employees should ideally contribute to a voluntary retirement savings program, this is especially true for employees who have not yet vested in the pension and may leave state employment before vesting. The overall turnover rate for the state was 17.3 percent in 2008; it was 39.7 percent for those with less than two years of service and 19.7 percent for those with two to four years of service.

LOW PARTICIPATION RATES

As of October 2008, participation rates in the Texa$aver Program were low. During this time, 27.1 percent of state employees were actively deferring to the Texa$aver 401(k) plan (or 41,366 out of 152,514 who were eligible). The 401(k) plan participants include 18,425 auto-enrollees. For the same period, 3.7 percent of state and higher education employees were actively deferring to the Texa$aver 457 plan (or 10,498 out of 286,160 who were eligible). There are multiple factors affecting participation. Some employees may not contribute because 6 percent of their salaries is deducted for the ERS pension.

As part of the research for this report, the Legislative Budget Board (LBB) staff conducted an electronic employee survey on the Texa$aver Program during July 2008. The survey was sent to all agency human resources directors to redistribute to their agency's employees via e-mail. The survey included questions on why employees do or do not participate, features they would like to see in the program, and what types of other retirement savings they use. Approximately 12,000 employees completed the survey. Out of 5,532 survey respondents who provided reasons for non-participation in the Texa$aver Program, they chose not to participate for the following reasons:

- 42.4 percent felt they could not afford to participate;
- 36.6 percent declined participation because the state does not offer an employer match in the Texa$aver Program;
- 21.5 percent were concerned about losing money by investing;
- 19.6 percent found it confusing to enroll in the program or select investments; and
- 19.3 percent were not aware of the Texa$aver Program.

Respondents were permitted to choose multiple responses to the above question.

In addition to low participation rates within the Texa$aver Program, state employees are more likely to not have any type of non-Texa$aver retirement savings. Of survey respondents who did not participate in Texa$aver, 64.6 percent also did not have any other type of voluntary retirement savings. For survey respondents who do participate in Texa$aver, 63 percent do not contribute to any other type of voluntary retirement savings.

NEED FOR INDIVIDUAL RETIREMENT SAVINGS

Most state employees have a potential of three income sources during retirement: their ERS or TRS pension, Social Security, and optional retirement savings, the most common being a 401(k) or an IRA. Access to a defined benefit pension may be in part driving the lack of individual savings of state employees. For many state employees the combination of their pension and Social Security may not be enough to live comfortably during retirement. Most financial advisors recommend enough savings to replace anywhere from 70 percent to 120 percent of pre-retirement salary, depending on an individual's circumstances.

In 2008, the ERS pension provided annuitants an average of $18,081 (or $1,507 per month) in benefits. **Figure 59** shows the average monthly benefit amounts based on years of service for employees who retired in fiscal year 2008.

For those state employees with 25 years or more of credited service, based on 2008 retirees, the ERS pension replaces 62 to 75 percent of an employee's salary.

FIGURE 59
AVERAGE ERS PENSION PAYMENTS FOR ERS MEMBERS RETIRING DURING FISCAL YEAR 2008

	YEARS OF CREDITED SERVICE					
9/30/07–8/31/08	5–10	10–15	15–20	20–25	25–30	30+
Average Monthly Benefit	$469.14	$810.83	$1,327.05	$1,888.19	$2,640.09	$3,516.60
Average Final Monthly Salary	$2,999.77	$3,127.14	$3,425.96	$3,888.34	$4,284.59	$4,700.85
Number of Retired Members	209	517	457	606	629	432
Percentage of Salary Replaced	15.6%	25.9%	38.7%	48.6%	61.6%	74.8%

SOURCES: Legislative Budget Board; Employees Retirement System.

For state employees, Social Security will also provide a portion of their income during retirement. **Figure 60** shows the estimated monthly Social Security benefit for the employees in **Figure 59**. This estimate is based on a person retiring at age 66 in December 2008.

Figure 60 provides a rough estimate of potential Social Security benefits. However, the concern regarding Social Security is that its solvency as a system is in doubt. According to projections by the Social Security Administration, the system will begin paying out more in benefits than it collects in revenue in 2017. These projections indicate that by 2041, the Social Security Trust Fund will be depleted and Social Security payroll taxes will only be able to pay out 78 percent of promised benefits. Fixing Social Security will likely require a combination of increased payroll taxes and reduced benefits. It is important for state employees to consider this possibility when planning for retirement.

Based on current Social Security benefit structure, for state employees with 25 years or more of service, Social Security would replace approximately 30 percent of their final salary. To see the full effect of both Social Security and the ERS pension, the combined percentage of salary has been summed in **Figure 61** for persons over 66 years of age.

For state employees with many years of service, the combination of a pension and Social Security may cover a large percentage of pre-retirement salary. However, certain circumstances can significantly increase the need for income during retirement, some of which may be hard to predict, including:

- job change, particularly if leaving state service;
- divorce;
- becoming disabled and having to quit work sooner than planned;
- living longer than planned;
- paying for health insurance and basic healthcare costs;
- developing serious health problems that require expensive medical care;
- needing to pay off a home mortgage; and
- taking care of an unexpected dependent (such as a grandchild).

FIGURE 60
ESTIMATED MONTHLY SOCIAL SECURITY BENEFITS BY EMPLOYEE YEARS OF SERVICE, DECEMBER 2008

	YEARS OF CREDITED SERVICE					
INCOME	5–10	10–15	15–20	20–25	25–30	30+
Average Final Monthly Salary	$2,999.77	$3,127.14	$3,425.96	$3,888.34	$4,284.59	$4,700.85
Annualized Final Salary	$35,997.00	$37,526.00	$41,112.00	$46,660.00	$51,415.00	$56,410.00
Estimated Monthly Social Security	$1,039.00	$1,066.00	$1,129.00	$1,227.00	$1,311.00	$1,399.00
Percentage of Salary Replaced	34.6%	34.1%	33.0%	31.6%	30.6%	29.8%

NOTE: Estimates for this figure are based on the online Social Security Benefits Estimator.
SOURCES: Legislative Budget Board; Employees Retirement System; Social Security Administration.

FIGURE 61
PERCENTAGE OF SALARY REPLACED BY THE ERS PENSION AND SOCIAL SECURITY, BASED ON FISCAL YEAR 2008 RETIREES

	YEARS OF CREDITED SERVICE					
	5–10	10–15	15–20	20–25	25–30	30+
Combined Pension and Social Security	50.3%	60.0%	71.7%	80.1%	92.2%	104.6%

SOURCE: Legislative Budget Board.

When planning for retirement, it is difficult for an individual to project with accuracy decades into the future and be certain of what his or her needs will be. By having individual savings set aside for retirement to complement any income from Social Security and a pension, state employees will be better prepared to ensure a comfortable retirement free from financial worries. State employees cannot control the future of the pension system or Social Security, but they can control whatever personal savings they build for retirement.

COMPARISON TO OTHER STATES

Comparing the Texa$aver Program features to other states' deferred compensation programs shows options that could be added to the Texa$aver Program. Many of the plan features discussed in this report are present in other public sector deferred compensation plans. **Figure 62** shows an overview of other states' deferred compensation plans.

FIGURE 62
DEFERRED COMPENSATION PLAN FEATURES OFFERED IN STATE 401(K) OR 457 PLANS, 2008

PLAN OPTION OR FEATURE	NUMBER OF STATES
401(k) Plan	12
457 Plan	49
401(k) and 457	12
Employer match	12
Automatic enrollment	5
Roth 401(k)	5

SOURCE: Legislative Budget Board.

As shown in **Figure 62**, only 12 states offer a 401(k) plan, all of which also offer a 457 plan. State of Texas employees have access to both plans, allowing them to maximize their savings by being able to contribute more than the $15,500 annual limit for 2008 if they only had access to one plan. Within each feature or recommendation discussed, relevant information on other state comparisons is discussed in that section.

PLAN FEES

Fees are an important component of any retirement savings program but especially for employer-sponsored plans such as a 401(k) or 457. Deferred compensation plans like the Texa$aver Program are one of the employee benefits funded almost entirely from participant fees; generally there is little or no cost to the employer unless the employer offers a match.

Plan fees play a vital role in retirement savings because at the end of a long-term period of saving, low fees compared to high fees can add up to thousands of dollars. Since 2005, plan fees for deferred compensation programs have received more attention due to reports issued by the General Accountability Office (GAO) and the Department of Labor (DOL).

In a DOL primer on 401(k) plan fees, the agency uses an example of how fees can affect an individual's long-term retirement savings within a 401(k) plan. According to the DOL, plan fees of approximately 0.5 percent compared to 1.5 percent can equal a difference of $64,000 for an employee starting with a $25,000 balance, saving for 35 years, and earning an average return of 7 percent. Under a plan with 0.5 percent in fees, the employee's account balance would grow to $227,000; under a plan with 1.5 percent in fees, the balance would grow to $163,000. As the DOL notes in its example, the 1 percent difference in fees (0.5 compared to 1.5) would reduce the account balance by 28 percent.

According to the DOL, plan fees for deferred compensation programs usually fall into one of three categories: (1) plan administration fees, (2) investment fees, and (3) service fees. Plan administration fees cover day-to-day operations and basic administrative services such as record keeping, accounting, legal services, educational seminars, access to customer service representatives, investment advice, and electronic access to plan information. Investment fees, which are typically the largest component of 401(k) plan fees, are associated with the management of plan investments. These types of fees are deducted directly from an individual's investments returns. Service fees are for services outside of basic account services, such as a loan.

The fees for the Texa$aver Program align with the DOL categories. **Figure 63** shows information on administration fees and service fees charged to Texa$aver Program participants.

Based on the average 401(k) account balance of $21,411 from **Figure 57**, and applying the fees from **Figure 63**, the average monthly required administrative and service fees for a 401(k) account in the Texa$aver Program equals $4.40.

A potential barrier to participation in a deferred compensation plan is concern that the cost of investing through an employer sponsored program is more than it would be if an individual saved on his or her own. To reassure an employee who is interested in the plan, plan sponsors, like the state of Texas, should properly educate employees about the potential fees

FIGURE 63
TEXA$AVER PROGRAM ADMINISTRATION AND SERVICE FEES, 2008

FEE	AMOUNT	FEE FREQUENCY
REQUIRED FEES – PAID BY ALL PARTICIPANTS		
Recordkeeping Fee	$0.1666 per $1,000 of account balance	Monthly
Plan Participation Fee	$0.33	Monthly
Basic Advisor Service	$0.50	Monthly
OPTIONAL FEES – PAID BY PARTICIPANTS WHO USE THE SERVICE THE FEE APPLIES TO		
Professional Account Management (PAM)	0.05% of account balance	Monthly
Loan initiation	$50	Per initiation
Monthly loan maintenance	$2	Monthly

SOURCES: Legislative Budget Board; Employees Retirement System; ING.

involved. Educating plan participants about fees can present a challenge. Comparing to peer groups, such as other state plans, can help. **Figure 64** shows the 29 states that had fee information available to help provide a comparison.

Of the 29 states listed in **Figure 64**, six states do not have administrative fees for their deferred compensation plans for the current year for actively deferring employees. Seven states have only flat administrative fees, 14 have only asset-based administrative fees, and 2 states, Montana and Texas, have a combination of flat and asset-based administrative fees. Of the 14 states with only asset-based fees, 7 states have higher asset-based fees than Texas.

Through the program's website, brochures, and newsletters, the Texa$aver Program has disclosed all fees. The translation of those fees for an individual's account is not easy. The website and paper statements do not isolate fees for review. Fees are listed as part of "other activities" which includes cash earnings and dividends. Plan fees are not summed up on statements to make it easy to distinguish the costs of the program. Due to the difficulty in applying those fees to an individual account, Texa$aver participants would benefit from more detailed information in quarterly account statements and examples with average monthly and annual costs. Recommendation 1 requires the Employees Retirement System to disclose plan fees and investment fees in a reader-friendly format on quarterly Texa$aver statements, with information on specific amounts applied to individual accounts so that plan participants have an easy way to understand the total cost of investing in the Texa$aver Program.

INVESTMENT OPTIONS WITH TEXA$AVER

The Texa$aver Program has evolved since 1991 when the responsibility for the deferred compensation program

FIGURE 64
ADMINISTRATION AND SERVICE FEES FOR STATE DEFERRED COMPENSATION PLANS, 2008

STATE	AMOUNT	FREQUENCY
PLANS WITH FLAT FEES		
California	$1.50	Monthly
Georgia	$4.17	Monthly
Missouri	$3.00	Monthly
Montana*	$0.42	Monthly
New Mexico	$4.92	Monthly
New York	$1.17	Monthly
Oklahoma	$1.00	Monthly
Texas*	$0.83	Monthly
Wisconsin	$1.00-$5.50	Monthly
PLANS WITH ASSET-BASED FEES		
Alaska	0.1500%	Annual
Connecticut	0.1200%	Annual
Hawaii	0.2310%	Annual
Kentucky	0.3200%	Annual
Maryland	0.1900%	Annual
Minnesota	0.1000%	Annual
Montana*	0.15%–0.35%	Annual
Oregon	0.2200%	Annual
South Carolina	0.1530%	Annual
South Dakota	0.2600%	Annual
Tennessee	0.2500%	Annual
Texas*	0.1999%	Annual
Vermont	0.1500%	Annual
Virginia	0.2800%	Annual
Washington	0.1300%	Annual
Wyoming	0.5000%	Annual
STATE PLANS WITH NO ADMINISTRATIVE FEES		
Alabama	Colorado	
Florida	Idaho	
New Hampshire	Ohio	

*Indicates a state that has both flat fees and asset-based fees.
SOURCE: Legislative Budget Board.

transferred to the Employees Retirement System (ERS) from the Comptroller of Public Accounts (CPA). At the time of the transfer, the 457 plan had 250 vendors and over 300 products. ERS made significant changes to the deferred compensation program during the 1990s to make it user friendly and affordable for state employees. Though having a choice of funds is important, according to *Smart Money* magazine, November 2006, having too many options may be overwhelming for deferred compensation participants and may contribute to the lack of participation. Almost 20 percent of non-Texa$aver participants who responded to the LBB survey on Texa$aver said they did not participate because they found it confusing to enroll or select investments.

Currently, the Texa$aver Program offers 11 core funds plus 10 target retirement date funds whose investments are allocated according to years of planned retirement. In addition, Texa$aver participants have the option of choosing their own investments through the Schwab Personal Choice Retirement Account, which is a self-directed brokerage account. The program offers a balanced choice of options including stable value, money market, small-cap, mid-cap, large-cap, and international fund. **Figure 65** shows a list of the Texa$aver Program options and related investment fees.

As mentioned previously, the cost of investing can have a significant impact on the savings an individual can accumulate. Investment funds group administrative costs into an expense ratio, which includes the costs for managing a specific fund. These expenses are deducted directly from returns and they are in addition to the plan administrative fees, such as the Texa$aver Program fees.

Experts recommend that investors select funds that have expense ratios that are less than 1.00 percent for funds that invest in large U.S. companies and no more than 1.25 percent for funds that invest in small or international companies. Within the Texa$aver Program, the cost of investing based on fund expense ratios falls within these guidelines. Of all the funds in the program, only three have gross expense ratios of 1 percent or more. ERS has negotiated rebates for five of the

FIGURE 65
TEXA$AVER PROGRAM INVESTMENT OPTIONS, 2008

FUND NAME	FUND TYPE	GROSS EXPENSE RATIO	REBATES	NET EXPENSE RATIO
CORE FUNDS				
Fidelity Retirement Money Market Fund	Money Market	0.42%	0.25%	0.17%
ING Stable Value Account	Stable Value	0.19%	0.00%	0.19%
Fidelity U.S. Bond Index Fund	Bond	0.32%	0.00%	0.32%
Vanguard Wellington Fund	Balanced	0.16%	0.00%	0.16%
Davis New York Venture Fund A	Large Cap Value	0.85%	0.45%	0.40%
Vanguard Institutional Index Fund	Large Cap Blend	0.03%	0.00%	0.03%
Vanguard Growth Index Fund	Large Cap Growth	0.07%	0.00%	0.07%
First Eagle Fund of American Y	Mid Cap Blend	1.40%	0.40%	1.00%
Munder Mid-Cap Core Growth Fund Y	Mid Cap Growth	1.08%	0.25%	0.83%
Lord Abbett Small Cap Value Fund I	Small Cap Value	0.93%	0.00%	0.93%
Fidelity Diversified International Fund	Foreign Stock	1.02%	0.25%	0.77%
TARGET RETIREMENT DATE FUNDS				
Target Today Fund	Target Retirement	0.62%	0.25%	0.37%
Target 2010 Fund	Target-Date 2010–2014	0.65%	0.25%	0.40%
Target 2015 Fund	Target-Date 2015–2019	0.66%	0.25%	0.41%
Target 2020 Fund	Target-Date 2020–2024	0.67%	0.25%	0.42%
Target 2025 Fund	Target-Date 2025–2029	0.67%	0.25%	0.42%
Target 2030 Fund	Target-Date 2030–2034	0.68%	0.25%	0.43%
Target 2035 Fund	Target-Date 2035–2039	0.69%	0.25%	0.44%
Target 2040 Fund	Target-Date 2040–2044	0.69%	0.25%	0.44%
Target 2045 Fund	Target-Date 2045–2049	0.69%	0.25%	0.44%
Target 2050 Fund	Target-Date 2050+	0.69%	0.25%	0.44%

Source: Employees Retirement System.

core funds and all ten of the Wells Fargo Retirement Date Funds. After rebates, all but one fund has a net expense ratio of less than 1 percent; the remaining fund, the First Eagle Fund, has a net expense ratio of 1 percent.

Some respondents to the LBB Texa$aver Program survey provided feedback on the number of funds and stated that they would like a greater selection of funds. This feedback clashes with the idea of "choice overload" where too many funds can have a paralyzing effect on new participants wanting to enroll and choose investments. Examining other states shows that, on average, states provide 18 fund choices. **Figure 66** shows an overview of states' fund options.

FIGURE 66
FUND OPTIONS AMONG STATE DEFERRED COMPENSATION PROGRAMS, 2008

NUMBER OF FUNDS	ALL STATES
Average Number of Funds*	18
Median Number of Funds*	17
FUND OPTIONS	**NUMBER OF STATES**
Stable Value Fund	46
FDIC or NCUA-Insured Option	2
Target Retirement or Lifecycle	38
Socially Responsible Investment (SRI)	19
Self-Directed Brokerage Option	21

*If a state had target retirement date or lifecycle funds, those groups of funds were counted as one since the intent is for an investor to choose only one.
Source: Legislative Budget Board.

Texas has fewer funds than most other states. To compare other states' plans, target retirement date funds or lifecycle funds were counted as a single fund since an investor is meant to choose only one. Using this methodology, Texas only has 12 funds—11 core and a set of target retirement date funds. One of the most common fund options across states was a stable value fund, which is a fund option with a lower rate of return and protection of principal. Forty-six states, including Texas, offer a stable value fund. Target retirement date funds or lifecycle funds were also common, with 38 states offering them, including Texas. Twenty-one states, including Texas, also offered a self-directed brokerage account which offers plan participants access to thousands of funds.

One option that the Texa$aver Program does not offer is a Federal Deposit Insurance Corporation (FDIC) insured fund option. An FDIC-insured option provides protection against losses. The FDIC is an independent federal agency created in 1933 to promote public confidence and stability in the nation's banking system. The maximum insurance amount is $250,000 per depositor, per insured bank. This amount includes principal and accrued interest up to a total of $250,000. The $250,000 amount applies to all depositors of an insured bank. The National Credit Union Administration (NCUA) provides a similar function to FDIC for depositors to a credit union. At least two states offer an FDIC-insured or NCUA-insured option within their deferred compensation plans. These states include Arizona, which offers a 3.25 percent interest on an NCUA-insured fund, and Wisconsin, which offers an FDIC-insured option. Like a stable value fund, an insured fund option would not be ideal for all Texa$aver participants because it offers a lower rate of return. However, offering an insured fund option may encourage more state employees to invest because they would not have to worry about losing money. Given the financial crisis in fall 2008, this may be a timely consideration for the Texa$aver Program.

Another option that the Texa$aver Program does not offer is a Socially Responsible Investment (SRI) fund. Nineteen other states offer an SRI fund in their deferred compensation program. With mutual funds, it is often difficult to decipher what types of industries and companies in which a given fund invests. An SRI fund is one that invests in businesses providing products or services that adhere to specific criteria. Some SRI funds will focus on specific issues, such as the PAX World Balanced Fund, offered within Iowa's plan, evaluates environment, social, and governance criteria before selecting companies in which to invest. An SRI fund may be a viable option for the Texa$aver Program that ERS should consider adding to the program as a core fund. Public sector employees tend to have an interest in public policy and service, and government employees may be interested in this type of investment option.

Recommendation 2 directs the Employees Retirement System to add a Federal Deposit Insurance Corporation (FDIC)-insured fund option and a Socially Responsible Investment Fund option to the Texa$aver Program. Including these funds will also warrant educational efforts by the program so that participants can understand these new options.

AUTOMATIC ENROLLMENT

Automatic enrollment for deferred compensation plans transforms voluntary 401(k), 457, and 403(b) plans from opt-in plans into opt-out plans (a 403(b) plan is the deferred

compensation plan typically offered at universities and non-profit employers). These plan types are typically offered as voluntary retirement plans intended to supplement other types of savings an individual might have, such as Social Security and pensions. As an opt-in plan, an employee has to make the decision to participate in a 401(k) or 457 plan and then take the steps to enroll. Automatic enrollment addresses employee inertia by requiring employees to make an active decision to not participate, otherwise they are automatically enrolled.

Texas sought to address employee inertia and boost individual retirement savings within the state employee population with the enactment of House Bill 957, Eightieth Legislature, 2007. This bill created the automatic enrollment of new state agency employees after January 1, 2008 into the 401(k) plan at 1 percent of their gross salary. Only employees who are eligible for the Texa$aver 401(k) plan are subject to automatic enrollment; higher education employees, who are eligible for the 457 plan and generally a university-sponsored 403(b) plan, are not included in automatic enrollment. Participants who are enrolled under this process have their contributions invested in an age-appropriate target retirement date fund unless they select another fund. As of October 2008, the 401(k) plan had 18,425 auto-enrollees. **Figure 67** shows information on 2008 automatic enrollments.

FIGURE 67
AUTOMATIC ENROLLMENT IN TEXA$AVER 401(k) PLAN THROUGH OCTOBER 2008

Total auto-enrollees	26,002
Total auto-enrollees still contributing	18,425
Percentage of new employees declining	6.33%
Retention rate for auto-enrollees	70.86%

SOURCE: Employees Retirement System.

As of October 2008, approximately 45 percent of Texa$aver 401(k) plan participants were auto-enrollees. Though increasing participation through automatic enrollment helps employees to save, the employees who are now enrolled through this process have a default deferral rate equal to 1 percent of their gross salary, which is a low savings rate.

For employers considering adding automatic enrollment to their deferred compensation plans, there are several key policy questions to consider:

- Who will automatic enrollment apply to? New hires only? All employees?
- What is the default deferral rate for any employees automatically enrolled?
- Will there be automatic escalation of the deferral rate on a periodic basis?
- What will the default investment product be for automatic enrollees?
- What is the opt-out timeframe before contributions will be deducted?

In crafting automatic enrollment features within their deferred compensation plans, public and private sector employer have taken slightly different approaches. Texas is one of five states that currently employ automatic enrollment in their deferred compensation plans. **Figure 68** shows the states and plans that feature automatic enrollment.

As shown in **Figure 68**, the five states that have implemented automatic enrollment use a low default enrollment level. Three of these states allow employees 30 to 90 days to opt out of the program and receive refunds from contributions. For default investment funds for those employees who are auto-enrolled, two of these states use target retirement date funds, one uses a balanced growth fund, and one uses a stable value fund. Employees can opt out at any time.

FIGURE 68
STATES THAT USE AUTOMATIC ENROLLMENT FOR DEFERRED COMPENSATION PLANS, 2008

STATE	PLAN TYPE	AUTO-ENROLLED POPULATION	DEFAULT DEFERRED AMOUNT
Indiana	457	New employees on or after July 1, 2007	$15 per bi-weekly paycheck
South Dakota	457	New employees; date undetermined	Undetermined
Texas	401(k)	New employees on or after January 1, 2008	1% per monthly paycheck
Virginia	457	New employees on or after January 1, 2008	$20 per semi-monthly paycheck
West Virginia	457	New employees on or after July 1, 2007	$10 per semi-monthly paycheck

SOURCE: Legislative Budget Board.

Currently, none of the five states listed in **Figure 68** offer automatic escalation within their plan. Automatic escalation is a feature where at regularly scheduled period, usually once per year, a plan participant's deferral rate is automatically increased by a pre-determined amount. Automatic escalation typically continues until the deferral rate of an individual participant reaches a pre-determined maximum. **Figure 69** shows an example of how automatic enrollment and automatic escalation could work together to help employees build retirement savings.

FIGURE 69
EXAMPLE OF AUTOMATIC ESCALATION

YEAR	DEFERRAL RATE
1	Employee initially enrolls at 3%
2	Increased to 4%
3	Increased to 5%
4	Increased to 6%

SOURCE: Legislative Budget Board.

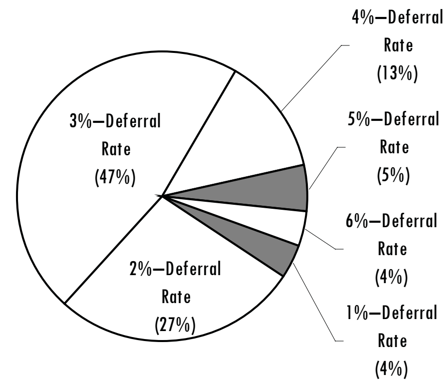
Within the private sector, automatic enrollment of participants in 401(k) plans has seen a significant increase since the passage of the Pension Protection Act of 2006. According to Deloitte's *401(k) Benchmarking Survey, 2008*, approximately 42 percent of the 436 plans surveyed now contain automatic enrollment within their plans; another 26 percent are considering offering it.

Default deferral rates under automatic enrollment for 401(k) plans in the private sector are somewhat different from comparable public sector plans. For the Deloitte survey respondents, 68 percent reported a default contribution rate of 3 percent of employee salary; 16 percent of respondents reported a default contribution rate of less than 2 percent of employee salary.

Vanguard, a mutual fund company and deferred compensation plan provider, completed a study on automatic enrollment in 2007 with detailed information on 55 plans that have implemented this feature. Of these 55 plans, 87 percent applied automatic enrollment to new hires only; the remaining 13 percent either applied to all employees or initially started with new hires and then expanded to all employees. The default deferral rates for auto-enrolled plans varied within the Vanguard study. **Figure 70** provides more information.

Forty-seven percent of the 55 plans included in the Vanguard study used a default deferral rate equal to 3 percent of an

FIGURE 70
DEFAULT DEFERRAL RATES FOR PLANS USING AUTOMATIC ENROLLMENT, 2007



SOURCE: Vanguard.

employee's salary. In addition, 55 percent of these plans include an automatic employee contribution increase of 1 percent per year.

Based on the LBB survey on Texa$aver, automatic enrollment is the least important feature to state and higher education employees. In the survey, respondents were asked to rank six features in terms of what would make them more likely to participate (non-participants) or more likely to participate at a higher rate (Texa$aver participants). The six features included (1) automatic enrollment, (2) Roth 401(k)/457, (3) employer match, (4) different fund options, (5) educational opportunities, and (6) investment advisor service. Of these features, both Texa$aver participants and non-participants typically ranked automatic enrollment last. Though weighing employee feedback is helpful in determining what changes, if any, to make to the Texa$aver Program, based on both the experience of other employers and the experience of Texas' automatic enrollment program, the expansion of automatic enrollment with an auto-escalation may prove to be the most successful strategy to encourage employees to save for retirement.

With the current automatic enrollment, the opt-out rate by new employees for the Texa$aver Program has been less than 7 percent, and the long-term retention rate of auto-enrollees is 71 percent. Though expanding automatic enrollment to all employees would likely increase the opt-out rate, some employees would not decline. By adding an automatic escalation feature, employees would not only be enrolled in the plan, but also benefit from small increases each year to help them build retirement savings. Both automatic enrollment and automatic escalation can be declined by an employee, but the benefit comes from making an active

choice to not participate or increase contributions, rather than an employee having to make an active choice to participate. Recommendation 3 would expand automatic enrollment to include all state agency employees as a one-time event. To accommodate the one-time event, automatic enrollment for all state agency employees into the 401(k) could be part of the open enrollment during the summer 2010. Much like the current automatic enrollment for new state employees, this enrollment would apply only to the population of employees who currently qualify for the Texa$aver 401(k) program; this process would not apply to employees of higher education institutions.

Recommendation 3 would also include an automatic employee contribution escalation feature which would increase employee contributions by 1 percent each year unless the employee opts out. This escalation feature would include a maximum contribution cap, set at 5 percent of an employee's salary.

EMPLOYER MATCH

Many employer-sponsored retirement savings plans in both the public and private sector offer an employer contribution. An employer contribution is a deferred compensation program feature where an employer offers a cash contribution, usually in the form of a match, based on an employee contributing to the program. An employer match is often structured in terms of a specified dollar amount or percentage of salary, up to a maximum.

An employer contribution has traditionally been one of the most effective incentives to encourage employees to save as part of a voluntary retirement plan. According to Deloitte, in its 401(k) Benchmarking Survey, 2008 edition, 62 percent of employers offered a matching contribution.

Though public sector employers are less likely to offer an employer match, 12 states currently offer one. One possibility for why employer contributions for defined contribution plans in the public sector is less likely is because these employers also tend to have traditional defined benefit plans. Of the 12 states that offer an employer contribution in their 401(k) or 457 plans, 11 of them also have traditional pension plans. **Figure 71** shows additional information on plans specifics for the 12 states that offer a match.

Offering an employer matching contribution typically provides a strong incentive for employees to save as part of the defined contribution plans. States that have implemented an employer match have seen a significant increase in participation. The National Association of Government Defined Contribution Administrators, Inc. (NAGDCA) does a biannual survey of public sector plans. From its 2006 survey, 10 of the states offering an employer match detailed their experiences with implementing a match. Four states, including Indiana, Michigan, Missouri, and Tennessee, have participation rates in excess of 50 percent, at least part of which is due to the match. Both Delaware and Iowa reported that their participation rates doubled after implementing a match.

Private sector employers tend to offer higher matches. One of the most common match structures is a $0.50 match for every $1.00 in employee contribution, up to 3 percent of an employee's salary. Offering this level of match to state employees would cost Texas more than $60 million annually.

One option for the state would be to establish an employer match for the Texa$aver 401(k) plan similar to the match offered by other states. This option would allow the state to offer a small match, which would provide an incentive to employees to save, while still being affordable to the state. **Figure 72** shows examples of the cost of a small match based on several scenarios of match amounts and participation levels.

Another match option for the state of Texas is to offer a time-limited employer match for the Texa$aver 401(k) plan to encourage employee savings. West Virginia offers a $100 per year match for the four-year period beginning in fiscal year 2008. This match program is based on a minimum $10 monthly contribution. Colorado has also used a temporary match, which increased participation in the state's 457 plan significantly. Colorado offered a four-year period for a match, from January 2001 to May 2004. The match was structured in such as way that it offered a 3 percent match in 2001 and 2002, 2 percent in 2003, and 1 percent in 2004.

Recommendation 4 would amend Texas Government Code, Chapter 609, to offer an employer match within the Texa$aver 401(k) plan, subject to appropriations by the Legislature. Recommendation 5 would add a contingency rider in the 2010–11 General Appropriations Bill to appropriate funds to the Comptroller of Public Accounts for an employer match of $10 per month ($120 per year) for participants within the Texa$aver 401(k) plan. These funds would be transferred to ERS during payroll processing and distributed among 401(k) participant accounts. These two recommendations would be subject to available funds and approved only if the pension system has sufficient

FIGURE 71
STATES WITH EMPLOYER MATCH FOR DEFERRED COMPENSATION PLANS, 2008

STATE	PLAN TYPE	VOLUNTARY DEFERRED COMPENSATION MATCH	MANDATORY RETIREMENT PLAN
Delaware	457	Offered in fiscal year 2008, but suspended in fiscal year 2009 to balance budget	**Defined Benefit** – Employees contribute 3% of salary that exceeds $6,000 per year. The state contributes 7.44%.
Indiana	457	Up to $15 per biweekly paycheck ($390 annually)	**A two-part plan** – For the pension, the employer contributes; no employee contribution. For the Annuity Savings, the state contributes 3% of an employee's salary; employees can voluntarily contribute up to an additional 10% of salary.
Iowa	457	Up to $75 per month ($900 annually)	**Defined Benefit** – Employees contribute 4.10% of salary; the state contributes 6.35% for the employee.
Maryland	457	Up to $600 annually	**Defined Benefit** – Employees contribute 5% of salary; the state contributes an amount determined annually.
Michigan	401(k)	Up to 3%	**401(k)** – State contributes 4%. The additional 3% is the matching contribution based on an employee's voluntary contribution.
Missouri	457	Up to $25 per month with at least 12 months of service	**Defined Benefit**
North Dakota	457	Up to 4% may be vested in a member account. The employer match will vest in a member account. While this does not increase the employer contribution overall, it allows members who cash out to roll it over to another pension system or retirement savings account.	**Defined Benefit** – Employer contributes 4.12% to retirement pool of funds; employee contributes 4% to a member account. If the employee also contributes to the 457 plan, 4.00% of the employer contribution goes to the member account; the other 0.12% is deposited to the retirement pool.
Oklahoma	457	Up to $25 per month as part of 401(a) account.	**Defined Benefit** – State contributes 13.5%; employee contributes 3.5%.
Tennessee	401(k)	Up to $50 per month ($600 annually).	**Defined Benefit** – State contributes 5% plus additional amount determined each year for actuarial soundness; no employee contribution.
Virginia	457	Up to $20 per pay period ($480 annually)	**Defined Benefit** – State contributes a percentage based on total payroll; employee contribution is 5%.
West Virginia	457	Up to $100 per year for four years	**Defined Benefit** – State contributes 10.5%; employee contribution is 4.5%.
Wyoming	457	Up to $20 per month ($240 annually).	**Defined Benefit** – State contributes 5.68%; employee contributes 5.57%.

Source: Legislative Budget Board.

FIGURE 72
ANNUAL COST OF OFFERING AN EMPLOYER MATCH WITHIN THE TEXA$AVER 401(K) PLAN

MATCH AMOUNT		ANNUAL COST BY NUMBER OF EMPLOYEES PARTICIPATING (IN MILLIONS)		
MONTHLY	ANNUAL	50,000	75,000	150,000
$10	$120	$6.0	$9.0	$18.0
$15	$180	$9.0	$13.5	$27.0
$20	$240	$12.0	$18.0	$36.0
$25	$300	$15.0	$22.5	$45.0

Source: Legislative Budget Board.

funding. Sufficient pension funding is defined as a 90 percent funded ratio and the Employees Retirement System receiving normal costs.

The cost for a $10 per month match ($120 annually) is $17.1 million per year if 142,860 employees participated. This estimate deducts the opt-out rate for automatic enrollment, 6.33 percent, from 152,514 employees for a total of 142,860 employees who would qualify for a match.

ROTH 401(K) OPTION

With the enactment of the federal Pension Protection Act of 2006, one of the retirement savings features made permanent was the Roth 401(k). Originally permitted in 2001, since its

permanency in 2006 the growth of the Roth 401(k) has increased significantly.

Tax benefits are one of the defining features of saving in retirement accounts such as the 401(k) and the individual retirement account (IRA). With the advent of Roth options, the tax benefits from these programs offer two distinct benefits. Traditional 401(k) plans provide a pre-tax benefit; contributions for these plans, which are deducted from employee paychecks, are deducted from pay before income taxes are withheld. The money saved in a traditional 401(k) grows tax-deferred and is taxed upon withdrawal. Roth savings offer an after tax benefit; the Roth 401(k) has the same advantages to savers as a Roth IRA. With a Roth 401(k), taxes are paid up front and withdrawals, including earnings, are tax-free.

The difference in the tax benefits offered by traditional 401(k)s compared to Roth 401(k)s is significant, and the population that may benefit from a Roth 401(k) varies. In long-term saving for retirement, one consideration is future tax rates. There is no certainty about what future income tax rates will be. Employees who are most likely to benefit from a Roth 401(k) include:

- an employee who anticipates being in a higher tax bracket during retirement; and
- an employee who would like to qualify for a Roth IRA, but does not due to income limits.

For many savers, contributing to a combination of pre-tax options such as the traditional 401(k) and the after tax options such as the Roth 401(k) may provide effective means to mitigate risks of future tax rates.

According to Deloitte's 401(k) Benchmarking Survey, 2008, the Roth 401(k) is one of the fastest developing features of 401(k) programs. In 2008, 23 percent of plans surveyed reported offering a Roth 401(k), which is nearly double the 12 percent of plans reporting one in 2007. Another 28 percent of 401(k) plans are planning to add a Roth option or looking at the possibility.

The public sector has been slower to adopt Roth 401(k) options. Out of the 50 states, only five states offer a Roth 401(k) option. These states include Kentucky, Michigan, North Carolina, South Carolina, and Tennessee. Part of why states have not adopted a Roth option within their deferred compensation plans is that 37 states only offer a 457 plan; under current federal law, Roth options are not permitted for 457 plans. As of August 2008, federal legislation is pending that would permit Roth options within 457 plans. At least two states, Minnesota and Oregon, are interested in offering a Roth 457 plan when it becomes available. Some public universities that tend to offer 457 and 403(b) plans are offering Roth 403(b) plans, which were also permitted within the Pension Protection Act of 2006. Texas A&M University now offers a Roth option in its 403(b) plan.

According to the LBB Texa$aver survey, employee interest in offering a Roth option within the 401(k) and 457 plans ranks as the second highest priority behind an employer match. Twenty-five percent of survey respondents who do not participate in the Texa$aver Program ranked a Roth option as the second highest priority of six different plan features that would encourage them to participate in the Texa$aver Program; 32 percent of survey respondents who do participate in Texa$aver ranked Roth second. In addition, of the survey respondents who provided information on the types of non-Texa$aver retirement savings plans that they contribute to, 35 percent responded that they contribute to a Roth IRA.

Recommendation 6 would amend Texas Government Code, Chapter 609, to require the Employees Retirement System (ERS) to offer a Roth 401(k) plan option and a Roth 457 option once it is permissible by federal law. Since adding a Roth 401(k) would essentially add another plan, costs would be paid from monthly participant fees.

RETIREMENT PLANNING EDUCATION

Tying into all of the major features discussed is financial literacy and education regarding retirement planning. The LBB Texa$aver survey and national trends in personal finance suggest that some state employees may not fully understand how to invest or how to participate in the Texa$aver Program. While some employees do enroll, they may not be sure of the best ways to build and maintain retirement savings once they have started.

Employees need to understand how to enroll in the Texa$aver Program and select investments. In the LBB Texa$aver survey, some employees' feedback suggested a need for education about retirement planning. Of survey respondents who do not participate in the Texa$aver Program, 19.6 percent cited confusion over enrolling or choosing investments as one of their reasons for not participating, and 19.3 mentioned not knowing about the Texa$aver Program.

Once an employee starts saving for retirement, savings need to be maintained and participation adjusted from time to time to account for changes in circumstances and the market. Employees should periodically evaluate whether they are contributing the right amount to reach retirement goals and

if their investment allocation is appropriate to those goals. To meet the needs of both new participants and ongoing participants, ERS includes a two-part advisor service in the Texa$aver Program. The basic service allows access to Financial Engines, an online software that allows participants to run detailed retirement savings scenarios based on their goals. Participants also receive an annual personal evaluation statement with recommendations for saving. For participants who want more advice, for an additional service fee they can use a Professional Account Manager. Employee feedback from the LBB Texa$aver survey suggests that current participants may not be doing periodic evaluations. Of the survey respondents who do participate in Texa$aver, 57.3 percent of them rarely or never change their contribution rate.

Another concern about participants' maintenance of retirement savings is highlighted by the loans used by Texa$aver Program participants. A loan is one of the features offered in deferred compensation programs. Loans from a 401(k) can be helpful if an account holder is in need. Both plans within the Texa$aver Program include a loan option. There is no credit check and a borrower pays back his or her account with interest that may be lower than what would be paid to a bank.

To take out a loan within the program, participants must have account balances of at least $1,050. The plan charges a $50 loan application fee (which is part of the $1,050 minimum balance required) and an ongoing $2 monthly maintenance fee while the loan is outstanding. Loan amounts are permitted under the following rules:

- if the balance is $1,000 to $10,000, the entire balance can be borrowed;
- if the balance is $10,001 to $20,000, up to $10,000 can be borrowed; and
- if the balance is $20,001 and higher, a participant can borrow 50 percent of the balance, not to exceed $50,000.

Financial advisors generally discourage taking loans against 401(k) or 457 accounts. ING, the Texa$aver Program vendor, notes some disadvantages to taking loans from a Texa$aver account. The interest paid back on the loan may be less than what would have been earned had it been invested. Loan payments are also made with after-tax dollars, which negates the pre-tax advantage of the current program. If an employee leaves state employment with a loan balance, the balance is due upon termination unless loan payments continue to be made to ING. If a participant defaults on the loan, it is taxable. In addition, many participants will cease monthly contributions while repaying a Texa$aver loan, which can affect progress in reaching retirement goals.

The Texa$aver Program participants use loans. As of December 2007, the Texa$aver Program participants had outstanding loans totaling $85.2 million; $80.2 million from the 401(k) plan and $5.0 million from the 457 plan. These outstanding loan amounts stem from 24,683 loans; the average loan amount in the 401(k) plan totaled $3,540 and the average loan amount in the 457 plan totaled $2,455. Of these loans, 8,792 participants had more than one loan. During the discussion of the October 2007 ERS Board Meeting, anecdotal information regarding Texa$aver loans indicates that a number of loans are taken out towards the end of the calendar year, suggesting that participants are using plan balances to do holiday shopping.

ERS offers a number of educational programs throughout the year. The two most frequent events are the "Be Benefit Wise and Ready, Set, Retire" program offered at least once a quarter and the Texa$aver Fair, which coincides with the National Save for Retirement week in October. In addition, Texa$aver Program information is also presented at the Summer Enrollment Benefits Fairs and specialized webcasting. During fiscal year 2007, 20,732 employees attended 739 education programs.

Despite the extensive educational efforts by ERS, employee feedback and participant behavior suggests that more education would be helpful to state employees. This need for additional education would be intensified if any of the previous recommendations described in this report are implemented. Plan fees, new fund options, automatic enrollment and escalation, a Roth 401(k), and an employer match would all require increased educational efforts by ERS and its Texa$aver Program vendor. Recommendation 7 would require the Employees Retirement System to revise its educational offerings in order to help employees not only enroll in the Texa$aver Program but also maintain savings efforts over time.

FISCAL IMPACT OF THE RECOMMENDATIONS

Implementing these recommendations would result in a total cost of $34.3 million in All Funds for the 2010–11 biennium. These biennial costs are allocated as follows: $19.5 million in General Revenue Funds, $2.1 million in General Revenue–Dedicated Funds, $6.9 million in Federal Funds, and $5.8 million in Other Funds.

Recommendation 1 relates to the disclosure of plan fees. There is no fiscal impact for this recommendation.

Recommendation 2 would add two new fund options to the Texa$aver Program, a FDIC-insured option and a SRI fund option. There is no fiscal impact for this recommendation.

Recommendation 3 expands automatic enrollment and adds auto-escalation for the 401(k) plan. Administrative fees for the program are funded from member contributions; new accounts added through automatic enrollment would be subject to the existing fees. There is no cost for this recommendation.

Recommendations 4 and 5 add a small employer match of $10 per month ($120 per year) per participant in the Texa$aver 401(k) plan. The estimate assumes participation by 142,860 employees (152,514 employees minus the automatic enrollment opt-out rate of 6.33 percent). The employer match comprises the total $34.3 million costs for the 2010–11 biennium. The cost for the employer match includes conservative figures that reflect the likely maximum cost. Since the long-term retention rate for auto-enrollees is 71 percent, the potential cost for an employer match of $10 per month would likely be lower than $34.3 million per biennium.

Recommendation 6 adds a Roth 401(k) feature. Administrative fees for the program are funded from member contributions; a Roth 401(k) account would incur the same monthly costs that the current 401(k) and 457 plans do. There is no cost for this recommendation.

Recommendation 7 directs ERS to extend educational efforts. There is no cost for this recommendation.

Figure 73 shows the fiscal impact of these recommendations.

The introduced 2010–11 General Appropriations Bill does not address these recommendations.

FIGURE 73
FIVE-YEAR FISCAL IMPACT, FISCAL YEARS 2010 TO 2014

FISCAL YEAR	PROBABLE SAVINGS/ (COST) IN GENERAL REVENUE FUNDS	PROBABLE SAVINGS/ (COST) IN GENERAL REVENUE–DEDICATED FUNDS	PROBABLE SAVINGS/ (COST) IN FEDERAL FUNDS	PROBABLE SAVINGS/ (COST) IN OTHER FUNDS
2010	($9,771,615)	($1,028,591)	($3,428,637)	($2,941,341)
2011	($9,771,615)	($1,028,591)	($3,428,637)	($2,941,341)
2012	($9,771,615)	($1,028,591)	($3,428,637)	($2,941,341)
2013	($9,771,615)	($1,028,591)	($3,428,637)	($2,941,341)
2014	($9,771,615)	($1,028,591)	($3,428,637)	($2,941,341)

Source: Legislative Budget Board.

END THE USE OF GENERAL REVENUE FUNDS TO PAY FOR INSURANCE COMPANY EXAMINATIONS

The Texas Department of Insurance conducts periodic examinations of insurance carriers based in the state. The examinations assess the ability of each carrier to meet its financial liabilities and the carrier's compliance with state law. Insurers pay an examination fee to cover the costs of the examination and an assessment to cover the overhead costs. Insurers receive tax credits for fees and assessments paid.

Revenue from the fees and assessments is deposited to the Insurance Operating Account, but the credits are taken against the insurance premium tax, which is General Revenue Funds. In effect, General Revenue Funds are being used to pay for insurance company examinations.

CONCERN

- Under the existing structure of insurance company examination fees, overhead assessments, and tax credits for those charges, insurance company examinations are, in effect, paid for with General Revenue Funds.

RECOMMENDATION

- **Recommendation 1:** Repeal Texas Insurance Code, Sections 221.006, 222.007, 223.009, 401.151(e), and 401.154 to eliminate the credit for examination fees and overhead assessments.

DISCUSSION

Insurance premium taxes are imposed on insurers doing business in Texas. The tax rates vary by the line of insurance, as shown in **Figure 74.**

FIGURE 74
TAX RATES FOR INSURANCE PREMIUMS TAX

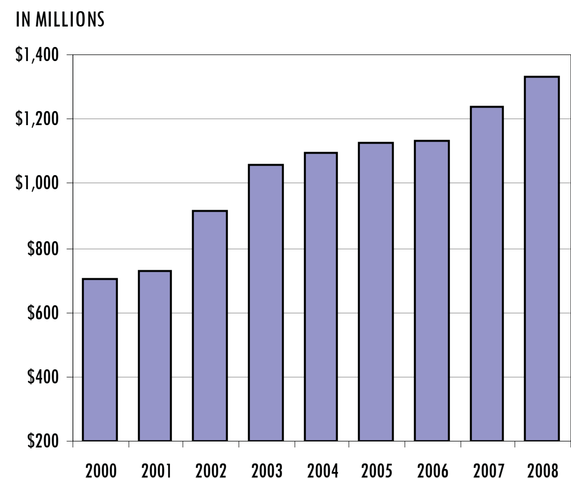
INSURANCE LINE	TAX RATE PERCENTAGE OF TAXABLE GROSS PREMIUMS
Property and Casualty	1.60%
Life, Accident, and Health	1.75%
Title	1.35%
Reciprocal or Inter-insurance Exchanges	1.70%
Unauthorized Insurance, Surplus Lines, and Independently Procured	4.85%

Source: Comptroller of Public Accounts.

The Comptroller of Public Accounts collects the taxes and deposits them to the General Revenue Fund. One-fourth of the tax is constitutionally dedicated to public education and is transferred to the Foundation School Fund for distribution to school districts. Because each dollar in public school funding from the Foundation School Fund reduces General Revenue Fund spending for public schools by $1, essentially, 100 percent of the insurance premium tax is General Revenue Funds.

The state collected more than $1.3 billion in insurance premium taxes in fiscal year 2008. **Figure 75** shows a history of tax collections for the insurance premium tax from fiscal year 2000 to fiscal year 2008.

FIGURE 75
INSURANCE PREMIUM TAX COLLECTIONS
FISCAL YEARS 2000 TO 2008



Note: Collections shown are net of all credits.
Source: Comptroller of Public Accounts.

EXAMINATIONS, FEES, AND ASSESSMENTS

The Texas Department of Insurance (TDI) conducts periodic examinations of insurance companies domiciled in Texas to evaluate their ability to meet financial obligations and to assess the carrier's compliance with state law. TDI can examine a carrier as often as TDI considers necessary, but not less frequently than once every five years. TDI is also responsible for examining foreign companies doing business

in the state, but TDI rules allow the agency to rely on examinations performed by the insurance regulatory agency in each carrier's home state to satisfy this requirement. As a result, TDI performs few examinations of foreign carriers.

In addition to financial examinations, TDI conducts quality of care examinations of Health Maintenance Organizations (HMOs) and Workers' Compensation Health Care Networks. These examinations occur at least every three years and evaluate each company's compliance with statute.

In fiscal year 2008, TDI performed 153 examinations at an average cost of $85,136 per examination, which includes direct, indirect, and overhead costs. TDI charges each insurer examined a fee to cover salaries of TDI employees and of third-party examiners hired by TDI, travel, and miscellaneous expenses of examiners. In addition, TDI imposes an overhead assessment on all domestic insurers to cover agency spending related to examinations. The assessments pay for operating expenses of the agency's Examinations Section, including support staff salaries, utilities, rent, office equipment, and supplies. TDI sets the rate of the overhead assessment annually.

In 2008, TDI charged Texas firms an overhead assessment of 0.00278 of 1 percent of assets plus 0.00967 of 1 percent of gross premiums, excluding premiums attributable to qualified pension plans. According to TDI, the maximum charge to any one insurer was more than $1 million, and at least 95 percent of that was overhead charge. **Figure 76** shows the amount of examination fees and overhead assessments billed and collected by TDI in fiscal years 2005 to 2008. Most of the cost of examinations is incurred in the form of the overhead assessment which spreads the cost of examinations over all domestic insurers. Revenue from the fees and assessments is deposited to Insurance Operating Account 0036 (General Revenue–Dedicated Funds).

Insurers and HMOs can claim a credit against the insurance premium tax for the examination fees and overhead assessments; Workers' Compensation Health Care Networks cannot claim a credit. Texas domiciled companies that maintain their books outside the state cannot claim credits for the travel portion of direct expenses. A company's credit may not exceed its tax liability. Credits cannot be carried forward to future years or back to previous years. As a result, the total amount of credits granted can be less than fees and charges collected by TDI.

Examination credits taken by Property and Casualty Insurers, Title Insurance Companies, and HMOs totaled $5.8 million in fiscal year 2007. **Figure 77** shows the total amount of examination and overhead credits taken by those insurance lines in fiscal year 2007.

Although not included in **Figure 77**, life, accident, and health insurers qualify for credits for examination fees and overhead assessments. Prior to fiscal year 2009, life insurers also received credits for valuation fees imposed to cover TDI's costs of checking life insurers' mortality reserves. Life insurers' filings reported valuation fees, examination fees, and overhead assessments in a way that made it difficult to determine the amount of examination and overhead credits separate from valuation credits. While it is difficult to determine the actual amount of examination and overhead credits taken by these insurers, examination fees and assessments collected from life, accident, and health insurers averaged $4.6 million per year in fiscal years 2004 through 2007. With the inclusion of credits for life, accident, and health insurers, tax credits to insurers for examination fees and overhead assessments total about $10.4 million per fiscal year.

Recommendation 1 would repeal the insurance premiums tax credits for examination fees and overhead assessments. Eliminating the credits would increase the amount of

FIGURE 76
COLLECTION OF EXAMINATION FEES AND OVERHEAD ASSESSMENTS
FISCAL YEARS 2005 TO 2008
IN MILLIONS

FISCAL YEAR	DIRECT EXAMINATION BILLING	OVERHEAD ASSESSMENT	QUALITY OF CARE BILLING	TOTAL BILLED	TOTAL COLLECTED
2005	$2.8	$8.3	$0.07	$11.2	$11.1
2006	$2.7	$11.1	$0.05	$13.9	$11.7
2007	$2.5	$8.2	$0.04	$10.7	$13.0
2008	$2.8	$10.2	$0.05	$13.0	$12.4

Source: Texas Department of Insurance.

FIGURE 77
CREDITS FOR EXAMINATION FEES AND OVERHEAD ASSESSMENTS FOR PROPERTY AND CASUALTY, HMOS, AND TITLE INSURANCE COMPANIES, FISCAL YEAR 2007 (IN MILLIONS)

LINE OF INSURANCE	CREDITS
Property and Casualty	$4.9
Title Insurance	0.2
Health Maintenance Organizations	0.6
TOTAL FOR THESE LINES	**$5.8**

SOURCE: Comptroller of Public Accounts.

insurance premiums tax due to the state by approximately $10.4 million per year, excluding the effect of other credits.

EFFECT OF OTHER CREDITS

In addition to the credits for examination expenses, companies receive insurance premium tax credits for guaranty fund assessments and certain Texas Windstorm Insurance Association (TWIA) assessments. Companies claim the examination and overhead credits before the guaranty and casualty pool credits because the guaranty and casualty pool credits, unlike the examination and overhead credits, do not expire. In some cases, insurers do not have enough premium tax liability to take the full amount of all credits available. For these insurers, repealing the examination and overhead credits would cause them to exhaust their guaranty and windstorm credits faster and resume paying insurance premium taxes sooner. In those instances, the gain to the General Revenue Fund from repealing the credit for examination fees and overhead assessments would be delayed, but not reduced or eliminated.

The effect of other credits will be particularly important for the next five years because of tax credits available to TWIA members for windstorm assessments related to hurricane damages in 2008. Insurers can take 20 percent of their TWIA credits each year for five years, and an insurer can take credits for more than five years if their tax liability is insufficient to exhaust the credits in five years.

RETALIATORY TAXES

Forty-nine states, including Texas, impose retaliatory taxes on insurers domiciled in other states. Retaliatory taxes encourage equal treatment of insurers engaged in interstate commerce. The Texas retaliatory tax applies if the aggregate taxes, fees, and assessments (net of credits) imposed on a Texas-based insurer by an insurer's state of incorporation are higher than those assessed on the out-of-state insurer writing insurance in Texas. Texas collected $33.5 million in retaliatory taxes in fiscal year 2007. Retaliatory taxes are included as part of the insurance premium taxes shown in **Figure 75**.

Under certain circumstances, the elimination of a Texas tax credit would reduce retaliatory taxes paid to this state by out-of-state insurers and increase the amount of retaliatory taxes paid by Texas companies in other states. Since TDI examines few out-of-state insurers, eliminating examination fees would have little impact on retaliatory taxes.

CONSIDERATION OF OTHER OPTIONS

Two other options for eliminating the General Revenue Fund loss from credits for examination fees and overhead assessments were considered. These options were repealing the examination fees and assessments or granting a credit for the fees against the insurance maintenance tax paid by insurers.

Insurance maintenance taxes are initially deposited to the General Revenue Fund then transferred to the Insurance Operating Account (General Revenue–Dedicated Funds). Appropriations from the maintenance tax and other insurance fees pay for TDI operations and, to a lesser extent, for programs at the following agencies: the Commission on Fire Protection, the Texas Cancer Council, the Department of State Health Services, the Texas Forest Service, the Texas Department of Transportation, the Office of Attorney General, and the Travis County Public Integrity Unit, which investigates allegations of insurance fraud. The Insurance Operating Account is a self-leveling account. After considering balances, fees, and other revenue collections in the account, TDI determines the amount of additional revenue necessary to fund expenditures from the account and sets maintenance tax rates to generate the needed revenue. Actual maintenance tax rates and the statutory maximum rates vary by line of insurance as shown in **Figure 78**.

Either repealing the examination fees and overhead assessments or granting a credit for those charges against the maintenance tax would initially reduce revenue in the Insurance Operating Account. TDI would have to increase maintenance tax rates to replace the lost revenue.

These options were rejected for two reasons. First, unlike the examination fees and overhead assessment, maintenance taxes are imposed on both domestic and out-of-state insurers. Increasing the maintenance tax on foreign insurers would reduce retaliatory taxes paid to the General Revenue Fund and possibly increase the taxes paid by Texas-based insurers

FIGURE 78
MAINTENANCE TAX BASES AND RATES, FISCAL YEAR 2008

TYPE OF INSURANCE	BASE	STATUTORY MAXIMUM	TAX RATE
Motor Vehicle	Premium Value	0.200%	0.070%
Fire	Premium Value	1.250%	0.280%
Workers' Compensation	Premium Value	0.600%	0.069%
Casualty	Premium Value	0.400%	0.129%
Title	Premium Value	1.000%	0.127%
Life, Accident, and Health	Premium Value	0.040%	0.040%
Third-Party Administrators	Administrative Fees	1.000%	0.149%
Prepaid Legal	Gross Revenue	1.000%	0.042%
HMO Multi-Service	Per Enrollee	$2.00	$1.23
HMO Single Service	Per Enrollee	$2.00	$0.41
HMO Limited Service	Per Enrollee	$2.00	$0.41

Source: Texas Department of Insurance.

in other states. Second, the maintenance tax rate on life, accident, and health insurers is at the statutory maximum. As a result, increases in the maintenance tax would be limited to other lines of insurance. This would shift the cost of examining life, accident, and health insurers to the other insurance lines.

FISCAL IMPACT OF THE RECOMMENDATION

Figure 79 shows the estimated fiscal impact of repealing the insurance premium tax credits for examination fees and overhead assessments. The estimate assumes that credits would be granted in fiscal year 2010 for fees and assessments imposed in 2009. The estimate also assumes that a number of TWIA members would have sufficient windstorm credits to eliminate their premium tax liability in fiscal years 2010 through 2014. In fiscal year 2015, the revenue gain would increase to approximately $14 million, and each year thereafter the revenue gain would be approximately $10 million. Seventy-five percent of the gain would go to the General Revenue Fund and 25 percent would go to the Foundation School Fund.

FIGURE 79
FIVE-YEAR FISCAL IMPACT OF REPEALING INSURANCE PREMIUM TAX CREDITS FOR EXAMINATION FEES AND OVERHEAD ASSESSMENTS

FISCAL YEAR	PROBABLE GAIN/(LOSS) IN GENERAL REVENUE FUNDS	PROBABLE GAIN/(LOSS) IN THE FOUNDATION SCHOOL FUND
2010	$0	$0
2011	$6,992,000	$2,331,000
2012	$6,992,000	$2,331,000
2013	$6,992,000	$2,331,000
2014	$7,467,000	$2,489,000

Source: Legislative Budget Board.

The introduced 2010–11 General Appropriations Bill does not reflect any changes as a result of this recommendation.

CLOSE LOOPHOLES RELATED TO SALES TAXES ON MOTOR VEHICLES

Texas receives almost $3 billion per year from the Motor Vehicle Sales and Use Tax. Statutory provisions related to leasing companies' deductions and the gift tax can currently be misapplied thereby reducing the amount of motor vehicles sales taxes paid to the state.

Texas taxes leasing companies on the purchase of vehicles intended for leasing, as opposed to taxing the gross receipts of a lease contract. Leasing companies can reduce their sales tax liability by deducting the fair market value of a vehicle, or multiple vehicles, that they are no longer leasing, and the Texas Tax Code provides that a retired vehicle titled in a "related company's name" can also be used to reduce the tax liability of the owner (lessor). With many franchised dealers having partial ownership of leasing companies, the pool of vehicles available to lessors for deductions is bigger than it would be without such a provision. In addition, the Texas Comptroller of Public Accounts does not receive the necessary information to verify compliance with provisions related to allowable deductions. This could reduce the amount of sales tax revenue that is paid to the state. Allowing lessors to make tax-exempt vehicle purchases and requiring them to pay on the gross receipts of the leased vehicle's contract would protect against abuse of the fair market value deduction provision and could generate an additional $46.6 million in motor vehicle sales tax revenue for the 2010–11 biennium.

Another area that has potential for abuse is the gift tax on motor vehicles. In Texas, individuals receiving a vehicle as a gift are exempt from the motor vehicle sales tax, and instead, pay a $10 gift tax. Tightening the eligibility rules that allow individuals to claim a vehicle as a gift could increase revenue from motor vehicle sales tax by an additional $29.3 million in General Revenue Funds for the 2010–11 biennium.

CONCERNS

- Short of an on-site audit of a lessor, the Texas Comptroller of Public Accounts does not have sufficient data to verify that the value of the retired vehicle has not been used more than once as a deduction or that the 18-month retirement limit has not been exceeded. The lack of such verification measures increases the risk of abuse and makes abuse difficult to detect.
- Data from the Texas Comptroller of Public Accounts from calendar year 2007 shows that the top 33 leasing companies (determined by number of car purchases) paid $48.1 million in motor vehicle sales tax on $2 billion of vehicle purchases. They also claimed $1.2 billion in fair market value deductions, allowing them to reduce their tax liability by $73.9 million. This is money that is foregone by the state.
- In the year after implementation of the law that requires purchasers of vehicles involving a private-party sale to pay tax on the standard presumptive value of a vehicle (as opposed to the reported purchase price), the number of transactions claiming the gift tax has increased by 23.6 percent, or 78,012 transactions.

RECOMMENDATIONS

- **Recommendation 1:** Effective September 1, 2010, amend Chapter 152 of the Texas Tax Code to require lessors of motor vehicles to report vehicle information for vehicles purchased and retired on a quarterly basis to the Comptroller. This would provide the Texas Comptroller of Public Accounts the necessary information to verify compliance with the law.
- **Recommendation 2:** Effective September 1, 2010, amend Section 152.026 of the Texas Tax Code to impose a tax of 6.25 percent on the gross receipts of a leasing contract, similar to the tax for rentals of motor vehicles of 30 days or more.
- **Recommendation 3:** Amend Section 152.025 of the Texas Tax Code to allow for a gift tax of $10 only if a person receives a vehicle as a gift from a parent, stepparent, spouse, grandparent, child, stepchild, grandchild, guardian, or estate. A notarized statement confirming the relationship should be required.

DISCUSSION

Texas assesses a motor vehicle sales tax of 6.25 percent on all vehicle purchases, with some exemptions provided. In fiscal years 2007 and 2008, the motor vehicle sales tax generated almost $3 billion in General Revenue Funds in each fiscal year. Leasing companies purchase several thousand vehicles

per year, with the top 33 leasing companies (by number of vehicles purchased) purchasing almost $2 billion in vehicles in calendar year 2007.

Individuals purchasing a vehicle are allowed to trade in a vehicle to reduce the portion of the purchase price that is taxable. Similarly, a leasing company is allowed to minimize or eliminate its tax liability by claiming a fair market value deduction. Section 152.002 of the Texas Tax Code provides that a person who is in the business of selling, renting, or leasing motor vehicles, who obtains the certificate of title to a motor vehicle, and who uses that motor vehicle for business or personal purposes may deduct its fair market value from the total consideration paid for a replacement vehicle if:

- the replacement vehicle is titled in the person's name;
- the person uses the replacement vehicle for business or personal use;
- the retired vehicle has not been used as a deduction before; and
- the replaced vehicle has been retired and offered for sale within the last 18 months of the time it was taken out of service.

The same section of the Texas Tax Code allows a licensed leasing agency to deduct the value of a retired vehicle even if the vehicle is titled to another person. This deduction is only possible if the retired vehicle has been leased for more than 180 days and "either person: (A) holds a beneficial ownership interest in the person of at least 80 percent; or (B) acquires all of its vehicles exclusively from franchised dealers whose franchisor shares common ownership with the other person." This provision was added by legislation enacted by the Seventy-sixth Legislature, 1999. The provision allows two entities, a leasing company and a car dealer, for example, under common ownership (80 percent threshold) to claim the fair market value deduction of vehicles the other has retired. With many dealers having partial ownership of the leasing companies, the pool of vehicles available to lessors for deductions is bigger than it would be without such a provision. This law may create ways to avoid paying the sales tax. While lessors did pay $48 million in motor vehicle sales tax, they were also able to avoid a substantial amount of tax responsibility. In calendar year 2007, 33 of the lessors with 10 or more vehicle purchases claimed $1.2 billion in fair market value deductions and reduced their tax liability by $73.9 million.

The fair market value deduction is claimed at the time the replacement vehicle is titled and registered at the county tax assessor-collector's office. Each county tax assessor collects and remits the motor vehicle sales tax to the Texas Comptroller of Public Accounts (CPA). A business claiming the deduction must maintain records necessary to document the accuracy of the retired vehicle's fair market value, and complete a title application/tax statement (Form 130-U) that includes a description of the retired vehicle, including its vehicle identification number (VIN). However, Form 130-U is not an effective tool for the purposes of verifying whether a leasing company is obtaining a deduction or complying with the law. Even though a leasing company can deduct the value of multiple retired vehicles, it is only required to provide the VIN of one vehicle and indicate whether there are additional trade-ins by marking "yes" or "no" on Form 130-U. No information is collected on the number of additional vehicles being claimed, the value of the additional vehicles, or their VINs.

Absent an on-site audit of each leasing company, CPA does not have the necessary information to ensure that the deductions leasing companies are claiming have not been used before or that the 18-month retirement limit has not been exceeded. The lack of data necessary to monitor the validity of these retired vehicles increases the risk of abuse.

ABUSE OF GIFT TAX

Another area that has potential for abuse is the gift tax on motor vehicles. If a person receives a vehicle as a gift, that person is exempt from the motor vehicle sales tax, and instead, incurs a $10 gift tax. Before October 2006, used vehicles purchased through private-party transactions were taxed based on the buyer's reported purchase price. Therefore, buyers could understate the purchase price on the Form 130-U and pay little tax on their vehicle purchases. It was possible to pay less than the amount of the gift tax if the reported purchase price was low enough. To reduce abuse of this provision, the Legislature passed a law that no longer allowed buyers to report the purchase price of their used vehicles. Instead, the Seventy-ninth Legislature, 2005, amended the law to require individuals to pay the sales tax on at least 80 percent of the standard presumptive value of a used vehicle or the appraised value of a used vehicle if the purchase price is less than 80 percent of the standard presumptive value. The standard presumptive value is determined by a national vehicle valuation guide that calculates prices based on Texas sales data.

Without the option to report the purchase price there is an incentive to claim a vehicle purchase as a gift and pay less tax. In the year after the implementation of the standard presumptive value provision, the number of vehicles claimed as gifts increased by 23.6 percent, or 78,012, in calendar year 2007, as shown in **Figure 80**. A total of 330,908 gift tax transactions were reported in calendar year 2006, while calendar year 2007 had 408,920 transactions.

There are no requirements that the person making the gift be a relative of the person claiming the gift tax or that the vehicle being given is below a certain value. The only evidence needed to confirm that the vehicle was received as a gift is the signature of the person making the gift on Form 130-U.

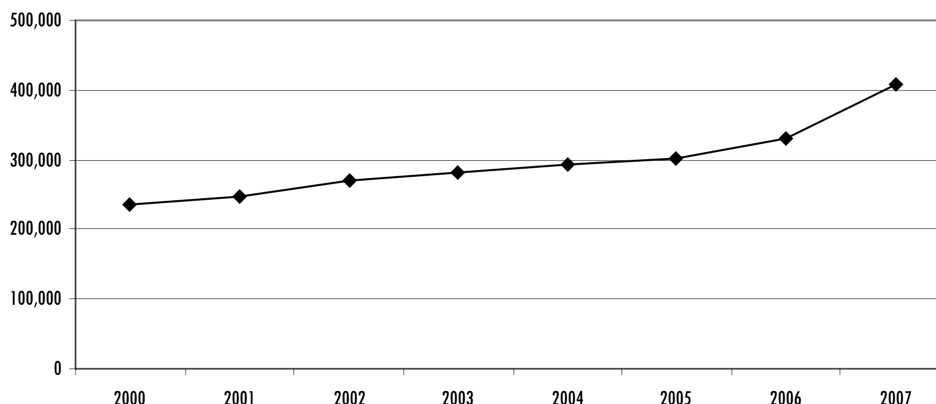
Some states verify compliance with the law by requiring statements of facts or affidavits from individuals claiming exemption from the sales tax. Furthermore, some states allow only tax-exempt vehicle gift exchanges only between related parties. **Figure 81** shows that California, Illinois, Michigan, and New York provide exemptions to the sales tax when a vehicle is received as a gift from a relative. They all require proof of relationship. Florida exempts gifts of vehicles from taxation if there is a sworn statement stating that it is a gift.

MITIGATING THE RISK OF ABUSE

Inappropriate reductions to the amount of tax owed on the purchase of a motor vehicle results in a loss to the state's General Revenue Fund. While the exemptions to the motor vehicle sales tax discussed above are allowed in statute, there is a risk that they may be used in a manner that is inconsistent with the intent of the Texas Legislature. Recommendation 1 would amend statute to require leasing companies to report detailed vehicle information for retired vehicles and VINs for those retired vehicles used as a deduction to CPA on a quarterly basis. Implementing these reporting requirements would enhance the state's ability to detect and reduce the potential for abuse of payment of motor vehicle sales tax on leased vehicles. Alternatively, the fair market value deduction for lessors could be repealed; which would make any reporting beyond Form 130-U unnecessary. This change would also increase tax revenues.

Recommendation 2 would also help to limit the risk of abuse by changing the way lessors pay taxes on the purchase of cars. Currently, lessors are required to pay tax on the purchase price of a vehicle, less any fair market value deduction. Recommendation 2 would amend Section 152.026 of the Texas Tax Code, which assesses a tax on gross rental receipts. Rental companies pay the tax on the rental contract on a monthly basis and not at the time the rental vehicle is purchased and titled. Section 152.026 provides that for vehicles rented for 30 days or less, a 10 percent tax is due on gross receipts; if the rental contract is for 31 to 180 days, a tax rate of 6.25 percent of gross rental receipts is due. Under Recommendation 2, leased vehicles would fall under the latter part of the provision. However, for vehicles leased for more than 180 days, the tax will be computed based on the total amount due under the lease agreement and paid at the time of the contract initiation. For example, a lessor would be required to collect $900 in tax upon leasing a vehicle with a 36-month lease agreement and $400 monthly payments as shown in **Figure 82**. This up-front collection of the sales tax is often referred to as an accelerated tax payment and is done in some states as an alternative to having the lessor collect the tax at the time each payment is made.

FIGURE 80
NUMBER OF VEHICLES CLAIMED AS GIFTS IN TEXAS, CALENDAR YEARS 2000 TO 2007



SOURCE: Comptroller of Public Accounts.

FIGURE 81
STATE LAWS ON TAX OWED ON VEHICLE RECEIVED AS A GIFT, 2007

STATE	STATE LAW
California	California exempts the sale or use of vehicles if the seller is the parent, grandparent, child, grandchild, or spouse of the purchaser or if the seller and purchaser are minor brothers or sisters. The seller must not be a car dealer. Those claiming this exemption must submit proof of the relationship. Sales by a stepchild to a stepparent, or vice versa, are not exempt. The sale of a motor vehicle to a revocable trust is exempt, provided that the sale does not change beneficial ownership of the property.
Florida	Vehicles acquired by gift accompanied by a sworn statement describing the motor vehicle and stating that there are no outstanding liens, a distribution to the heirs of an estate, a transfer between spouses of marital property, and a transfer between former spouses as part of the property settlement in a divorce are exempt from tax.
Illinois	The tax rate is $15 for each vehicle acquired when the transferee or purchaser is the spouse, mother, father, brother, sister, or child of the transferor; or when the transfer is a gift to a beneficiary in the administration of an estate who is not a surviving spouse.
Michigan	No tax is owed on transfers or purchases of vehicles when the transferee or purchaser is the spouse, parent, sibling, child, stepparent, stepchild, stepbrother, stepsister, grandparent, grandchild, legal ward, or a legally appointed guardian with a certified letter of guardianship, of the transferor; or vehicles transferred as a gift to a beneficiary.
Minnesota	Vehicles acquired by inheritance, acquired by gift between individuals or by gift from a limited use vehicle dealer to an individual, when the transfer is without monetary or other consideration, transferred by guardian to ward, transferred between joint tenants without monetary consideration, or transferred between a husband and wife in a divorce proceeding are exempt from tax.
New York	A sales tax exemption is provided for motor vehicles sold between spouses, parents, children, stepparents, and stepchildren, unless the vendor is a dealer.
Texas	A tax of $10 is imposed on the recipient of a gift of a motor vehicle.

Source: Legislative Budget Board.

Rental companies can also deduct the fair market value of a retired vehicle. This deduction is used to establish the minimum gross rental receipts tax liability in the same way that a leasing company establishes its tax liability. **Figure 82** shows an example of how the minimum gross rental receipts tax is determined for rental companies and applies the same methodology to leased vehicles.

The rental company can satisfy the minimum tax liability by collecting tax when it rents the vehicle and reports and remits the tax to the CPA. If the vehicle is retired from rental service prior to the minimum tax amount being met, the company must pay the difference as shown in **Figure 82**. The CPA indicates that not collecting enough tax to satisfy the minimum due is not a common occurrence. Under Recommendation 2, leasing companies would be subject to these same rules. There is also a potential to generate more revenue for the state because the leasing company will continue to collect the tax on lease payments even after the minimum tax liability is met if the vehicle remains in service. Given the economic downturn the automobile industry is currently facing, Recommendations 1 and 2 would be effective September 1, 2010, to allow time for the economy to recover.

Recommendation 3 would amend Section 152.025 of the Texas Tax Code to allow a $10 gift tax only if a person receives a vehicle as a gift from a parent, stepparent, spouse, grandparent, child, stepchild, grandchild, guardian, or estate. This change could reduce the number of people claiming vehicles as gifts. Furthermore, requiring a notarized statement confirming such a relationship to qualify for the gift tax on motor vehicles may address the increase in the number of vehicles claimed as gifts and the subsequent loss in revenue.

FISCAL IMPACT OF THE RECOMMENDATIONS

Recommendation 1 would have no fiscal impact to appropriations of General Revenue Funds. Recommendation 2 is estimated to generate an additional $46.6 million in motor vehicle sales tax in the 2010–11 biennium as a result of collecting the tax on the gross receipts of the lease contract. This revenue estimate accounts for delayed implementation and decreased motor vehicle sales tax collections. Additional revenue may be generated, capturing revenue that is currently not collected due to non-compliant deductions and from tax

FIGURE 82
CALCULATION OF MINIMUM GROSS RECEIPTS TAX ON LEASED VEHICLES

		UNDER CURRENT LAW	RECOMMENDATION 2	
	TAX DUE DATE	MULTIPLE RETIRED VEHICLES	ONE RETIRED VEHICLE	MULTIPLE RETIRED VEHICLES
Monthly Lease Rate		$400	$400	$400
Length of Lease (in Months)		36	36	36
Total Lease Contract		$14,400	$14,400	$14,400
Tax Rate		NA	.0625	.0625
Taxes on Lease Payment	Due upon Initiation of contract	NA	$900	$900
Purchase Price of Leased Vehicle		$40,000	$40,000	$40,000
Value of Retired Vehicle 1		$15,000	$15,000	$15,000
Value of Retired Vehicle 2		$25,000	N/A	$25,000
Taxable Receipts		$0	$25,000	$0
Motor Vehicle Sales Tax Rate		.0625	.0625	.0625
Minimum Tax Due		NA	$1,562.50	$0
Taxes Paid on Lease Payment		NA	$900	$900
Remaining Tax Due	Once leased vehicle is retired	NA	$662.50	$0
TOTAL TAX DUE		**$0**	**$1,562.50**	**$900**

SOURCE: Legislative Budget Board.

receipts collected beyond the minimum tax due. An accelerated payment provision, which requires lessors to pay the full amount of tax owed on the leasing contract, would protect the state against any initial loss of not collecting the tax upon titling and registering the vehicle as currently assessed.

The fiscal impact of Recommendation 3 to amend gift tax provision would generate $29.3 million in General Revenue Funds in the 2010–11 biennium. This estimate is based on the difference of the increased growth in gift transactions (78,012) after the implementation of the standard presumptive value provision and the expected average growth (19,854) for calendar year 2007. The average value of vehicles received as gifts during calendar year 2007 was estimated to be $4,035 and calculated based on data provided by the Texas Department of Transportation from Forms 130-U.

Figure 83 shows that $75.9 million in General Revenue Funds will be generated in 2010–11 biennium as a result of these recommendations. The subsequent biennia are expected to generate a similar amount.

The introduced version of the 2010–11 General Appropriations Bill does not include any adjustments as a result of these recommendations.

FIGURE 83
FIVE-YEAR FISCAL IMPACT, FISCAL YEARS 2010 TO 2014

FISCAL YEAR	PROBABLE GAIN/(COST) IN GENERAL REVENUE FUNDS
2010	$14,666,660
2011	$61,218,802
2012	$61,218,802
2013	$61,218,802
2014	$61,218,802

SOURCE: Legislative Budget Board.

REVISE THE PROPERTY TAX EXEMPTION FOR POLLUTION CONTROL EQUIPMENT

Equipment used for the control of air, water, or land pollution has been exempted from property taxation by constitutional amendment since 1994. The Texas Commission on Environmental Quality maintains a list of qualifying equipment, and property owners can submit an application for a partial or total exemption from property tax for this equipment. Although the agency has kept such a list for some time, House Bill 3732, Eightieth Legislature, 2007, directed the agency to adopt a nonexclusive list by rule that would include 18 categories of pollution control equipment.

In February 2008, the agency implemented rules with the new nonexclusive pollution control equipment list and an application procedure for property owners seeking an exemption. County tax appraisers, county governments, and environmental groups oppose certain aspects of the rules, especially related to heat recovery steam generators, one of the new categories specifically named in the legislation. These groups argue that the function of these generators is not primarily pollution control, although some percentage of their function does help control pollution. The appraisers and environmental groups estimate that the current 100 percent exemption for heat recovery steam generators and related equipment could reduce taxable values of commercial property by $2 billion. Total taxable value for each school district is an element in the state's school funding formula. A modification to the methodology that the Texas Commission on Environmental Quality uses to assess pollution control equipment would likely reduce exemptions to property tax, which could cause a change in school district taxable values.

FACTS AND FINDINGS

- In February 2007, the Comptroller of Public Accounts estimated the cost of the school property tax exemption for pollution control equipment would grow from $92.0 million out of $7.4 billion in taxable value lost in 2007 to $157.9 million out of $11.9 billion in taxable value lost in 2012.
- The first 35 applications for pollution control property tax exemptions related to heat recovery steam generators and enhanced steam turbine systems, which were statutorily added to Section 11.31 of the Texas Tax Code by House Bill 3732, Eightieth Legislature, 2007, account for equipment valued at more than $2 billion.
- The Texas Commission on Environmental Quality is now creating a new methodology to determine the tax-exempt value of heat recovery steam generators.

CONCERNS

- The Texas Commission on Environmental Quality requires property owners seeking tax exemption for equipment that is not on the agency's list to use an established cost analysis procedure, but it allows property owners seeking tax exemption for equipment in the 18 new categories to generate their own methodology for determining the pollution control exemption. Some of the methodologies proposed by property owners have produced greater tax exemptions than the established cost analysis procedure would permit.
- Property owners who receive a determination from the Texas Commission on Environmental Quality before the agency modifies its methodology are not currently required to reapply for a new determination, which could give them a greater tax exemption than property owners with similar equipment after the methodology change.
- Since the enactment of House Bill 3732, Eightieth Legislature, 2007, the Texas Commission on Environmental Quality established and dissolved two advisory groups to address issues related to the statute. As a result, the agency does not have ongoing advisory body for issues related to the tax exemption for pollution control equipment.

RECOMMENDATIONS

- **Recommendation 1:** Amend Texas Tax Code, Chapter 11, to require the Texas Commission on Environmental Quality to use its own cost analysis procedure as a maximum exemption when making a use determination for equipment listed in Texas Tax Code, Section 11.31(k).
- **Recommendation 2:** Amend Texas Tax Code, Chapter 11, to require property owners to re-apply

for a use determination from the Texas Commission on Environmental Quality when the agency has modified the use determination methodology.

- **Recommendation 3:** Amend Texas Tax Code, Chapter 11, to require a permanent advisory committee on tax exemptions of pollution control property.
- **Recommendation 4:** Include a contingency rider in the 2010–11 General Appropriations Act allowing members of the permanent advisory committee on tax exemptions of pollution control property to be reimbursed for travel expenses.

DISCUSSION

In 1993, Texas voters approved a constitutional amendment permitting an exemption from property taxation for pollution control equipment, which is any facility, device, or method used for the control of air, water, or land pollution. This exemption applied to pollution control equipment installed on or after January 1, 1994. According to the Texas Constitution, Article 8, Section 1-l, pollution control property exempted from ad valorem taxation must be "all or part of real and personal property used, constructed, acquired, or installed wholly or partly to meet or exceed rules or regulations adopted by any environmental protection agency of the United States, this state, or a political subdivision of this state for the prevention, monitoring, control, or reduction of air, water, or land pollution."

In 2001, the Seventy-seventh Legislature directed the Texas Commission on Environmental Quality (TCEQ) to adopt specific standards for evaluating applications and a formal procedure for applicants and appraisal districts to appeal a determination. **Figure 84** shows the estimated cost of exemptions for pollution control property from 2007 to 2012, as reported by the Comptroller of Public Accounts (CPA) in February 2007. As **Figure 84** shows, CPA estimated the cost of the school property tax exemption for pollution control equipment would grow from $92.0 million out of $7.4 billion in taxable value lost in 2007 to $157.9 million out of $11.9 billion in taxable value lost in 2012. The CPA estimates are based on the school tax rate after the recent property tax relief legislation. Additional tax is lost to other jurisdictions.

The estimates in **Figure 84** pre-date the enactment of House Bill 3732 by the Eightieth Legislature, 2007, which directed TCEQ to adopt a nonexclusive list of pollution control equipment, including 18 property categories that were previously not included in exemptions for pollution control equipment. The legislation further required TCEQ to review the list every three years and establish standards for removing equipment from it. The bill established a 30-day period for application review. Because much of the legislation addressed advanced clean energy projects, TCEQ requested direction from the Attorney General of Texas in October 2007 regarding whether House Bill 3732 applied only to pollution control property associated with such projects. In December 2007, the Attorney General issued an opinion that the amendments to Section 11.31 of the Texas Tax Code in House Bill 3732 applied to all pollution control equipment. In February 2008, TCEQ adopted rules to implement the legislation. Because CPA's reported pollution control property tax exemptions in **Figure 84** were estimated before the enactment of the legislation or TCEQ's rules implementing the bill, the fiscal impact of the legislation on tax exemptions for pollution control property is still undetermined. The first 35 applications for pollution control property tax exemptions related to two of the 18 categories added by House Bill 3732 account for equipment valued at more than $2 billion, although TCEQ is unlikely to grant exemptions for the entire value of that property.

The only states that do not allow for some type of tax exemption or credit for pollution control equipment are Alaska, Delaware, and South Dakota. The District of Columbia also has no tax exemption or credit for pollution control. These exemptions and credits are administered in vastly different ways, as states have vastly different tax

FIGURE 84
COST OF SCHOOL PROPERTY TAX EXEMPTION FOR POLLUTION CONTROL EQUIPMENT, 2007–2012, AS ESTIMATED IN FEBRUARY 2007

YEAR	2007	2008	2009	2010	2011	2012
Taxable Value Lost (in millions)	$7,385.1	$8,123.6	$8,935.9	$9,829.5	$10,812.5	$11,893.7
Estimated Tax Lost (in millions)	$92.0	$103.2	$114.8	$127.7	$142.0	$157.9

Source: Comptroller of Public Accounts.

structures. Texas provides for a property tax exemption and, as in Idaho, Indiana, Mississippi, and South Carolina, an exemption on sales and use tax for state or federally mandated equipment only.

PROCESS FOR EXEMPTION OF POLLUTION CONTROL EQUIPMENT

To receive a tax exemption for pollution control, a property owner must first file an application with TCEQ. Applications must be postmarked by January 31 for property constructed or installed during the previous calendar year. TCEQ will issue its final determination by or before April 30, the deadline for filing an exemption request with an appraisal district. The agency's finding will include a use determination of the pollution control property. "Use determination" is a positive or negative finding that the property is used wholly or partially for pollution control purposes and a listing of the percentage of the property that the agency has determined to be used for pollution control. After receiving a use determination from TCEQ, the property owner must file the use determination with its local appraisal district to receive a property tax exemption. The chief appraiser is required by statute to accept the agency's use determination as conclusive evidence that the property is used wholly or partly as pollution control property.

According to statute, the following specific types of property are not eligible for use determination:

- motor vehicles;
- residential property;
- property for recreational, park, or scenic uses; and
- property subject to a tax-abatement agreement executed before January 1, 1994, except for property acquired, constructed, or installed after the agreement has expired.

For commercial waste facilities, the statute does not allow owners to receive the exemption solely because a facility manufactures or produces a product used in pollution control or provides a service that monitors, controls, or reduces pollution. While land is eligible, only the part that actually contains the pollution control equipment or that is used solely for pollution control purposes is eligible. Land used solely as a buffer zone is not eligible.

EQUIPMENT AND CATEGORIES LIST

Since February 2008, TCEQ has maintained an Equipment and Categories List (ECL) of pollution control equipment. Part A of the ECL consists of property that the agency previously evaluated and determined to be either wholly or partly pollution control equipment. Before the enactment of House Bill 3732, TCEQ kept the list of the equipment in Part A, which it called the predetermined equipment list. Most of the equipment listed in Part A is 100 percent exempted from property tax. Part B consists of 18 categories added to Texas Tax Code, Section 11.31(k) by House Bill 3732, and this equipment is wholly or partly exempted on a case-by-case basis. **Figure 85** shows the 18 categories in Part B. By rule, property owners seeking an exemption for equipment listed in Part B may request a specific percentage of the equipment to be exempted by using either a predetermined Cost Analysis Procedure (CAP) or proposing a different calculation method. The pollution control percentage for this equipment is listed as "V" for variable and must be calculated on an application-specific basis.

Application fees for a use determination by TCEQ are based on the ECL. Statute requires that these fees not exceed TCEQ's administrative costs for processing the information, making the determination, and issuing a notification of the determination to the applicant. TCEQ sets these fees by rule. They increase according to the level of analysis that TCEQ expects will be necessary to issue a use determination. **Figure 86** shows the tiers of application fees.

HEAT RECOVERY STEAM GENERATORS

Heat recovery steam generators (HRSGs) and enhanced steam turbine systems (ESTSs) are two of the 18 categories of pollution control equipment in Part B of the ECL. These types of equipment are sometimes used in tandem. The initial group of applications for tax exemption of HRSGs and ESTSs requested a wide range of use determinations based on the calculation used. In 34 of the first 35 applications, there were three primary types of calculations used:

- output-based emissions (20 applications), of which 19 requested 100 percent and the other requested 71 percent;
- efficiency-based output (7 applications), of which two requested 35 percent and five requested 61.2 percent; and
- best available control technology (7 applications), which ranged from 13 percent to 25 percent.

For the applications using calculations based on output emissions and comparison with the best available substitute technology, TCEQ performed a use determination of 100

FIGURE 85
PART B OF THE TCEQ EQUIPMENT AND CATEGORIES LIST, CREATED 2008

NO.	PROPERTY	%
B-1	Coal Cleaning or Refining Facilities	V
B-2	Atmospheric or Pressurized and Bubbling or Circulating Fluidized Bed Combustion Systems and Gasification Fluidized Bed Combustion Combined Cycle Systems	V
B-3	Ultra-Supercritical Pulverized Coal Boilers	V
B-4	Flue Gas Recirculation Components	V
B-5	Syngas Purification Systems and Gas-Cleanup Units	V
B-6	Enhanced Heat Recovery Systems	V
B-7	Exhaust Heat Recovery Boilers	V
B-8	Heat Recovery Steam Generators	V
B-9	Super heaters and Evaporators	V
B-10	Enhanced Steam Turbine Systems	V
B-11	Methanation	V
B-12	Coal Combustion or Gasification By-product and Co-product Handling, Storage, and Treatment Facilities	V
B-13	Biomass Cofiring Storage, Distribution, and Firing Systems	V
B-14	Coal Cleaning or Drying Processes, such as coal drying/moisture reduction, air jigging, precombustion decarbonization, and coal flow balancing technology.	V
B-15	Oxy-Fuel Combustion Technology, Amine or Chilled Ammonia Scrubbing, Catalyst based Fuel or Emission Conversion Systems, Enhanced Scrubbing Technology, Modified Combustion Technology, Cryogenic Technology	V
B-16	If the United States Environmental Protection Agency adopts a final rule or regulation regulating carbon dioxide as a pollutant, property that is used, constructed, acquired, or installed wholly or partly to capture carbon dioxide from an anthropogenic source in this state that is geologically sequestered in this state.	V
B-17	Fuel Cells generating electricity using hydrocarbon derived from coal, biomass, petroleum coke, or solid waste.	V
B-18	Any other equipment designed to prevent, capture, abate, or monitor nitrogen oxides, volatile organic compounds, particulate matter, mercury, carbon monoxide, or any criteria pollutant.	V

SOURCE: Texas Commission on Environmental Quality.

FIGURE 86
APPLICATION FEES FOR A POLLUTION CONTROL EQUIPMENT USE DETERMINATION

TIER	EQUIPMENT AND CATEGORIES LIST	WHOLE OR PARTIAL USE FOR POLLUTION CONTROL	FEE
Tier I	All property listed on the application must be located on Part A of the ECL or must be necessary for the installation or operation of property located on Part A.	NA	$150
Tier II	Not on the ECL	100% pollution control	$1,000
Tier III	Not on the ECL	Partially used for pollution control	$2,500
Tier IV	All property listed on the application must be located on Part B of the ECL or must be necessary for the installation or operation of property located on Part B.	NA	$500

SOURCE: Legislative Budget Board.

percent for HRSGs and 0 percent for the ESTSs. The applications using calculations based on efficiency have not yet been decided. This determination proved controversial with county tax appraisers, county governments, and some environmental groups, all of which wanted to ensure that the value of the tax exemption was proportional with the value of the pollution control part of the equipment. TCEQ assembled an Advisory Group on Heat Recovery Steam Generators that met twice in August 2008 to discuss the HRSG applications. Attendees included representatives from industry, appraisal districts, local governments, and an environmental group. These groups were unable to achieve consensus on the appropriate method of use determination.

HRSGs are much more costly than most of the equipment in Part A of the ECL. The cost of HRSGs can be up to three times the cost of the ESTSs, as well. Because the first 35 applications for pollution control property tax exemptions related to HRSGs and ESTSs account for equipment valued at more than $2.0 billion, TCEQ's use determination of 100 percent for HRSGs and 0 percent for ESTSs could reduce taxable property value in the affected tax districts by as much as $1.5 billion for these applications alone. The reported cost of each application requesting tax exemptions for both HRSGs and ESTSs ranges from $13.9 million to $129.9 million. The reported cost of each application requesting tax exemptions for HRSGs alone ranges from $9.3 million to $46.0 million.

COST ANALYSIS PROCEDURE

The Cost Analysis Procedure (CAP) is TCEQ's default formula for assessing the use determination of equipment that is in Tier III (not on the ECL and partially used for pollution control) and an available method of use determination for equipment in Tier IV (on Part B of the ECL). Tier III applicants must use the CAP formula, but Tier IV applicants may propose a different calculation. None of the applications for property tax exemptions for HRSGs used the CAP formula. **Figure 87** shows the CAP formula.

The inclusion of the PCF and BP variables in the CAP formula consider the economic benefit to the property owner of the pollution control equipment. The statute requires that the applicant provide any information requested by the Executive Director. If an applicant cannot provide the information required to use the formula, then a negative determination will be issued. If the CAP formula produces a negative number or a zero, then there is no creditable partial percentage for the project and the result is a negative use determination.

USE THE COST ANALYSIS PROCEDURE AS A CAP ON USE DETERMINATION

Recommendation 1 would amend Texas Tax Code, Section 11, to require TCEQ to use the CAP formula as a maximum exemption when making a use determination for equipment listed in Texas Tax Code, Section 11.31(k). The maximum exemption granted any applicant requesting an exemption for equipment under Part B of the ECL should not exceed

FIGURE 87
COST ANALYSIS PROCEDURE FORMULA, 2008

FORMULA

$$\text{Partial Use Determination} = \frac{[(PCF \text{ X } CCN) - CCO - BP]}{CCN} \text{ X } 100$$

VARIABLES

Production Capacity Factor (PCF)
The capacity of the existing equipment (or process) divided by the capacity of the new equipment (or process). For an increase in production capacity, PCF adjusts the capacity of the new equipment to the capacity of the existing equipment. For a decrease in production capacity, PCF adjusts the capacity of the existing equipment to the production capacity of the new equipment. In this case, the method of calculation is modified so that PCF is applied to Capital Cost Old rather than Capital Cost New.

Capital Cost New (CCN)
The estimated total capital cost of the new equipment or process.

Capital Cost Old (CCO)
The cost of comparable equipment/process without the pollution control. There are three methods for calculating CCO, all of which must follow generally accepted accounting principles. These methods are: (1) if comparable equipment without the pollution control feature is on the market in the U.S., then CCO is the average market price of the most recent generation of technology; (2) if condition 1 above does not apply, and the company is replacing an existing unit, then the company shall index the original cost of the unit to today's dollars using a published industry-specific standard; and (3) if neither conditions 1 nor 2 apply, and the company can obtain an estimate of the cost to manufacture the alternative equipment without the pollution control feature, then CCO is the average estimated cost to manufacture the unit, using the most recent generation of technology.

Byproduct (BP)
For property that generates a marketable byproduct, in addition to providing pollution control, the net present value of the byproduct reduces the partial determination. The value of the byproduct is calculated by subtracting transportation and storage costs of the byproduct from the market value of the byproduct. This value is then used to calculate the Net Present Value of the byproduct over the lifetime of the equipment. TCEQ provides an equation for calculating BP.

Source: Texas Commission on Environmental Quality.

the exemption that would be granted if the applicant were using the formula. The CAP formula includes variables that account for the economic benefit to the property owner of the pollution control equipment. TCEQ allows Tier IV applicants to develop their own methodology to encourage innovation in use determination. If the agency would prefer to continue to encourage such innovation, the statutory change should be permissive in allowing applicants to develop their own use determination methodology. However, that methodology should not exceed the maximum allowable use determination from an application of the CAP formula.

Recommendation 2 would require property owners to re-apply for a use determination when the TCEQ has modified the use determination methodology. All Tier IV applications that have been approved by the agency would therefore need to re-apply for determination under the new methodology.

ESTABLISH A PERMANENT ADVISORY COMMITTEE FOR POLLUTION CONTROL EQUIPMENT

Since the enactment of House Bill 3732, TCEQ established two advisory bodies to address the ECL: the Advisory Group for the Predetermined Equipment List, which is now dissolved, and the Advisory Group on Heat Recovery Steam Generators, which is not expected to meet again. With the possibility of more applications from equipment in Part B of the ECL, the TCEQ may need further advice from outside experts when making use determinations for unfamiliar technologies. As statute requires that TCEQ reconsider the ECL every three years and as there may be more complexities involving the equipment categories on Part B of the ECL, an established advisory committee consisting of representatives from industry, appraisal districts, local governments, and environmental groups could help guide the public policy decisions of TCEQ regarding these new categories for pollution control equipment. Recommendation 3 would require TCEQ to create a permanent advisory committee on tax exemptions for pollution control property tax exemptions. Recommendation 4 would include a contingency rider in the 2010–11 General Appropriations Act allowing members of this advisory committee to be reimbursed for travel expenses.

FISCAL IMPACT OF THE RECOMMENDATIONS

Section 403.302 of the Texas Government Code requires CPA to conduct a property value study to determine the total taxable value for each school district. Total taxable value is an element in the state's school funding formula. These recommendations would likely reduce exemptions to property tax, which could cause a change in school district taxable values reported to the Commissioner of Education by CPA, and thereby avoid future state costs.

The amount by which these recommendations would reduce property tax exemptions is undetermined. The taxable property listed in Section 11.31(k) of the Texas Tax Code (and again in Part B of the ECL) has not been valued yet. The first 35 applications for tax exemptions for HRSGs alone and HRSGs acting in tandem with ESTSs are related to only one or two of the 18 new pollution control categories in Part B of the ECL, and these applications dealt with over $2.0 billion in taxable property. The total actual taxable value lost of pollution control property in 2007 was $8.2 billion, which was greater than CPA's estimated taxable value lost of $7.4 billion in pollution control property for 2007, as shown in **Figure 84**. If TCEQ had granted a 100 percent use determination for both HRSGs and ESTSs, those 35 applications would have increased the total taxable value lost from pollution control property in Texas by 25 percent. However, TCEQ did not grant a 100 percent use determination for both HRSGs and ESTSs, and the agency is in the process of developing a new methodology for this equipment. CPA will not have data available on the cost of school property tax exemptions or special appraisals until February 2009.

The introduced 2010–11 General Appropriations Bill does not include any adjustments as a result of these recommendations.

IMPROVE COLLECTION OF ALCOHOL TAXES AT PORTS OF ENTRY

The Texas Alcoholic Beverage Commission is the agency responsible for the enforcement and regulation of all aspects of the use, distribution, sale, storage, exportation, and importation of alcoholic beverages. The Texas Alcoholic Beverage Code requires individuals entering Texas to pay the tax on alcoholic beverages and cigarettes imported for personal consumption. The agency collected $3.5 million to $4.0 million annually in taxes on importations from fiscal years 2003 to 2008.

Several factors reduce the efficiency with which the state collects this revenue. The Texas Alcoholic Beverage Commission permanently staffs 19 of 26 border crossings and does not staff air or seaports. However, no formal cost-benefit analysis has been conducted to determine the most efficient use of staffing for the collection of alcohol and cigarette tax revenue. Secondly, the limit on importation of alcohol for personal consumption into the state for Texas residents differs from the limit for non-residents. Standardizing the importation limits for Texas residents and non-residents would streamline and maximize the efficient collection of this tax. Increasing the importation limits for Texas residents and non-residents to the greatest of either current limit on the importation of alcohol for personal consumption would generate an additional $150,000 in General Revenue Funds per fiscal year.

CONCERNS

- No formal cost-benefit analysis has been conducted to base an allocation of staffing resources for the collection of alcohol and cigarette revenue at ports of entry. From fiscal years 2003 to 2007, this revenue as a percentage of expenses ranged from 101 percent to 115 percent. Revenue as a percentage of expenses decreased to 92 percent in fiscal year 2008, and the Texas Alcoholic Beverage Commission projects that this percentage will decrease further in fiscal years 2009 and 2010.
- The limit on importation of alcohol for personal consumption into the state for Texas residents differs from the limit for non-residents. Standardizing the importation limits for Texas residents and non-residents would streamline and maximize the efficient collection of this tax.

RECOMMENDATIONS

- **Recommendation 1:** Amend the Texas Alcoholic Beverage Code to direct the Texas Alcoholic Beverage Commission to conduct a cost-benefit analysis, including air and seaports, and use the findings of the analysis to make staffing determinations for the placement of taxpayer compliance officers at ports of entry.
- **Recommendation 2:** Amend the Texas Alcoholic Beverage Code to raise the importation limits for Texas residents and non-residents to the greatest of either current limit on the importation of alcohol for personal consumption.

DISCUSSION

The Texas Alcoholic Beverage Commission (TABC) is the agency responsible for the enforcement and regulation of all aspects of the use, distribution, sale, storage, exportation, and importation of alcoholic beverages. In fiscal year 2008, an average of 628.4 full-time-equivalents positions carried out the agency's functions. TABC is primarily funded with fees, fines, and other revenues paid by the alcoholic beverage industry. TABC collected an estimated $245.2 million in fiscal year 2008, including taxes, fees, and other revenue. This revenue is deposited into the General Revenue Fund. TABC operates under an appropriations limited to revenue collection rider which means that all agency appropriations are contingent on the agency's ability to generate enough revenue through collection of fees to cover its biennial allocation. The agency was appropriated $80 million in General Revenue Funds for the 2008–09 biennium.

TABC is responsible for the collection of taxes and an administrative fee on alcohol imported into Texas for personal consumption. The twenty-first amendment to the U.S. Constitution grants each individual state the authority to control the importation and use of alcoholic beverages within its boundaries. Beginning in 1982, TABC is required to collect the cigarette tax on the importation of small quantities of cigarettes for personal consumption from foreign countries.

TAXES, FEES, AND LIMITS ON IMPORTATION OF ALCOHOL AND CIGARETTES FOR PERSONAL CONSUMPTION

The Texas Alcoholic Beverage Code requires individuals entering Texas to pay the tax on alcoholic beverages and cigarettes imported for personal consumption, plus an additional administrative fee of $0.50 for each container of alcohol. The administrative fee on alcohol is a flat rate per container, and no fee is collected on cigarettes. The state tax on alcohol varies depending on volume and the type of alcohol, and ranges from $0.25 to $1.25. As shown in **Figure 88**, restrictions on importation also include age and frequency of importation.

FIGURE 88
RESTRICTIONS ON THE IMPORTATION OF ALCOHOL FOR PERSONAL CONSUMPTION, FISCAL YEAR 2009

RESTRICTION	TEXAS RESIDENTS	NON-RESIDENTS
Importation Limit	• 3 gallons of wine • 1 quart of distilled spirits	• 1 gallon of wine or distilled spirits combined
	24 12-ounce containers of beer	
Age	Age 21 or older	
Frequency	Individual can import alcohol only once in 30-day period	

SOURCE: Texas Alcoholic Beverage Commission.

Before 1982, the Comptroller of Public Accounts' (CPA) staff was responsible for the collection of the cigarette tax at border crossings. This duty is now carried out by TABC officers at the ports of entry. TABC now collects $1.50 per pack of cigarettes. The state tax on cigarettes is $1.41 per pack but TABC is authorized by statute to round the tax imposed on the importation of both alcohol and cigarettes to the nearest quarter of a dollar.

PORTS OF ENTRY PROGRAM AND BORDER COLLECTIONS

The Ports of Entry (POE) program is operated within TABC's Tax Division and is responsible for the operation of the state's tax stamp program used for the collection of state taxes on alcohol and cigarette imports into Texas. TABC taxpayer compliance officers sell and affix stamps to alcohol containers and each pack of cigarettes as proof that the state tax has been paid. TABC recently automated the stamping process, and the agency reports that this practice streamlined the administration and processing of the stamps for alcohol containers. Before the implementation of this new technology, each officer was liable for as much as $10,000 worth of stamps kept in a binder or locked in a cashbox. The stamps had to be physically issued, tracked, logged, and audited. Cigarette stamps issued by CPA are still stored and sold manually.

TABC taxpayer compliance officers are responsible for selling stamps for the importation of alcohol and cigarettes for personal consumption, verifying compliance with importation limits, age restrictions, and other rules that may disqualify a person from importing alcohol or cigarettes. If consumers do not meet alcohol and cigarette importation restrictions, taxpayer compliance officers are authorized to confiscate the items. Each confiscated item must be destroyed and a receipt given to the consumer. In fiscal year 2007, there were 15,704 containers confiscated and 12,357 were confiscated in fiscal year 2008 (including packs of cigarettes).

Six TABC port offices monitor Texas' 26 international border crossings, seven of which are unstaffed. TABC reports that random checks are conducted at the unstaffed international crossings that allow vehicle passengers to enter the state. **Figure 89** shows the 26 international crossings in Texas and shows the staffing status of each.

Although authorized to do so, TABC does not collect taxes at other ports of entry, such as airports or cruise terminals where travelers are returning from international flights or cruises. TABC reports that over the last 10 years staff conducted two random checks at airports in Houston and Austin and determined that staffing airport terminals was not cost effective due to the limited amount of alcohol brought into Texas via airlines. According to agency staff, restrictions on carry-on items and luggage contents imposed since September 11, 2001 further reduced the likelihood of alcohol imports by air travelers.

For the 2008–09 biennium, the POE program was appropriated $8.1 million in General Revenue Funds, an estimated $3.8 million of which was expended in fiscal year 2008. According to TABC, as of the beginning of fiscal year 2009, the POE program had 103 employees and a budget of $3.7 million. Taxpayer compliance officers collected $4.0 million in fiscal year 2007 and $3.5 million in fiscal year 2008. This makes up a small portion of the $182.1 million collected in excise taxes in fiscal year 2007 and the $191.4 million collected in fiscal year 2008. **Figure 90** shows the number of containers stamped and revenue collections at ports of entry from fiscal year 2003 to 2008.

FIGURE 89
TABC STAFFING OF TEXAS/MEXICO PORTS OF ENTRY, FISCAL YEAR 2009

REGION	INTERNATIONAL BRIDGE	TABC STAFFING
El Paso Region	PDN - Paso Del Norte	Permanent
	BOTA - Bridge of the Americas (Cordova)	Permanent
	Ysleta or Zaragosa	Permanent
	Stanton Street Bridge (designated commuter lane only)	No
	Fabens	Permanent
	Fort Hancock	No
	Presidio	Permanent
Eagle Pass Region	Amistad Dam	Random Check
	Del Rio	Permanent
	Eagle Pass International Bridge I	Permanent
	Eagle Pass Bridge II	Permanent
Laredo Region	Columbia	Random Check
	Laredo IV (World Trade Bridge) - only commercial traffic	No
	Gateway (Bridge I)	Permanent
	Lincoln/Juarez (Bridge II)	Permanent
Hidalgo Region	Falcon Dam	Random Check
	Roma	Permanent
	Rio Grande City	Permanent
	Los Ebanos Ferry	No
	Anzalduas (not open yet)	NA
	Hidalgo	Permanent
	Pharr	Permanent
Progreso Region	Donna (not open yet)	NA
	Progreso	Permanent
Brownsville Region	Los Indios	Permanent
	Gateway Bridge	Permanent
	B & M Railroad	Permanent
	Veterans International Bridge (Los Tomates)	Permanent

Source: Texas Alcoholic Beverage Commission.

FIGURE 90
REVENUE AND CONTAINERS FROM IMPORTATION OF ALCOHOL AND CIGARETTES AT PORTS OF ENTRY, FISCAL YEARS 2003 TO 2008

FISCAL	CIGARETTES		ALCOHOL	
YEAR	CONTAINERS	REVENUE	CONTAINERS	REVENUE
2003	3,088,489	$1,595,204	2,274,620	$2,357,935
2004	2,927,695	$1,332,193	2,614,627	$2,667,966
2005	2,385,021	$977,859	2,603,444	$2,603,671
2006	1,943,999	$945,959	2,431,746	$2,709,685
2007	1,221,659	$1,240,261	2,439,214	$2,746,750
2008	604,454	$906,681	2,277,899	$2,550,079

Source: Texas Alcoholic Beverage Commission.

FACTORS IMPACTING THE COLLECTION OF REVENUE

Several factors impact importation of alcohol and cigarettes for personal consumption and the efficient collection of the related tax. The onset of violence along the Mexican border has deterred tourists and Texas residents from visiting the area. TABC believes that new travelling requirements for U.S. citizens have also contributed to the decrease in border crossing traffic. Entry to the U.S. from Mexico has become stricter for U.S. citizens—requiring identification cards and birth certificates. Starting in 2009, U.S. citizens will need to provide passports to enter the U.S. from Mexico. Also curtailing people's travel has been the increase in gas prices. Data from the Texas Center for Border Economic and

Enterprise Development at Texas A&M International University shows that vehicular and pedestrian border crossings in Texas decreased by 39.4 percent and 34.3 percent, respectively, from 2007 to 2008. Furthermore, importation for personal consumption is also affected by economic conditions in both the U.S. and Mexico, especially those affecting currency valuations. TABC staff believes that with fewer people crossing the border, fewer alcohol and cigarette imports will likely occur.

Taxpayer compliance officers are not peace officers and lack the authority to search or detain the public for failure to declare taxable items. If a person neglects to declare their importation of alcohol or cigarettes for personal consumption to a taxpayer compliance officer, even if a container is visible, the taxpayer compliance officer cannot require the person to declare the container or pay the tax. In effect, taxpayer compliance officers are available at border POEs to provide persons with the opportunity to comply with the law via the purchase of stamps, but they do not actively collect the tax. TABC staff suggests that this problem is exacerbated by the proximity of taxpayer compliance officers to the "primary" U.S. border-crossing stop, which U.S. Customs controls. The closer the TABC taxpayer compliance officer is to U.S. Customs officials, the more likely individuals are to declare their imported items to TABC officials and pay the required tax. The more distance between these two points, the more opportunity individuals have to conceal their imported items and to avoid stopping to declare items to the taxpayer compliance officer.

TABC reports that no formal cost-benefit analysis has been conducted to base the allocation of staffing resources for the collection of alcohol and cigarette revenue at POEs. As noted above, taxpayer compliance officers are permanently assigned to 19 crossings of the 26 border crossings and another three crossings are spot checked periodically. The seven crossings that are not permanently staffed are considered by the agency to be low-volume and are monitored on an informal basis. Further, air and seaports are not staffed but the cost-benefit analysis of staffing these ports has been informal and limited. Because no formal analysis has been done, the state cannot accurately determine the amount of uncollected revenue being forgone at unstaffed POEs.

Furthermore, Legislative Budget Board (LBB) staff analysis shows that collection of alcohol and cigarette revenue per taxpayer compliance officer at border POEs in fiscal year 2008 ranges from approximately $6,000 to $95,000 (with only one bridge above $50,000), the average being about $34,000. The average cost of salary and benefits for one taxpayer compliance officer is approximately $38,000. From fiscal years 2003 to 2007 collection of alcohol and cigarette revenue at POEs as a percentage of expenses, a performance measure for TABC, ranged from 101 percent to 115 percent. For fiscal year 2008, the measure dropped to an estimated 92 percent and the agency projects that it will continue to decline in fiscal years 2009 and 2010. TABC's POE program budget for fiscal year 2009 exceeds alcohol and cigarette revenue collections in fiscal year 2008 by approximately $270,000. Recommendation 1 would amend the Texas Alcoholic Beverage Code to direct TABC to conduct a cost-benefit analysis, including air and seaports, and use the findings of the analysis to make staffing determinations for the placement of taxpayer compliance officers at POEs. TABC should report its findings and resulting POE staffing assignments to the LBB and the Governor no later than January 1, 2010.

Another factor affecting the collection of taxes on alcohol is that the importation limits for Texas residents differs from non-residents. These differing importation limits existed in statute at least as far back as the 1977 re-codification of the Texas Alcoholic Beverage Code. **Figure 91** shows the importation limits for residents and non-residents.

FIGURE 91
TEXAS IMPORTATION LIMITS FOR THE PERSONAL CONSUMPTION OF ALCOHOL, FISCAL YEAR 2009

ALCOHOL	IMPORTATION LIMIT, TEXAS RESIDENTS	IMPORTATION LIMIT, NON-RESIDENTS
Beer	24 12-ounce containers	24 12-ounce containers
Wine	3 gallons (10.5 liters)	1 gallon (3.5 liters) of wine or distilled spirits combined
Distilled Spirits	1 quart (1 liter)	

SOURCE: Texas Alcoholic Beverage Commission.

Differences in limits for residents and non-residents require taxpayer compliance officers to verify residency and apply the appropriate limit on the importation of alcohol for personal consumption. TABC reports that standardizing importation limits would streamline the process and reduce confusion for consumers.

Recommendation 2 would amend the Texas Alcoholic Beverage Code to raise the importation limits for Texas residents and non-residents to the greatest of either current limit into one limit on the importation of alcohol for personal consumption. The new limit on importation for both Texas residents and non-residents would be the following: 1 gallon

(3.5 liters) distilled spirits; 24 12-ounce containers of beer; and 3 gallons (10.5 liters) of wine. Raising the importation limits to the greatest of either current limit would result in an increase in revenue collections of $300,000 in General Revenue Funds for the 2010–11 biennium.

FISCAL IMPACT OF THE RECOMMENDATIONS

These recommendations would result in a gain of $300,000 in General Revenue Funds for the 2010–11 biennium. Recommendation 1 would not have a fiscal impact as the POE staffing analysis could be conducted with existing resources.

Recommendation 2 would result in increased collections of alcohol taxes and fees of approximately $150,000 per fiscal year as shown in **Figure 92**. This estimate assumes that Texas residents import 90 percent of the containers of distilled spirits of a volume of less than 1.75 liters, and that 14 percent of those persons would import the new maximum limit. An increase in revenue from importation for personal consumption may be offset by a reduction in sales tax on alcohol sold in Texas, but this decrease is assumed to be negligible.

FIGURE 92
FISCAL IMPACT OF THE RECOMMENDATIONS, FISCAL YEARS 2010 TO 2014

FISCAL YEARS	PROBABLE GAIN/(LOSS) IN GENERAL REVENUE FUNDS
2010	$150,000
2011	$150,000
2012	$150,000
2013	$150,000
2014	$150,000

SOURCE: Legislative Budget Board.

No adjustment has been made to the introduced 2010–11 General Appropriations Bill as a result of these recommendations.

PROTECT TEXAS CONSUMERS BY STRENGTHENING GIFT CARD LAWS

Consumer demand and adept marketing have caused sales of gift cards to become a multi-billion revenue stream for retailers nationwide. Businesses have benefitted from this trend, but their practices sometimes prevent consumers from redeeming a gift card's original worth. Businesses issuing the cards can charge monthly service, dormancy, and other fees or decline to reinstate cards that were lost or stolen, in spite of ownership verification. By amending state statute, Texas could provide more controls to ensure that consumers keep the full value of their gift cards.

FACTS AND FINDINGS

- Until a new Texas law went into effect September 2005, gift cards not used for three years became abandoned property, and their unused amount transferred to the state (a process known as escheatment). Consumers could then reclaim the dollar amount of any card that was lost or stolen with adequate proof of ownership.
- Businesses issuing the gift cards can legally charge reasonable fees under these circumstances: issuing or adding value to a card, automated teller machine access, and replacing lost or stolen cards. A year after the card's sale, they may assess any reasonable fee that decreases the card's value.

CONCERNS

- Gift cards that are sold in Texas with no expiration date and for which allowable fees are charged and disclosed never become abandoned property, which prevents consumers from recovering full value if a business refuses to reissue a lost or stolen card under any circumstances.
- Because state statute does not define what constitutes a "reasonable" fee, there is no real limit on the amount businesses can charge under the allowable circumstances mentioned above. One year after issuance, gift cards can quickly decrease in value for the same reason.
- Both the assessment of fees by businesses and the exclusion of cards with no expiration date from escheatment decrease state revenue associated with unclaimed property.

RECOMMENDATIONS

- **Recommendation 1:** Amend Section 72.1016, Texas Property Code, and Section 604.002, Texas Business and Commerce Code, to require businesses to report gift cards having no expiration date as abandoned property under the same three-year dormancy standard applied to those that do expire.
- **Recommendation 2:** Amend Sections 604.051 and 604.052, Texas Business and Commerce Code, to prohibit companies from charging any fees associated with gift cards.

DISCUSSION

State escheatment laws protect the financial interest of property owners by giving them the opportunity to claim assets legally defined as abandoned. In Texas, personal property meets this definition when the existence and location of the owner is unknown, and a claim to it has not been asserted nor an act of ownership exercised for three years. The law governing gift cards that expire is similar in that they are considered abandoned after the earlier of its expiration date, three years after the last transaction, or if no transaction has ever occurred, three years from its issuance date.

Once a gift card is considered abandoned, the business that sold the card must report it to the Comptroller of Public Accounts (CPA) and then transfer its cash value to the state in the next reporting period. At that point, the state must make certain attempts to contact the card owner. Upon receipt of unused gift card-related money, CPA deposits it into the General Revenue Fund. In fiscal years 2005, 2006, and 2007, the General Revenue Fund received $379,000, $1,100,000, and $774,000, respectively, associated with the unused portion of gift cards

Legislation enacted in 2005 amended statute to exempt non-expiring cards from escheatment as long as they carry only reasonable and permissible fees that are disclosed properly. Prior statute treated gift cards like any other personal property—a three-year dormancy provision applied in all cases. The 2005 legislation considers cards with no expiration date as being under the control of the issuing business permanently.

To claim abandoned property in Texas, a person must present identification and proof of ownership, in this case a purchase receipt and the card's serial number. While people can obtain the value of a card with an expiration date, they cannot for cards without one. In that situation, if a merchant will not reissue a lost or stolen card under any circumstances, a person cannot use the remaining amount on the card even if they can prove ownership.

As a result of making non-expiring gift cards exempt from escheatment, a source of state revenue will eventually disappear. Because the legislation went into effect three years ago, which is also the dormancy period for personal property escheatment, the revenue loss cannot be determined at this point.

Recommendation 1 would address the inability of people who own gift cards without an expiration date to recover the unused value of card presumed abandoned by state law. It would amend Section 72.1016 of the Texas Property Code and Section 604.002 of the Texas Business and Commerce Code to provide the same escheat provision that existed prior to September 1, 2005.

ELIMINATE GIFT CARD FEES

Sales of gift cards have increased significantly in recent years. Many consumers prefer them because of their convenience and the freedom they give recipients to make their own shopping choices. According to Business Intelligence Group's market research, the average shopper planned on spending $156.24 for gift cards, and 78 percent would buy at least one during the 2007 holiday season.

Retailers and banks have benefitted from this demand. A financial research firm, the Tower Group, projects that gift card sales will exceed $100 billion in 2008, compared to $80 billion in 2006. What makes the cards even more profitable is consumers usually buy more than what the card is worth in a typical transaction. On average, people spend 20 percent above the value of their cards when shopping.

Businesses can avoid redeeming the amount a consumer paid. A 2007 survey by *Consumer Reports* found that 27 percent of respondents had not used their cards within a year after receiving them. A similar survey in 2006 indicated a non-use rate of 19 percent. The Tower Group's analysis found that consumers nationwide lost nearly $8 billion annually from unused cards.

People who wait several months to use their card may find its worth significantly less than what they expected. This devaluation occurs when a business charges maintenance or dormancy fees. While the fees encourage more immediate usage, they also provide an additional source of income for the issuer. Often, charges begin several months after issuance. Fees can range from $1.00 for retailer's cards to $4.95 a month for bank-issued cards. When combined with fees charged for issuance or adding value, a significant portion of the card's original value can diminish over time.

Gift cards fall into two categories. Closed-loop cards are issued by retailers to purchase items only at their stores or online sites. Open-loop cards have the logo of a credit card company such as VISA and are accepted throughout their network. Banks, however, are the actual sellers of open-loop cards. Although open-loop cards are more likely to carry dormancy or maintenance fees, some closed-loop retail cards have them as well.

States have adopted laws that control fees and expiration dates. Currently, 12 states prohibit merchants from charging post-purchase fees for closed-loop cards at any time. A trend towards even stronger consumer protection in this area has emerged in recent years. States such as Minnesota, Montana, and Rhode Island prohibit both expiration dates and dormancy fees.

Texas law allows reasonable charges that reduce a card's value one year after its sale. The same provision prevents businesses from assessing fees after the card is presumed abandoned (i.e., three years after issuance or inactivity). Consequently, a two-year-plus window exists within which the unused amount can decrease substantially.

The law does not define what a "reasonable" fee level means. Given that a wide variety of fee categories are permitted, this open-ended provision allows businesses to decrease the card's value significantly. The combined effect of the two-year window and unrestricted charges not only harms consumers but also reduces state revenue because money that escheats to the state is lower than if no fees were charged.

Recommendation 2 would ensure that consumers receive the full purchasing power of their gift cards by prohibiting any fees from being assessed. Consumers would know from the outset what they are buying, and the state would not lose revenue from escheated cards.

FISCAL IMPACT OF THE RECOMMENDATIONS

Implementation of Recommendations 1 and 2 would result in a revenue gain to the General Revenue Fund. The gain

cannot be estimated because the effect of fees on abandoned property revenue is unknown. Additionally, because the 2005 legislation regarding cards with no expiration dates applies only to those issued after September 1, 2005, the effect of eliminating the three-year dormancy period has not had its full impact yet.

No adjustment to the introduced 2010–11 General Appropriations Bill has been made as a result of these recommendations.

REDUCE HOSPITAL MEDICAL ERRORS BY PROHIBITING PAYMENT AND COLLECTING DATA

Preventable medical errors are a leading cause of death in the U.S. that also result in significant costs to patients, payers, and providers. Almost 10 years after a national report drew attention to medical errors, there is limited information about the frequency and cost of these events, and quality efforts remain uncoordinated and gains limited. Recently, in response to medical errors, payers including the federal Medicare program and three state Medicaid programs have announced policies to deny reimbursement for certain medical errors, and federal and state-level data collection programs are underway. By requiring the Texas Medicaid Program to deny payment for medical errors and hospitals to report data on the frequency of errors, Texas could improve the quality of hospital care and reduce preventable errors.

FACTS AND FINDINGS

- Preventable medical errors are a leading cause of death in the U.S. In 1999, the Institute of Medicine estimated up to 98,000 deaths each year were due to preventable errors, and these events cost between $17 billion to $29 billion annually when considering the direct and indirect health and other costs. While the full extent of the frequency and cost of these errors remains largely unknown, researchers believe the rates and severity of events have not changed significantly since the early 1990s due to the limited, fragmented, and uncoordinated nature of quality improvement efforts.
- The Centers for Medicare and Medicaid Services began denying reimbursement to Medicare acute-care hospitals on October 1, 2008 for 11 hospital-acquired conditions.
- Twenty-seven states collect data on the frequency of some medical errors. Pennsylvania and New York have announced recently that their Medicaid programs will deny reimbursement for some preventable medical errors. Massachusetts reports it will no longer reimburse for preventable medical errors across state government health programs and will prohibit hospitals from billing for payment when these errors occur. The Centers for Medicare and Medicaid Services reports as many as 20 states are considering policies to deny payment for some medical errors.
- The Texas Hospital Association Board of Trustees developed guidelines for hospitals to use in billing claims containing medical errors and encouraged its member hospitals not to bill for nine preventable errors.

CONCERNS

- The Texas Medicaid Program and four state health plans (Employees Retirement System, Teacher Retirement System, Texas A&M University, and The University of Texas) currently reimburse hospitals for preventable medical errors.
- On October 1, 2008, the Centers for Medicare and Medicaid Services began paying claims containing certain hospital errors that were not present-on-admission at lower rates, and, as a result, it is possible that the Texas Medicaid Program and state employee health plans will incur additional costs for dual-eligible clients and retirees.
- Texas does not collect data on the frequency of hospital errors, which prevents the state from understanding the extent of the problem and identifying quality improvement strategies to improve the processes or systems most likely to contribute to their occurrence. In addition, hospitals are not held accountable to the public for their medical error rates, and the public lacks quality information to use when making decisions about where to seek medical treatment.

RECOMMENDATIONS

- **Recommendation 1:** Amend the Texas Human Resources Code to require the Texas Health and Human Services Commission to deny Medicaid payment for 28 medical errors, as defined by National Quality Forum, and any additional conditions for which the Centers for Medicare and Medicaid Services deny payment. The Texas Health and Human Services Commission should develop rules regarding the processes for event identification, event verification, denial of payment, and management of provider appeals for a June 1, 2010 implementation date. The Texas Health and Human Services Commission should modify the Medicaid State Plan as needed to account for the denial of payment for the 28 medical

errors and any additional Centers for Medicare and Medicaid Services conditions.

- **Recommendation 2:** Include a contingency rider in the 2010–11 General Appropriations Bill to require the Texas Health and Human Services Commission to provide a report on the implementation of the new rules to the Governor and the Legislative Budget Board no later than November 1, 2010.
- **Recommendation 3:** Include a rider in Article IX of the 2010–11 General Appropriations Bill requiring that the Employees Retirement System, Teacher Retirement System, The University of Texas, and Texas A&M University health plans jointly study (1) the feasibility and cost-effectiveness of including a provision to deny payment for the 28 National Quality Forum events and additional conditions identified by the Centers for Medicare and Medicaid Services in their next request for proposal for a third-party administrator, and (2) the potential impact of "balance billing" of clients and identify recommendations to address the impact, and provide a report on their recommendations to the Governor and the Legislative Budget Board no later than December 31, 2009.
- **Recommendation 4:** Amend Chapter 98 of the Texas Health and Safety Code to require the Texas Department of State Health Services to collect data on 28 medical errors and any other Centers for Medicare and Medicaid Services' selected conditions in addition to surgical site infections.
- **Recommendation 5:** Include a contingency rider in the 2010–11 General Appropriations Bill to require the Texas Department of State Health Services to provide a report on the implementation of the data collection system and summarize collected data to the Governor and the Legislative Budget Board no later than November 1, 2010.
- **Recommendation 6:** Include a contingency rider in the 2010–11 General Appropriations Bill to appropriate funding to the Texas Department of State Health Services to collect data as required by Chapter 98 of the Texas Health and Safety Code.

DISCUSSION

In 1999, the Institute of Medicine (IOM) released *To Err Is Human: Building a Safer Health System*. This report estimated that up to 98,000 annual deaths in the U.S. could be attributed to medical errors, making medical errors a leading cause of death. The analysis concluded healthcare has lagged behind other high-risk industries in adopting safety practices. In both the 1999 report and a follow-up 2001 report, IOM offered recommendations to develop mandatory and voluntary reporting systems to improve hospital quality. IOM and other proponents of the collection and public reporting of data on adverse events argue that data collection holds providers accountable and spurs quality improvement by focusing attention on weak points in the healthcare system and giving all providers an incentive to increase investments in quality. The IOM report spawned further state-level data collection and research on medical errors and how to improve hospital quality.

Despite this data collection and research, almost 10 years after the first IOM report, the frequency and cost of hospital errors remains largely unknown, and researchers believe the rates and severity of adverse events have not changed since the early 1990s. Data collection program and quality improvement efforts remain limited, fragmented, and uncoordinated.

DEFINING NEVER EVENTS

The IOM report focused on "preventable adverse events," or medical errors resulting in injury. Since the IOM report, researchers and policymakers have coined new terms including "hospital-acquired infection" and "Never Event" to refer to specific groups of errors. While often used interchangeably, these terms retain distinct definitions.

A medical error is a failure of planned actions in a healthcare setting. Examples include surgery on the wrong body part or patient, retention of a foreign object in a person post-surgery, and performance of the wrong surgery. A hospital-acquired infection (HAI), also known as a nosocomial infection, is an infection caused by a medical intervention. Examples include a surgical site infection or an infection obtained from a medical device such as a catheter. Methicillin-Resistant Staphylococcus Aureus (MRSA), a bacterial infection resistant to antibiotics, is an HAI that has received recent attention in many states.

National Quality Forum (NQF), a private organization dedicated to improving the reporting of adverse events, developed a "Never Event" list of serious, reportable events that should never occur in a medical setting. The list contains 28 HAIs and medical errors that have serious and adverse impacts on patients, are preventable, and fall within a healthcare provider's span of control. **Figure 93** shows the NQF Never Event list.

FIGURE 93
NATIONAL QUALITY FORUM'S SERIOUS REPORTABLE EVENTS IN HEALTHCARE, 2006

EVENT CATEGORY	HEALTHCARE-ASSOCIATED INFECTIONS AND ERRORS
Surgical	• Surgery performed on the wrong body part • Surgery performed on the wrong patient • Wrong surgical procedure performed on a patient • Unintended retention of a foreign object in a patient after surgery or other procedure • Intraoperative or immediately postoperative death in an ASA Class I patient
Product or Device	• Patient death or serious disability associated with the use of contaminated drugs, devices, or biologics provided by the healthcare facility • Patient death or serious disability associated with the use or function of a device in patient care in which the device is used or functions other than as intended • Patient death or serious disability associated with intravascular air embolism that occurs while being cared for in a healthcare facility
Patient Protection	• Infant discharged to the wrong person • Patient death or serious disability associated with patient elopement (disappearance) • Patient suicide, or attempted suicide, resulting in serious disability while being cared for in a healthcare facility
Care Management	• Patient death or serious disability associated with a medication error (e.g., errors involving the wrong drug, wrong dose, wrong patient, wrong time, wrong rate, wrong preparation, or wrong route of administration) • Patient death or serious disability associated with a hemolytic reaction due to the administration of ABO/HLA-incompatible blood or blood products • Maternal death or serious disability associated with labor or delivery in a low-risk pregnancy while being cared for in a healthcare facility • Patient death or serious disability associated with hypoglycemia, the onset of which occurs while the patient is being cared for in a healthcare facility • Death or serious disability (kernicterus) associated with failure to identify and treat hyperbilirubinemia in neonates • Stage 3 or 4 pressure ulcers acquired after admission to a healthcare facility • Patient death or serious disability due to spinal manipulative therapy • Artificial insemination with the wrong donor sperm or wrong egg
Environmental	• Patient death or serious disability associated with an electric shock while being cared for in a healthcare facility • Any incident in which a line designated for oxygen or other gas to be delivered to a patient contains the wrong gas or is contaminated by toxic substances • Patient death or serious disability associated with a burn incurred from any source while being cared for in a healthcare facility • Patient death or serious disability associated with a fall while being cared for in a healthcare facility • E. Patient death or serious disability associated with the use of restraints or bedrails while being cared for in a healthcare facility
Criminal	• Any instance of care ordered by or provided by someone impersonating a physician, nurse, pharmacist, or other licensed healthcare provider • Abduction of a patient of any age • Sexual assault on a patient within or on the grounds of a healthcare facility • Death or significant injury of a patient or staff member resulting from a physical assault (i.e., battery) that occurs within or on the grounds of a healthcare facility

SOURCE: National Quality Forum.

In this report, "medical error" refers to HAIs and medical errors, and the term "Never Event" refers to an event included on NQF's list.

FREQUENCY OF NEVER EVENTS

There is no single source of data that quantifies how many Never Events occur annually in the U.S. There are many public and private, voluntary and mandatory data collection efforts to quantify the frequency of select groups of medical errors (primarily HAIs) but most do not directly correspond to a Never Event. As a result, the frequency of these events is difficult to quantify.

The Centers for Disease Control (CDC) collects the most robust national HAI data through the National Healthcare Safety Network program. This program began in 2005 and approximately 1,000 hospitals participate as of December 2007. The CDC collects data on device-associated infections and procedure-related HAIs such as surgical site infections and post-procedure pneumonia. In its most recent analysis using 2002 data, the CDC estimated 1.7 million HAIs occur annually, with 99,000 resulting in death.

COST OF NEVER EVENTS

While it is difficult to determine national or state costs of Never Events without robust frequency data, several studies attempted to quantify the direct health and indirect other costs of certain adverse events and identify who pays for them. The 1999 IOM report estimated the annual costs of hospital errors ranged from $17 billion to $29 billion. This estimate includes health costs which comprise about half of overall costs, and also other costs including lost income, lost household production, and disability costs. IOM cautioned its estimate was likely to be an underestimate of the true cost because it only analyzed adverse events in the context of hospital care, and did not include estimates for adverse events that occur in other healthcare settings.

Analysis conducted by the Agency for Health Research and Quality (AHRQ) in 2008 found that previous analyses of the cost of patient safety events are likely to have underestimated the full extent of hospital costs. These costs could vary by as much as 25 percent because they did not consider post-discharge activities that occur as a direct result of the event such as readmissions or outpatient visits.

Hospitals, the federal and state governments, and patients and their families share the costs of medical errors. In 2007, APIC reported HAIs are harmful financially to hospitals because reimbursement from payers rarely covers the full cost of treating HAIs, and hospitals lose potential revenue from new patients when current patients occupy beds longer. In addition, a hospital could encounter additional costs through malpractice suits. A 2006 study of Medicare claims found that hospitals absorbed two-thirds of costs associated with injuries and billed Medicare for one-third. However, most of the studies examining the health costs absorbed by hospitals do not account for the non-health costs of adverse events such as lost income, lost household production, future medical expenses, and noneconomic losses. A 2007 study found hospitals actually only bear 22 percent of the total costs of adverse events. Hospitals were able to shift costs to other payers for 78 percent of all injuries and 70 percent of negligent injuries. The shifted costs are typically paid by patients and their families. State and federal governments take on some costs if persons become disabled as a result of medical errors and receive benefits through long-term disability programs.

EFFORTS TO IMPROVE HOSPITAL QUALITY

IOM determined that most medical errors were due to problems with underlying hospital processes and systems. Since the late 1990s, countless quality improvement initiatives have been implemented at the federal, state, and hospital levels. Despite these efforts, improvements have been isolated and not applied consistently across the entire healthcare industry. According to NQF, quality improvement is not occurring in a "unified, national fashion." The Leapfrog Group for Patient Safety, an organization working to improve health care safety and quality, has found varying levels of compliance with best practices. The Leapfrog Group reports that 87 percent of 1,256 hospitals voluntarily participating in its 2007 Hospital Quality and Safety Survey lacked policies to avoid HAIs. Examples of uneven hospital compliance with best practices include the following:

- 25 percent fully meet the standard for the Leapfrog Safe Practices Score (measures whether hospitals implemented most of the NQF's Safe Practices);
- 44 percent implemented procedures to avoid wrong-site surgeries;
- 36 percent have an adequate hand-washing policy for employees;
- 35 percent have a satisfactory policy for preventing pressure ulcers;
- 29 percent require a pharmacist to review medication orders;

- 39 percent fully comply with prevention practices for Aspiration and Ventilator Associated Pneumonia;
- 25 percent fully comply with central venous catheter-related bloodstream infection prevention practices; and
- 33 percent fully comply with prevention practices for surgical site infections.

DATA COLLECTION TO REDUCE PREVENTABLE ERRORS

To improve hospital quality, many state governments have begun to collect data on medical errors. New York and Pennsylvania began collecting patient safety data in the mid-1980s and 1990s, but it was not until after the IOM reports that many states became active in the area. By October 2007, mandatory data collection programs for some group of adverse events existed in 25 states and Washington, D.C., and one state maintained a voluntary program. At least 15 states have taken regulatory or legislative actions in this area since 2005. State approaches to data collection and reporting vary in several respects, and data on the effectiveness of the different program design features are not yet available.

The type of data collected by states differs. Some states collect data on process measures, and others evaluate outcomes. According to a 2007 report by the National Academy for State Health Policy, about half of the states with reporting systems use the Never Events, while others create their own list of events to track using CMS, AHRQ, and Joint Commission recommendations. Some others use National Healthcare Safety Network definitions, and at least 10 states mandate reporting to the National Healthcare Safety Network data collection system. Some states no longer track the data themselves and have made arrangements with the state's hospitals to report to the National Healthcare Safety Network, and each hospital grants the state agency access to the data. Other states have more targeted infection-tracking systems for conditions like MRSA.

Aside from the events to track, how states define "an event" varies. Pennsylvania's system counts actual events and near-misses, while many states only count actual events. Reporting requirements also vary by state. Some states require hospitals to report on data hospital-wide, and others collect data only from Intensive Care Units and surgery wards.

Lastly, states differ widely in determining whether to share the data with the public and how much information to make available. Of the 27 entities with reporting systems, all but 3 share or plan to share the information with the public. Sixteen post information online, and five plan to post information online in the near future. The frequency of the data's release varies by state. Most states release data annually, and some release data sporadically as funding allows. Colorado issues data weekly. States also do not agree on the level of the data to share with the public. Seventeen states release aggregated data, while seven provide or will provide data at the hospital level. Some states issue raw data, while small groups of states such as Pennsylvania, Florida, and Missouri have issued summary reports on findings.

In the absence of national data, some of the most complete data available are collected by Florida, New York, and Pennsylvania. **Figure 94** shows the profiles of the activities in these states. In addition to collecting data from all of the hospitals in their states, they have continued to improve the quality of the data collected by training hospital staff, refining definitions and reporting guidelines, and improving data collection and validation processes.

FIGURE 94
STATE PROFILES OF ADVERSE EVENT AND HOSPITAL-ACQUIRED INFECTION DATA COLLECTION SYSTEMS, 2008

COLLECTION SYSTEM	FLORIDA	NEW YORK	PENNSYLVANIA
Administration	Agency for Health Care Administration (AHCA)	Department of Health	Patient Safety Authority
Program history	Florida began collecting data from hospitals in 1995, and three agencies/programs have administered the data collection effort. The current program is housed within AHCA.	New York's adverse event data collection began in 1985, but the current system was implemented in 1998. The New York Patient Occurrent Reporting Tracking System (NYPORTS) was implemented with "outcomes" focus. The newest system enables collection of more uniform data through clear definitions and instructions.	The Authority was established in 2002. The Authority implemented the Pennsylvania Patient Safety Reporting System (PA-PSRS) and began collecting data in 2004. The system is a secure, web-based reporting tool. A dedicated Treasury account supports the Authority, funded through assessments on medical facilities.

FIGURE 94 (CONTINUED)
STATE PROFILES OF ADVERSE EVENT AND HOSPITAL-ACQUIRED INFECTION DATA COLLECTION SYSTEMS, 2008

COLLECTION SYSTEM	FLORIDA	NEW YORK	PENNSYLVANIA
Data collected	Serious patient injury reporting includes: patient death, brain/spinal damage, surgery on wrong patient, wrong-site surgical procedure, wrong surgical procedure, performance of unnecessary/ unrelated surgery, surgery to repair damage from planned surgical procedure when damage is not recognized as a risk or disclosed to the patient through the informed consent process, and surgery to remove foreign object from previous surgery.	Wrong patient; wrong-site surgical procedure; incorrect procedure or treatment; unintentional retention of foreign body; unexpected death; cardiac and/or respiratory arrest requiring ACLS intervention; loss of or impairment of limb, organ, or body function; malfunction of equipment during treatment or diagnosis; medication error resulting in permanent harm, near-death, or patient death; pulmonary embolism; deep vein thrombosis; acute myocardial infarction unrelated to a cardiac procedure; burns; falls; post-operative infection within 30 days of hospitalization; other serious occurrence; specific patient transfers; misadministration of radiation or radioactive material; crime; suicides; elopement; strike by hospital staff; external disaster which impacts hospital operation; termination of services vital to safe operation of hospital or health or safety of patients; poisoning; fire; malfunction of equipment; infant abduction or discharge to wrong family; and rape.	The authorizing legislation requires hospitals, ambulatory surgical centers, birthing centers, and abortion facilities to report serious events (actual events), incidents (near misses), and infrastructure failures.
Public reporting	State law requires summaries and trend analysis be posted at least quarterly and a summary to be drafted and posted online annually. Data is available at: http://www.fdhc.state.fl.us.	The agency submits annual reports. In addition, a hospital profile system is available online: http://www.health.state.ny.us.	The Patient Safety Authority is required to hire contractors to complete analysis and reports and publishes data on an annual basis. Data is available at: http://www.psa.state.pa.us.
HAI Reporting	In 2004, the Florida Legislature passed legislation requiring healthcare facilities to submit HAI data, among other required elements, to AHCA.	In 2005, legislation passed requiring hospitals to report certain HAIs to the Department of Health. Data collection began during a one-year pilot in 2007. The Department of Health selected the NHSN as its reporting mechanism, making New York the first state to require its hospitals to use this system.	The Department of Health, Patient Safety Authority, and Pennsylvania Health Care Cost Containment Council share responsibilities in HAI Reporting. In 2007, Act 52 required that hospitals begin to report HAI data to the NHSN.

SOURCE: Legislative Budget Board.

CHANGES TO REIMBURSEMENT POLICIES TO REDUCE PREVENTABLE ERRORS

More recently, both the federal and some state governments have announced plans to reduce reimbursement when certain medical errors or Never Events occur, linking payment to quality of care. Programs affected include the Medicare program and the Medicaid programs in Pennsylvania, New York, and Massachusetts.

The federal Deficit Reduction Act of 2005 identified cost savings across federal benefits programs and sought to leverage Medicare spending to influence hospital quality. One provision was designed to increase patient safety and attention to quality by denying reimbursement for preventable hospital errors through a change in reimbursement policy. **Figure 95** provides summary information on the current reimbursement methodology used by the Centers for Medicare and Medicaid Services (CMS). The legislation requires the Secretary of Health and Human Services to select

FIGURE 95
MEDICARE REIMBURSEMENT METHODOLOGY

Hospitals bill the Medicare program for inpatient hospital services using the prospective payment system. Each claim is assigned to a Diagnosis Related Group (DRG) based on a principal diagnosis, up to eight secondary diagnoses, and up to six procedures performed during the hospital visit.

Coding staff use the *International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM)* to report diagnostic codes and procedure information. Classification for a small number of DRGs is based on patient factors, including age, sex, and discharge status.

The presence of some secondary diagnoses can result in assignment of a case into a higher-paying DRG; a total of 258 DRGs for fiscal year 2008 could be split into multiple groups based on the presence of these secondary diagnoses, referred to as complications and co-morbidities (CCs) or major complications and co-morbidities (MCCs). This system does not reimburse facilities for the actual expenses of treating patients but provides payments based on the average cost of treating a claim in a given DRG. DRGs reflect the "bundle" of services a patient receives based on the primary and secondary diagnoses. Medicare pays hospitals using a flat rate based on the DRG, which encourages efficient treatment.

The majority of cases are addressed in this manner, but a separate methodology is used to pay for outlier cases with high costs. Once a case reaches the outlier threshold for the year, $23,015 in fiscal year 2008, CMS will reimburse hospitals 80 percent of costs above the threshold.

Source: Legislative Budget Board.

at least two conditions that are both (a) high cost or high volume or both, (b) result in the assignment of a case to a DRG that has a higher payment when present as a secondary diagnosis, and (c) could reasonably have been prevented through the application of evidence-based guidelines by October 1, 2007 and to deny payment by October 1, 2008.

In August 2007, CMS adopted rules to implement this law. Effective October 1, 2008, hospitals, excluding certain hospitals that do not use the DRG-based methodology, do not receive additional payment for cases in which one of the CMS-selected conditions is present on a claim as a CC/MCC but was not present-on-admission (POA). As of the final fiscal year 2008 rule, these conditions include: falls, mediastinitis, urinary tract infections that result from improper use of catheters, pressure ulcers, vascular infections that result from improper use of catheters, objects left in the body during surgery, air embolisms, and blood incompatibility. The final fiscal year 2009 rule added three conditions including surgical site infections following elective procedures including certain orthopedic surgeries and bariatric surgery for obesity, deep vein thrombosis or pulmonary embolism following total knee and hip replacement procedures, and some manifestations of poor glycemic control.

To facilitate implementation, hospitals were required to begin reporting POA codes for primary and secondary diagnoses on October 1, 2007. This reporting enabled CMS to determine if a condition was present-on-admission or hospital-acquired. CMS processed POA data and educated hospitals on reporting errors from January 1, 2008 to March 31, 2008. Effective April 1, 2008, claims with incorrect coding were returned to hospitals. CMS provided and defined five POA indicator options including:

(1) "Y"–diagnosis present at time of inpatient admission;

(2) "N"–diagnosis was not present at time of inpatient admission;

(3) "U"–documentation is insufficient to determine if condition was POA;

(4) "W"–clinically undetermined, provider unable to determine whether condition was present or not; and

(5) "1"–unreported/not used, exempt from POA reporting. CMS will not pay for additional cost of care in claims in which the CC/MCC is coded as "N" or "U," but provisions exist for exceptional circumstances.

It is difficult to quantify the savings from this rule based on the absence of data on the frequency of these errors. CMS expects $21 million in annual savings for the Medicare program beginning in fiscal year 2009, and increasing to $22 million in 2012, when accounting for the conditions selected during the fiscal year 2008 and 2009 rules. Savings are expected in two areas:

- Initial savings will come from paying for a claim at a lower-paying DRG. In fiscal year 2008, 258 DRGs are split into two or three subgroups based on presence/absence of a CC/MCC, with different rates associated with the subgroups. Congress required the conditions selected by CMS to result in assignment to a higher paying DRG when present. The rule would have

CMS reimburse a hospital at the lower DRG level as if the CC/MCC did not exist. However, if another CC/MCC is present, the claim could still be classified at a higher-paying DRG, resulting in no cost savings. CMS found very few cases have only one CC/MCC, so cost savings are unlikely.

- In the long term, avoidance of costs is expected as hospitals make quality improvements prompted by the rule, resulting in fewer incidents in which DRG-based claims or outlier cases contain the conditions.

CMS activities in the area of medical errors remain ongoing. In the final federal fiscal year 2009 rule, CMS indicated it will continue to examine conditions for inclusion in future rules and proposed draft rules to expand the policy of not paying for healthcare-associated conditions in other care settings.

It is possible that some of the federal savings will be passed on as costs to states in the case of Medicare/Medicaid dual-eligible clients and for retirees covered by state health plans. When the federal Medicare program begins to reduce the amount paid on claims which contain the select hospital-acquired conditions, the unpaid portion could be passed onto secondary payers, including the Texas Medicaid Program and the state employee health plans.

STATE CHANGES TO REIMBURSEMENT POLICIES

CMS reports as many as 20 states are considering policies to deny payment for some medical errors. Pennsylvania became the first state to apply CMS' concept to its Medicaid program. In January 2008, the Department of Public Welfare issued a bulletin announcing that its fee-for-service Medicaid program would no longer reimburse hospitals for Never Events. Agency staff will generate reports using the POA indicator and ICD-9 diagnosis codes and injury (E) codes for possible cases involving Never Events. Agency staff will then review the inpatient medical record for each case to verify that a preventable adverse event occurred. Other cases with potential errors will be identified during case reviews and outlier and quality reviews. In these reviews, the Medical Assistance Program will determine if a Never Event occurred and, if so, whether the event could have been prevented. If it could have been prevented, Pennsylvania will not reimburse the hospital for the additional cost in treating the error associated with the case. Pennsylvania expects minimal savings from the policy change, anticipating that only about 100 cases would receive reduced payment per year. Pennsylvania also expects its managed care plans to adopt similar policies in the future.

In New York's fiscal year 2009 budget, the state reformed its Medicaid payment methodology and included a provision to deny payment for the following Never Events:

- surgery performed on the wrong body part;
- surgery performed on the wrong patient;
- wrong surgical procedure on a patient;
- foreign object inadvertently left in patient after surgery;
- medication error;
- air embolism;
- blood incompatibility;
- patient disability from electric shock;
- patient disability from use of contaminated drugs;
- patient disability from wrong function of a device;
- incidents whereby a line designated for oxygen intended for patient is wrong item or contaminated;
- patient disability from burns;
- patient disability from use of restraints or bedrails; and
- patient disability from failure to identify and treat hyperbilirubinemia (bilirubin in blood) in newborns.

New York will identify Never Events using the POA indicator and cease payment for 14 selected conditions effective October 2008.

In December 2007, Massachusetts launched the HealthyMass initiative, a collaboration of public and private stakeholder groups, to focus on access to healthcare, control of health costs, improving quality, promoting wellness, and improving community health. In June 2008, policymakers announced that a uniform non-payment policy for Never Events will be included in HealthyMass which will prohibit providers from billing for these events and deny payment for these events in the state's Medicaid program, the state health plans, and correctional facility health programs. The Office of Medicaid, Group Insurance Commission, Commonwealth Health Insurance Connector Authority, and Department of Correction have adopted the policy and will work together

on the implementation. They plan to include the new policy in each of their next contract cycles. Further details on the implementation have not been determined. Massachusetts hospitals had previously agreed to a voluntary billing ban for Never Events.

Mandatory and voluntary billing bans for some or all Never Events have been enacted in some states and at the hospitallevel. In April 2008, Maine's governor signed a law which prevents healthcare facilities from charging patients or insurers for Never Events, effective July 18, 2008. Maine expects minor savings to state health insurance programs from the ban. Maine is the first state to pass legislation preventing hospitals from charging for Never Events, though hospital associations in Maine, Massachusetts, Minnesota, Vermont, Washington, and Georgia had previously announced voluntary policies not to bill payers for some or all Never Events. Washington also recently announced that in addition to hospitals, ambulatory surgery centers will not bill patients for Never Events.

In May 2008, the Texas Hospital Association (THA) Board of Trustees developed guidelines for hospitals to use when drafting their own policies regarding billing for medical errors. The Board of Trustees advised hospitals to only withhold the billing request when the error or event is preventable, is within the hospital's control, is the result of a mistake made in the hospital, resulted in significant harm, and can be clearly or precisely defined in advance. Based on these guidelines, THA identified nine Never Events that meet the criteria including:

- surgery performed on the wrong body part;
- surgery performed on the wrong patient;
- the wrong surgical procedure performed on a patient;
- patient death or serious disability associated with intravascular air embolism that occurs while being cared for in a facility;
- an infant discharged to the wrong person;
- patient death or serious disability associated with a hemolytic reaction due to the administration of ABO-incompatible blood or blood products;
- death or serious disability, including kernicterus, associated with failure to identify and treat hyperbilirubinemia in neonates during the first 28 days of life;
- artificial insemination with the wrong donor sperm or donor egg; and
- patient death or serious disability associated with a burn incurred from any source while being cared for in a facility.

The Leapfrog Group reports that many individual hospitals have also developed policies not to charge for Never Events. Nearly two-thirds of hospitals completing its annual survey in 2008 reported that they would not charge for these events.

Nationally, private insurers have also begun to evaluate payment for Never Events. Individual Blue Cross and Blue Shield plans began phasing out payment for Never Events beginning on October 1, 2008. WellPoint has already started implementing provisions in its contracts to prevent payments for certain medical errors. Aetna now includes a Never Events policy, as developed by the Leapfrog Group, in its hospital contract templates which requires hospitals to report each medical error, take action to prevent future events, waive related costs, and apologize to the patient and/or family. Cigna Corp. is studying CMS' policy.

THE STATE OF TEXAS POLICY RESPONSE TO NEVER EVENTS

The Texas Medicaid Program and four state health plans (Employees Retirement System, Teacher Retirement System, Texas A&M University, and The University of Texas) currently reimburse hospitals for Never Events, which does not provide hospitals with an incentive to invest in quality improvements.

Medicaid payments are determined without regard to whether a Never Event occurred. The current payment methodologies used by the Texas Medicaid Program include: fee schedules, reasonable cost with interim rates, hospital reimbursement methodology, provider-specific encounter rates, reasonable charge payment methodology, and manual pricing. For inpatient hospital stays, other than those that occur at children's and psychiatric hospitals, providers are reimbursed based on a prospective payment methodology based on DRGs.

The health plans Blue Cross and Blue Shield and Aetna administer for Texas state employees and retirees currently reimburse providers for Never Events. However, at the national level, Blue Cross and Blue Shield and Aetna have announced plans to deny reimbursement for some Never Events. In addition, Blue Cross and Blue Shield of Texas

announced in July 2008 that it would no longer reimburse providers for the additional costs to treat hospital-based preventable medical errors including the conditions selected by CMS and the nine NQF events selected by THA in its policy.

Texas does not collect data on the frequency of Never Events currently. This lack of data prevents the state from developing an understanding of the extent of the problem and identifying tailored quality improvement strategies to improve the specific processes or systems most likely to contribute to Never Events. In addition, hospitals are not held accountable to the public for their rates of Never Events, and the public lacks quality information to use when making decisions about where to seek medical treatment.

Three recent initiatives would have had the state collect Never Events or related data, and although one was in place and collected data for three years, none are operational currently. Legislation enacted by the Seventy-eighth Legislature, Regular Session, 2003, established the Patient Safety Program. It required that hospitals report annually on the occurrence of 10 Never Events to the Department of State Health Services (DSHS). **Figure 96** shows reported data for the three years of the program.

The legislation also established a patient safety program in hospitals, ambulatory surgical centers, and mental health facilities. DSHS established rules and collected data for three years, but the legislation expired on September 1, 2007. DSHS continues to provide some program support, but hospitals are not required to submit data or other documentation as previously required.

Senate Bill 288, passed during the Eightieth Legislature, 2007, requires public reporting of HAIs. DSHS was required to establish the Texas Health Care-Associated Infection Reporting System no later than June 1, 2008; but because DSHS did not receive appropriations specifically to implement this provision, it has been unable to create this system. According to DSHS, some preliminary activities related to Senate Bill 288 including planning and meetings of the HAI Advisory Council have occurred in conjunction with the implementation of Senate Bill 1731, the "Citizen's Guide to Healthcare," but DSHS indicated that additional funding is required for implementation. The HAI Advisory Council recommended that Texas use the CDC National Healthcare Safety Network system, and DSHS requested funding from the Legislature as part of the budget process for fiscal years 2010–11 to move forward with this recommendation.

In September 2007, the DSHS Center for Health Statistics issued a proposed rule in the *Texas Register* indicating that POA indicator data would be collected in fiscal year 2008, as part of the hospital discharge data already collected by the agency's Health Care Information Collection program. This data could have enabled analysis of all diagnostic codes to determine if the conditions were hospital-acquired. However, the POA indicator was removed from the list of required data elements in the final December 2007 rule.

Legislative Budget Board (LBB) and Texas Health and Human Services Commission (HHSC) staff estimated the frequency and cost of 28 Never Events and four additional CMS events not included as Never Events to the state. LBB and HHSC staff used a list of ICD-9-CM codes and injury codes
(E codes) to screen Medicaid data for Never Events and the additional events selected by CMS to estimate their occurrence in Texas. Certain claims from long-term, limited, specialized hospitals, psychiatric and rehabilitative hospitals, and children's hospitals were excluded from the analysis because they do not use a DRG-based payment system. For other patient settings, when multiple claims were associated with one visit, the claims were consolidated to a single visit. The findings indicate the events are rare, but when they occur, tend to involve significant costs.

Figure 97 shows the frequency of these events for the Medicaid fee-for-service (FFS) and Primary Care Case Management (PCCM) programs, the non-managed care Medicaid services provided in Texas. Never Events are infrequent relative to the total number of FFS and PCCM Medicaid claims. In fiscal year 2007, only 4,892 (1 percent) of claims included one of the given conditions. The most frequently occurring conditions in total claims across the four years include stage three or four pressure ulcers, medication errors, patient death or serious disability associated with a fall, severe allergic reactions, and catheter-associated urinary tract infections. It is important to note that because Texas does not collect the POA indicator, it is not possible to determine how many of these conditions were hospital-acquired.

Preliminary analysis involving the state health plans suggests the frequency and costs of these errors to the state plans are minimal. Blue Cross and Blue Shield estimated that the state plans it administers in total would save about $100,000 per

FIGURE 96
PATIENT SAFETY PROGRAM DATA, JULY 2004 TO JUNE 2007

OCCURRENCE DESCRIPTION	JULY 1, 2004– JUNE 30, 2005	JULY 1, 2005– JUNE 30, 2006	JULY 1, 2006– JUNE 30, 2007	TOTAL
A medication error resulting in a patient's unanticipated death or major permanent loss of bodily function in circumstances unrelated to the natural course of the illness or underlying condition of the patient	26	22	17	65
A perinatal death unrelated to a congenital condition in an infant with a birth weight greater than 2,500 grams	19	15	19	53
The suicide of a patient in a setting in which the patient received care 24 hours a day	3	6	5	14
The abduction of a newborn infant patient from the hospital or the discharge of a newborn infant patient from the hospital into the custody of an individual in circumstances in which the hospital knew, or in the exercise of ordinary care should have known, that the individual did not have legal custody of the infant	0	0	0	0
The sexual assault of a patient during treatment or while the patient was on the premises of the hospital or facility	12	8	11	31
A hemolytic transfusion reaction in a patient resulting from the administration of blood or blood products with major blood group incompatibilities	3	10	9	22
A surgical procedure on the wrong patient or on the wrong body part of the patient	59	42	64	165
A foreign object accidentally left in a patient during a procedure	73	73	81	227
A patient death or serious disability associated with the use or function of a device designed for a patient that is used or functions other than as intended	10	4	3	17
TOTAL	**205**	**180**	**209**	**594**

Source: Texas Department of State Health Services.

year if they implemented a policy similar to CMS' approach. Aetna reviewed claims data for codes associated with the 28 Never Events and found minimal occurrences of the conditions, limiting the potential for savings.

IMPROVING QUALITY IN TEXAS HOSPITALS

Recommendation 1 would require HHSC to deny Medicaid payment for the 28 Never Events and any additional CMS-identified conditions, adopt rules regarding the processes for event identification, event verification, denial of payment, and management of provider appeals. The agency would pursue amendments to the Texas Medicaid State Plan as needed to avoid incurring costs associated with CMS' policy. Recommendation 2 would require that HHSC report to the Governor and Legislative Budget Board on the program features selected no later than November 1, 2010. Recommendation 4 would require DSHS to collect data on the 28 Never Events and any other CMS-identified conditions, and resources for this collection effort are provided in Recommendation 6. These recommendations could enable Texas to improve the quality of hospital care by implementing incentives for hospitals to invest in quality and reduce Never Events.

Recommendations 1 and 4 use the list of Never Events as the basis to deny payment and collect data. These events are an appropriate list of events to be used for data collection and the denial of reimbursement for several reasons:

- The events selected by NQF have serious and adverse impacts on patients.
- They are preventable and within the sphere of influence of healthcare organizations.
- The NQF-endorsed "Never Events" were selected initially using a consensus-based approach involving several stakeholder groups, and revisions to the list follow the same consensus-oriented approach.
- Use of these defined, standardized events would provide a basis to compare Texas data to other states. The NQF-endorsed list has been adopted in its entirety for state reporting systems in Minnesota, California, Connecticut, Illinois, Indiana, New Jersey, Oregon,

FIGURE 97
FREQUENCY OF NEVER EVENT CODES IN TEXAS MEDICAID, FISCAL YEARS 2004 TO 2007

NEVER EVENTS	2004	2005	2006	2007
Wrong surgical procedure on patient	0	0	0	0
Patient death or serious disability associated w/use of contaminated drugs, devices, or biologics provided by the healthcare facility	0	0	0	0
Patient death or serious disability associated w/use or function of a device in patient care in which the device is used or functions other than as intended	0	0	0	0
Patient suicide, or attempted suicide resulting in serious disability, while being cared for in a healthcare facility	28	23	5	3
Patient death or serious disability associated w/a medication error (e.g., error involving the wrong drug, wrong dose, wrong patient, wrong time, wrong rate, wrong preparation, or wrong route of administration)	2,459	2,367	2,402	2,271
Patient death or serious disability associated w/a fall while being cared for in a healthcare facility	270	4	40	23
Unexpected removal of organ	0	1	1	0
Unexpected amputation of limb	1	0	0	0
Intraoperative or immediately postoperative death in a normal healthy patient (defined as a Class 1 patient for purposes of the American Society of Anesthesiologists patient safety initiative)	3	2	1	1
Patient death or serious disability associated with a hemolytic reaction due to the administration of ABO-incompatible blood or blood products	103	92	92	77
Maternal death or serious disability associated with labor or delivery on a low-risk pregnancy while being cared for in a healthcare facility	14	6	11	13
Stage 3 or 4 pressure ulcers acquired after admission to a healthcare facility, excluding those that progress from Stage 2 to Stage 3	3,367	2,876	2,451	2,228
Severe Allergic Reaction	227	210	149	46
Retention of a foreign object in a patient after surgery or other procedure	16	23	20	16
Patient death or serious disability associated with a burn incurred from any source while being cared for in a healthcare facility	33	25	28	21
CMS CONDITIONS				
Catheter-associated Urinary Tract Infections	213	210	180	179
Catheter-associated Vascular Infections	0	0	0	0
Air Embolism	0	1	0	2
Mediastinitis	14	9	4	12

Note: Data includes Fee-For-Service and Primary Care Case Management claims only. It is not possible to determine how many claims were present-on-admission.
Sources: Legislative Budget Board; Texas Health and Human Services Commission.

Washington, and Wyoming. Pennsylvania adopted NQF's list for its policy to end reimbursement for Never Events.

When implementing Recommendation 1 and creating rules for event reporting, event verification, denial of payment, and management of a provider appeals process, HHSC and the managed care plans have several program design options.

In determining how to collect and verify Never Events data, the agency and the managed care organizations can use claims data and require providers to use the POA indicator or can obtain data pertinent to their plan from the statewide, all-payer reporting program discussed in Recommendation 4. Use of the POA indicator approach would require little modification from the current reimbursement process. It would enable continued use of claims forms, as space for the POA indicator exists, and would require little additional training of providers because most hospitals have already trained physicians and coding staff as part of their compliance with CMS' rule. In addition, it is possible for the Texas Medicaid Program and most of the plans to use this approach,

which would simplify reporting for hospitals. Some criticize use of administrative data to identify events because its purpose is to facilitate billing and not to serve as the final record of the case outcome. Pennsylvania's approach to event detection addresses this concern because in addition to POA data, the state will use case reviews to verify that Never Events actually occurred.

When selecting the best approach to end reimbursement for these events, HHSC could adopt CMS' methodology and pay for the base DRG and not pay for the enhanced level of payment triggered by the event, or could adopt a flat rate reduction in payment set at whatever rate found to be prudent. Ultimately, the size of the savings to the state programs will also determine the share of costs absorbed by hospitals and the strength of the incentive to change. Use of CMS approach is advantageous because Texas can monitor CMS' experience. However, the approach has limitations. It would need to be adjusted to apply to hospitals that do not bill using a DRG-based methodology, and for the managed care organizations to account for the capitated payments (managed care) and varied reimbursement methodologies used.

There are some general criticisms of the approach to end payment for adverse events. First, some critics object to the basic assumptions of the CMS approach that the conditions selected are preventable, and whether it is possible to determine whether they are POA. There are also challenges in determining whether the conditions are POA, as many of the tools used to diagnose whether events are present on admission will inevitably result in the false diagnosis of some and will fail to diagnose others. Authors advocate a framework of evaluating each potential condition for inclusion in CMS' rule based on whether a condition is important, measurable, and truly preventable. Use of Never Events should mitigate these concerns because they were selected using a consensus-based approach, because of their adverse patient impact, and due to their definable and measurable nature.

There are additional concerns about the unintended consequences of this approach. Critics contend that hospitals will be less likely to accept high-risk patients out of fear that they are more prone to adverse events. Others argue that it is expensive for hospitals to track the occurrence of Never Events. These costs could be mitigated depending on the reporting mechanism selected, given that these hospitals have already had to comply with CMS'Medicare rule. Finally, there are concerns that hospitals will increase diagnostic testing to ensure conditions are not POA or prescribe unnecessary antibiotics to prevent infections. HHSC will need to monitor for these unintended consequences and include discussion in the report to the Legislature about their occurrence.

An additional risk of reducing payment for claims involving medical errors is the potential for providers to bill patients for the unpaid portion of claims attributable to the errors. Because federal law prohibits providers from seeking payment from Medicaid clients beyond state-identified patient deductibles, coinsurance, or copayments, Recommendation 1 is not expected to result in "balance billing," or the shift of costs to Medicaid clients. State employees and persons with other third-party health insurance are not protected through similar provisions.

Recommendation 3 would require the state health plans, including the Employees Retirement System, the Teacher Retirement System, Texas A&M University, and The University of Texas, to evaluate jointly whether it would be feasible and cost effective to include a provision to deny payment for Never Events in their next request for proposal for a third-party administrator, and identify the potential impact of "balance billing" of clients and identify recommendations to address the impact, and report to the Legislative Budget Board and the Governor on their recommendations. In the short term, plan members will benefit from quality improvement initiatives in hospitals that comply with Recommendations 1 and 3.

Recommendations 4 and 6 would operationalize a statewide Never Events reporting system. Recommendation 4 uses the existing framework developed by Senate Bill 288 (Eightieth Legislature, 2007) to implement a statewide reporting system but broadens the conditions tracked from HAIs to Never Events and CMS-identified conditions to provide the state with a greater understanding of problems with hospital quality. Recommendation 6 provides the funding needed to implement the statewide reporting system. Experiences from other states demonstrate the many sources of cost in developing reporting systems. Staff functions include administrative and systems support; data collection, review/analysis, and validation; and training of users (hospital staff to be reporting data). Few states have capacity to perform these tasks internally and require new staff or contractors.

In implementing this system, DSHS should address and remain aware of three issues. First, the state should develop a data collection process that is meaningful to stakeholders and can facilitate quality improvement efforts. New York built its

current system using stakeholder input. The system enables any user to generate reports, making information retrievable and useful.

Second, data collected must be accurate and complete. Unclear reporting definitions or requirements, ineffective event validation and auditing processes, and untimely collection or release of information could result in the release of inaccurate or outdated information to the public. This could result in greater patient harm than if no data on Never Events are available. The state must ensure compliance with reporting requirements so that not just the hospitals with the greatest resources submit data. Ensuring the quality of data collected and released requires constant vigilance for even the most mature of data collection systems. For example, the state of New York implemented several iterations of its adverse events reporting systems but in 2004, the New York Comptroller issued a report identifying concerns including the lack of timely entry of data and recommended improvements in the areas of validity and confidentiality of the data. In a 2007 follow-up analysis, the Comptroller reported that the state had implemented all but one recommendation fully.

Finally, the state must ensure the confidentiality of data collected, but balance confidentiality against the need for public disclosure. Hospitals might not report data or might under-report out of fear that data could be released for legal proceedings including malpractice suits. However, too much protection of data risks loss of public trust and transparency, and may fail to generate the pressure on hospitals to improve the quality of care because consumers do not have facility or incident-specific information and purchasers cannot apply incentives. Chapter 98 of the Texas Health and Safety Code contains several adequate confidentiality protections consistent with statutes in other states such as Pennsylvania, Illinois, and Florida.

Recommendations 1 and 4 could lead to quality improvements in the following ways:

- In the current reimbursement system, hospitals can avoid many of the costs of Never Events. Recommendation 1 strengthens the business case for hospitals to implement activities to reduce the frequency of Never Events because they will not be able to transfer costs to the Texas Medicaid Program. In addition, it places the state in line with Medicare reimbursement and private insurers that are already linking payment to quality so that the state of Texas is not the only major payer in the state rewarding Never Events. The case for quality improvement is strengthened by the concerted efforts of the major public and private payers.
- Collection of statewide data on Never Events should be undertaken with the goal of using the data to improve hospital quality. Data collection can spur quality improvement in several ways. First, it can enable the state to gather information from multiple entities to understand why Never Events occur. The state can create or facilitate the creation of programs designed to address some of these causes. In addition, by providing consumers with knowledge about hospital safety and quality, data collection programs can spur greater competition among hospitals to provide more safe environments. While limited research exists to support the argument that the public makes use of quality data in choosing a provider when it is available, more evidence suggests that publicizing quality data causes providers to shore up their own performance to that of their competitors.

FISCAL IMPACT OF THE RECOMMENDATIONS

If Texas does not modify the Texas Medicaid Program to correspond with the federal Medicare program which began reducing payments on October 1, 2008, the state could incur additional costs by paying for portions of claims that had been previously paid by the federal government. Implementation of Recommendation 1 would prevent Texas from incurring these additional costs and result in additional cost avoidance from not paying for Never Events in the Texas Medicaid Program. Although there would be some cost to modify the state's claims processing and information retrieval systems to change payment practices for the related codes, it would be minimal because the federal government matches state contributions at the rate of 90 percent for design, development, or installation of mechanized claims processing and information retrieval systems and at 75 percent for operation of required systems. There would likely be no net state cost due to savings from avoiding additional costs.

If the Texas Medicaid Program denied payment for Never Events and additional CMS conditions, it would result in greater cost avoidance, though it is hard to quantify absent a data collection mechanism. In addition, savings would be shared with the federal government since state Medicaid payments are matched with Federal Funds.

Recommendation 4 would also involve expected costs for Information Technology system development and

maintenance, and costs for 5 and 13 additional full-time-equivalent (FTE) positions in fiscal years 2010 and 2011, respectively. DSHS will incur a one-time technology cost of $725,000 to create a reporting system for Never Events data. DSHS will require 5 FTE positions to develop the program, and will require 13 additional positions by the second year of implementation to collect, validate, analyze, and issue reports on the data submitted. Costs include salaries, benefits, travel, technology, and other administrative expenses.

To implement Recommendation 4, a contingency rider to the 2010–11 General Appropriations Bill would be required. **Figure 98** shows the five-year cost to implement this recommendation.

FIGURE 98
COSTS TO DEVELOP A STATEWIDE DATA COLLECTION SYSTEM, FISCAL YEARS 2010 TO 2014

FISCAL YEAR	PROBABLE COST IN GENERAL REVENUE FUNDS	FULL-TIME-EQUIVALENT POSTIONS
2010	($1,104,483)	5
2011	($1,032,906)	13
2012	($948,894)	13
2013	($948,894)	13
2014	($948,894)	13

Source: Legislative Budget Board.

Article IX of the introduced 2010–11 General Appropriations Bill contains a rider to implement Recommendation 3, requiring the state health plans to study jointly implementation of a provision to deny payment for the 28 Never Events and additional CMS-identified conditions. No other adjustments are included in the introduced bill.

IMPROVE EMPLOYMENT SCREENING OF LONG-TERM CARE WORKERS

The screening of prospective long-term care workers is one method to ensure the safety of residents in a long-term care facility. Workforce registries are a tool states use to screen workers and ensure workers who commit acts of abuse, neglect, or exploitation are not employed in long-term care facilities. Texas has two registries and one reporting system to help prevent unlicensed direct care workers who commit acts of abuse from working in long-term care settings.

The Texas Department of Aging and Disability Services oversees the two state registries and shares oversight with the Texas Department of State Health Services for the reporting system to prevent persons who have committed an act of abuse, neglect, or mistreatment of a resident from working in state long-term care facilities. Despite the use of the registries, there are regulatory gaps that allow employees with a confirmed finding of abuse to continue to work in long-term care facilities. These gaps include: maintaining separate systems for private sector employees and state workers, requiring only pre-employment registry checks, and hiring nurse aides who lack the required credentials. Each of these regulatory gaps can be closed through statutory changes.

CONCERNS

- The Texas Department of Aging and Disability Services and the Texas Department of State Health Services use a reporting system to identify direct care workers who have committed acts of abuse, neglect, or exploitation in state facilities. Information in the reporting system is not available to private providers who may unknowingly hire former state workers who committed an act of abuse, neglect, or exploitation in a state school or state hospital.
- State school and state hospital workers who have committed an act of abuse, neglect or exploitation may be hired by private long-term care facilities because they are not required to be listed on the Employee Misconduct Registry, a publicly accessible database.
- State records documenting incidents of abuse in state schools and state hospitals contain inconsistencies, such as mistyped social security numbers and name variations, which may allow banned workers to be employed in private long-term care facilities.
- Long-term care facilities regulated by the Texas Department of Aging and Disability Services are not statutorily required to check the Employee Misconduct Registry after the hiring process, thereby missing an opportunity to ensure barred persons do not remain employed after an act of misconduct.
- Seventeen percent of long-term care facilities nationwide hire individuals to work as nurse aides without the required certification despite federal regulations and state efforts against it.

RECOMMENDATIONS

- **Recommendation 1:** Amend Texas Health and Safety Code, Chapter 253, and Texas Human Resources Code, Chapter 48, to include the following employee groups in the Employee Misconduct Registry if found to have committed a confirmed act of abuse, neglect, or exploitation after the effective date of this statute change: state hospital, state school, community mental health and mental retardation center employees, certified nurse aides, and employees with pending abuse allegations.
- **Recommendation 2:** Include a contingency rider in Article II Special Provisions in the 2010–11 General Appropriations Bill to appropriate $1 million in fiscal year 2010 to the Texas Department of Aging and Disability Services for upgrading the Employee Misconduct Registry and $126,220 in fiscal year 2010 and $126,220 in fiscal year 2011 to the Department of Family and Protective Services for additional legal staff to oversee misconduct hearings.
- **Recommendation 3:** Amend Texas Health and Safety Code, Chapter 253, and Texas Human Resources Code, Chapter 48, to include in the Employee Misconduct Registry state school, state hospital, and community mental health and mental retardation center employees currently listed in Client Abuse and Neglect Reporting System who have had or waived due process.

- **Recommendation 4:** Include a contingency rider in the 2010–11 General Appropriations Bill to require the Texas Department of Aging and Disability Services and the Texas Department of State Health Services to submit a report to the legislature describing a process for moving names from the Client Abuse and Neglect Reporting System to the Employee Misconduct Registry.
- **Recommendation 5:** Include a rider to the 2010–11 General Appropriations Bill to require the Texas Department of Aging and Disability Services, the Texas Department of State Health Services, and the Texas Department of Family and Protective Services to establish sufficient input, processing, and output controls as well as a system for auditing client abuse/neglect/exploitation data to ensure each agency has accurate, complete data. The agencies should also report their progress to the LBB and the Governor.
- **Recommendation 6:** Amend Texas Health and Safety Code, Chapter 253.008, to require long-term care facilities to check the Employee Misconduct Registry and the Nurse Aide Registry at least once a year after initial employment to ensure no barred employees are working in a long-term care facility.
- **Recommendation 7:** Amend Texas Health and Safety Code, Chapter 242.02, to require nursing facilities regulated by the Texas Department of Aging and Disability Services to publicly display the certification credentials of all certified nurse aides working in the facility.

DISCUSSION

Older adults and persons with disabilities are vulnerable populations because of their dependence upon assistance with daily activities. According to the U.S. Health and Human Services Department, abuse, neglect, and exploitation (hereafter collectively referred to as abuse) may occur in any long-term care setting by both paid and volunteer caregivers; however, the federal government has focused its oversight efforts on nursing facilities because of past reports demonstrating higher incidences of abuse in comparison with other settings. A combination of federal, state, and local agencies ensure that nursing home residents receive proper care. The main regulatory activity to ensure safety is an annual survey conducted by state regulators to determine if nursing homes are complying with federal Medicare and Medicaid standards. State regulators perform these inspections annually and also investigate complaints of inadequate care and abuse.

The screening of prospective long-term care workers is another way of ensuring the safety of residents in a long-term care facility. Workforce registries are one of the tools states use to screen workers and ensure that workers who commit acts of abuse are not employed in long-term care facilities. Texas has two registries and one reporting system to help prevent unlicensed direct care workers who commit acts of abuse from working in long-term care settings—the Employee Misconduct Registry (EMR), the Nurse Aide Registry (NAR), and the Client Abuse and Neglect Reporting System (CANRS).

The EMR was established by the Seventy-sixth Legislature, Regular Session, 1999, to protect facility residents and consumers by ensuring that unlicensed personnel who commit acts of abuse, misappropriation, or misconduct against residents and consumers are denied employment in Department of Aging and Disability Services' (DADS) regulated facilities and agencies.

The NAR was created as an additional protective measure for nursing home residents because nurse aides are their primary caregivers. The NAR is a federally required registry of all individuals registered to work as nurse aides in the state. Texas established its registry in 1989. If a certified nurse aide (CNA) has been found to have committed an act of abuse, neglect, or exploitation, then that information would also be noted in the NAR.

The CANRS is administered by the Texas Health and Human Services Commission (HHSC) for DADS and the Texas Department of State Health Services (DSHS). This database captures information regarding individual consumer abuse in state schools, state hospitals, and community mental health and mental retardation centers. CANRS contains information regarding the injury, treatment, diagnosis, physician's determination of seriousness of the abuse, family contact, law enforcement contacted, name of the abuser, and disciplinary action taken. The Texas Department of Mental Health and Mental Retardation created CANRS in 1982 as a risk management tool. A limited number of DADS and DSHS staff have access to CANRS. According to the HHSC human resources handbook, staff members at state schools and state hospitals are required to check CANRS, EMR, and NAR to ensure job applicants do not have a finding of abuse against them.

Figure 99 shows a comparison of each registry and the reporting system. It includes the factors that determine which agency investigates the act and which registry or reporting system will register the employee's name.

GAPS IN REGULATION

Certain employee groups who have committed a confirmed act of abuse are not added to the Employee Misconduct Registry (EMR). They include employees of state hospitals, state schools, and community-based mental health/mental retardation centers. CANRS, a state reporting system not available to public employers, is used to track these workers to ensure they are not hired by another state facility.

Certified nurse aides (CNAs) are not added to the EMR because federal law requires information about acts of abuse committed by CNAs to be added to the Nurse Aide Registry (NAR). The NAR is the only registry that tracks CNAs who have committed an act of abuse. While DADS' administrative rules allow for a nurse aide who is listed on the EMR as unemployable to also be listed that way on the NAR; the reverse is not true. A nurse aide guilty of an act of abuse is listed on the NAR but does not appear in the EMR as unemployable. This gap may allow nurse aides guilty of abuse to continue to work in long-term care facilities in jobs other than a nurse aide. While misconduct acts committed by CNAs will continue to be noted in the NAR as required by federal law, adding CNAs to the EMR will help to ensure all unlicensed personnel barred from employment at DADS-regulated facilities are listed in the database.

One additional employee group not contained in the EMR is employees with pending abuse allegations. Employees suspected of an act of misconduct and under investigation in one long-term care facility may resign while the investigation is underway and take another job at a different long-term care facility without the new employer being aware of the pending allegation. At least three states (Arizona, Washington,

FIGURE 99
COMPARISON OF TEXAS LONG-TERM CARE WORKFORCE REGISTRIES AND REPORTING SYSTEM

	EMPLOYERS REQUIRED TO CHECK PRIOR TO EMPLOYMENT	INVESTIGATING AGENCY	ENTITY RESPONSIBLE FOR DUE PROCESS	STATUTORY REQUIREMENT TO CHECK PRIOR TO EMPLOYMENT	OTHER INFORMATION
Employee Misconduct Registry (EMR) (includes unlicensed direct care workers)	All DADS-regulated facilities and agencies, state schools, state hospitals, HCSSA	DADS, DFPS, HCSSA	SOAH	Yes Health and Safety Code, Chapter 253, Section 253.008	Registry maintained by DADS. State created registry. Created in 1999.
Nurse Aide Registry (NAR) (includes Nurse Aides)	All DADS-regulated facilities and agencies, state schools, state hospitals, HCSSA	DADS	SOAH	Yes 42 Code of Federal Regulations 483.156	Registry maintained by DADS. Also contains certification information. Federally required registry. Created in 1989.
Client Abuse and Neglect Reporting System (CANRS) (includes state school, state hospital, and Community MHMR Center workers)	State schools, State hospitals	DFPS	**State Employees:** DADS/DSHS provide grievance process/ hearing. **Community MHMR Center Employees:** Due process occurs at discretion of local authority or Community MHMR Center.	No HHSC Human Resources Manual, Chapter 2, Subchapter D	Reporting maintained by HHSC, DSHS, and DADS. Created in 1982.

NOTE: DADS = Department of Aging and Disability Services; DFPS = Department of Family and Protective Services; SOAH = State Office of Administrative Hearings; MHMR = Mental Health Mental Retardation; HHSC = Health and Human Services Commission; DSHS = Department of State Health Services; HCSSA = Home and Community Support Service Agency.
SOURCES: Legislative Budget Board; Texas Department of Aging and Disability Services.

and North Carolina) include pending allegations against workers in their misconduct registries. There are concerns on both sides of the issue about including pending abuse allegations in a registry. On one side, employers appreciate having the information to make an informed hiring decision. On the other side, all allegations, no matter how frivolous, must be investigated. Investigations take time and workers falsely accused may unintentionally be placed in a "guilty until proven innocent" category until the case is resolved.

From a cautious standpoint, opting to include pending allegations in the EMR allows employers to better protect clients with an opportunity they do not have now—the ability to ask questions. Learning more about a pending incident from potential applicants allows employers to make an informed hiring decision. Before a name is added to the EMR, the statute affords each accused employee due process to present their side of the incident to ensure all the information is known. **Figure 100** shows the process that DADS uses before placing an employee on the EMR.

According to Texas Health and Safety Code, Chapter 253, after an initial report of abuse is made to DADS, the agency begins an investigation. When the investigation is complete, DADS gives written notice of its findings, including a summary and notice of the employee's right to a hearing if reportable conduct did occur. At this point in the process, step 3, sufficient information has been gathered about an incident that a pending allegation notice could be added to the EMR. The pending allegation notice would continue to allow workers to be employed in long-term care facilities until the EMR process is complete. Once completed, the pending allegation can be made permanent if the act is substantiated or removed if overturned during the process.

To strengthen safety for residents of long-term care facilities, all unlicensed personnel guilty of misconduct, regardless of whether they work in a private or public facility, should be noted in one registry, the EMR. Recommendation 1 would amend Texas Human Resources Code, Chapter 48, and Texas Health and Safety Code, Chapter 253, to allow state school employees, state hospital employees, employees of community mental health and mental retardation centers, CNAs, and employees with pending abuse allegations to be added to the EMR. This recommendation would affect members of the above employee groups who commit an act of abuse after the effective date of the statutory change and would not be retroactive.

To implement this recommendation, the current internal grievance process used by certain DADS and DSHS employees would be incorporated into the employee misconduct registry process. This would ensure state employees accused of a confirmed act of abuse would maintain their ability to grieve a disciplinary action, as required by federal law (42 U.S.C., Section 1396a(a)(4), 42 C.F.R., Section 432.10, and 5 C.F.R., Section 900.603), and have access to due process of law without duplicating processes already in place. HHSC has a grievance process for all five health and human service agencies because certain state school and state hospital employees are not at-will employees, and federal statutes require their job status to be based on performance. The Texas Department of Family and Protective Services (DFPS) is the agency responsible for investigating acts of abuse in state schools and hospitals.

FIGURE 100
STEPS IN THE EMPLOYEE MISCONDUCT REGISTRY REPORTING PROCESS FOR THE TEXAS DEPARTMENT OF AGING AND DISABILITY SERVICES

STEP	ACTION TAKEN
1	Facility reports suspected act of abuse/neglect/exploitation (abuse) to DADS.
2	DADS begins investigation of suspected act.
3	DADS gives written notice of its findings if abuse occurred. Includes summary of DADS' findings and the employee's right to a hearing.
4	Employee has 30 days to accept DADS' determination of conduct or request hearing via written notice.
5	If the employee fails to respond within 30 days, DADS commissioner issues order to add employee to EMR.
6	If a hearing is requested by the employee, then written notice is given to employee and a hearing examiner is designated.
7	If the hearing examiner determines that the abuse occurred, then the DADS commissioner issues an order to add employee to EMR.
8	The employee is notified of hearing examiner's finding and is given notice of right to judicial review. If a review is not requested by employee, the employee is added to EMR.
9	If judicial review is requested by the employee and sustained by the court, the decision is final and the employee's name is added to EMR.

Source: Legislative Budget Board.

After the grievance process, a state employee would have access to a judicial review prior to placement on the EMR. Judicial review provides persons going through the EMR process an opportunity for a district judge to review the findings and statements of the EMR hearing. The judge's sole decision is to decide if procedures and laws were followed correctly up to this point.

The EMR process ensures each person who becomes eligible for placement on the EMR has access to due process of law. **Figure 100** shows the steps taken for placement on the EMR. Before a government may legally deprive a person of life, liberty, or property, the government must observe due process of law which means to respect all of the person's legal rights. Due process of law must be observed when adding a name to the EMR because adding a name to the registry deprives the named person of something—a right to work at a particular type of job. Once added to the EMR, an employee is permanently prohibited from working in certain long-term care facilities. Due process of law ensures an employee is not unfairly deprived of their ability to earn a living and allows an accused employee to participate in the complaint investigation.

STATE WORKERS WITH CONFIRMED ABUSE FINDINGS CONTINUE TO WORK

State hospitals and state schools use CANRS to track state workers and employees of community-based mental health/ mental retardation centers who have been found to have committed an act of abuse. Information in CANRS is not available to private providers, thereby allowing these providers to unknowingly hire a former state worker who committed an act of abuse.

Legislative Budget Board (LBB) staff selected a random sample of CANRS data from state schools and hospitals from fiscal years 1999 to 2008 and cross-checked it with names on the NAR and EMR. This comparison of state school employees revealed one employee out of the sample was listed on the EMR and is not eligible to work in state or private long-term care facilities. Except for this one employee, all other former state school employees who have committed an act of abuse remain eligible to be employed in private long-term care facilities. Some of the employees in the sample had multiple CANRS entries for acts of abuse. Moreover, these workers can continue to be hired for certain key jobs in long-term care settings. Other findings include:

- 7 percent of state school workers in the CANRS sample have active nurse aide or medication aide credentials and can seek employment as a CNA or medication aide. Extrapolating the sample results to the population of CANRS employees means up to 188 state school workers with confirmed abuse findings could have the credentials which would allow them to work as a CNA or medication aide in private long-term care settings; and
- 9 percent of state school workers in the CANRS sample had expired CNA or medication aide credentials. These workers could renew their certification because confirmed abuse findings in state schools are not listed on the EMR. Extrapolating the sample results to the population of CANRS employees means that up to 241 state school workers with confirmed abuse findings could renew their credentials and seek employment in a private long-term care setting as a CNA or medication aide.

Additionally, the CANRS data showed that 15 state school employees were involved in an act of abuse or neglect resulting in the death of clients. All 15 former state school employees remain eligible to work in a private long-term care facility. Five of these former employees remain eligible to seek employment as either a nurse aide or medication aide.

CANRS data for state hospitals pointed to findings similar to findings for the state school data. The random sample data from state hospitals revealed no former state hospital workers listed on the EMR. Therefore, all former state hospital employees in the sample who have committed an act of abuse may be employed in private long-term care facilities. Moreover, these workers can continue to be hired for direct care jobs as medication aides or CNAs. Additional findings include:

- 3.7 percent of state hospital workers in the CANRS sample have active nurse aide or medication aide credentials and can seek employment as a CNA or medication aide. Extrapolating the sample results to the population of CANRS employees means up to 48 state hospital workers with confirmed abuse findings could have the credentials which would allow them to work as a CNA or medication aide in private long-term care settings; and
- 8.6 percent of state hospital workers in the CANRS sample had expired CNA or medication aide credentials. These workers could renew their certification because confirmed abuse findings in state hospitals are not listed on the EMR. Extrapolating

the sample results to the population of CANRS employees means that up to 112 state hospital workers with confirmed abuse findings could renew their credentials and seek employment in a private long-term care setting as a CNA or medication aide.

Incorporating information from CANRS into the EMR would allow private long-term care facilities access to needed information before making a hiring decision. According to DADS and DSHS, some of the employees in CANRS did not have access to due process of law during the investigation of the abuse, neglect, or exploitation complaint. Because of this, DADS and DSHS staff will need to differentiate between employees who have had due process and those who have not. DADS and DSHS will also need to notify affected former employees in CANRS if their name will be moved to the EMR.

Staff at DADS and DSHS has been working to implement a plan to allow public access to CANRS data. Their plan is to create an expedited open records request web site where employers could access limited CANRS information. This information would indicate if a name is listed in CANRS and would allow an employer to see if a potential employee has committed an act of abuse in a state facility. According to the agencies, a standard open records request might take ten days to two weeks to fulfill. This access would only apply to the names of employees who have had access to due process and would not include a significant portion of people listed in CANRS. This interim measure creates another database for employers to be made aware of and to check prior to hiring direct care personnel.

Recommendation 2 would include a contingency rider in Article II Special Provisions in the 2010–11 General Appropriations Bill for additional costs incurred by DADS and the Texas Department of Family and Protective Services (DFPS) by the statutory change. The contingency rider would appropriate $1 million in fiscal year 2010 to the DADS for upgrading the Employee Misconduct Registry and $126,220 in fiscal year 2010 and $126,220 in fiscal year 2011 to DFPS for additional legal staff to oversee misconduct hearings and for 1.5 additional full-time-equivalent positions.

Recommendation 3 would amend Chapter 48 of the Texas Human Resources Code and Chapter 253 of the Texas Health and Safety Code to include in the EMR state school, state hospital, and community mental health and mental retardation center employees currently listed in CANRS who have had or waived due process. This recommendation would help to ensure all unlicensed personnel who have committed an abuse act, regardless of place of employment, are listed in the same place.

Recommendation 4 would include a contingency rider to require DADS and DSHS to submit a report to the Legislative Budget Board and the Governor about the progress of adding names from CANRS to the EMR. The report should include, but not be limited to:

- total number of names in CANRS eligible to be listed in the EMR;
- total number of names in CANRS that cannot be moved to the EMR because of a lack of access to due process;
- an explanation of the process the agencies will use to identify who in CANRS has had due process and who has not;
- an explanation of how the non-due process names in CANRS could receive due process and potentially be moved into the EMR;
- a description of the process each agency will implement to ensure the accuracy of client abuse data and the accuracy of the data reported across agencies; and
- any other relevant information related to improving the workforce registries in Texas.

The report would be submitted to the Legislative Budget Board and the Governor by September 1, 2010.

ACCURACY OF WORKFORCE REGISTRY AND STATE REPORTING SYSTEM DATA

Accurate information in the state's workforce registries and in CANRS is as important as the technology that operates each system. A 2006 study by the U.S. Health and Human Services Department Office of the Inspector General revealed that nurse aide registries may not always contain the most up-to-date or accurate information. Simple and unintentional mistakes, like misspellings or typing errors when entering data into a workforce registry, could prevent a qualified worker from obtaining employment or allow an unqualified worker to continue to abuse vulnerable clients in long-term care facilities. A workforce registry is only helpful to employers if the information is accurate and current. In an examination of a random sample of CANRS data from fiscal years 1999 to 2007 from state schools and hospitals, LBB staff found

inconsistencies, such as misspelling, possible typing errors, and mistyped social security numbers, in confirmed abuse cases.

LBB staff compared fiscal year 2007 data from DFPS, the agency that conducts state facility abuse investigations, to data in CANRS. Both sets of data contained confirmed abuse incidents in state facilities and should be nearly identical; however, they are not. Differences between the two data sets fell in to these broad categories:

- the abuse incident was listed in DFPS, but was not in CANRS;
- the abuse incident was listed in CANRS, but was not in DFPS;
- DFPS identified the abuse as physical and CANRS identified it as No Physical Injury;
- DFPS identified the abuse as sexual and CANRS identified it as No Physical Injury; and
- incident dates and perpetrator names differed.

Moreover, DFPS data identifies more confirmed abuse acts by state workers than CANRS for fiscal years 2002 to 2008. **Figures 101 and 102** compare the number of confirmed abuse incidents reported by DFPS and CANRS for fiscal years 2002 to 2008 for state school and state hospitals.

Agency reporting procedures can explain some of the difference in the number of confirmed acts of abuse. DFPS reports every incident separately while CANRS lists one incident per date per employee. For example, an employee committed two different types of abuse: emotional abuse and physical abuse during one situation. In DFPS' system, both types of abuse would be investigated and reported, while in

FIGURE 101
COMPARISON OF CONFIRMED ABUSE INCIDENTS IN STATE SCHOOLS FROM CANRS AND DFPS, FISCAL YEARS 2002 TO 2008

FACILITY	REGISTRY	2002	2003	2004	2005	2006	2007	2008*
El Paso State Center	CANRS	10	5	1	3	1	3	7
	DFPS	23	14	11	7	12	8	20
San Antonio State School	CANRS	23	17	21	26	21	29	23
	DFPS	33	23	31	36	33	54	64
Denton State School	CANRS	35	34	14	48	36	38	23
	DFPS	65	59	34	80	71	53	48
Richmond State School	CANRS	14	19	8	8	3	6	1
	DFPS	23	35	12	18	8	11	1
Lufkin State School	CANRS	21	13	3	10	10	14	7
	DFPS	38	23	7	12	15	26	23
Corpus Christi State School	CANRS	25	29	20	20	19	28	23
	DFPS	40	49	45	51	43	55	67
San Angelo State School	CANRS	30	26	31	33	38	42	16
	DFPS	40	47	66	89	83	94	58
Mexia State School	CANRS	16	13	19	14	18	24	27
	DFPS	39	56	68	38	78	63	103
Abilene State School	CANRS	59	28	30	32	64	55	18
	DFPS	85	46	46	65	99	91	51
Austin State School	CANRS	18	17	8	5	14	16	9
	DFPS	33	33	22	28	17	19	21
Lubbock State School	CANRS	29	14	25	23	6	21	13
	DFPS	46	34	36	36	13	48	37
Brenham State School	CANRS	5	8	1	4	4	13	10
	DFPS	9	11	3	6	18	7	23
FISCAL YEAR TOTAL	**CANRS**	**285**	**223**	**181**	**226**	**234**	**289**	**177**
	DFPS	**474**	**430**	**381**	**466**	**490**	**529**	**516**

*2008 data is through July 2008.
SOURCES: Texas Department of Aging and Disability Services; Texas Department of Family and Protective Services.

FIGURE 102
COMPARISON OF CONFIRMED ABUSE INCIDENTS IN STATE HOSPITALS FROM CANRS AND DFPS, FISCAL YEARS 2002 TO 2008

FACILITY	REGISTRY	2002	2003	2004	2005	2006	2007	2008*
Rio Grande State Center	CANRS	1	0	2	0	5	4	0
	DFPS	4	10	5	12	10	9	12
El Paso Psychiatic Center	CANRS	0	2	0	2	5	2	0
	DFPS	0	2	6	2	8	11	3
Vernon State Hospital	CANRS	33	40	18	46	25	44	26
	DFPS	126	97	56	106	69	93	77
Kerrville State Hospital	CANRS	6	7	1	8	6	4	3
	DFPS	14	7	4	12	9	5	8
Austin State Hospital	CANRS	18	15	4	7	3	8	6
	DFPS	20	26	11	10	7	14	10
Rusk State Hospital	CANRS	25	26	3	9	8	22	9
	DFPS	39	47	3	16	10	41	19
Waco Center for Youth	CANRS	8	7	1	0	2	2	0
	DFPS	20	14	3	2	1	13	2
San Antonio State Hospital	CANRS	22	14	10	8	13	27	9
	DFPS	42	29	13	24	20	53	37
Terrell State Hospital	CANRS	16	22	23	9	10	20	10
	DFPS	32	38	43	22	13	33	13
Big Spring State Hospital	CANRS	17	8	0	11	10	7	7
	DFPS	32	14	5	14	10	10	7
FISCAL YEAR TOTAL	**CANRS**	**146**	**141**	**62**	**100**	**87**	**140**	**70**
	DFPS	**329**	**284**	**149**	**220**	**157**	**282**	**188**

*2008 data through July 2008.
SOURCES: Texas Department of Aging and Disability Services; Texas Department of Family and Protective Services.

CANRS only one incident for that situation would be listed.

All differences between the DFPS investigatory data and the CANRS tracking data should be minimized to ensure each act of abuse is recorded fully and accurately so that a complete record of the incident is available. Recommendation 5 would require DFPS, DADS, and DSHS to establish sufficient input, processing, and output controls as well as a system for auditing abuse data to ensure each agency has accurate, complete data. The rider would require the agencies to work together to develop reporting and auditing performance standards to ensure the same client abuse data is reported accurately and completely across all three agencies and report their progress to the LBB and the Governor by September 1, 2010. Recommendation 5 could be accomplished by including a rider in the 2010–11 General Appropriations Bill.

EMPLOYEE MISCONDUCT REGISTRY USE

DADS-regulated facilities are statutorily required to check the EMR and the NAR before hiring an individual to determine if the person is listed in either registry as having committed an act of abuse and is therefore unemployable. However, after employment, there is no requirement for employers to continue to check both registries to ensure they are not employing an individual listed on either registry. A 2006 study by the U.S. Health and Human Services Office of the Inspector General revealed that there are significantly more resources allocated to the pre-employment phase. Research shows that the policy focus at the state and facility level is on pre-screening applicants before employment, and there are structures and regulations in place that support this effort. Once a worker is hired and working, less guidance exists about how best to monitor existing employees.

Recommendation 6 would amend Chapter 253 of the Texas Health and Safety Code to require facilities to check the EMR and the certified NAR at least once a year after initial employment to ensure no barred employees are working in a long-term care facility.

EMPLOYMENT OF NURSE AIDES WITHOUT REQUIRED CREDENTIALS

Federal regulations require that all nurse aides working in a Medicare- or Medicaid-certified facility for more than four months be certified and listed on their state's NAR. Regulations allow nurse aides to work for up to four months in a long-term care facility to complete necessary training and testing to become certified in their state.

According to 2005 research conducted by the U.S. Health and Human Services Department Office of the Inspector General (OIG), 17 percent of long-term care facilities employed a nurse aide for longer than four months without the required certification or with an expired certification, which is a violation of federal law. During follow-up with the affected long-term care facility administrators, OIG learned that despite these facilities reporting they had practices in place to ensure that individuals without certifications are not employed for longer than four months, these long-term care facilities could not produce documentation that the nurse aides in question were certified.

While there are no Texas-specific statistics to determine the seriousness of this issue, regulatory officials are not aware of violations until after the fact. Nursing facilities are surveyed once a year by DADS' regulatory staff for compliance with state and federal regulations, so non-CNAs could be hired between the annual state inspections.

To remedy this noncompliance, Recommendation 7 would amend the Chapter 242.02 of the Texas Health and Safety Code to require all nursing facilities to display publicly the certificates of each nurse aide working in their facility. The display of a CNA's credentials would allow the public and residents as well as state inspectors to ensure all nurse aides working in a facility have the proper current credentials.

FISCAL IMPACT OF THE RECOMMENDATIONS

Implementing these recommendations would result in a cost of $1.3 million in General Revenue Funds for the 2010–11 biennium. Recommendation 1 would amend statute to add state hospital, state school, community mental health/mental retardation center employees, CNAs, and employees with pending abuse allegations to the employee misconduct registry and cost $126,000 in General Revenue Funds annually. CNAs are already listed in the NAR if an act of abuse is substantiated and adding them to the EMR would not add any additional cost to the state. Adding employees with pending abuse allegations would also not result in a new cost to the state since these employees are already being investigated for an act of abuse. No additional cost would be incurred for the investigation of state employees because DFPS already conducts investigations of abuse at state schools and state hospitals. The existing grievance process for state employees would be incorporated into the EMR process. The additional cost for Recommendation 1 would be incurred to add legal staff to conduct hearings for community mental health/mental retardation center staff who would request such a hearing. DFPS estimates the number of community mental health/mental retardation center employees who would request an EMR hearing to be based on a rate similar to the number of home and community support service agency employees and home and community-based service employees who request hearings. This is estimated at 26 hearings per year. The estimated cost for the hearings is $126,220 per year in General Revenue Funds, which would fund 1.5 full-time- equivalent positions to prepare for and participate in EMR hearings.

The opportunity to take an EMR case to the judicial review stage would need to be incorporated into the state employee EMR process to ensure it matches current EMR statute that applies to other direct care workers. Few cases are appealed to the judicial review stage. According to HHSC, in fiscal year 2007, none of the four hearings resulted in judicial review. The option for judicial review is not estimated to have a significant fiscal impact on HHSC because the number of new employee groups subject to the EMR is less than the current number of employees already subject to it and currently few cases result in judicial review.

Recommendation 1 would also result in a one-time cost of $1 million in General Revenue Funds for fiscal year 2010. DADS would need to update and upgrade the current Employee Misconduct Registry hardware and software to add additional search and report capabilities as well as to increase capacity to accommodate new employee groups that have been added the registry.

Recommendation 2 would add a contingency rider to appropriate money for additional costs to be incurred by DFPS for an increased number of EMR hearings and a one-time cost to be incurred by DADS for upgrading EMR software and hardware.

Recommendation 3 would amend statute to add state hospital, state school, and community mental health/mental retardation employees listed in CANRS to the Employee Misconduct Registry. A fiscal impact could not be determined until DSHS and DADS staffs research which employees

listed in CANRS have or have not had access to due process of law.

Recommendation 4 would require DADS and DSHS to submit a report to the Governor and the LBB about the progress of moving names in the CANRS to the EMR. Recommendation 5 would require DFPS, DADS, and DSHS to develop controls and an audit process for ensuring accurate information about abuse incidents in state facilities is reported across the three agencies. Recommendation 6 would amend the Texas Health and Safety Code to require long-term care facilities to check the Employee Misconduct Registry and the certified NAR at least once a year after initially hiring an individual. Recommendation 7 would require nursing facilities regulated by DADS to display publicly the credentials of every CNA working in the facility. Recommendations 4 to 7 could be implemented using existing resources.

Figure 103 shows the fiscal impact of Recommendations 1 through 3.

FIGURE 103
FIVE-YEAR FISCAL IMPACT TABLE

FISCAL YEAR	PROBABLE GAIN/(LOSS) IN GENERAL REVENUE FUNDS	CHANGE TO FULL-TIME EQUIVALENTS COMPARED TO 2008–09 BIENNIUM
2010	($1,126,220)	1.5
2011	($126,220)	1.5
2012	($126,220)	1.5
2013	($126,220)	1.5
2014	($126,220)	1.5

SOURCE: Legislative Budget Board.

The introduced 2010–11 General Appropriations Bill does not address these recommendations.

STRENGTHEN CERTIFIED NURSE AIDE TRAINING TO IMPROVE THE QUALITY OF LONG-TERM CARE

Nurse aides are direct-care workers who provide the bulk of bedside care, such as assistance with eating, bathing, housekeeping, and observing and reporting changes in a client's condition. Federal law requires nurse aides who work in nursing homes participating in Medicare or Medicaid to be certified. To become a certified nurse aide, candidates must complete a state-approved training program, pass a competency test, and be listed in the state's nurse aide registry.

In 2002, the Office of Inspector General at the U.S. Department of Health and Human Services concluded that the current training for certified nurse aides is too short and outdated. Federal legislation enacted in 1987 created regulations regarding education for certified nurse aides. Since that time, the educational requirements have not been updated. Twenty-six states require more education than the federal standard. Texas requires the federal minimum of 75 hours with 51 hours devoted to classroom training and 24 hours for practical or clinical training.

Research shows that inadequate training leads to higher turnover and lower retention rates. The fiscal year 2005 turnover rate for certified nurse aides working in Texas nursing homes was 140 percent. Turnover affects the quality of care of residents. New employees may not be able to identify changes in mental and physical health easily or develop relationships that are the key to residents' quality of life. Turnover is expensive and can have serious financial impacts on federal, state, and local governments. Research conducted in 2002 by the Institute for Future Aging Services conservatively estimates the direct cost of turnover per direct-care worker to be $2,500. Increasing nurse aide training hours, updating the nurse aide curriculum, and strengthening the recertification process by requiring continuing education hours may help reduce turnover rates and improve the quality of long-term care.

CONCERNS

- During licensing inspections of Texas nursing homes, nurse aides under observation were not able to demonstrate they had the proper skills to care for patients. This is the fourth most frequently cited health code deficiency in fiscal year 2007 and was the third most frequently cited in fiscal year 2006, according to the Texas Department of Aging and Disability Services.
- The Office of Inspector General at the U.S. Department of Health and Human Services reported in 2002 that nurse aide training had not kept pace with nursing home industry needs and clinical exposure was too short and unrealistic. Nurse aides who do not receive adequate training resign because they are unprepared for what they face on the job.
- Turnover for nurse aides in Texas nursing facilities reached a high of 182 percent in 1999 and was last reported to be 140 percent in 2005. This level of turnover negatively affects continuity of care and care recipient relationships because care is frequently provided by new hires.
- Federal regulations require nursing facilities to offer at least 12 hours of continuing education each year to certified nurse aides. However, there is no state or federal regulation requiring continuing education be completed as a condition of recertification, thus missing an opportunity to ensure certified nurse aides receive ongoing training needed to improve their skills.

RECOMMENDATIONS

- **Recommendation 1:** Amend the Texas Occupations Code to require the Texas Department of Aging and Disability Services to establish an advisory committee, which would provide input to the agency regarding the training and curriculum for certified nurse aides.
- **Recommendation 2:** Include a contingency rider in the 2010–11 General Appropriations Bill that authorizes advisory committee members to receive reimbursement for travel expenses.
- **Recommendation 3:** Amend the Texas Occupations Code to increase the number of hours required for a nurse aide certification program to no less than 120 hours and no more than 359 hours.
- **Recommendation 4:** Amend the Texas Occupations Code to require 12 hours of continuing education annually as a condition for the renewal of nurse aide certification.

- **Recommendation 5:** Amend the Texas Health and Safety Code to require the Texas Department of Aging and Disability Services to strengthen the renewal process for nurse aide certification by auditing a sample of renewal applications for compliance and adding an expiration date to each nurse aide certificate issued.
- **Recommendation 6:** Amend the Texas Health and Safety Code to authorize the Texas Department of Aging and Disability Services to charge a fee for certified nurse aide renewal certificates.
- **Recommendation 7:** Include a contingency rider in the 2010–11 General Appropriations Bill that appropriates revenue collected from fees for certified nurse aide renewal certificates to the Texas Department of Aging and Disability Services for the regulation of certified nurse aides.

DISCUSSION

Long-term care is a broad term to describe the type of assistance with daily activities that older persons and persons with a disability receive to minimize, rehabilitate, or compensate for the loss of independent physical or mental functioning. Long-term care may be provided in an institutional setting, such as a nursing home, or through home- and community-based settings, such as an adult day care center, board and care homes, or an individual's home.

Instrumental in the ability to provide long-term care is an adequate, skilled, and diverse workforce. Doctors, registered nurses, licensed vocational nurses, nurse aides, and informal caregivers (family and friends) are all a part of the long-term care workforce. Nurse aides are direct-care workers who provide the bulk of bedside care, such as assistance with eating, bathing, housekeeping, and observing and reporting changes in a client's condition. Nurse aides are also known as nurse assistants, personal care workers, orderlies, attendants, home health aides, and certified nurse aides. Federal law requires nurse aides who work in nursing homes participating in Medicare or Medicaid to be certified. To become a certified nurse aide (CNA), one must complete a state-approved training program, pass a competency test, and be listed in the state's CNA registry.

There is a growing concern about the current and future supply of long-term care paraprofessionals. Many aspects of the work environment that affect workforce shortages are magnified in the long-term care sector. Previous research points to many interrelated factors contributing to high rates of turnover including low wages, lack of a full-time work schedule, lack of health insurance benefits and paid time off, emotionally taxing and physically daunting work, limited opportunities for advancement, and inadequate and outdated training. There is an immediate need to develop a committed, stable pool of direct-care workers who are willing, able, and prepared to provide quality care to people with long-term care needs. Training is the first step to improving the stability of the long-term care workforce. If nurse aide training does not adequately prepare a worker for the job, then no amount of money, benefits, or work schedule flexibility will be able to compensate for its inadequacy.

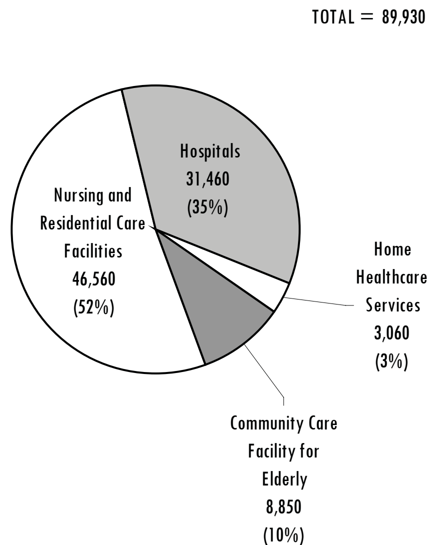
In 2005, 1.4 million paraprofessional workers were employed nationwide as a nurse aide, orderly, or attendant, according to the U.S. Bureau of Labor Statistics. In 2006, the Texas Workforce Commission reported there were 78,000 nursing aides employed in nursing facilities and hospitals. The direct-care workforce is predominantly female. **Figure 104** shows the characteristics of direct-care workers compared to all female workers. **Figure 105** shows the number of nurse aides, orderlies, and attendants by work setting in Texas.

FIGURE 104
CHARACTERISTICS OF DIRECT-CARE WORKERS AND ALL FEMALE WORKERS

CHARACTERISTIC	ALL FEMALE WORKERS	DIRECT-CARE WORKERS	NURSING HOME AIDES	HOSPITAL AIDES
Race and Ethnicity				
• White, non-Hispanic	70%	51%	51%	55%
• Black, non-Hispanic	13%	29%	35%	30%
• Hispanic	11%	15%	10%	11%
• Other	6%	5%	4%	5%
Have Children under 18	41%	43%	50%	32%
Average Age	42	41	38	40
Education Level: High School or Less	37%	62%	65%	51%

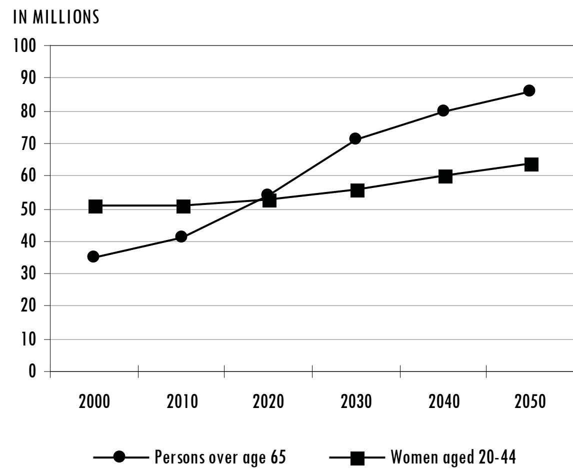
Source: U.S. Bureau of Labor Statistics.

FIGURE 105
TEXAS NURSE AIDES, ORDERLIES, AND ATTENDANTS' EMPLOYMENT BY SETTING, 2006



SOURCE: Texas Workforce Commission.

FIGURE 106
PROJECTED ELDERLY POPULATION AND THE POTENTIAL CAREGIVER POPULATION, 2000 TO 2050



SOURCE: U.S. Census Bureau.

As **Figure 104** shows, direct-care workers are older and typically have a high school education or less. The average age for a direct-care worker is 41. Forty-three percent of direct-care workers have children under age 18. According to the American Association for Retired Persons (AARP), direct-care workers are usually natural caretakers and choose this type of work because of a desire to help people in the healthcare system. Throughout history, female family members provided care for older persons in their extended family. However, in the late 20th century, large numbers of women entered the workforce and many families moved away from their extended families, thereby increasing the demand for paid caregivers.

The primary pool of workers for direct-care jobs are women aged 18 to 45, and the future demand for direct-care jobs is expected to grow. AARP reports that between 2002 and 2012 the demand for direct-care workers is expected to increase by 34 percent. However, according to projections by the U.S. Census Bureau, the supply of women aged 18 to 45 is expected to decrease in relation to the increasing numbers of older Americans. This is the "care gap" shown in **Figure 106**.

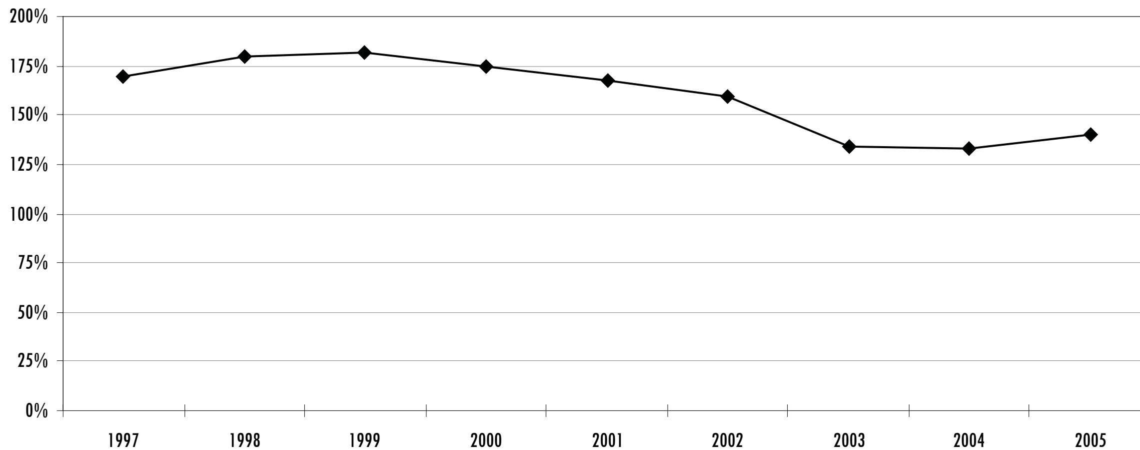
The "care gap" illustrates a shortage of workers will occur beginning in 2020. However, high turnover in direct-care jobs is already occurring. In 2005, the turnover rate for certified nurse aides (CNA) at Texas nursing facilities was 140 percent. **Figure 107** shows the CNA turnover rates from 1997 to 2005.

The combination of a "care gap" and high turnover rates underscore the need to develop a committed, stable pool of direct-care workers who are willing, able, and prepared to provide quality care to people with long-term care needs. As previously mentioned, research reveals several interrelated factors contributing to high rates of turnover including: low wages, lack of a full-time work schedule, lack of health insurance benefits and paid time off, emotionally and physically taxing work, limited advancement opportunities, and inadequate and outdated training.

Figure 108 shows the mean, entry, and experienced hourly wages for Texas workers employed as a nurse aide, orderly, or attendant by work setting in 2006.

Low hourly wages for direct-care workers is a national concern. The U.S. Bureau of Labor Statistics reported in 2005 that the median hourly wage for direct-care workers nationwide was $9.56, while the median wage for all U.S. workers was $14.15. If a direct-care worker is employed full-time all year at the median 2005 wage, then their average annual income would be $19,884. However, more than half of the direct-care workforce is employed part-time; therefore, workers' earnings are much less. Research from the Center for California Health Workforce Studies in 2006 cited that direct-care workers who are single-parents, 30 to 35 percent receive food stamps and rely on publically funded health care. In addition to low wages and lack of benefits, the physical and emotional demands of direct-care work make the job less appealing for many workers to remain when they

FIGURE 107
CERTIFIED NURSE AIDE TURNOVER RATE IN TEXAS NURSING FACILITIES, 1997 TO 2005



SOURCE: Texas Health and Human Services Commission.

FIGURE 108
HOURLY WAGES FOR TEXAS WORKERS EMPLOYED AS A NURSE AIDE, ORDERLY, OR ATTENDANT BY WORK SETTING, 2006

TYPE OF FACILITY	MEAN WAGES	ENTRY WAGES	EXPERIENCED WAGES
Hospitals	$10.21/hour	$8.06/hour	$11.29/hour
Nursing and Residential Care Facilities	$9.04	$7.50	$9.81
Community Care Facility for the Elderly	$9.07	$7.57	$9.82

SOURCE: Texas Workforce Commission.

could work in other industries, such as retail or food service for nearly the same hourly rate.

Turnover may be an ongoing issue in many low-wage jobs; but in direct-care work, constant turnover negatively affects patient outcomes. Frequent turnover results in residents being cared for by new employees who may not be able to identify changes in mental and physical health easily or develop relationships that are the key to residents' quality of life. The experienced nurse aides who do remain on the job are unable to spend adequate time with residents due to an increase in workload and, therefore, are also at a disadvantage when staff turnover is constant. Turnover not only impacts the quality of care of residents but it is expensive and can have serious financial impacts on federal, state, and local governments. Research conducted in 2002 by the Institute for Future Aging Services conservatively estimates the direct cost of turnover over per direct-care worker to be $2,500. Direct costs include costs of recruiting and training new employees as well as costs of separation and vacancy.

Training is related to turnover. Good quality care for nursing home residents requires providing nursing aides with the training they need to be well prepared for their jobs. Job satisfaction is linked to preparation. Research shows that inadequate training leads to higher turnover and retention rates are strongly associated with the number of hours trained. According to the U.S. Health and Human Services Department Office of Inspector General, certified nurse aide training is too short and has not kept up-to-date with the pace of nursing home needs. Federal requirements for certified nurse aide training have not changed since their creation in 1987.

PRE-EMPLOYMENT EDUCATION REQUIREMENTS

The Nursing Home Reform Act which was part of the Omnibus Budget Reconciliation Act of 1987 created federal requirements regarding certified nurse aide (CNA) education. It established CNAs must have a minimum of 75 hours of training, of which 16 hours must be supervised practical or clinical training. **Figure 109** shows the current federal curriculum requirements.

Texas requires the federal minimum number of hours, with 51 hours devoted to classroom training and 24 hours for clinical training.

Twenty-six states require more pre-employment training hours than federally required. Missouri requires the highest number of hours at 175 followed by California at 150 hours. All Texas training facilities teach the same curriculum distributed by the Texas Department of Aging and Disability Services (DADS); however, each training facility can vary the length of training provided it meets the minimum federal

FIGURE 109
FEDERAL CERTIFIED NURSE AIDE CURRICULUM REQUIREMENTS, 2008

COMMUNICATION AND INTERPERSONAL SKILLS	
INFECTION CONTROL	
SAFETY AND EMERGENCY PROCEDURES	• Heimlich maneuver
PROMOTING THE RESIDENT'S INDEPENDENCE	
RESPECTING THE RESIDENT'S RIGHTS	
BASIC NURSING SKILLS	• taking and recording vital signs • measuring and recording height and weight • caring for the resident's environment • recognizing abnormal changes in body functioning and the importance of reporting such changes to a supervisor • caring for the resident when death is imminent
PERSONAL CARE SKILLS	• bathing • grooming • mouth care • dressing • toileting • assisting with eating and hydration • proper feeding techniques • skin care and transfers • positioning • turning
MENTAL HEALTH AND SOCIAL SERVICE	• modifying aide's behavior in response to the resident's behavior • awareness of developmental tasks associated with the aging process • how to respond to the resident's behavior • allowing the resident to make personal choices, • providing and reinforcing other behavior consistent with the resident's dignity • using the resident's family as a source of emotional support
CARE OF COGNITIVELY IMPAIRED RESIDENTS	• techniques for addressing the unique needs and behaviors of an individual with dementia (Alzheimer's disease and others) • communicating with a cognitively impaired resident • understanding the behavior of cognitively impaired residents • appropriate responses to the behavior of a cognitively impaired resident • methods of reducing the effects of cognitive impairments
BASIC RESTORATIVE SERVICES	• training the resident in self care according to the resident's abilities • use of assistive devices in transferring, • ambulation, eating, and dressing • maintenance of range of motion • proper turning and positioning in bed and chair • bowel and bladder training care • use of prosthetic and orthotic devices
RESIDENT'S RIGHTS	• providing privacy and maintenance of confidentiality • promoting the resident's right to make personal choices to accommodate their needs • giving assistance in resolving grievances and disputes • providing needed assistance in getting to and participating in resident, family, group, and other activities maintaining care and security of the resident's personal possessions • promoting the resident's right to be free from abuse, mistreatment, and neglect and the need to report any instances of such treatment to appropriate facility staff • avoiding the need for restraints in accordance with current professional standards

SOURCE: Code of Federal Regulations.

and state requirements. CNA training may be facility-based, as in a nursing home, or non-facility-based, such as a community college, vocational-technical school, high school, or private school. According to DADS, Texas had 318 facility-based training programs and 424 non-facility-based training programs in fiscal year 2007.

CNA training that is facility-based is free to students due to federal regulations prohibiting nursing facilities from charging for it. Medicaid and Medicare-certified nursing facilities receive reimbursement for a portion of CNA training and examination costs. Nursing facilities are reimbursed at a pro rata share based on each facility's specific ratio of Medicaid clients to the total number of clients in a facility. In fiscal year 2007, DADS reimbursed nursing facilities $458,283 in All Funds for certified nurse aide training. Students receiving training other than from a nursing home may be reimbursed a portion of their expenses for tuition, textbooks, testing, or other required course materials if the student accepts an offer of employment from a certified Medicaid or Medicare facility within one year of the completion of their training.

Inadequate training may lead to high turnover according to a growing body of research. According to the Paraprofessional Health Institute, 40 to 50 percent of all nurse aides leave the job within the first six months because they have not learned to manage competing demands on the job. Research also demonstrates trainees resign out of frustration or disillusionment because what they are taught in class does not prepare them for the realities of direct-care work. Higher levels of training for direct-care workers can help employers both find and keep employees. The belief is that more effective training may reduce turnover rates by giving new workers much needed confidence to know that they are doing the job right. Other service occupations in Texas, such as a registered veterinary technician, a barber, and a cosmetologist all require substantially more hours of training than the current federal and state standards require for a nurse aide to work in a long-term care facility. **Figure 110** shows a comparison of these training requirements.

FIGURE 110
REQUIRED TRAINING HOURS FOR CERTIFIED NURSE AIDES AND OTHER OCCUPATIONS IN TEXAS, 2008

OCCUPATION	REQUIRED TRAINING HOURS
Certified Nurse Aide	75 hours
Barber	1,500 hours
Cosmetologist	1,500 hours
Registered Veterinary Technician	Associate of Science degree (2 years)

SOURCE: Legislative Budget Board.

In 2002, the U.S. Department of Health and Human Services Office of the Inspector General studied nurse aide training to determine if the training prepares nurse aides for jobs in nursing homes. The national study determined that nurse aide training has not kept pace with nursing home industry needs. Current nursing home residents are sicker and require more care, which results in the use of medical technologies previously only seen in hospitals. Technology, such as intravenous feedings, ventilators, and oxygen are now used regularly in nursing homes. Nationally, nurse aides report that they are taught outdated practices and how to use outdated equipment.

The Texas Department of Health last updated Texas' CNA training in 2000. Representatives from several nurse aide-training programs, registered nurses and licensed vocational nurses from nursing facilities and colleges, program specialists, and a nursing specialist from the Texas Department of Human Services participated in the process.

The Inspector General's report found nurse aide training does not meet the needs of the current nursing home population. According to the Paraprofessional Health Institute, nurse aides are put in situations that require unusually sophisticated interpersonal and communication skills in addition to being called upon to manage conflict, set limits, make ethical decisions, grieve, help others grieve, and support other members of the care-giving team. Current training does not address the psycho-social needs of residents. Nurse aides need additional training in interpersonal communication and an understanding of the aging process. According to research conducted in 2006 by AARP, states already requiring more pre-employment training (classroom and clinical) than the federal minimum believe there is still a need to increase total training hours further. There is not agreement among researchers or stakeholders about the number of training hours needed for CNAs. However, in 2008, the Institute of Medicine recommended to Congress to increase the federal standard for certified nurse aide training to at least 120 hours.

The U.S. Health and Human Services Office of the Inspector General also found that nurse aide clinical training exposure is too short and unrealistic. Twenty-nine states, including Texas, have clinical training requirements beyond the 16-hour federally required minimum. Texas requires 24 clinical hours. California and Missouri are tied for the state requiring the highest number of clinical training hours, each requires 100 hours. Long-term care stakeholders agree more clinical training is needed, but there is not a clear consensus on the

number of hours needed. Some stakeholders suggest a new minimum of 50 to 60 hours, while others support 50 percent of the overall CNA training be devoted to clinical or practical training.

Recommendation 1 would amend the Texas Occupations Code to establish a CNA curriculum and training advisory committee. The advisory committee would provide recommendations to the Texas Department of Aging and Disability Services (DADS) regarding increasing CNA training hours and the subjects to be added to strengthen and update the CNA curriculum to ensure its continued relevancy in health care. Recommendations of the committee would be submitted to the executive director of DADS in a time period established by the executive director. The executive director would request written recommendations from the committee regarding future certified nurse aide curriculum and training issues.

This recommendation would require a statutory change and contingency rider for travel expense reimbursement for advisory committee members could included in the 2010–11 General Appropriations Bill.

The advisory committee should include stakeholders affected by a CNA curriculum change including, but not limited to:

- two nursing home representatives,
- two representatives with community college CNA training programs,
- one hospital representative,
- one home health industry representative,
- two certified nurse aides: one with one to five years experience and the other with more than five years experience,
- two representatives of non-facility-based training programs (other than community colleges) offering CNA training,
- one registered nurse with at least two years experience training CNAs, and
- one licensed vocational nurse with at least two years experience working directly with CNAs.

Topics for the advisory group to consider adding to the curriculum include: successful strategies to deal with dementia or other difficult patients, time management, prioritizing tasks, interpersonal communication skills, cultural sensitivity, how to work as a team, psycho-social skills, and the aging process.

Recommendation 2 would authorize advisory committee members to be reimbursed for travel expenses. This recommendation could be implemented by including a contingency rider in the 2010–11 General Appropriations Bill.

Recommendation 3 would amend the Texas Occupations Code to increase the number of hours required for a nurse aide certification program to no less than 120 hours and no more than 359 hours. This would not only help to ensure nurse aides are better prepared for their work, but would also position the state to comply with any future federal requirements.

NURSE AIDE RECERTIFICATION

Certified nurse aides are required to renew their certification every two years to maintain an “active” status on the state Nurse Aide Registry. Federal regulations require states to maintain a registry of persons who meet all state and federal requirements to work as a certified nurse aide. In Texas, to maintain certification, CNAs must demonstrate paid employment as a CNA for any length of time during the preceding two-year period and register any address or telephone number changes. To renew their certification, a nurse aide must contact DADS to update their contact information and submit proof of employment for the preceding two years.

Federal regulations also require nursing facilities to offer at least 12 hours of continuing education each year to CNAs, but there is no matching state or federal requirement for CNAs to attend continuing education as a condition to renew their certification. Without a requirement tying continuing education to the recertification process a regulatory gap exists. Continuing education allows CNAs to receive ongoing training needed to improve their skills.

To strengthen the CNA renewal process, two changes are recommended. Recommendation 4 would amend the Texas Occupations Code to authorize DADS to require CNAs to obtain a minimum of 12 hours of continuing education each year as a condition of renewing one’s certification.

Recommendation 5 would amend the Texas Health and Safety Code to require DADS to establish a process to audit a sample of nurse aide renewal applications for compliance with the continuing education and all other federal and state requirements. Additionally, an expiration date would be added to each CNA certificate issued. Adding the expiration date will help to ensure current and accurate information

about each CNA is present in the Nurse Aide Registry, as well as helping to ensure each CNA's credentials are kept current. Establishing an auditing process for compliance with all state and federal requirements will not only increase compliance, but will ensure CNAs are taking advantage of all required opportunities to strengthen their skills and update their knowledge about care delivery.

Currently, nurse aide certificates are not issued with an expiration date; as a result, new costs may be incurred by the agency because the number of certificates issued each year will increase. Recommendation 6 would amend Texas Health and Safety Code to authorize DADS to charge a $30 fee for biennial renewal certificates.

This fee would not violate federal law because it is not a charge for placement on the Nurse Aide Registry. Federal law (Sections 1819(e)(2) and 1919(e)(2) of the Social Security Act) prohibits charges to nurse aides for facility-based training and placement on the state Nurse Aide Registry. Implementing Recommendation 6 would generate approximately $755,000 in fiscal year 2010. A portion of the revenue would be used to fund the increased administrative costs of strengthening the regulation of CNAs.

Recommendation 7 would direct a portion of the new revenue from the collection of the renewal certificate fee to DADS for the regulation of certified nurse aides. Because DADS has existing regulatory staff and processes in place, it is estimated the agency would need an additional $300,000 in General Revenue Funds to implement the new regulatory requirements. This recommendation could be implemented by including a contingency rider in the 2010–11 General Appropriations Bill.

FISCAL IMPACT OF THE RECOMMENDATIONS

Recommendations 1 and 2 direct DADS to establish an advisory committee to improve the certified nurse aide curriculum and authorizes committee members to be reimbursed for travel expenses. Recommendation 3 increases the certified nurse aide pre-employment training hours to at least 120 hours but not greater than 359 hours. It is estimated DADS could implement Recommendations 1, 2, and 3 by using existing resources.

Recommendations 4 and 5 would strengthen the recertification process for nurse aides and would require 12 hours of continuing education annually. It is estimated DADS could implement Recommendation 4 with existing resources. Costs associated with the increased regulation in Recommendation 5 would be offset with the revenue generated from Recommendation 6.

Recommendation 6 amends the Texas Health and Safety Code to authorize DADS to charge a $30 fee for a renewal certificate. The fee is estimated to generate $755,971 in fiscal year 2010 and $771,090 in fiscal year 2011. The revenue estimates are based on the following assumptions:

- Biennial renewal of certificates at a cost of $30 per certificate ($15 per year).
- The Texas Workforce Commission estimates in 2006 there were 46,560 nurse aides working in nursing home facilities.
- Approximately 50 percent of CNAs renew their certification in even-numbered years and would request a new certificate.
- The number of CNAs grows approximately 2 percent each year based on a 10-year average from 1997 to 2007.

Recommendation 7 would appropriate a portion of the revenue collected from the renewal certificate fee to DADS for the regulation of certified nurse aides. The cost estimate is based on increased administrative costs for issuing renewal certificates and verifying continuing education requirements, such as postage, printing, and responding to customer inquiries.

Figure 111 shows the fiscal impact of these recommendations.

FIGURE 111
FIVE-YEAR FISCAL IMPACT, FISCAL YEARS 2010 TO 2014

FISCAL YEAR	PROBABLE GAIN/ (LOSS) IN GENERAL REVENUE FUNDS	PROBABLE SAVINGS/ (COST) IN GENERAL REVENUE FUNDS
2010	$755,971	($300,000)
2011	$771,090	($300,000)
2012	$786,512	($300,000)
2013	$802,242	($300,000)
2014	$818,287	($300,000)

SOURCE: Legislative Budget Board.

The introduced 2010–11 General Appropriations Bill does not address these recommendations.

IMPROVE REGULATION OF CERTIFIED NURSE AIDES

Certified nurse aides are unlicensed assistive personnel who work in many healthcare settings, such as hospitals and long-term care facilities. Their work fills the void created by the shortage of nurses and decreases the cost of providing patient care. To become a certified nurse aide, candidates must complete a state-approved training program, pass a competency test, and be listed in the state's nurse aide registry. In Texas, unlike nurses who are regulated by their licensing board, certified nurse aides' work is regulated only if care is delivered in a long-term care setting. For example, if there were a complaint of abuse or misconduct regarding a nurse aide working in a hospital, the hospital's internal policies would direct the investigation of the complaint; however, if the same act occurred in a nursing home, the Texas Department of Aging and Disability Services would investigate. Regulation is dependent on the workplace setting. In Texas, there is no single regulating entity for the occupation of nurse aide.

Regulation of certified nurse aides by the Texas Department of Aging and Disability Services, rather than the Board of Nursing, segregates the certified nurse aides from the nursing continuum and does not promote communication or understanding within the profession about the various roles nurses have in healthcare. Transferring the regulation of certified nurse aides to the Texas Board of Nursing would allow the agency to oversee the entire continuum of nursing, beginning with the certified nurse aide to the advanced practice nurse.

CONCERN

- ♦ Certified nurse aides provide the most direct care in long-term care facilities and spend the most time with patients; however, their work is not regulated by the Texas Board of Nursing as is the work of licensed nurses. This separation creates fragmentation in the education and regulation of nursing care and duplicates processes already undertaken by the Texas Board of Nursing.

RECOMMENDATIONS

- ♦ **Recommendation 1:** Amend Texas Occupation Code, Chapter 301, to allow the Texas Board of Nursing to regulate the occupation of certified nurse aides and Nurse Aide Training and Competency and Evaluation programs.
- ♦ **Recommendation 2:** Include a contingency rider in the 2010–11 General Appropriations Bill requiring the Texas Board of Nursing and the Texas Health and Human Services Commission to enter into an interagency contract to allow the Board of Nursing to conduct day-to-day operations of certified Nurse Aide Registry and obtain federal reimbursement for managing the certified nurse aide program.
- ♦ **Recommendation 3:** Amend Texas Occupation Code, Chapter 301, to create a certified nurse aide advisory committee to advise the agency regarding issues affecting certified nurse aides.
- ♦ **Recommendation 4:** Include a contingency rider in the 2010–11 General Appropriations Bill allowing members of the nurse aide advisory committee to be reimbursed for travel expenses.
- ♦ **Recommendation 5:** Include a contingency rider in the 2010–11 General Appropriations Bill to increase the Texas Board of Nursing full–time-equivalent cap to add 12 positions for the regulation of certified nurse aides.

DISCUSSION

In 1986, the Institute of Medicine (IOM) Committee on Nursing Home Regulations issued a report, *Improving the Quality of Care in Nursing Homes*. As a result of this report, the U.S. Congress enacted major reforms in the regulation of nursing homes. These reforms were contained in the Omnibus Budget Reconciliation Act (OBRA) of 1987 and created educational requirements for certified nurse aides who work in Medicare- or Medicaid-certified nursing homes. The OBRA 1987 reforms were intended to improve the quality of care provided in nursing homes. The federal government set standards for some personnel in nursing homes because nonprofessionals, such as certified nurse aides, provide the majority of care and have an impact on both the health status and the quality of life of nursing home residents. (For more detailed information about certified nurse aide training, refer to *Strengthen Certified Nurse Aide Training* in this publication.) According to the

IOM, long-term care services are labor intensive, and therefore the quality of care depends largely on the performance, knowledge, and skills of the caregiving personnel.

The OBRA 1987 regulations set new standards for the regulation of nursing homes. As a result of the federal government implementing personnel standards through the regulation of nursing home facilities, the responsibility for ensuring an adequate and trained workforce has fallen to providers and not to an occupational board like other professions. The Texas Department of Aging and Disability Services (DADS), which regulates facilities, also oversees certain occupations like certified nurse aides.

A new issue has developed during the 20 years since the OBRA 1987 regulations were implemented. Certified nurse aides (CNA) now work in many healthcare settings other than long-term care. For example, due to the registered nurse shortages, hospitals have increasingly turned to a new kind of healthcare worker, the unlicensed assistive personnel (UAP). CNAs are unlicensed assistive personnel used to fill the void created by the shortage of nurses and to decrease costs of providing patient care. The American Nurses Association identifies the role of a UAP as one "who is trained to function in an assistive role to the licensed nurse in the provision of patient activities as delegated by the nurse." Additionally, state boards of nursing recognize the UAP "as a nonprofessional or paraprofessional whose role is to assist the registered nurse in the provision of health care."

However, unlike nurses who are regulated by their licensing board, certified nurse aides' work is regulated only if care is delivered in a long-term care setting. For example, if there is a complaint of abuse or misconduct by a CNA working in a hospital, the hospital's internal policies would direct the investigation of the complaint; however, if the same act occurred in a nursing home, then DADS would investigate. In Texas there is no single regulating entity for the occupation of nurse aide. Regulation is dependent on the workplace setting.

According to the National Clearinghouse on the Direct Care Workforce, the demand for direct care workers, like CNAs, is expected to increase by 35 percent from 2004 to 2014. As recruitment efforts increase to fill these jobs, IOM concludes that it may be more important than ever to expand training and education to develop and implement additional competency standards that allow all staff to perform well and deliver high-quality care.

OVERSIGHT OF CERTIFIED NURSE AIDES IN TEXAS

In Texas, CNAs are regulated by DADS, which is the state certification and licensing agency for long-term care facilities. The agency regulates primarily facilities and services, not people. However as a result of the OBRA 1987 regulations, it is also responsible for the issuance and continuance of nurse aide registrations, oversight of nurse aide testing development and administration, and approval and monitoring of the Nurse Aide Training and Competency Evaluation Program (NATCEP). DADS reviews and investigates allegations of abuse, neglect, or misappropriation of resident property by nurse aides and maintains the state's Nurse Aide Registry (NAR). The NAR is a federally required registry that states must maintain of all individuals registered to work as nurse aides in the state. If a CNA is found to have committed an act of abuse, neglect, or exploitation, that information would also be noted in the NAR. DADS' enforcement activities include coordinating due process related to referrals of misconduct by a nurse aide that occur in nursing facilities and entering findings of abuse, neglect, and misappropriation of resident property as appropriate in the NAR.

The Texas Board of Nursing (BON) regulates the practice and education of licensed vocation nurses (LVN) and registered nurses (RN). While nurse aides are "certified" and not "licensed," processes essential to the regulation of CNAs are similar, if not identical, to what BON conducts for licensed nurses. **Figure 112** shows the overlap of functions between DADS and BON.

In its 2006 Sunset Self Evaluation Report, BON discussed the issue of regulating certified nurse aides. BON believes having one agency regulate all types of nursing (CNAs, LVNs and RNs) would improve services. At least 13 states and the District of Columbia regulate CNAs through a nursing board. Kansas and Rhode Island have active legislation to move CNA regulation to their respective state nursing board. Transferring the regulation of CNAs to BON would allow BON to oversee the entire continuum of nursing, beginning with the CNA and continuing with the LVN, the RN, and the advanced practice nurse. Current regulation of CNAs by DADS segregates the CNAs from the nursing continuum and does not promote communication or understanding within the profession about the various roles nursing has in healthcare. More importantly, current CNA regulation does not facilitate the movement of CNAs upwards into the licensed nursing professions. Aligning the CNA curriculum to qualify as a part of the educational requirements for a

FIGURE 112
COMPARISON OF TEXAS BOARD OF NURSING FUNCTIONS AND DEPARTMENT OF AGING AND DISABILITY REGULATION OF CERTIFIED NURSE AIDES, 2008

FUNCTION	BOARD OF NURSING	DEPARTMENT OF AGING AND DISABILITY SERVICES
Regulation of Profession's Educational Requirements	✓	✓
Issuance and Continuance of Certification or Licensure	✓	✓
Oversight of Competency Testing/Evaluation	✓	✓
Investigate Allegations of Abuse, Neglect, Exploitation, or other Misconduct	✓	✓
Online Verification Registry	✓	✓
Coordinate or Conduct Due Process Related to Acts of Misconduct	✓	✓
Investigate Complaints	✓	✓

SOURCE: Legislative Budget Board.

licensed vocational nurse may encourage more CNAs to stay in the nursing profession and help to grow the supply of nurses.

Recommendation 1 would amend Chapter 301 of the Texas Occupations Code to authorize BON to regulate CNAs and Certified Nurse Aide Competency and Training and Evaluation Programs (NATCEP).

Recommendation 2 would direct the Texas Health and Human Services Commission (HHSC) to enter into an interagency contract with BON to allow BON to receive Federal Funds for the administration of the CNA program. In fiscal year 2007, DADS received $73,954 in Federal Funds for the administration of the CNA program and used the same amount in General Revenue Funds as matching money for these Federal Funds. The interagency agreement would also allow BON to oversee the state's Nurse Aide Registry (NAR). Federal guidelines require that only the state's survey and certification agency (DADS) may place findings of abuse, neglect, or exploitation on the registry. An interagency contract would allow the ultimate responsibility for the NAR to remain at DADS, while BON would manage the day-to-day responsibilities and receive necessary federal funding for this responsibility. DADS would continue to be responsible for reimbursement to nursing home providers for the cost of certified nurse aide training at their facilities. A contingency rider could be included in the 2010–11 General Appropriations Bill to implement Recommendation 2.

Through the transfer of CNA regulation to BON, an opportunity exists to promote better communication and role understanding between the licensed nurses and the CNAs they supervise. The relationship between the various nursing occupations is tenuous. Studies have identified that ineffective supervision is a contributing factor to high CNA turnover rates. Qualitative research reveals direct care workers' relationship with their supervisors is often the most influential factor in whether they feel valued and respected at work and whether they decide to remain at a job. A strong foundation of respect through supportive supervision, peer mentoring, and team building is needed to break through hierarchical barriers within the nursing professions. To foster better communication and understanding between the licensed nurse professions and the CNAs they supervise, an advisory committee should be established to provide input to the agency about issues affecting CNAs. Specifically, the CNA advisory committee would provide recommendations to the executive director about improving communication, role expectation, and role relationships between licensed nurses and CNAs. The committee would also recommend ways to improve the CNA occupation and its training so that CNAs may better meet the health care system's acute and long-term care demands.

Recommendation 3 would amend Chapter 301 of the Texas Occupations Code to create a certified nurse aide advisory committee to advise the agency regarding issues affecting CNAs. The advisory committee would include stakeholders knowledgeable about CNA workforce and training issues. The executive director of BON would appoint the CNA advisory committee, which should include, but not be limited to, the following members:

- two nursing home representatives;
- two representatives of community college CNA training programs;
- one hospital representative;
- one home health industry representative;
- three certified nurse aides: two with one to five years' experience and the other with more than five years' experience;
- two representatives of non-facility-based training programs (other than community colleges) offering CNA training;

- one registered nurse with at least two years' experience training CNAs; and
- one licensed vocational nurse with at least two years' experiencee working directly with CNAs.

This recommendation would require a statutory change.

Recommendation 4 would require a contingency rider for travel expense reimbursement for advisory committee members and could be included in the 2010–11 General Appropriations Bill.

Recommendation 5 increases BON FTE position cap, currently at 84.7, to allow 12 additional positions to be hired for the regulation of certified nurse aides. This recommendation could be implemented by including a contingency rider in the 2010–11 General Appropriations Bill.

FISCAL IMPACT OF THE RECOMMENDATIONS

Recommendation 1 amends Chapter 301 of the Texas Occupations Code and authorizes the transfer of the responsibility for the regulation of certified nurse aides from DADS to BON. According to BON, they estimate 15 part-time contract nurses to oversee nurse aide training programs across the state and 12 new FTE positions would be needed to administer the CNA program responsibilities. The new positions would be responsible for the following activities:

- one nursing consultant to oversee CNA Competency, Training, and Evaluation Program and oversee the skills portion of CNA exam;
- three nursing investigators to process, investigate, and prepare board orders for alleged violations of law and rules;
- one administrative assistant to assist nursing investigators with processing CNA alleged violations;
- two customer service staff to answer CNA inquiries;
- one clerk to open mail;
- two licensing staff to process CNA initial and endorsement applications; and
- two licensing staff to process CNA renewals.

The estimate for BON one-time start-up costs in 2010 is $151,900. The transfer of CNA regulation is assumed to occur in 2011. The start-up costs include computer programming, building out of 2,000 square feet of office space, office furniture, personal computers, printers, and telephones. Annual program costs are estimated to be $944,606, of which a portion would be funded at a 50 percent match rate in Federal Funds that was previously appropriated to DADS. In addition, the revenue from the CNA recertification fee (recommended in the *Strengthen Certified Nurse Aide Training* report in this publication), if implemented, could offset any additional cost of General Revenue Funds. The CNA recertification fee is estimated to generate $755,971 in fiscal year 2010 and $771,090 in fiscal year 2011. **Figure 113** shows the net cost to General Revenue Funds and Federal Funds without using any new fee revenue.

Recommendation 2 would require HHSC and BON to enter into an interagency contract that ensures BON receives federal funding for the administration of the certified nurse aide program and registry.

Recommendation 3 would establish an advisory committee to ensure BON receives ongoing input about improving the CNA occupation and its role in health care delivery settings, and Recommendation 4 would allow CNA board members to be reimbursed for their travel expenses. It is estimated BON could implement Recommendation 3 and 4 with existing resources.

FIGURE 113
FIVE-YEAR FISCAL IMPACT, 2010 TO 2014

FISCAL YEAR	PROBABLE SAVINGS/(COST) IN GENERAL REVENUE FUNDS	PROBABLE GAIN/(LOSS) IN FEDERAL FUNDS	PROBABLE SAVINGS/(COST) IN FEDERAL FUNDS	CHANGE TO FULL-TIME EQUIVALENTS COMPARED TO 2008–09 BIENNIUM
2010	($151,900)	$0	$0	0
2011	($472,303)	$472,303	($472,303)	12
2012	($472,303)	$472,303	($472,303)	12
2013	($472,303)	$472,303	($472,303)	12
2014	($472,303)	$472,303	($472,303)	12

SOURCE: Legislative Budget Board.

Recommendation 5 would increase the FTE cap for BON to allow for new positions to be hired for the regulation of certified nurse aides.

The introduced 2010–11 General Appropriations Bill does not address these recommendations.

ELIMINATE THE MEDICAID CONSOLIDATED WAIVER PROGRAM AND TRANSFER CLIENTS TO OTHER EXISTING PROGRAMS

Medicaid 1915(c) long-term care waivers allow states to use Medicaid funds to pay for community-based care in lieu of institutional care. The Texas Department of Aging and Disability Services administers seven Medicaid 1915(c) long-term care waiver programs. One of these waiver programs, the Consolidated Waiver Program, has operated as a pilot program since fiscal year 2002. This program tests the feasibility of addressing potential administrative and operational inefficiencies by consolidating five of the state's Medicaid 1915(c) waivers into one program. The program serves about 200 clients in Bexar County and is intended to serve a proportionate number of adults and children who would otherwise receive care in the state's other Medicaid 1915(c) waiver programs. The program will require federal renewal in September 2009.

Continued operation of the Consolidated Waiver Program is no longer necessary. The small size of the program and the self-selection enrollment method make it difficult to determine its effectiveness relative to other Medicaid 1915(c) waiver programs in Bexar County. Furthermore, the expansion of a Medicaid managed care program, STAR+PLUS, limits the number and type of clients who could participate in the Consolidated Waiver Program. Eliminating the Consolidated Waiver Program, transferring clients to other Medicaid 1915(c) waiver programs, implementing activities to streamline the administration and delivery of these waiver programs, and reporting on streamlining efforts could help the state achieve the intended goals of the Consolidated Waiver Program and save about $900,000 in All Funds during the 2010–11 biennium.

CONCERNS

- Given the state's inability to determine the effectiveness of the Consolidated Waiver Program and changes in the policy landscape since the program's implementation, continued operation of the Consolidated Waiver Program is no longer necessary.
- The Texas Health and Human Services Commission is statutorily required to make certain functions relating to the administration and delivery of Medicaid 1915(c) waiver programs uniform. However, there is no similar requirement for the Texas Department of Aging and Disability Services even though the agency is responsible for operating the waiver programs.
- Neither the Texas Department of Aging and Disability Services nor the Texas Health and Human Services Commission is required to report on planned or implemented efforts related to streamlining the administration and delivery of Medicaid 1915(c) waiver programs. As a result, the Texas Legislature lacks the information needed to evaluate efforts to improve the long-term care waiver delivery system.

RECOMMENDATIONS

- **Recommendation 1:** Amend the Texas Government Code to eliminate the Consolidated Waiver Program.
- **Recommendation 2:** Include a contingency rider in the 2010–11 General Appropriations Bill that would reduce funding for the Consolidated Waiver Program by $897,326 in All Funds and would direct the Texas Department of Aging and Disability Services to transfer the remaining funds from the Consolidated Waiver Program to other strategies to serve clients who otherwise would have received services through the Consolidated Waiver Program in the appropriate Medicaid 1915(c) waiver program. The agency should be required to submit their plan for transferring funds to the Legislative Budget Board for approval.
- **Recommendation 3:** Amend the Texas Human Resources Code to require the Texas Department of Aging and Disability Services to streamline the administration and delivery of Medicaid 1915(c) waiver programs and to work with the Texas Health and Human Services Commission on this effort as appropriate.
- **Recommendation 4:** Include a rider in the 2010–11 General Appropriations Bill that would direct the Texas Department of Aging and Disability Services, in consultation with the Texas Health and Human Services Commission, to submit a report on efforts planned or implemented to streamline the administration and delivery of Medicaid 1915(c) waiver programs to the Legislative Budget Board

and the Governor by December 1 of each year of the biennium.

DISCUSSION

Long-term care refers to a wide range of supportive and health services for persons who have lost the capacity for self-care due to illness or frailty. Major groups of persons needing long-term care services and supports include older adults and non-aged persons with disabilities. Long-term care services include a continuum of health and social services provided in institutions, in the community, and at home.

Medicaid, financed with both federal funds and state funds, is a healthcare program for low-income families, the elderly, and persons with disabilities. Medicaid is the single largest source of public financing for long-term care. In Texas, Medicaid long-term care spending totaled approximately $9.9 billion in All Funds during the 2006–07 biennium. Of this amount, 57 percent (or $5.6 billion) was spent on care provided in institutional settings and 43 percent (or $4.3 billion) was spent on home- and community-based services.

MEDICAID 1915(C) LONG-TERM CARE WAIVER PROGRAMS

Medicaid 1915(c) long-term care waivers allow states to use Medicaid funds to pay for community-based treatment alternatives in lieu of care provided in institutional settings. Federal law defines institutions as "hospitals, nursing facilities, and Intermediate Care Facilities for persons with Mental Retardation." According to federal rules, 1915(c) home and community-based waivers cannot cost any more than institutional care would have cost for the group served by the waiver. In fiscal year 2007, the average monthly cost per Medicaid client for nursing facility care was $2,567 compared to $1,286 for a person receiving waiver services through the Community-Based Alternatives (CBA) program. Similarly, the average monthly cost per Medicaid client for care received in an Intermediate Care Facility for Persons with Mental Retardation or Related Conditions (ICF-MR/RC) was $4,175 compared to $3,224 for a person receiving waiver services through the Home and Community-Based Services (HCS) program.

The Texas Department of Aging and Disability Services (DADS) administers seven Medicaid 1915(c) waiver programs. In addition, clients enrolled in STAR+PLUS (a Medicaid managed care program) or Integrated Care Management may receive long-term care services through two additional Medicaid 1915(c) waivers. STAR+PLUS and Integrated Care Management are models that integrate the delivery of Medicaid acute and long-term care services. An individual can be enrolled in only one waiver program. Demand for waiver services typically exceeds authorized funding. As a result, there is an interest list for most waiver programs. **Figure 114** shows key characteristics of each of the nine Medicaid 1915(c) waiver programs operating in Texas.

CONSOLIDATED WAIVER PROGRAM

The Consolidated Waiver Program (CWP) is a Medicaid pilot program established by legislation enacted by the Seventy-sixth Legislature, 1999. CWP, which has operated in Bexar County since fiscal year 2002, provides home- and community-based services to no more than 200 individuals who are on the interest list and eligible for one of the following Medicaid 1915(c) waiver programs:

- STAR+PLUS 1915(c) (CBA equivalent);
- Medically Dependent Children Program (MDCP);
- Community Living Assistance and Support Services (CLASS);
- Home and Community-Based Services (HCS); and
- Deaf Blind Multiple Disabilities (DBMD).

CWP tests the feasibility of consolidating five of the state's Medicaid 1915(c) waivers into one program. The state's regular Medicaid 1915(c) waiver programs are limited to serving a specific group based on age or disability. These waiver programs were developed over time by different state agencies. The Texas Department of Human Services operated the CBA, MDCP, CLASS, and DBMD waiver programs and the Texas Department of Mental Health and Mental Retardation operated the HCS waiver program. CWP is intended to address potential inequities and inefficiencies across these waiver programs caused by differences in services, definitions, rates, providers, regulations, and contracting and monitoring processes. Under CWP, there is one set of services, rates, and providers.

Although CWP is one program, it includes two Medicaid 1915(c) waivers. The Centers for Medicare and Medicaid Services (CMS) requires the state to submit one waiver for clients receiving services through CWP who qualify to receive care in a nursing facility and another waiver for clients who qualify to receive care in an ICF-MR/RC. The two waivers that allow Texas to operate CWP require renewal in September 2009.

FIGURE 114
TEXAS MEDICAID 1915(C) LONG-TERM CARE WAIVER PROGRAMS, FISCAL YEAR 2007

PROGRAM	ELIGIBILITY CRITERIA[1]	SERVICE AREA	AVERAGE CLIENTS SERVED PER MONTH	AVERAGE MONTHLY COST PER CLIENT	ANNUAL SPENDING (IN MILLIONS)	INTEREST LIST (AS OF JUNE 2008)
Community-Based Alternatives (CBA)	Individuals age 21 or older who qualify for nursing facility care	Statewide	26,712	$1,286	$413.1	29,316
STAR+PLUS 1915(c) (CBA equivalent)	Individuals age 21 or older who qualify for nursing facility care	Bexar, Harris, Nueces, and Travis Service Areas	5,712	$1,581	$108.4	2,125*
ICM 1915(c) (CBA equivalent)	Individuals age 21 or older who qualify for nursing facility care	Dallas and Tarrant Service Areas	Data not available	Data not available	Data not available	263*
Medically Dependent Children Program (MDCP)	Individuals under age 21 who qualify for nursing facility care	Statewide	1,480	$1,192	$212	9,920
Home and Community-Based Services (HCS)	Individuals of any age with mental retardation or a related condition who qualify to receive ICF-MR/RC Level-of-care I	Statewide	11,798	$3,224	$456.7	37,187
Community Living Assistance and Support Services (CLASS)	Individuals of any age with a related condition who qualify to receive ICF-MR/RC Level-of-care VIII	Statewide	3,052	$2,797	$102.5	21,496
Deaf-Blind Multiple Disabilities (DBMD)	Individuals age 18 or older with deaf-blindness and one or more other disabilities who qualify to receive ICF-MR/RC Level-of-care I or VIII care	Statewide	138	$3,723	$6.3	28
Texas Home Living (TxHmL)	Individuals of any age with mental retardation or a related condition who qualify to receive ICF-MR/RC Level-of-care I	Statewide	1,404	$454	$7.7	–
Consolidated Waiver Program (CWP)	Individuals of any age who qualify for nursing facility or ICF-MR/RC care	Bexar County	183	$1,756	$4.2	–

[1]All clients must meet income and care plan cost requirements.
*Clients who qualify for nursing facility care living with a monthly income between 100 percent and 300 percent of the monthly income limit for SSI residing in a STAR+PLUS or ICM service area are placed on an interest list for CBA equivalent services. Clients with incomes up to 100 percent of the monthly income limit for SSI may receive CBA equivalent services without waiting through the Medicaid 1915(c) waivers operating in STAR+PLUS or ICM.
SOURCE: Legislative Budget Board.

CWP is designed to serve a proportionate number of adults and children who would otherwise receive care in one of the regular Medicaid 1915(c) waiver programs. As shown in **Figure 115**, CWP includes 100 slots for individuals who qualify for nursing facility care and 100 slots for individuals who qualify for ICF-MR/RC care. The 100 individuals who qualify to receive ICF-MR/RC care are divided evenly between clients with mental retardation and clients with related conditions.

In fiscal year 2007, CWP served an average of 183 clients per month and expenditures totaled $4.2 million in All Funds. CWP waiver slots were initially funded during the 2002–03 biennium by transferring funds from the other Medicaid 1915(c) waiver programs to CWP. Since the number of CWP slots has remained constant at 200, additional budget transfers have not been made.

FIGURE 115
CONSOLIDATED WAIVER PROGRAM SLOT ALLOCATION, 2008

CLIENT TYPE	AGE GROUP	CORRESPONDING MEDICAID 1915(C) WAIVER PROGRAM	NUMBER OF CWP SLOTS
Individuals who qualify to receive nursing facility care	Adults	STAR+PLUS 1915(c) (CBA equivalent)	50
	Children	MDCP	50
Individuals with mental retardation or a related condition who qualify to receive ICF-MR/RC Level-of-care I	Adults	HCS	25
	Children	HCS	25
Individuals with related conditions who qualify to receive ICF-MR/RC Level-of-care VIII	Adults	CLASS	25[1]
	Children	CLASS	25[2]
TOTAL CWP SLOTS			**200**

[1]One of the CLASS adult slots in CWP is dedicated to an adult who would qualify for the DBMD waiver program.
[2]One of the CLASS child slots in CWP is dedicated to a child who would qualify for the DBMD waiver program.
SOURCE: Legislative Budget Board.

EVALUATION FINDINGS FOR THE CONSOLIDATED WAIVER PROGRAM

HHSC evaluated CWP in 2003 and found that CWP's average service cost was comparable to the combined average service costs for the CBA, CLASS, HCS, and MDCP 1915(c) long-term care waiver programs. Also, the per capita average service cost for three of the four CWP client groups was considerably lower than the per capita average service costs for the corresponding waiver clients (i.e., HCS, CLASS, and MDCP). These CWP client groups included individuals with mental retardation, individuals with related conditions, and children who qualify for nursing facility care. For the fourth CWP client group, adults who qualify for nursing facility care, service costs were higher than clients in the corresponding waiver, CBA. However, the report stated that these findings should be interpreted with caution due in part to the program's small size and that overall the program data is inconclusive regarding whether CWP is administratively efficient and cost-effective. Also, since a process evaluation was not conducted, it is not possible to know how implementation of CWP may have impacted the findings.

The design of CWP affects the state's ability to determine the effectiveness of CWP relative to other waiver programs in Bexar County. An evaluation of the effect of CWP on certain outcome measures (e.g., service cost) requires that CWP clients, experimental group, be compared to a group of clients that did not participate in CWP, comparison group. In this case, the comparison group consists of clients enrolled in other Medicaid 1915(c) waiver programs in Bexar County. Since clients are not randomly assigned to CWP but rather choose to participate, the CWP evaluation is a non-randomized quasi-experiment. This model requires that statistical procedures be used to control for differences between participants and non-participants when measuring program effectiveness. These statistical techniques require an adequate number of observations in both the experimental and comparison groups. The small size of CWP makes it difficult to conclude that any differences on key outcome measures observed between CWP clients and comparison group clients can be attributed to CWP.

EFFECT OF STAR+PLUS EXPANSION ON THE CONSOLIDATED WAIVER PROGRAM

The recent expansion of STAR+PLUS in select service areas has changed the structure for delivering long-term care services to certain populations. STAR+PLUS and CWP both operate in Bexar County. Clients enrolled in STAR+PLUS cannot participate in CWP. As a result, the existence of STAR+PLUS limits the number and type of clients who could participate in CWP in Bexar County or other areas considered for expansion.

Client groups have different enrollment requirements for STAR+PLUS that affect whether or not they can participate in CWP. **Figure 116** shows the types of long-term care clients and a description of whether or not they can participate in CWP.

CURRENT EFFORTS TO STREAMLINE THE ADMINISTRATION OF WAIVER PROGRAMS

Legislation enacted by the Seventy-sixth Legislature, 1999, requires HHSC to make certain functions relating to the administration and delivery of Medicaid 1915(c) waiver programs uniform. The functions discussed in the legislation include: rate-setting, the applicability and use of service definitions, quality assurance, and intake data elements. The legislation also requires that HHSC ensure that information on individuals seeking to obtain long-term care waiver services is maintained in a single computerized database accessible to all staff administering those programs. HHSC is now considering standardizing billing guidelines and rates

FIGURE 116
PARTICIPATION OF LONG-TERM CARE CLIENTS IN CWP, 2008

AGE GROUP	CLIENT TYPE	CWP PARTICIPATION
Adult	Clients who qualify for nursing facility care with a monthly income up to 100 percent of the monthly income limit for Supplemental Security Income (SSI)	Clients must enroll in STAR+PLUS in participating service areas and may receive CBA equivalent services through the Medicaid 1915(c) long-term care waiver operating in STAR+PLUS without waiting. At no point can these clients participate in CWP.
Adult	Clients who qualify for nursing facility care with a monthly income between 100 percent and 300 percent of the monthly income limit for SSI residing in a STAR+PLUS service area	Clients are placed on an interest list where they wait to receive CBA equivalent services through the Medicaid 1915(c) waiver operating in STAR+PLUS. These clients may choose to enroll in CWP if a slot is available while they wait to participate in STAR+PLUS. When a slot becomes available in STAR+PLUS, clients who have enrolled in CWP can stay in CWP or move to STAR+PLUS. However, once these clients enroll in STAR+PLUS, they must stay in STAR+PLUS and no longer have the option to participate in CWP.
Adult	Clients who qualify for ICF-MR/RC care	Clients are exempt from mandatory participation in STAR+PLUS. If they choose to enroll in STAR+PLUS, they cannot participate in CWP. However, these clients may choose to enroll in CWP if they qualify and a slot is available either before or after enrollment in STAR+PLUS.
Children	Clients who qualify for ICF-MR/RC or nursing facility care	Clients are exempt from mandatory participation in STAR+PLUS. If they choose to enroll in STAR+PLUS, they cannot participate in CWP. However, these clients may choose to enroll in CWP if they qualify and a slot is available either before or after enrollment in STAR+PLUS.

SOURCE: Legislative Budget Board.

for certain services, such as nursing, across the Medicaid 1915(c) waiver programs.

DADS has also taken steps to address historical differences in the Medicaid 1915(c) waiver programs that may contribute to potential inequities and inefficiencies. Agency activities to streamline the administration and delivery of long-term care waiver programs can help the state achieve the intended goals of CWP. Legislation enacted by the Seventy-eighth Legislature, 2003, included provisions to consolidate the operations of 12 health and human service agencies into five agencies. Prior to the reorganization, the state's long-term care waiver programs were operated by two state agencies—the Texas Department of Human Services and the Texas Department of Mental Health and Mental Retardation. The legislation combined all long-term care functions into one agency, DADS. As a result, one agency now operates the waiver programs, thereby making it is easier to improve the operation of these programs.

In fiscal year 2007, DADS implemented a Waiver Standardization and Streamlining Initiative to review, analyze, and make recommendations for efficiencies related to the administration of Medicaid 1915(c) waiver programs. As part of this effort, DADS held a series of stakeholder meetings to obtain input on waiver optimization, including potential administrative efficiencies. DADS has created the following six workgroups to review opportunities for streamlining oversight functions and processes:

- **Forms Analysis Workgroup:** The workgroup has made recommendations to reduce the number of forms used for the Medicaid 1915(c) waiver programs by identifying forms that can be collapsed.
- **CLASS Provider Handbook Workgroup:** The workgroup is considering revisions to Medicaid 1915(c) waiver program provider manuals and training curriculums.
- **Level of Care Requirement for Physician's Signature Workgroup:** The workgroup is reviewing the requirement for a physician signature on Level of Care assessments across Medicaid 1915(c) waiver programs.
- **Level of Care Standardization Workgroup:** The workgroup is overseeing a project that will consolidate two separate service authorization systems into a single service authorization system for Medicaid 1915(c) waiver programs.
- **Prior Authorization Functions Workgroup:** The workgroup is analyzing prior authorization functions for long-term care programs, including Medicaid 1915(c) waiver programs, for possible transfer to the Texas Medicaid and Healthcare Partnership.
- **Individual Service Plan Workgroup:** This workgroup will make recommendations to standardize individual

service plan processes across long-term care programs to the extent possible.

ELIMINATE THE CONSOLIDATED WAIVER PROGRAM AND TRANSFER CLIENTS TO OTHER EXISTING PROGRAMS

Given the state's inability to determine the effectiveness of the CWP and changes in the policy landscape since the program's implementation, continued operation of the CWP is no longer necessary. Also, the state continues to incur almost $450,000 in additional administrative costs annually to operate the program. Administrative costs include eligibility determination and case management functions. In CWP, these functions are performed by DADS staff. In fiscal year 2007, administrative expenditures to operate CWP totaled $448,663 in All Funds or almost $1 million per biennium.

Recommendation 1 would amend the Texas Government Code to eliminate CWP.

Recommendation 2 would include a contingency rider in the 2010–11 General Appropriations Bill that reduces funding for CWP by $897,326 in All Funds and directs DADS to transfer the remaining funds from CWP to other strategies to serve clients who otherwise would have received services through CWP in the appropriate Medicaid 1915(c) waiver program. The agency should be required to submit its plan for transferring funds to the Legislative Budget Board for approval. Funds should be transferred as appropriate to the DADS-operated Medicaid 1915(c) waiver programs or the HHSC-operated STAR+PLUS 1915(c) waiver program. Former CWP clients should receive services in the appropriate Medicaid 1915(c) waiver program without a break in service.

HHSC is statutorily required to make certain functions relating to the administration and delivery of Medicaid 1915(c) waiver programs uniform. However, there is no similar statutory requirement for DADS, even though the agency is responsible for operating the waiver programs. Recommendation 3 would amend the Texas Human Resources Code to require DADS to streamline the administration and delivery of Medicaid 1915(c) waiver programs and work with HHSC on this effort as appropriate.

Neither DADS nor HHSC is required to report on efforts related to streamlining the administration and delivery of Medicaid 1915(c) waiver programs. As a result, the Texas Legislature lacks the information needed to evaluate efforts to streamline the long-term care waiver delivery system. Recommendation 4 would include a rider in the introduced 2010–11 General Appropriations Bill directing DADS, in consultation with HHSC, to submit a report on efforts planned or implemented to streamline the administration and delivery of Medicaid 1915(c) waiver programs to the Legislative Budget Board and the Governor by December 1 of each year of the biennium.

FISCAL IMPACT OF THE RECOMMENDATIONS

The recommendations would result in a net savings of $448,663 in General Revenue Funds for the 2010–11 biennium by eliminating the administrative costs used to operate CWP.

Recommendation 1 would amend the Texas Government Code to eliminate CWP. Recommendation 2 would include a contingency rider in the 2010–11 General Appropriations Bill that reduces funding for CWP by $897,326 in All Funds and directs DADS to transfer the remaining funds from CWP to other strategies to serve clients who otherwise would have received services through CWP in the appropriate Medicaid 1915(c) waiver program. As shown in **Figure 117**, this recommendation would result in estimated savings of $224,332 in fiscal year 2010 and $224,332 in fiscal year 2011 in General Revenue Funds and $224,332 in fiscal year 2010 and $224,332 in fiscal year 2011 in Federal Funds. The estimated FMAP for administrative costs for state fiscal years 2010–11 (i.e., 50 percent) was used to estimate General Revenue Funds and Federal Funds for the 2010–11 biennium. These estimated savings are based on administrative expenses incurred to operate CWP during fiscal year 2007. Also, it is assumed that the cost to serve former CWP clients in the appropriate DADS-operated Medicaid 1915(c) waiver program or the

FIGURE 117
FIVE-YEAR FISCAL IMPACT, FISCAL YEARS 2010 TO 2014

FISCAL YEAR	PROBABLE SAVINGS/(COST) IN GENERAL REVENUE FUNDS	PROBABLE SAVINGS/(COST) IN FEDERAL FUNDS	CHANGE TO FULL-TIME-EQUIVALENT POSITIONS COMPARED TO 2008–09 BIENNIUM
2010	$224,332	$224,332	(8)
2011	$224,332	$224,332	(8)
2012	$224,332	$224,332	(8)
2013	$224,332	$224,332	(8)
2014	$224,332	$224,332	(8)

Source: Legislative Budget Board.

STAR+PLUS 1915(c) waiver program would equal the amount it would have cost to serve these clients in CWP.

Recommendation 3 would require DADS to implement streamlining activities. Recommendation 4 would include a rider in the introduced 2010–11 General Appropriations Bill directing DADS, in consultation with HHSC, to submit a report on efforts planned or implemented to streamline the administration and delivery of Medicaid 1915(c) waiver programs to the Legislative Budget Board and the Governor by December 1 of each year of the biennium. It is estimated that these recommendations would have no significant fiscal impact because the streamlining activities and the report could be conducted by DADS using existing resources.

The introduced 2010–11 General Appropriations Bill includes a rider directing DADS, in consultation with HHSC, to submit a report on efforts planned or implemented to streamline the administration and delivery of Medicaid 1915(c) waiver programs to the Legislative Budget Board and the Governor by December 1 of each year of the biennium. The introduced bill does not include any other adjustments as a result of these recommendations.

INCREASE ACCESS TO SUBSTANCE ABUSE TREATMENT FOR ADULT MEDICAID CLIENTS

Substance abuse disorders include two subcategories—substance abuse and substance dependence. According to the National Institutes of Health, these disorders are brain diseases that can be managed successfully, similar to diabetes, asthma, or heart disease. These disorders increase the risk of illness and result in greater use of medical care, including services paid by the Texas Medicaid Program. Research has found that untreated individuals have double the medical costs of those without a substance abuse disorder. Evaluation studies support the conclusion that substance abuse treatment is associated with reductions in future healthcare spending for treated individuals. Furthermore, the cost of treatment may be offset by reductions in overall healthcare spending.

In fiscal year 2006, fewer than one quarter of the 47,663 adult clients in the Texas Medicaid Program with an identified substance abuse disorder received some level of treatment that was funded by the state or federal government. This is due in part to limited coverage of substance abuse treatment for adult clients in the Texas Medicaid Program. Also, limited funds and set-aside requirements in other state and federally funded substance abuse treatment programs limit the number of adult Texas Medicaid clients who might receive treatment. To decrease Texas Medicaid Program spending related to substance abuse disorders among adults, which total about $109.5 million in All Funds per year, the Texas Health and Human Services Commission should amend the Texas Medicaid State Plan and use existing funds to provide coverage for comprehensive substance abuse treatment for adult clients. The estimated annual cost to add these services to the Texas Medicaid State Plan is $31.4 million in All Funds, including $13.3 million in General Revenue Funds. Based on studies in other states and the preliminary analysis conducted by Legislative Budget Board staff, it is expected that the cost to provide comprehensive substance abuse treatment to adults would be offset by reductions in other Texas Medicaid Program spending due to declines in the use of medical services for clients receiving treatment. The state could also realize savings through reduced criminal justice spending.

CONCERN

- Substance abuse disorders increase the risk of illness and result in greater use of medical care, including services paid by the Texas Medicaid Program. Yet, access to comprehensive substance abuse treatment for adult clients in the Texas Medicaid Program, which has the potential to reduce overall healthcare spending, is limited.

RECOMMENDATIONS

- **Recommendation 1:** Amend the Texas Human Resources Code to direct the Texas Health and Human Services Commission to amend the Texas Medicaid State Plan to provide coverage for comprehensive substance abuse treatment for adult clients in the Texas Medicaid Program.
- **Recommendation 2:** Amend the Texas Human Resources Code to require the Texas Health and Human Services Commission to conduct a study to evaluate the cost-effectiveness of providing comprehensive substance abuse treatment to adult clients in the Texas Medicaid Program, including the impact on Texas Medicaid Program spending. The agency should be required to submit their evaluation methodology to the Legislative Budget Board for approval by December 1, 2009, and to submit a report on the evaluation results to the Legislative Budget Board, the State Auditor, and the Governor by December 1, 2012. The agency should be required to discontinue coverage for comprehensive substance abuse treatment for adult Medicaid clients if the services are found to be ineffective and result in an increase in overall Texas Medicaid Program spending.
- **Recommendation 3:** Include a contingency rider in the 2010–11 General Appropriations Bill directing the Texas Health and Human Services Commission to use existing Medicaid funds to provide coverage for comprehensive substance abuse treatment for adult clients in the Texas Medicaid Program.

DISCUSSION

According to the fourth edition of the *American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV), substance abuse disorders encompass two subcategories—substance abuse and substance dependence. Substance abuse refers to the repeated use of alcohol or other drugs that leads to clinically significant impairment or distress, but does not meet the criteria for substance dependence. Substance dependence refers to

compulsive and repetitive use of a drug that may result in tolerance and withdrawal symptoms when stopping the drug. **Figure 118** shows the number and percentage of individuals in Texas who meet the definitions for substance abuse or dependence as found in the DSM-IV.

According to the National Institutes of Health (NIH), substance dependence is a chronic, relapsing brain disease that is characterized by compulsive drug seeking and use despite harmful consequences to the individual that is addicted and to those around them. Substance dependence is a brain disease because the abuse of drugs leads to changes in the structure and function of the brain. NIH reports that brain imaging studies from drug-addicted individuals show physical changes in areas of the brain that are critical to judgment, decision making, learning, memory, and behavior control. Scientists believe that these changes alter the way the brain works, and may help explain the compulsive and destructive behaviors of addiction.

Similar to other chronic, relapsing diseases, such as diabetes, asthma, or heart disease, substance dependence can be managed successfully. According to NIH, research shows that combining treatment medications with behavioral therapy is the best way to ensure success for most patients. As with other chronic diseases, a person may relapse and begin abusing substances again. For the addicted patient, lapses back to substance abuse indicate that treatment needs to be reinstated or adjusted, or that alternate treatment is needed.

The Texas Medicaid Program, financed with both federal and state funds, is a healthcare program for low-income families, the elderly, and persons with disabilities. Individuals eligible for Temporary Assistance for Needy Families (TANF) or Supplemental Security Income (SSI) are automatically eligible for Medicaid. Other persons who do not receive cash assistance may be eligible for Medicaid depending on age, family income, pregnancy, or disability (i.e. TANF-related or SSI-related groups). Persons enrolled in Medicaid under age 21 are considered children. The Texas Health and Human Services Commission (HHSC) administers the Texas Medicaid Program.

The exact number of clients enrolled in the Texas Medicaid Program who meet the definition for a substance abuse disorder is unknown. However, in fiscal year 2006, there were 14,574 children and 42,828 adults enrolled in Medicaid who received a healthcare service where a substance abuse diagnosis was listed on the Medicaid claim or encounter. There were also 1,555 children and 7,044 adults enrolled in Medicaid who received a substance abuse treatment service funded by the federal Substance Abuse Prevention and Treatment (SAPT) block grant program. After accounting for individuals who fell into both groups (i.e., 922 children and 2,209 adults), there were 15,207 children and 47,663 adults enrolled in Medicaid with an identified substance abuse disorder during fiscal year 2006. This amount includes persons enrolled in fee-for-service and managed care models (i.e., primary care case management, STAR, STAR+PLUS and NorthSTAR). **Figure 119** shows an estimate of the number of adults and children enrolled in Medicaid with an identified substance abuse disorder. This is a conservative

FIGURE 118
PREVALENCE OF SUBSTANCE ABUSE OR DEPENDENCE IN TEXAS, 2006

	AGE GROUP			
MEASURE	AGE 12 OR OLDER	AGE 12 TO 17	AGE 18 TO 25	AGE 26 OR OLDER
Annual number of persons with alcohol or illicit drug dependence or abuse	1,695,000	151,000	530,000	1,014,000
Annual percentage of population with alcohol or illicit drug dependence or abuse during the past year	9.22%	7.22%	19.83%	7.44%

Source: U.S. Substance Abuse and Mental Health Services Administration.

FIGURE 119
ESTIMATED NUMBER OF TEXAS MEDICAID PROGRAM CLIENTS WITH AN IDENTIFIED SUBSTANCE ABUSE DISORDER, FISCAL YEAR 2006

CLIENT DESCRIPTION	CHILDREN	ADULTS
Medicaid clients with a substance abuse diagnosis listed on a Medicaid claim or encounter	14,574	42,828
Medicaid clients who received a Substance Abuse Prevention and Treatment (SAPT) block grant funded service	1,555	7,044
Medicaid clients with a substance abuse diagnosis listed on a Medicaid claim or encounter who also received a SAPT block grant treatment service.	922	2,209
Estimated Medicaid clients with an identified substance abuse disorder (unduplicated)	15,207	47,663

Source: Legislative Budget Board.

estimate of the number of Medicaid clients with a substance abuse disorder because it only includes clients with a substance abuse disorder identified during a medical or treatment visit.

IMPACT OF SUBSTANCE ABUSE DISORDERS ON THE TEXAS MEDICAID BUDGET

Substance abuse disorders increase the risk of illness and result in greater use of medical care, including services paid by the Texas Medicaid Program. Research has found significantly higher medical utilization and costs among individuals with substance abuse disorders. Specifically, research studies supported by NIH in 1998 and the Robert Wood Johnson Foundation in 2005 found that untreated individuals have double the medical costs of those without a substance abuse disorder. Substance abuse and dependence increase Medicaid costs in the following three ways:

- People become ill or injured as a result of their own substance abuse and receive health care services related to the illness.
- Substance abuse complicates other illnesses or injuries, resulting in more frequent and severe episodes of sickness, such as influenza.
- Substance abuse injures third parties, including children born to mothers who abused alcohol or drugs during pregnancy. This increases Medicaid costs upon the child's birth and may increase Medicaid expenditures throughout the child's life.

As shown in **Figure 120**, estimated Texas Medicaid spending related to substance abuse and dependence based on available data totaled $111.4 million in All Funds during fiscal year 2006. Of this amount, $109.5 million included spending related to substance abuse and dependence among adults. This amount does not include the amount spent on substance abuse treatment. This is a conservative estimate because spending for clients enrolled in Medicaid health maintenance organizations (HMOs) is underreported due to data limitations. Texas Medicaid non-treatment spending related to substance abuse and dependence is summarized below.

Healthcare services primarily for substance abuse disorder episodes: Some clients in the Texas Medicaid Program receive healthcare services where substance abuse is the primary diagnosis on the Medicaid claim or encounter. These services may include both substance abuse treatment and other healthcare services. Medicaid spending on non-treatment healthcare claims and encounters with a primary substance abuse disorder diagnosis totaled $11.2 million in All Funds in fiscal year 2006. Of this amount, $9.3 million included services provided to adults and $1.9 million included services provided to children.

Healthcare services for illnesses specifically caused by a substance abuse disorder: Alcohol or drug abuse specifically causes some illnesses, such as alcoholic cardiomyopathy. Texas Medicaid Program spending on healthcare claims and encounters that include a primary diagnosis for one of the illnesses specifically caused by substance abuse totaled $17.5 million in All Funds in fiscal year 2006. Most of this amount included services provided to adults. This amount does not include medical care provided to infants exposed to alcohol or drugs.

Healthcare services for illnesses partially caused by alcohol: Some illnesses are partially caused by substance abuse, such as hypertension. A national study sponsored by NIH in 1998 estimated how many episodes for certain

FIGURE 120
ANNUAL ESTIMATED TEXAS MEDICAID NON-TREATMENT SPENDING RELATED TO SUBSTANCE ABUSE AND DEPENDENCE, FISCAL YEAR 2006

	ESTIMATED SPENDING (IN MILLIONS)[1]		
CATEGORY	CHILDREN (UNDER AGE 21)	ADULTS (AGE 21 AND OVER)	TOTAL SPENDING
Healthcare services primarily for substance abuse disorder episodes (non-treatment)	$1.9	$9.3	$11.2
Healthcare services for illnesses specifically caused by a substance abuse disorder	0.0	17.5	17.5
Healthcare services for illnesses partially caused by alcohol	NA	41.6	41.6
Healthcare services for initial treatment of fetal alcohol syndrome	NA	5.8	5.8
Healthcare services for drug-exposed infants	NA	35.3	35.3
TOTAL COSTS	**$1.9**	**$109.5**	**$111.4**

[1]Due to data limitations, spending for clients enrolled in Medicaid health maintenance organizations is underreported.
NOTE: Spending on healthcare services related to fetal alcohol syndrome and drug-exposed infants is for calendar year 2005.
SOURCE: Legislative Budget Board.

illnesses can be attributed to alcohol abuse. Similar national evidence is not available for the role of drug abuse in partially causing certain illnesses. Legislative Budget Board staff estimate that Texas Medicaid Program spending on healthcare claims and encounters that include illnesses partially caused by alcohol abuse totaled $41.6 million in All Funds in fiscal year 2006. This amount includes services provided to adults. This amount includes only the portion of spending on the episodes of certain illnesses that are attributed to alcohol abuse based on national studies.

Healthcare services for pregnancy complications related to a substance abuse disorder: Maternal abuse of alcohol and drugs during pregnancy is associated with many complications, including pre-term labor and delivery, pregnancy-induced hypertension, and placental abruption. In fiscal year 2007, 10,067 clients age 18 and older were enrolled in the Texas Medicaid Program with an identified substance abuse disorder who received a maternity service. Maternity services include delivery, prenatal visits, postnatal visits, and newborn exams. This amount includes clients enrolled in Medicaid fee-for-service, primary care case management, and STAR health maintenance organizations. Of the 10,067 clients, only 962 or 10 percent received substance abuse treatment through the SAPT block grant program. Some clients with an identified substance abuse disorder who received a maternity service may have had pregnancy complications related to drug dependence resulting in increased Medicaid spending. However, practitioners may not consistently specify drug dependence as the cause of a pregnancy complication. As a result, the amount spent by the Texas Medicaid Program to treat pregnancy complications related to substance abuse disorders is not available.

Healthcare services for initial treatment of fetal alcohol syndrome: Fetal alcohol spectrum disorders (FASD) is a term that describes a group of conditions related to prenatal alcohol exposure. Fetal alcohol effects can include physical and mental disabilities as well as problems with behavior and learning. FASDs include fetal alcohol syndrome (FAS). FAS causes prenatal and postnatal growth deficiency, developmental delay or mental retardation, fine motor dysfunction, and abnormal facial features. Legislative Budget Board staff estimate that the Texas Medicaid cost to provide medical care to infants born with FAS was $5.8 million in All Funds during calendar year 2005. This amount is based on a rate of 1.5 cases of FAS per 1,000 Medicaid births and includes medical care provided during the first year following birth. The cost of medical care used for the calculation is based on national studies estimating the cost to treat individuals with FAS. Long-term costs, including lifetime treatment costs and the cost to provide care to children and adult survivors of FAS are not included.

Healthcare services for drug-exposed infants: On average, healthcare costs to treat infants born exposed to drugs are higher than those of unexposed infants. Based on national studies, the additional hospital medical cost to care for infants exposed to cocaine plus other drugs is $10,910, and the additional hospital medical cost to care for infants exposed to cocaine only is $1,726. Legislative Budget Board staff estimate that the Texas Medicaid cost to provide hospital medical care to drug-exposed infants was $35.3 million in All Funds during calendar year 2005. This amount assumes that 4.3 percent of infants were born to mothers who used illicit drugs during pregnancy. National data was used to estimate the percentage of drug-exposed cases that are attributed to cocaine plus other drugs versus cocaine only. Long-term costs, including lifetime treatment costs and the cost to provide care to children and adult survivors of infant drug exposure are not included.

POTENTIAL FOR SUBSTANCE ABUSE TREATMENT TO REDUCE MEDICAID SPENDING

Several studies on the cost-effectiveness of substance abuse treatment have been conducted in recent years. Some studies have used comparison groups to evaluate substance abuse treatment and others have used pre-post evaluation designs. These studies support the conclusion that substance abuse treatment affects future healthcare spending for treated individuals and have found significant declines in medical utilization and spending after individuals entered a substance abuse treatment program. Furthermore, the cost of treatment may be more than offset by reductions in other healthcare spending resulting in net Medicaid cost savings, specifically:

- In 1999, the Washington State Department of Social and Health Services implemented the SSI Cost Offset Pilot Project to provide comprehensive substance abuse treatment to SSI clients and to determine whether receiving treatment resulted in Medicaid cost savings. The evaluation compared adult SSI clients identified as needing substance abuse treatment who received services to those who needed treatment, but did not get it. The study found an overall reduction in Medicaid costs of $414 per client per month among SSI clients who entered substance abuse treatment. After accounting for the cost of substance abuse

treatment, the net cost savings was $252 per client per month. Reduced emergency room costs were a significant component of the overall Medicaid cost offset. The net cost savings was even greater, $363 for clients who completed treatment. In 2005, based on anticipated cost savings, the Washington Legislature expanded funding for substance abuse treatment for Medicaid clients, $32 million for adults and $6.7 million for children. The adult expansion funds were used to provide services to three categories of clients: Aged, Blind, and Disabled; General Assistance Unemployable Clients (GA-U); and TANF clients. Actual net cost savings for the adult Aged, Blind, and Disabled and GA-U client groups who received substance abuse treatment under the expansion has been greater than expected.

- In 2003, Oregon eliminated coverage for outpatient substance abuse treatment, including methadone treatment, for certain Medicaid clients. A university study found that the elimination of the outpatient substance abuse benefit was associated with increased spending on emergency department visits and physician office visits among methadone users.
- An analysis of fiscal year 2005 Texas Medicaid claims data conducted by HHSC found that average monthly emergency room costs among Medicaid clients with a substance abuse diagnosis who received SAPT-funded treatment were about 35 percent lower than for Medicaid clients with a substance abuse diagnosis who did not receive treatment.
- A 2005 study supported by the Robert Wood Johnson Foundation found a 30 percent decline in medical costs among Medicaid clients in California who received outpatient substance abuse treatment. Cost trends reflected declines across settings, including use of hospital days, emergency department visits, and non-emergent outpatient visits. The study design compared costs one-year before intake into treatment and up to three years after intake into treatment.

A preliminary analysis conducted by Legislative Budget Board staff in 2008 found that overall Texas Medicaid spending was lower for Medicaid adults who received substance abuse treatment through NorthSTAR during fiscal year 2006. The analysis compared healthcare spending between the following two groups:

- Adult Texas Medicaid clients with an identified substance abuse disorder who received physical healthcare services through fee-for-service or primary care case management and who did not receive substance abuse treatment through the federal Substance Abuse Prevention and Treatment (SAPT) block grant program or NorthSTAR.
- Adult Texas Medicaid clients with an identified substance abuse disorder who received physical healthcare services through fee-for-service or primary care case management and who did receive substance abuse treatment services through NorthSTAR.

As shown in **Figure 121**, Texas Medicaid spending in fiscal year 2006 was $5,869 less per client among SSI and SSI-related Medicaid adults who received substance abuse treatment services through NorthSTAR and $4,439 less per client among TANF and TANF-related Medicaid adults. After accounting for the cost of substance abuse treatment, annual Texas Medicaid spending was $3,505 less per client for SSI and SSI-related Medicaid adults and $2,996 less per client for TANF and TANF-related Medicaid adults.

FIGURE 121
MEDICAID SPENDING DIFFERENCES ASSOCIATED WITH RECEIVING SUBSTANCE ABUSE TREATMENT, FISCAL YEAR 2006

	AVERAGE ANNUAL PER CLIENT SPENDING	
	SSI/SSI-RELATED CLIENTS	TANF/TANF-RELATED CLIENTS
Untreated Group	$14,239	$8,366
NorthSTAR Treatment Group	$8,371	$3,928
Spending Reduction	$5,869	$4,439
NorthSTAR Treatment	$2,364	$1,443
Net Spending Reduction	$3,505	$2,996

SOURCE: Legislative Budget Board.

Both groups used in the analysis were limited to clients who had Medicaid claims for physical healthcare services. However, there were adult Medicaid clients who received NorthSTAR substance abuse treatment services in fiscal year 2006 who did not have a Medicaid claim for a physical healthcare service. Due to data limitations, it was not possible to determine whether the substance abuse treatment these clients received is responsible for the lack of Medicaid claims for a physical healthcare service.

The analysis included Texas Medicaid spending on physical health inpatient and outpatient services delivered through fee-for-service and primary care case management. An individual client may have received physical health services through fee-for-service, primary care case management, and a Medicaid HMO. However, due to data limitations, spending on services delivered through Medicaid HMOs is not included. As a result, overall annual client spending could be higher. This should not significantly impact the difference in spending since Medicaid HMO data is excluded from both groups. Also, it is unknown whether there would have been a similar reduction in Texas Medicaid spending among clients who received physical healthcare services through Medicaid HMOs and substance abuse treatment through NorthSTAR.

The analysis did not control for all variables that might account for the overall reduction in Medicaid spending, including differences in health status. However, since most Texas Medicaid clients in the Dallas service delivery area are enrolled in NorthSTAR, the experience of NorthSTAR clients may reflect what would happen if the general adult Texas Medicaid population received additional substance abuse treatment services comparable to the services provided to NorthSTAR clients.

MEDICAID CLIENT ACCESS TO SUBSTANCE ABUSE TREATMENT

Medicaid clients may receive substance abuse treatment funded by Medicaid and/or the federal Substance Abuse Prevention and Treatment (SAPT) block grant program. Some clients may also receive services through local or private programs.

The Medicaid-funded substance abuse treatment available to adults and children enrolled in the Texas Medicaid Program includes in-patient hospital detoxification and prescription drugs. Inpatient detoxification services are only provided as part of an overall treatment plan for a separate acute condition requiring inpatient hospitalization. Persons age 13 to 17 may also receive outpatient chemical dependency counseling. Children who are age 10 to 12 and young adults who are age 18 to 20 may receive outpatient chemical dependency counseling only when the assessment indicates that the individual's needs, experiences, and behavior are similar to those of adolescent clients. Adults and children may also receive mental health services (e.g., outpatient mental health counseling, targeted case management, and mental health rehabilitation) for their substance abuse disorder. **Figure 122** shows the substance abuse treatment services included in the Texas Medicaid State Plan.

HMOs participating in Texas Medicaid may, at their own discretion, provide substance abuse treatment value-added services that provide additional coverage beyond those required by law or contract. Medicaid HMOs do not receive additional reimbursement for provision of value-added services. The type of value-added substance abuse treatment services offered by Medicaid HMOs varies. NorthSTAR clients are offered a comprehensive array of value-added substance abuse treatment services including, but not limited to, residential detoxification and treatment, outpatient detoxification, methadone maintenance therapy, and outpatient chemical dependency counseling for adults.

As shown in **Figure 123**, Texas Medicaid spending on substance abuse treatment services included in the Texas Medicaid State Plan totaled $3.8 million in All Funds during fiscal year 2006, $3.6 million for children and $0.2 million for adults. Due to data limitations, the amount spent does not include prescription drugs.

The primary source of public funding for substance abuse treatment is the federal Substance Abuse Prevention and Treatment (SAPT) block grant administered by the Texas Department of State Health Services (DSHS). In fiscal year 2008, Texas received $135.5 million in SAPT block grant

FIGURE 122
SUBSTANCE ABUSE TREATMENT SERVICES INCLUDED IN THE TEXAS MEDICAID STATE PLAN, FISCAL YEAR 2008

	INPATIENT DETOXIFICATION RELATED TO THE TREATMENT OF AN ACUTE CONDITION	PRESCRIPTION DRUGS	OUTPATIENT CHEMICAL DEPENDENCY COUNSELING	OUTPATIENT MENTAL HEALTH COUNSELING	TARGETED CASE MANAGEMENT	MENTAL HEALTH REHABILITATION
Children (under age 21)	X	X	X	X	X	X
Adults (age 21 and over)	X	X		X	X	X

Note: The Medicaid Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) service for persons under age 21 requires that any medically necessary healthcare service be provided to an EPSDT recipient even if the service is not available under the Medicaid State Plan.
Source: Texas Health and Human Services Commission.

FIGURE 123
TEXAS MEDICAID SPENDING ON SUBSTANCE ABUSE TREATMENT SERVICES INCLUDED IN THE TEXAS MEDICAID STATE PLAN, FISCAL YEAR 2006

	CHILDREN (UNDER AGE 21)		ADULTS (AGE 21 AND OVER)	
PROGRAM	PERSONS SERVED[1]	SPENDING (IN MILLIONS)	PERSONS SERVED[1]	SPENDING (IN MILLIONS)
Medicaid Fee-for-Service and Primary Care Case Management	3,413	$3.51	1,139	$0.19
Medicaid Health Maintenance Organizations – STAR	237	0.05	62	0.00[3]
Medicaid Health Maintenance Organizations – STAR+PLUS	5	0.00[3]	78	0.02
NorthSTAR[2]	110	0.00[3]	270	0.02
TOTAL	**3,707**	**$3.56**	**1,537**	**$0.23**

[1]The number of persons served is duplicated across programs because clients may have been served by more than one program during the fiscal year. However, the total count of persons served is unduplicated.
[2]Data for NorthSTAR is limited to Medicaid clients enrolled in NorthSTAR.
[3]Spending data totals less than $10,000.
Source: Texas Health and Human Services Commission.

funding. The SAPT block grant funds a continuum of substance abuse treatment services including, but not limited to:

- outpatient detoxification;
- residential detoxification;
- residential treatment;
- outpatient chemical dependency counseling; and
- methadone maintenance therapy.

To receive SAPT block grant-funded treatment, an individual must meet the DSM-IV criteria for a substance abuse disorder and have an income that is 200 percent or less of the federal poverty level. Individuals with income above 200 percent of the federal poverty level can receive assistance on a sliding scale basis. The SAPT block grant program has specific set-aside requirements for select populations, such as pregnant and parenting women.

Medicaid clients may receive substance abuse treatment services that are not covered by Medicaid through the SAPT block grant program. **Figure 124** shows the number of Texas Medicaid clients who received these services and reported spending. In fiscal year 2006, SAPT block grant funding for substance abuse treatment provided to Texas Medicaid clients totaled $21.5 million in All Funds, $7.7 million for children and $13.8 million for adults.

In fiscal year 2006, of the adult Texas Medicaid clients with an identified substance abuse disorder, fewer than one quarter received some level of state or federally funded substance

FIGURE 124
SAPT BLOCK GRANT SPENDING ON SUBSTANCE ABUSE TREATMENT FOR TEXAS MEDICAID PROGRAM CLIENTS, FISCAL YEAR 2006

CLIENT TYPE	PERSONS SERVED[1]	SPENDING (IN MILLIONS)
Children (under age 21)	1,555	$7.7
Adults (age 21 and over)	7,044	13.8
TOTAL	**–**	**$21.5**

[1]The number of persons served is duplicated across client types because clients may have reached age 21 during the fiscal year.
Source: Texas Department of State Health Services.

abuse treatment. Specifically, of the 47,663 Medicaid adults with an identified substance abuse disorder, 7,932 or 17 percent received SAPT block grant-funded substance abuse treatment and/or services paid by Medicaid. This amount includes the 7,044 Medicaid adults who received SAPT block grant-funded services and the 1,537 Medicaid adults who received services for their substance abuse disorder paid by Medicaid minus 649 to account for the Medicaid adults who fell into both groups.

INCREASE ACCESS TO SUBSTANCE ABUSE TREATMENT FOR ADULT MEDICAID CLIENTS

Substance abuse disorders increase the risk of illness and result in greater use of medical care, including services paid by the Texas Medicaid Program. Yet, access to comprehensive substance abuse treatment for adult clients in the Texas Medicaid Program, which has the potential to reduce overall healthcare spending, is limited. With the exception of value-added services provided by HMOs participating in Medicaid

managed care, including NorthSTAR, the Medicaid-funded substance abuse treatment services available to adults are limited to in-patient hospital detoxification, mental health services, and prescription drugs. Inpatient detoxification services are only available as part of an overall treatment plan for a separate acute condition requiring inpatient hospitalization. Although adult clients in the Texas Medicaid Program can receive substance abuse treatment through the SAPT block grant program, limited grant funds and set-aside requirements limit the number of adult Medicaid clients who receive SAPT-funded treatment.

To decrease Texas Medicaid Program spending related to substance abuse disorders among adults, which total about $109.5 million in All Funds per year, the state should increase access to comprehensive substance abuse treatment for adults enrolled in Medicaid. Recommendation 1 would amend the Texas Human Resources Code to direct HHSC to amend the Texas Medicaid State Plan to provide coverage for comprehensive substance abuse treatment for adult clients in the Texas Medicaid Program. The estimated annual cost to add each of the services listed in **Figure 125** to the Texas Medicaid State Plan as a covered benefit for adults is $31.4 million in All Funds, including $13.3 million in General Revenue Funds. The services listed in **Figure 125** are comparable to the substance abuse treatment services available to NorthSTAR clients.

FIGURE 125
COMPREHENSIVE SUBSTANCE ABUSE TREATMENT FOR TEXAS MEDICAID ADULTS: ESTIMATED ANNUAL ALL FUNDS COST, 2010–11 BIENNIUM

SERVICE	ESTIMATED ANNUAL COST
Assessment	$91,868
Residential detoxification	1,431,482
Outpatient detoxification	622,906
Methadone maintenance	5,389,077
Outpatient chemical dependency counseling	10,743,534
Adult residential services	6,250,054
Specialized female residential services	6,910,592
TOTAL	**$31,439,513**

Source: Texas Department of State Health Services.

These cost estimates are based on projected utilization of each service among the entire adult Texas Medicaid Program population. The projected utilization is based on actual utilization of these services in the NorthSTAR program. Most Medicaid clients in the Dallas service delivery area are enrolled in NorthSTAR. As a result, service utilization in the NorthSTAR program was used to project service utilization in the general adult Medicaid population. The service rates used in the cost estimate include the existing reimbursement rates for similar services in NorthSTAR or the SAPT block grant program and assume some level of future rate increases for certain services. The cost estimate could potentially be greater if the Texas Medicaid Program has to comply with the new federal Mental Health Parity and Addiction Equity Act of 2008.

Based on studies in other states and the preliminary analysis conducted by Legislative Budget Board staff, it is expected that the cost to provide comprehensive substance abuse treatment to adults would be offset by reductions in other Texas Medicaid Program spending. These reductions are expected due to declines in the use of medical services for clients receiving treatment. For example, the evaluation of the Washington State SSI Cost Offset Pilot Project identified a net Medicaid spending reduction of $252 per client per month after providing comprehensive substance abuse treatment to adult SSI Medicaid clients. The spending reduction was realized in the same year that substance abuse treatment services were provided. The substance abuse treatment services provided to adult Medicaid clients in Washington are similar to the services listed in **Figure 125**.

Similarly, the preliminary analysis conducted by LBB staff found a net reduction in Texas Medicaid spending among adult clients in the Texas Medicaid Program who received physical healthcare services through fee-for-service or primary care case management and substance abuse treatment through NorthSTAR during fiscal year 2006. Specifically, after accounting for the cost of substance abuse treatment, annual Texas Medicaid spending was $3,505 less per client for SSI and SSI-related Medicaid adults and $2,996 less per client for TANF and TANF-related Medicaid adults. On a monthly basis, this amount is similar to the net reduction in Medicaid spending identified by Washington State after providing additional substance abuse treatment services to adult Medicaid clients.

The state could realize additional savings through reduced criminal justice spending. For example, the evaluation of the Washington State SSI Cost Offset Pilot Project found that adult SSI clients with recent criminal histories who received substance abuse treatment were less likely to be re-arrested or convicted than those who remained untreated.

Recommendation 2 would amend the Texas Human Resources Code to require HHSC to conduct a study to evaluate the cost-effectiveness of providing comprehensive substance abuse treatment to adult clients in the Texas Medicaid Program, including the impact on Texas Medicaid Program spending, submit their evaluation methodology to the Legislative Budget Board for approval by December 1, 2009, and submit a report on the evaluation results to the Legislative Budget Board, the State Auditor, and the Governor by December 1, 2012. The agency should be required to discontinue coverage for comprehensive substance abuse treatment for adult Medicaid clients if the services are found to be ineffective and result in an increase in overall Texas Medicaid Program spending. Other states have taken a similar approach. For example, in 2005, Colorado enacted legislation that added additional substance abuse treatment to the Colorado Medicaid State Plan. The legislation included a provision that requires the Colorado State Auditor to analyze the cost-effectiveness of the new services by 2011 and to repeal the services if the evaluation finds that providing outpatient substance abuse treatment has resulted in an overall increase in Medicaid spending.

Recommendation 3 would include a contingency rider in the 2010–11 General Appropriations Bill directing HHSC to use existing Medicaid funds to provide coverage for comprehensive substance abuse treatment for adult clients in the Texas Medicaid Program.

FISCAL IMPACT OF THE RECOMMENDATIONS

The recommendations in this report have no direct impact on General Revenue Fund appropriations during the 2010–11 biennium.

Recommendation 1 would amend the Texas Human Resources Code to direct HHSC to amend the Texas Medicaid State Plan to provide coverage for comprehensive substance abuse treatment for adult clients in the Texas Medicaid Program. Recommendation 3 would include a contingency rider in the introduced 2010–11 General Appropriations Bill directing HHSC to use existing Medicaid funds to provide coverage for comprehensive substance abuse treatment for adult clients in the Texas Medicaid Program. It is anticipated that providing comprehensive substance abuse treatment to adult clients in the Texas Medicaid Program would reduce other Medicaid spending by an amount that would, at a minimum, offset the cost to provide comprehensive treatment. These reductions, which are due to declines in the use of medical services by clients receiving substance abuse treatment, would be realized in the same year that substance abuse treatment services are provided.

Recommendation 2 would amend the Texas Human Resources Code to require HHSC to conduct a study to evaluate the cost-effectiveness of providing comprehensive substance abuse treatment to adult clients in the Texas Medicaid Program. It is estimated that this recommendation would have no significant fiscal impact because the study could be conducted by HHSC using existing resources.

The introduced 2010–11 General Appropriations Bill does not address these recommendations.

INDIGENT HEALTHCARE IN TEXAS

Provision of and funding for indigent healthcare in Texas involves a combination of federal, state, and local government programs as well as the contributions of public, for-profit, and non-profit healthcare providers. Government programs have focused on insuring low-income persons, providing direct healthcare services to the uninsured, and reimbursing providers for delivering uncompensated care. Evaluation of these programs indicates gaps remain; nearly one-fourth of the Texas population remains uninsured, uncompensated care costs are high, and inequities exist among counties in the financing and provision of indigent healthcare. Recent reforms seek to address the size of the uninsured population and uncompensated care. County inequities remain an area for reform, and several options exist including altering county indigent healthcare requirements and providing state grant funding to encourage regional innovation.

FACTS AND FINDINGS

- Federal and state programs insure approximately 3.4 million low-income Texans, and provide direct care services to a substantial number of persons, but over one-fourth of the Texas population is uninsured. Texas has the largest percentage of uninsured residents of any state.
- Federal and state programs provided approximately $3.4 billion in reimbursement for uncompensated care (which includes charity care) in fiscal year 2007.
- State law defines the provision of indigent healthcare in Texas as a county responsibility, but variation exists among counties in terms of eligibility criteria, service provision, and total spending, which can result in persons seeking care outside of their county of residence or at state hospitals.

DISCUSSION

According to 2007 data from the U.S. Census Current Population Survey, 5.9 million Texans are uninsured; at least one-fourth of the state's population lacks health insurance. The uninsured population includes persons with various family incomes. The Texas Health and Human Services Commission (HHSC) estimates that approximately 2.2 million uninsured Texans are adults and children who are citizens or legal permanent residents with family incomes at or below 200 percent of the federal poverty guidelines. **Figure 126** shows the federal poverty guidelines and 200 percent of the federal poverty line (FPL). **Figure 127** shows the share of uninsured persons by ranges of family income in relation to FPL.

FIGURE 126
FEDERAL POVERTY LEVEL, 2007

PERSONS IN FAMILY OR HOUSEHOLD	100% FEDERAL POVERTY LEVEL 48 CONTIGUOUS STATES AND DC	200% FEDERAL POVERTY LEVEL
1	$10,210	$20,420
2	$13,690	$27,380
3	$17,170	$34,340
4	$20,650	$41,300
5	$24,130	$48,260
6	$27,610	$55,220
7	$31,090	$62,180
8	$34,570	$69,140
For each additional person, add	$3,480	$6,960

Sources: Legislative Budget Board; U.S. Department of Health and Human Services.

FIGURE 127
SHARE OF UNINSURED TEXAS POPULATION BY FEDERAL POVERTY LEVEL RANGE, 2007

FPL	UNINSURED PERSONS	SHARE OF UNINSURED	CUMULATIVE SHARE OF UNINSURED PERSONS
Below 50%	666,000	11.2%	11.2%
50% to 99%	957,000	16.1%	27.3%
100% to 149%	981,000	16.5%	43.8%
150% to 199%	842,000	14.2%	57.9%
200% to 249%	751,000	12.6%	70.6%
250%+	1,749,000	29.4%	100.0%
TOTAL	**5,944,000**	**100.0%**	

Source: U.S. Census.

The lack of insurance can negatively affect an individual's health as uninsured persons are three times more likely to delay seeking medical care than insured persons, according to a 2008 report by Families USA, a national healthcare advocacy organization. Families USA also reports that

uninsured persons are less likely to have access to preventive care and are four times more likely than insured persons to lack a regular source of healthcare. As a result, the uninsured are also as much as 25 percent more likely to die prematurely than insured persons.

Because they lack access to a "medical home" and due to federal legal requirements for hospitals to provide emergency care to anyone who presents, many uninsured persons rely on the hospital emergency room as their primary source of healthcare. Care delivered in this setting is more expensive typically than care delivered in doctors' offices or outpatient settings. A federal Agency for Healthcare Research and Quality study found 2003 median expenses for an emergency room visit were two times larger than in an outpatient hospital department and five times larger than in a doctor's office. These increased costs are born by insured individuals as higher premiums and local taxes, and by healthcare providers in the form of uncompensated care.

The Texas Department of State Health Services (DSHS) collects data on uncompensated care in Texas. When reducing data collected to cost, 508 acute-care hospitals including public, non-profit, and for-profit hospitals incurred $4.5 billion in uncompensated care costs in fiscal year 2007 (adjusted to cost). Excluding for-profit hospitals, public hospitals, hospital districts, counties, and cities reported providing $2.1 billion in unreimbursed healthcare expenditures in fiscal year 2007. Nationwide, hospitals that care for a disproportionate number of low-income and uninsured persons, known as "safety net" providers, must identify many sources of funding to continue to defray the cost of serving this population. Many of these hospitals struggle to remain profitable.

POLICY AND PROGRAM INTERVENTIONS

Defining indigent healthcare requires an understanding of several concepts including the indigent, uninsured, and uncompensated care. These terms are defined in **Figure 128**, which also presents the relationships between them. "Indigent" refers to a socioeconomic status, not an insurance status; there are insured and uninsured indigent persons. There are uninsured persons with family incomes above and below 200 percent FPL, suggesting that some uninsured persons can afford to make some contributions toward their health insurance or healthcare costs. Uninsured persons, including indigent persons, generate uncompensated care. There is also a small share of uncompensated care generated by insured indigent persons, due to a gap between the rates of payment and the costs of care.

Provision of indigent healthcare is complex and fragmented, and involves many entities including the federal, state, and local governments in addition to healthcare providers. The healthcare system includes a combination of programs that address specific needs. Programs can be grouped in the three following categories:

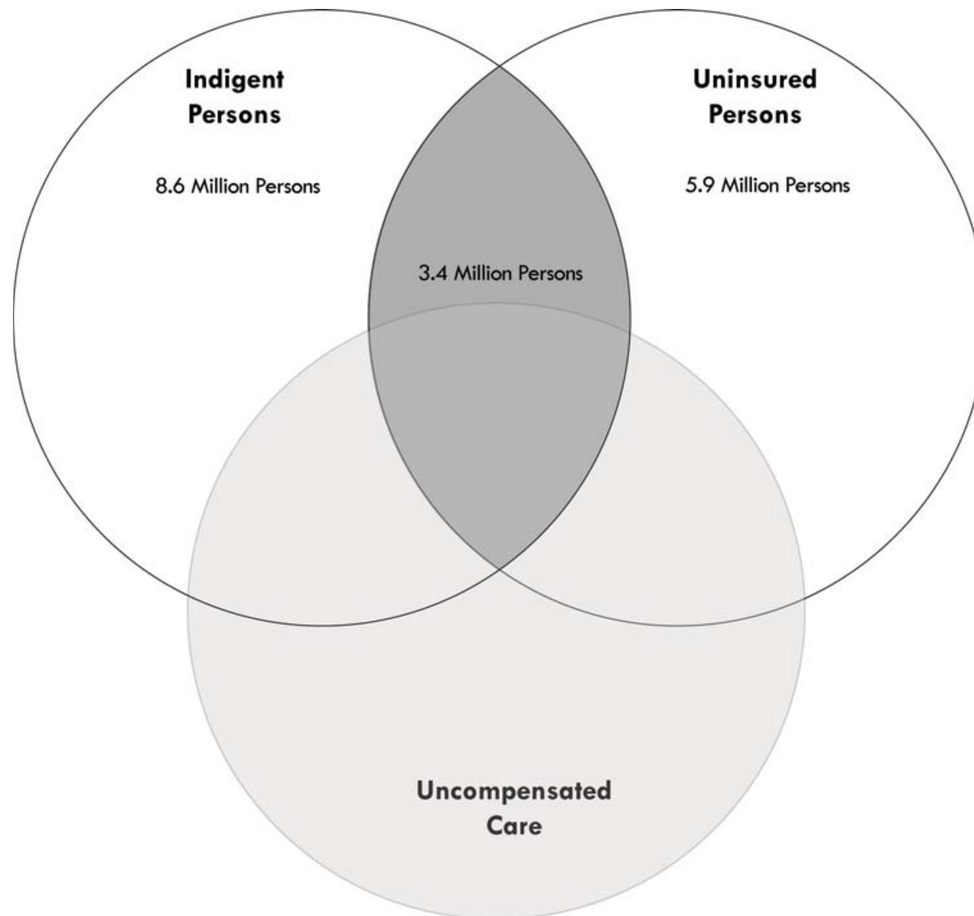
- programs providing healthcare services and insurance to persons who cannot afford to pay for the costs of their health care (indigent population);
- programs providing access to healthcare and insurance to the uninsured (and sometimes underinsured) population; and
- programs reimbursing providers for the uncompensated care they deliver.

Figure 129 groups programs based on their purpose. Programs to insure the indigent population are found in Segment A. Direct–care programs to indigent uninsured persons are found in Segment B. These programs could also provide assistance to underinsured persons, but for the purpose of this review, the two populations are addressed in tandem. Reimbursement programs for providers are in Segments D, F, and G. Programs outside these segments either focus on persons above 200 percent FPL or on the share of uncompensated care attributed to insured persons or persons with income above 200 percent FPL, and exceed the scope of this analysis. Programs that do not focus on indigent persons, such as those that focus on a specific condition, but which might provide some benefit to indigent persons are excluded from this analysis.

LEGAL FRAMEWORK FOR INDIGENT CARE

Federal law requires that hospitals provide emergency care regardless of a patient's ability to pay. The Emergency Medical Treatment and Active Labor Act, passed by the U.S. Congress in 1986, is the legal framework for "nondiscriminatory access to emergency medical care" in the U.S. The law requires hospitals to perform a medical screening examination on any person who requests care to determine if an emergency medical condition exists. If such a condition exists, the hospital must stabilize the condition or transfer the person to another hospital that could provide better care. Finally, hospitals with specialized services are required to accept patient transfers if they have the capacity. Hospitals cannot delay the screening examination or care

FIGURE 128
INTERSECTING ISSUES IN TEXAS HEALTHCARE POLICY, CALENDAR YEAR 2007



Uninsured: A person lacking self-purchased, employer, or state-provided insurance through programs such as Medicaid or the Children's Health Insurance Program (CHIP). This term is distinct from underinsured. An underinsured person has health insurance but lacks adequate coverage due to a limited scope of benefits or because the cost-sharing of the insurance plan is unaffordable.

Indigent: A person financially unable to afford insurance or pay for health care costs, with an income or family income at or below 200 percent of Federal Poverty Level (FPL). This income threshold encompasses eligibility criteria for the Temporary Assistance for Needy Families, Medicaid, and CHIP programs. This term is distinct from that of a medically indigent person, whose medical bills are large relative to the person's income and the person cannot pay for the costs of his/her health care. It also differs from the Texas statutory definition of "indigent" for the purposes of county health care assistance, which uses the threshold of 21 percent of FPL.

Uncompensated Care: Charges providers incur for charity care and bad debt, adjusted to cost. Uncompensated care (bad debt + charity care) x cost-to-charge ratio (total expenses / gross patient revenue + other operating revenue. This enables more accurate comparisons across providers, given the different payer mix. It should be noted that definitions of uncompensated care vary.

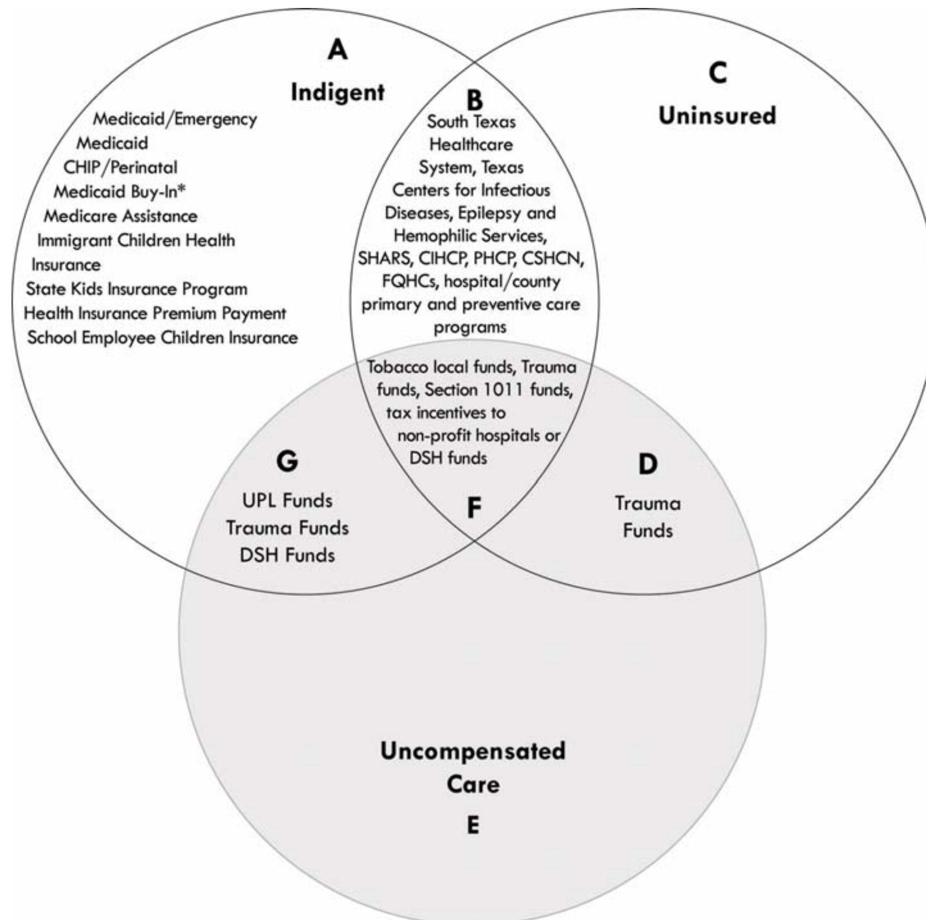
SOURCE: Legislative Budget Board.

"in order to inquire about the individual's method of payment or insurance status."

Texas state law identifies counties as the providers of last resort. Counties must provide healthcare to those without other means of paying for such care. The Indigent Health Care and Treatment Act, enacted by the Sixty-Ninth Legislature, First Called Session, 1985, specifies: "The county is the payor of last resort and shall provide assistance only if other adequate public or private sources of payment are not available." Further, with regard to ability to pay, the act stipulates: "The county, public hospital, or hospital district may not deny or reduce assistance to an eligible resident who cannot or refuses to contribute."

Federal law creates hospital-level responsibility in provision of emergency care, and state law creates county responsibility for indigent care. However, all levels of government are

FIGURE 129
GOVERNMENT AND PRIVATE HEALTHCARE PROGRAMS AND EXPENDITURES



*The Medicaid Buy-In Program serves persons with incomes up to 250 percent FPL.
NOTE: Children's Health Insurance Program (CHIP), School Health and Related Services (SHARS), County Indigent Health Care Program (CIHCP), Primary Health Care Program (PHCP), Children with Special Health Care Needs (CSHCN), Federally Qualified Health Center (FQHC), Upper Payment Limit program (UPL), and Disproportionate Share Hospital program (DSH).
SOURCE: Legislative Budget Board.

involved in the financing and provision of healthcare to low-income persons and in the reimbursement of providers for the uncompensated care they deliver.

PROGRAMS TO INSURE AND SUPPLEMENT INSURANCE FOR THE INDIGENT POPULATION

As referenced in **Figure 128**, there are a total of 8.6 million persons in Texas with family incomes at or below 200 percent of FPL. Of this group, approximately 3.4 million persons are insured through federal and state programs. Combined federal and state spending to insure this population was approximately $12.0 billion in fiscal year 2007. **Figure 130** provides a summary of the Texas Medicaid Program and other programs that insure low-income persons in Texas.

PROGRAMS TO PROVIDE DIRECT SERVICES TO UNINSURED INDIGENT PERSONS

Another category of indigent care programs are programs that provide uninsured, indigent persons with direct healthcare services. These programs reduce the amount of uncompensated care attributable to this population. **Figure 131** provides a summary of the federal, state, and county programs including total expenditures and persons served for fiscal year 2007. There are additional city programs but data on total expenditures are not readily available. The total number of persons receiving these services is not provided because the nature of care is not always comparable, and because of the potential for duplication in persons served across programs.

FIGURE 130
SUMMARY OF PROGRAMS TO INSURE INDIGENT PERSONS

PROGRAM/AGENCY	PURPOSE	SUMMARY OF SERVICES	ELIGIBILITY CRITERIA	FISCAL YEAR 2007 EXPENDITURES	FISCAL YEAR 2007 CLIENTS
1. **Texas Medicaid Program** Centers for Medicare and Medicaid Services; Health and Human Services Commission	Insure low-income individuals and families, the aged, and persons with disabilities.	Services mandated by federal law: • Early Periodic Screening, Diagnosis, and Treatment (Texas Health Steps), • Family planning/genetics, • Federally Qualified Health Centers, • Home healthcare, • Inpatient and outpatient hospital, • Lab and x-ray, • Nursing facility care, • Pregnancy-related services, • Rural Health Clinics, • Physician, Certified Nurse Midwife, Certified Pediatric and Family Nurse Practitioner. Texas also provides services that are optional under federal law. Access to certain optional services is limited using age requirements (e.g., dental clients must be under 21) or through waiver programs.	• Families and children, pregnant women and newborns (under age 1): up to 185% of FPL. • Expansion children (age 1 to 5): up to 133% of FPL. • Federal mandate children (age 6 to 18): up to 100% of FPL. • Medically needy: up to $275/month. • TANF adults and children: up to $188/month. • SSI adults or children and the aged: up to $603/month. • Eligible foster children up to age 21 and some adopted children up to age 18.	$11.3 billion All Funds $6.9 billion Federal Funds (for acute-care Medicaid only) $4.4 billion General Revenue Funds (This includes DSH and UPL Funds.)	2,832,214 (average monthly enrollment)
2. **Emergency Medicaid** Health and Human Services Commission	Fund emergency medical expenses for persons ineligible for Medicaid due to their immigration status.	Emergency Medicaid reimburses providers for emergency care, such as childbirth-related expenses.	A person must meet other Medicaid requirements.	$327.5 million All Funds $203.7 million Federal Funds $123.8 million General Revenue Funds Note: These costs are broken out for reference, but are included in Medicaid costs.	9,229 persons/month
3. **Health Insurance Premium Payment Program (HIPP)** Health and Human Services Commission	Encourage Medicaid-eligible persons to purchase private insurance and employers to provide private insurance.	Premium assistance.	Medicaid-eligible persons and their family members are eligible, even if family members are ineligible for Medicaid.	Cost included in Medicaid	10,055 Unique Medicaid Eligible Clients
4. **Medicaid Buy-In** Health and Human Services Commission	Enable disabled, working persons to purchase Medicaid coverage.	Medicaid benefits.	• Person must earn enough in a calendar quarter to meet Social Security Administration's definition of a "qualifying quarter" (approx. $1,000 in 2007). • Countable resources must be less than or equal to $2,000. • Persons who receive Social Security Administration disability benefits automatically meet the disability criteria, but for persons not receiving these benefits, HHSC processes the request using Supplemental Security Income criteria and does not consider earned income.	Cost included in Medicaid	27 clients (August 2007)

FIGURE 130 (CONTINUED)
SUMMARY OF PROGRAMS TO INSURE INDIGENT PERSONS

PROGRAM/AGENCY	PURPOSE	SUMMARY OF SERVICES	ELIGIBILITY CRITERIA	FISCAL YEAR 2007 EXPENDITURES	FISCAL YEAR 2007 CLIENTS
5. **Medicare Buy-In (Medical Savings Programs)** Health and Human Services Commission	Assist low-income Medicare-eligible clients in paying for some level of Medicare premiums, deductibles, and coinsurance.	Benefits vary by the person's income level. Fully-eligible persons are considered "Fully dual-eligible." Medicaid pays for deductibles and co-insurance, as well as non-Medicare covered services such as long-term care. Partially-eligible persons: • Supplemental Security Income (SSI): Monthly cash payment for persons 65 years or older or disabled/blind based on the number of dollars below the income limit (person also receives Medicaid) and Medicaid coverage; • Qualified Medicare Beneficiary (QMB): Payment of Medicare parts A, B, and D premiums, coinsurance, and deductibles; • Specified Low-Income Medicare Beneficiary (SLMB): Payment of Medicare Part B premiums and Part D premiums and deductibles; • Qualified Individuals (QI-1): Payment of Medicare Part B premium and Part D premiums or deductibles; • Qualified Disabled Working Individuals (QDWI): Payment of Medicare Part A premiums.	• Income requirements: SSI - $623 / $934, QMB – 100% FPL, SLMB – 120% FPL, QI-1 – 120% to 135% FPL, QDWI – 200% FPL. • Resource limit of $4,000 individual/$6,000 couple. • Citizenship requirements. Medicare-eligible (65) or younger if have reached or been able to receive Social Security or railroad disability for 24 consecutive months, or those qualified for Medicare Part A due to chronic renal disease are also eligible. For QDWIs, in addition to meeting the income criteria, persons must be under age 65 and are entitled to enroll in Medicare Part A. They are not eligible for Medicaid.	$1.2 billion All Funds for clients dually eligible for Medicare and Medicaid. Medicaid Part A assistance: $233.8 million Part B expenditures: $521.0 million, QMB services: $129.1 million. This includes $639.7 million in state funds (including clawback) and $563.8 million in Federal Funds. NOTE: Estimated. These costs are broken out here for reference, but are included in Medicaid costs.	78,071 SMLBs and QI-1s 79,510 QMBs
6. **Children's Health Insurance Program (CHIP)** Health and Human Services Commission	Insure low-income children.	Benefits: • Physician services and office visits, • Prescription drugs and medical supplies, • Dentist visits, cleanings, and fillings, • Specialists, • Immunizations, • Hospital care, • X-rays and lab tests, • Mental health care, • Eye exams and glasses, and • Coverage for special health needs and pre-existing conditions. Members pay annual enrollment fees and co-payments for physician and emergency visits, and prescription drugs.	Family income must be at or below 200% of FPL. Asset limit of $10,000 for families above 150% of FPL. Children must not have other insurance. Children must be citizens, legal permanent residents, or meet Alien Status requirements for Medicaid.	$371.1 million All Funds $267.6 million Federal Funds $103.5 million General Revenue Funds NOTE: Other state general revenue used for indirect administration not included. Perinatal funds excluded.	312,101 (average monthly enrollment)

FIGURE 130 (CONTINUED)
SUMMARY OF PROGRAMS TO INSURE INDIGENT PERSONS

PROGRAM/AGENCY	PURPOSE	SUMMARY OF SERVICES	ELIGIBILITY CRITERIA	FISCAL YEAR 2007 EXPENDITURES	FISCAL YEAR 2007 CLIENTS
7. **CHIP Perinatal** Health and Human Services Commission	Provide health services to the unborn children of low-income pregnant women who are uninsured and do not qualify for Medicaid.	Perinatal coverage lasts for twelve months, which includes months in utero after the point of eligibility determination. Services prior to the birth of the child include a maximum of 20 prenatal visits, prescription drugs, and prenatal vitamins. The birth is covered by Emergency Medicaid (CHIP pays professional charges) for women with income at or below 185% FPL, and by CHIP for women with incomes of 186–200% FPL. Post-birth, the mother may receive two physician visits and the child receives traditional CHIP benefits.	Woman must be ineligible for Medicaid because of the income requirements (income is above 185% FPL but at or below 200% FPL) or citizenship status.	$55.0 million All Funds $39.9 million Federal Funds $15.1 million General Revenue Funds	34,885 (August 2007) which included 28,117 mothers and 6,768 children.
8. **Immigrant Children Health Insurance** Health and Human Services Commission	Provide health insurance to immigrant children ineligible for CHIP due to citizenship status.	Services are comparable to CHIP: • Inpatient and outpatient hospital services; • Physicians' surgical and medical services; • Laboratory and x-ray services; • Well-baby and well-child care, immunizations; • Prescription drugs; • Mental health services; • Vision and dental services; and • Hearing services.	Children must be: • Under age 19; • Legal permanent residents; • Residing in Texas; • With family income at or below 200% of FPL. • Financial eligibility is based on CHIP criteria.	$6.4 million General Revenue Funds	13,354 NOTE: Client total presented for reference, but data are included in CHIP enrollment count.
9. **School Employee Children Insurance** Health and Human Services Commission Teacher Retirement System	Provide health insurance to eligible children of public school district employees.	Services are comparable to CHIP: • Inpatient and outpatient hospital services; • Physicians' surgical and medical services; • Laboratory and x-ray services; • Well-baby and well-child care, immunizations; • Prescription drugs; • Mental health services; • Vision and dental services; and • Hearing services.	Children of school district employees must be: • Under age 19; • With family income at or below 200% of FPL. • Financial eligibility is based on CHIP criteria.	$4.2 million General Revenue Funds	8,534 NOTE: Client total presented for reference, but data are included in CHIP enrollment count.
10. **State Kids Insurance Program** Employees Retirement System	Provide health insurance to eligible children of state and higher education employees.	The program mirrors CHIP. SKIP benefits are provided by the state employee health plan administered by ERS.	Children of state and higher education employees must be: • Under age 19 • With family income at or below 200% of FPL. • Financial eligibility is based on CHIP criteria. • The program covers 80% of the premium amount.	$8.1 million General Revenue Funds	6,329 members; 12,658 children

SOURCE: Legislative Budget Board.

FIGURE 131
SUMMARY OF FEDERAL, STATE, AND COUNTY PROGRAMS PROVIDING DIRECT CARE SERVICES TO UNINSURED INDIGENT PERSONS

PROGRAM/AGENCY	PURPOSE	SUMMARY OF SERVICES	ELIGIBILITY CRITERIA	FISCAL YEAR 2007 EXPENDITURES	FISCAL YEAR 2007 CLIENTS
1. **State Teaching Hospitals** University of Texas Medical Branch (UTMB) University of Texas Health Science Center-Tyler (UTHSC-Tyler) MD Anderson Cancer Center	Texas provides funding to the state teaching hospitals, which provide care to indigent and uninsured persons from across the state.	• UTMB and UTHSC-Tyler: General medical and surgical. • MD Anderson: Care for cancer and related conditions, and screenings.	All state hospitals have Texas residency requirements for indigent health services. Additional requirements include: • UTMB: 100% assistance up to 200% FPL. 50% assistance up to 400% FPL. 400% FPL and above have full-pay but discounts are available in some cases. • UTHSC-Tyler: Share of expenses based on patient income. 100% assistance available up to 185% FPL, and 50% up to 250% FPL. Resource limits exist. • MD Anderson: Sliding scale payments based on patient income. 100% assistance if person's income and 25% of assets are less than 185% of FPL. 50% assistance if person's income and 25% of assets are between 185–250% of FPL. Citizenship, legal permanent residence status, or qualified alien status required.	Informational appropriations items: Indigent health care for biennium: UTMB: $7 million UTHSC-Tyler: $2.6 million Lottery unclaimed prize funds: $10 million to UTMB County contracts for providing indigent services: UTMB: $6.6 million Charity care provided in FY 2007 (adjusted to cost): UTMB: $116.4 million MD Anderson: $66.0 million UTHSC-Tyler: $5.9 million	UTMB: 332,283 UTHSC-Tyler: N/A MD Anderson: 6,004
2. **Federally Qualified Health Centers (FQHCs)** Health and Human Services Commission; Department of State Health Services distributes FQHC Incubator Grants	Provide primary care in medically underserved areas. 58 FQHCs operate 300+ sites in Texas. Examples include facilities receiving grants under Section 330 of the Public Health Service Act, some tribal health organizations, and FQHC "look-alikes" that meet all of the	Services provided include primary care, women's health, and preventive health care and screenings.	FQHCs must serve all persons, regardless of need. FQHCs develop sliding scale fee schedules for clients based on family size and federal poverty guidelines.	Federal Fiscal Year 2007 Expenditures: $391.2 million • Federal Section 330 and other grants: $171.4 million • Medicaid payments: $94.2 million	770,578 (Federal Fiscal Year 2007)

FIGURE 131 (CONTINUED)
SUMMARY OF FEDERAL, STATE, AND COUNTY PROGRAMS PROVIDING DIRECT CARE SERVICES TO UNINSURED INDIGENT PERSONS

PROGRAM/AGENCY	PURPOSE	SUMMARY OF SERVICES	ELIGIBILITY CRITERIA	FISCAL YEAR 2007 EXPENDITURES	FISCAL YEAR 2007 CLIENTS
2. **Federally Qualified Health Centers (FQHCs)** (continued)	eligibility requirements of FQHCs but do not receive Section 330 funding. Examples of provider types include community health clinics, migrant health centers, health care for the homeless programs, public housing primary care programs, and urban Indian and tribal health centers.			• Medicare payments: $20.7 million • State and Local Grants: $32.7 million • Other: $72.2 million FQHC Incubator Grants: DSHS awarded $4.6 million in grants to assist providers in attaining FQHC designation and federal funding.	
3. **Primary Health Care Program** Department of State Health Services administers the program and contracts with providers.	Provide primary health care services to persons with unmet primary health needs.	Services include: • Diagnosis and treatment, • Emergency services, • Family planning, • Preventive health services (including immunizations), • Health education, and • Laboratory, x-ray, nuclear medicine, or other appropriate diagnostic services). When possible, secondary services are provided including: • Nutrition services, • Health screenings, • Home health care, • Dental care, • Transportation, • Prescription drugs, • Devices and durable medical supplies, • Environmental health services, • Podiatry services, and • Social services.	• Requirements include that persons have a family income up to 150% of FPL, reside in Texas, and are not eligible for other similar programs or benefits. • Ability to pay does not determine access to services; clients with the financial means might contribute up to 25% of the total cost of services.	$13.6 million, almost entirely General Revenue Funds	80,095
4. **County Indigent Health Program** Counties fund indigent care. Department of State Health Services administers the program and provides matching funds.	Establishes county responsibility for indigent health care and reasonably limits county liability (maximum liability of $30,000 or 30 days of skilled nursing care per person per year). Creates a mechanism for state reimbursement of counties that spend 8% of their general tax levy on indigent health	Counties are required to provide services including: • Immunizations, • Medical screenings, • Annual physicals, • Inpatient hospital services, • Outpatient hospital services, • Rural health clinics, • Laboratory and x-ray services, • Family planning services, • Physician services, • Up to three prescription drugs per month, and • Skilled nursing facility services.	• An applicant must reside in the county in which s/he applies for assistance, and cannot have assets greater than $3,000 if the person is aged or disabled or $2,000 for other households. • Counties must serve at a minimum persons with family incomes at or below 21% FPL. • Counties can elect to serve persons up to 50% FPL and still have those expenditures count toward state matching.	Counties: $57.5 million in reported expenditures. (This is incomplete as only 100 counties out of 140 with CIHCPs reported to DSHS.) State funds: $2.6 million for ten counties that requested state assistance.	19,613 unduplicated persons; incomplete as only 110 counties reported to DSHS

FIGURE 131 (CONTINUED)
SUMMARY OF FEDERAL, STATE, AND COUNTY PROGRAMS PROVIDING DIRECT CARE SERVICES TO UNINSURED INDIGENT PERSONS

PROGRAM/AGENCY	PURPOSE	SUMMARY OF SERVICES	ELIGIBILITY CRITERIA	FISCAL YEAR 2007 EXPENDITURES	FISCAL YEAR 2007 CLIENTS
4. **County Indigent Health Care Program** (continued)	care. A county can receive reimbursement for 90% of medical expenses over the spending threshold. If the state fails to provide funds, a county is not obligated to make additional expenditures.	Optional services include: • Ambulatory Surgical Centers services, • Diabetic and colostomy medical supplies and equipment, • Durable medical equipment, • Home and community health care services, • Psychotherapy services, • Physician assisted services, • Advanced practice nurse services, • Dental care, • Vision care, • FQHCs, and • Emergency medical services.			
5. **South Texas Health Care System** Department of State Health Services **Texas Center for Infectious Diseases** Department of State Health Services	Provides inpatient and outpatient care for indigent persons in the lower Rio Grande Valley and for treatment of tuberculosis.	Most services provided can be grouped into these categories: • Primary care services, • Women's health, • Diabetes and other endocrinology, • Diagnostic services, • Social services, and • Inpatient TB treatment and laboratory services (both outsourced). Services are provided at STHCS in Harlingen. Access is coordinated with other facilities in 11 public health regions in the state in which patients cannot travel to Harlingen.	Requirements include that persons must be Texas residents, afflicted with infectious and chronic diseases, and unable to access medical care due to financial circumstances. Most persons have incomes at or below 200% FPL.	South Texas Health Care System: $6.5 million All Funds $5.3 million General Revenue Funds Texas Center for Infectious Diseases: $34,877 Federal Funds $9.8 million All Funds $9.3 million General Revenue and General Revenue–Dedicated Funds	South Texas Health Care System: 52,751 outpatient visits Texas Center for Infectious Diseases: 14,904 inpatient days
6. **Epilepsy and Hemophilia Services** Department of State Health Services	Provide treatment support and referral assistance to persons with epilepsy and hemophilia in order to reduce disability and premature death.	The Epilepsy Assistance Program: Outpatient care including diagnosis, treatment, and case management and has public awareness/education component. The Hemophilia Assistance Program: Limited financial assistance for reimbursement of blood derivatives, blood concentrates, and manufactured pharmaceutical products.	Epilepsy Assistance Program: Available to Texas residents with income up to 200% of FPL who are not eligible for Medicaid, Medicare, or the Children with Special Health Care Needs program. Hemophilia Assistance Program: Available to Texas residents aged 21 and older with income up to 200% of FPL who are not eligible for Medicaid or Medicare.	$1.3 million almost entirely General Revenue Funds	Epilepsy program clients: 8,539 Hemophilia Assistance Program recipients: 9

FIGURE 131 (CONTINUED)
SUMMARY OF FEDERAL, STATE, AND COUNTY PROGRAMS PROVIDING DIRECT CARE SERVICES TO UNINSURED INDIGENT PERSONS

PROGRAM/AGENCY	PURPOSE	SUMMARY OF SERVICES	ELIGIBILITY CRITERIA	FISCAL YEAR 2007 EXPENDITURES	FISCAL YEAR 2007 CLIENTS
7. **Children with Special Health Care Needs (CSHCN)** Department of State Health Services	Provide supplemental healthcare for low-income children with healthcare needs and their families, and individuals with cystic fibrosis regardless of age. Recipients must maintain the insurance they had at the point of application or are required to apply for Medicaid or CHIP if uninsured.	Services include: • Case management, • Ambulance transportation, • Ambulatory surgery, • Primary and preventative care, • Speech and hearing services, • Vision and dental care, • Mental health services, • Inpatient rehabilitation, • Diagnosis and evaluation, • Care by medical specialists, • Equipment and medical supplies, • Home health nursing, • Hospice care, • Hospital care, • Physical and occupational therapy, • Meals, lodging, and transportation when needed to obtain medical care, • Medicine, • Orthotics and prosthetics, • Special nutritional products and services, • Outpatient renal dialysis, and • Family supports, such as respite care and vehicle modifications. Family supports are limited and provided only to ongoing CSHCN clients.	The applicant's family income must be at or below 200% of FPL and the income, family size, and disregards mirror CHIP program eligibility requirements. Requirements about the nature of the healthcare needs exist. A person with cystic fibrosis qualifies at any age.	The program is state and federally funded under Title V of the Social Security Act. $37.4 million All Funds $12.1 million Federal Funds $23.3 million General Revenue Funds	1,872 persons received medical services 373 individuals from the waiting list received limited services for a two-month period.
8. **School Health and Related Services (SHARS)** Health and Human Services Commission; Texas Education Agency; Local school districts	Enable school districts that provide health and related services to low-income, special education students to receive Medicaid reimbursement. The school district's expenditures count as the state matching funds for the purposes of drawing Federal Funds. The district must be a Medicaid provider.	Services include: • Assessment, • Audiology, • Counseling, • School health services, • Medical services, • Occupational therapy, • Physical therapy, • Psychological services, • Speech therapy, and • Special transportation.	The child must be Medicaid eligible, meet Special Education requirements of the Individuals with Disabilities Education Act, and have Individual Educational Plans which demonstrate need for the service(s).	$106.4 million All Funds $62.7 million Federal Funds $43.7 million local funds	NA

SOURCE: Legislative Budget Board.

Although indigent healthcare has been defined as a county responsibility, the state's teaching hospitals have a significant role in indigent healthcare. In fiscal year 2007, they reported providing $188.4 million in charity care (reduced to cost) and $266.5 million in uncompensated care (also reduced to cost). The Legislature provided the state teaching hospitals with approximately 15 percent of their funding in fiscal years 2008–09 and makes several appropriations for indigent healthcare, as shown in **Figure 131**. The future role of The University of Texas Medical Branch (UTMB) in providing indigent healthcare to residents or neighboring counties remains unknown, given staffing reductions that occurred as a result of Hurricane Ike. Harris and other counties have reported increased emergency room volumes.

PROGRAMS TO REIMBURSE PROVIDERS FOR UNCOMPENSATED CARE

The federal government and the state of Texas established reimbursement programs to compensate hospitals for providing uncompensated care, which are shown in **Figure 132**. The federal government distributes several sources of funding to states and directly to hospitals for certain uncompensated care expenditures through the Disproportionate Share Hospital (DSH), Upper-Payment Limit, and Section 1011 programs. Texas maintains several programs to redistribute funds to counties, hospital districts, and other providers including trauma funding, tobacco funding, and tax incentives. These programs provided $3.4 billion in reimbursement in fiscal year 2007.

CONTRIBUTIONS OF NON-PROFIT AND PRIVATE HOSPITALS

In addition to these federal, state, and county programs, individual physicians and private and non-profit hospitals also make significant contributions in the provision of indigent health care in Texas. According to DSHS, non-profit hospitals provided 33.1 percent of uncompensated care charges ($1.6 billion) and for-profit hospitals provided 15.0 percent ($717.0 billion) in fiscal year 2007 (data adjusted to cost).

Many hospitals have provided charity care historically as part of their missions. Non-profit hospitals also qualify for federal and state tax exemptions for providing benefits for their communities. Non-profit hospitals qualify for federal tax exemption if they meet certain community benefit requirements. They are not required to provide charity care, but must engage in activities benefitting their communities. Hospitals have latitude in defining those activities. In Texas, non-profit hospitals are required by the Texas Health and Safety Code to provide a certain amount of free healthcare to maintain their tax exempt status. The Texas Health and Safety Code requires them to provide community benefits and indigent health care at a level that is reasonable based on the community's needs, that is at least equal to the hospital's tax-exempt benefits excluding federal income tax, or at least 5 percent of the hospitals' net patient revenue, provided that charity care and government-sponsored care are at least 4 percent of net patient revenue. Non-profit hospitals must report to the state on the charity care and the amount of government-sponsored indigent healthcare provided. DSHS reports that nearly all providers complied with reporting requirements and met one of the three standards in provision of community care fiscal year 2006.

ONGOING PROGRAMS TO ADDRESS INDIGENT HEALTHCARE

Federal, state, and local indigent healthcare programs enabled 3.4 million Texans to obtain health insurance, thousands of people to receive some healthcare through direct service programs, and healthcare providers to receive over $3.4 billion in reimbursement for charity and other uncompensated care in fiscal year 2007. Despite the programs outlined in **Figures 130, 131, and 132**, Texas continues to have a large uninsured population and high rates of uncompensated care, which resulted in the enactment of Senate Bill 10 by the Eightieth Legislature, 2007, to seek new ways to provide insurance and invest in primary and preventive care to reduce uncompensated care.

Gaps exist in the existing programs that provide insurance. A number of low-income persons do not qualify for Medicaid under Texas and federal eligibility criteria, or the 21 percent of FPL eligibility requirement of county indigent programs. For the Texas Medicaid Program, the largest optional population not covered in Texas is non-disabled, low-income adults without children. The Texas Health and Human Services Commission (HHSC) estimates 1.2 million childless adults, 960,000 adults with children, and 857,000 children all with incomes under 200 percent of FPL are not covered by Medicaid. In addition to persons ineligible for Medicaid, many uninsured persons are also ineligible for county assistance. **Figure 127** shows that at least 88.8 percent of uninsured persons have family incomes at or above 50 percent FPL, which is over two times the required eligibility threshold for county programs. Uninsured persons often lack access to

FIGURE 132
FEDERAL AND STATE SOURCES OF REIMBURSEMENT FOR UNCOMPENSATED CARE

PROGRAM/AGENCY	DESCRIPTION	FISCAL YEAR 2007 DISTRIBUTION
1. **Disproportionate Share Hospital Program (DSH)** Administered by the Health and Human Services Commission	The Disproportionate Share Hospital (DSH) program provides funding to hospitals that treat a disproportionate share of Medicaid and uninsured patients. The funding is intended to reimburse hospitals for the uncompensated care and additional costs from treating Medicaid patients. Texas uses funds from state-owned hospitals and intergovernmental transfers (IGTs) from large public hospitals to generate the funds needed to draw federal matching funds. Federal and state requirements define the hospitals eligible for payments. Hospitals receive payments based on federal limits and the state's methodology.	For fiscal year 2007, total DSH funding was $427.0 million for state hospitals and $1.02 billion for non-state hospitals. DSH allocations included (in millions): • State Teaching Hospitals: $180.7 • Chest Hospital: $2.2 • State Psychiatric Hospitals: $244.1 • Large Urban Public Hospitals: $570.9 ($171.3 after IGT) • Children's: $73.4 • Urban hospitals: $274.1 • Small urban: $38.0 • Rural hospitals: $58.6 These payments are based on IGTs of $567.5 million.
2. **Upper Payment Limit Program (UPL)** Administered by the Health and Human Services Commission	The Upper Payment Limit (UPL) program provides hospitals with a supplemental payment to represent the difference between what Medicare would pay for the services they have provided to low-income patients, and what Medicaid pays (Medicare's payments are higher generally than Medicaid's). To receive federal UPL funds, the state uses matching intergovernmental transfer funds from hospital districts that receive UPL payments. In the future, UPL payments could be reduced due to federal rulemaking. CMS has finalized rules regarding limits on Medicaid payments to state hospitals and funds for physician training, but a Congressional rule moratorium through April 2009 prevents the rules from taking effect.	For fiscal year 2007, UPL Payments included (in millions): • State teaching hospitals: $144.6 • Children's hospitals: $31.9 • Rural Hospitals: $77.7 • Urban hospitals: $1,200.0 State academic institutions also receive physician UPL payments for individual practitioners - $301.1 million All Funds, $182.7 million Federal Funds, and $118.4 IGT. (NOTE: Data from fiscal year 2007 include retroactive payments dating to the state plan amendment in 2004.) These payments are based on IGTs of $495.5 million.
3. **Section 1011** Centers for Medicare and Medicaid Services	Section 1011 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 created a five year program to reimburse providers for emergency care they are required by federal law to provide to undocumented persons. The program distributes $250 million over five years to states based on the state's estimated undocumented resident population and the number of apprehensions of undocumented persons. Providers submit payment requests for each claim for which they wish to receive reimbursement. CMS can use a pro-rata reduction when the requests exceed the available funds for reimbursement and can adjust the payments based on medical review findings.	For fiscal year 2007, 190 Texas hospitals submitted 68,107 payment requests (each request is a claim for services provided to one person) totaling $385.7 million and received reimbursement for $50.1 million of the care provided.
4. **Tobacco Settlement Proceeds** Department of State Health Services	Tobacco Settlement Proceeds from the Tobacco Settlement Permanent Trust Account are distributed to cities, counties, and hospital districts based on their unreimbursed healthcare expenditures. Entities complete a county expenditure statement reflecting county indigent healthcare services, unreimbursed jail healthcare, additional unreimbursed personal healthcare services, and other expenditures.	For fiscal year 2008, based on fiscal year 2007 expenditures of $2.1 billion, DSHS distributed a total of $12.4 million to counties, $79.8 million to hospital districts, and $86,162.15 to cities.

FIGURE 132 (CONTINUED)
FEDERAL AND STATE SOURCES OF REIMBURSEMENT FOR UNCOMPENSATED CARE

PROGRAM/AGENCY	DESCRIPTION	FISCAL YEAR 2007 DISTRIBUTION
5. **Trauma Funding** Department of State Health Services	Uncompensated trauma care represents a source of uncompensated care for many of the state's 244 trauma-designated facilities. The Texas Legislature built a statewide emergency medical services and trauma care system in the Omnibus Rural Health Care Rescue Act in 1989. Trauma centers cannot refuse to accept a transfer patient based on insurance status, as required in the Texas Health and Safety Code and through EMTALA. Many trauma centers are also the regional source of specialty emergency services such as trauma, burn care, neonatal and pediatric ICU, cancer care, and tertiary services. For the purposes of state reimbursement, Texas hospitals reported fiscal year 2008 trauma charges of $595.8 million, reduced to $210.3 million when applying the cost-to-charge ratio.	Several funding sources support trauma care, but the programs specifically funding uncompensated trauma care include: • The Designated Trauma Facility and Emergency Medical Services Account: Funded a portion of uncompensated trauma care to eligible state trauma facilities or a hospital meeting "in active pursuit" requirements. Sources of funding included the Driver Responsibility Program and a $30 state traffic fine for traffic offense convictions. The program distributed $30.1 million in fiscal year 2007 based on uncompensated trauma charges from calendar year 2006. • Emergency Medical Services and Trauma Care System Account and Emergency Medical Services, Trauma Facilities and Trauma Care Systems Fund: Provided $488,981 and $662,611, respectively, in additional uncompensated trauma care funds. • The Tobacco Settlement Permanent Trust Account: (funded through part of the state's tobacco settlement funds) was set aside to create a permanent endowment for trauma and EMS needs. The annual interest from the fund supports local project grants to EMS agencies and regional advisory councils. Approximately $4.2 million was expended in fiscal year 2007. • A tertiary medical account was created in 1999 to fund uncompensated trauma care for out-of-county patients, but funds have not been appropriated since 2002.

Source: Legislative Budget Board.

primary and preventive healthcare and seek care in emergency rooms, which is an inefficient and expensive method of care delivery.

Several initiatives in Senate Bill 10, Eightieth Legislature, 2007, remain ongoing and seek to address the level of uninsurance and uncompensated care expenditures. This legislation authorized HHSC to create the Health Opportunity Pool (HOP), a program to increase the number of insured persons and increase access to greater primary and preventive healthcare, thereby reducing uncompensated care. The underlying concept for the HOP is to take funds used to reimburse providers for emergency care and invest them in the front-end of the healthcare delivery system. Adults with income at or below 200 percent of FPL will be offered premium subsidies to encourage purchase of employer-sponsored insurance or other insurance. This approach will be pursued along with efforts to support local programs to expand healthcare access, reduce uncompensated care, and build health infrastructure. The program financing included an appropriation of $150 million in General Revenue Funds to rebase hospital rates to free Disproportionate Share Hospital program funds. The Disproportionate Share Hospital and Upper Payment Limit funds would be used to assist clients in purchasing private insurance (additional detail on these funds is found in **Figure 132**, lines 1 and 2). Additional local funds will be used as a state match for federal funding. HHSC submitted a waiver request in April 2008 and awaits federal approval.

INDIGENT HEALTHCARE CHALLENGES AT THE COUNTY LEVEL

Texas statute defines counties as the payors of last resort for indigent healthcare and provides a state reimbursement mechanism for counties that expend 8 percent or more of their general revenue tax levy for indigent healthcare. The statutory requirements affect counties differently; and as a

result, counties have taken different approaches to administering their indigent healthcare programs.

County programs differ in terms of eligibility criteria, services offered, provision of services, and total spending, which results in a distribution of healthcare services that varies by location across the state, with people accessing more or fewer services based on their county of residence.

ELIGIBILITY CRITERIA

Many counties that operate a County Indigent Health Care Program (CIHCP) use the 21 percent FPL eligibility standard for their programs. Public hospitals have higher eligibility standards than CIHCP programs, and hospital districts tend to have the most generous programs in terms of eligibility criteria. Legislative Budget Board (LBB) staff surveyed nine of the largest urban hospital districts in the state, including Bexar, Dallas, Ector, El Paso, Harris, Lubbock, Nueces, Tarrant, and Travis, and of seven responding districts, all served persons up to at least 100 percent FPL, and most provided services along with a portion of patient cost-sharing to at least some persons with incomes ranging from 100 percent to 300 percent FPL.

SCOPE OF SERVICES

Statute requires that counties provide services to persons up to 21 percent of FPL, and specifies a list of required services shown in **Figure 130**, line 4. The law requires that county public hospitals and hospital districts "endeavor" to provide the same basic services as offered through CIHCPs. CIHCPs typically provide required services; public hospitals and hospital districts often exceed statutory requirements. Hospital districts varied in provision of optional services or services exceeding mandatory or optional requirements. For example, LBB research found that at least two of the state's large hospital districts provided cancer treatment, which is not a mandatory or optional service under CIHCP.

PROVISION OF SERVICES

According to DSHS, 140 counties administer a CIHCP, 23 counties operate public hospitals, and 140 counties operate hospital districts. Some counties operate multiple programs (e.g., a hospital district serves a portion of the county, and the CIHCP serves the remaining area of the county). Some counties that operate CIHCPs contract with state teaching hospitals to provide their county's healthcare. The University of Texas Medical Branch (UTMB) has entered into contracts with several counties.

TOTAL COUNTY SPENDING

Large differences in total county spending also exist, as has been documented by other researchers including Morningside Research and Consulting, Inc. Fiscal year 2007 data reported by counties and hospital districts to DSHS on indigent and other unreimbursed healthcare for the purposes of receiving Tobacco Permanent Settlement funds illustrate a wide range of spending. A comparison of expenditures is presented in **Figure 133**. As other researchers have raised, comparing this data is difficult without an understanding of differences between counties in the operation of indigent healthcare programs, basic county demographics, and the level of county resources (taxable value).

FIGURE 133
COMPARATIVE UNREIMBURSED HEALTHCARE EXPENDITURES OF COUNTY PROGRAMS, FISCAL YEAR 2007

	AVERAGE EXPENDITURE	MEDIAN EXPENDITURE
Hospital Districts	$13,172,260	$1,045,587
Nine Largest Hospital Districts	$162,976,616	$106,486,734
Public Hospitals	$1,571,677	$926,322
CIHCPs	$1,456,674	$496,709
Counties with Multiple Programs	$1,179,072	$550,979

NOTE: Unreimbursed jail expenses were removed from unreimbursed health care expenditures.
SOURCES: Legislative Budget Board; Texas Department of State Health Services.

Although there are many factors that contribute to how much counties spend on indigent healthcare, total spending is constrained by the availability of funds (determined by the county's taxable value and tax rate) and the existence of other budgetary priorities and is influenced by the county's unmet healthcare needs. Some counties have greater uninsured and indigent populations to support than others. The effect of the uninsured is concentrated in 10 counties that, together, comprised over 60 percent of the uninsured in 2005. These counties are shown in **Figure 134**. The figure also shows that in some cases, counties with large uninsured populations have a limited relative tax base. Of the 10 counties with the largest uninsured populations, Cameron, Hidalgo, and El Paso have the highest percentage of their populations uninsured and also have the lowest tax bases per capita to support resident services including healthcare.

Data suggest many large urban counties have taken on greater regional roles in the provision of healthcare. LBB staff also surveyed nine of the largest urban hospital districts to obtain

FIGURE 134
TEXAS COUNTIES WITH THE 10 LARGEST UNINSURED POPULATIONS, FISCAL YEAR 2005

COUNTY	UNINSURED POPULATION FISCAL YEAR 2005	UNINSURED AS PERCENTAGE OF TOTAL COUNTY POPULATION FISCAL YEAR 2005	HOSPITAL DISTRICT OR COUNTY'S TAXABLE VALUE FISCAL YEAR 2007 (IN MILLIONS)	PER CAPITA TAXABLE VALUE (IN DOLLARS)
Harris*	1,099,223	29.8%	$252.3	$68,325
Dallas*	633,522	27.5%	$163.5	$70,923
Bexar*	372,115	24.5%	$92.2	$60,737
Tarrant*	371,301	22.9%	$114.7	$70,793
El Paso*	235,752	32.7%	$31.3	$43,401
Hidalgo	217,286	32.0%	$24.7	$36,451
Travis*	183,975	20.7%	$85.9	$96,737
Cameron	127,937	33.8%	$14.4	$38,025
Collin	123,487	18.7%	$68.4	$103,757
Denton	108,512	19.6%	$48.6	$87,610
TOTAL, 10 COUNTIES	**3,473,110**	**62.1%[1]**	**NA**	**NA**
STATE OF TEXAS	**5,589,436**	**24.5%[2]**	**NA**	**NA**

[1]62.1 percent of the state's uninsured population resides in the 10 counties.
[2]24.5 percent of the state's population is uninsured.
NOTES: Fiscal year 2005 is the most recent year with available county-level data on the uninsured.
The taxable value for counties with * are based on hospital district's taxable value.
SOURCES: Texas State Data Center; Texas Comptroller of Public Accounts.

data on out-of-county clients served. Of the districts that provided data on out-of-county clients, all five reported providing charity or uncompensated care to out-of-county residents.

To understand the regional role of large urban hospital districts in healthcare financing, LBB staff analyzed the county uninsured population and county or hospital district unreimbursed healthcare expenditures for each county with a hospital district and a cluster of contiguous counties. For each region, the total number of uninsured individuals and unreimbursed healthcare expenditures were calculated, and each county was assigned a percentage of the overall regional uninsured population and a percentage of contributions in terms of overall regional contributions. **Figure 135** shows a summary table for the state's hospital districts. If a county comprised 25 percent of the total regional uninsured population, it was expected that the county would incur a comparable level of the region's unreimbursed health expenditures. For example, Harris County residents comprise 75.2 percent of its region's uninsured population, but Harris County expended 89.7 percent of its region's total unreimbursed health care expenditures. The analysis found several hospital districts were expending greater resources on healthcare than expected based on the size of their uninsured populations. This suggests county taxpayers could be subsidizing some care for other counties' residents, though other factors could be involved such as the health of the county's population and the cost of healthcare.

Research conducted by Morningside Research and Consulting, Inc., found some hospital districts that seek reimbursement from other counties encounter difficulties recovering their costs because their neighboring counties limit out-of-county payment to match the eligibility requirements for in-county care or prohibit out-of-county reimbursement. Some neighboring counties of hospital districts have testified to interim committees of the Eightieth Legislature that because they meet the Texas Health and Safety Code, Chapter 61, requirement to pay for care to residents with incomes up to 21 percent FPL, they should not be responsible for reimbursing hospital districts that choose to provide care to persons with incomes exceeding Chapter 61 requirements.

In addition to disputes among counties, there are also disputes between counties and the state teaching hospitals. Although some counties contract with state teaching hospitals to provide care for their indigent residents, other counties do not have arrangements to reimburse the hospitals. UTMB reports receiving $6.6 million in county payments in fiscal year 2007, with $1.6 million outstanding. These outstanding sums could be due to disputes over patient residency, whether the services are included in the required services under

FIGURE 135
HOSPITAL DISTRICT'S REGIONAL SHARES OF UNREIMBURSED HEALTHCARE EXPENDITURES, FISCAL YEAR 2007, AND UNINSURED POPULATION, FISCAL YEAR 2005

HOSPITAL DISTRICT	UNREIMBURSED HEALTHCARE EXPENDITURES (IN MILLIONS, FISCAL YEAR 2007)	EXPENDITURES PER CAPITA OF COUNTY'S UNINSURED RESIDENTS (IN DOLLARS)	PERCENTAGE OF REGIONAL UNINSURED POPULATION (FISCAL YEAR 2005)	PERCENTAGE OF REGIONAL EXPENDITURES FOR UNREIMBURSED HEALTH CARE (FISCAL YEAR 2007)	DIFFERENCE, PERCENTAGE EXPENDITURES, PERCENTAGE UNINSURED
Harris	$433.9	$394.72	75.2%	89.7%	14.5%
Dallas	$384.6	$607.10	43.6%	59.3%	15.6%
Tarrant	$232.1	$625.21	25.6%	35.8%	10.2%
Bexar	$185.6	$498.73	83.5%	94.5%	11.0%
Travis	$106.5	$578.81	60.9%	83.1%	22.2%
Nueces	$30.2	$356.71	61.5%	84.9%	23.4%
El Paso	$52.5	$222.56	94. 5%	83.4%	(11.2%)
Lubbock	$15.4	$249.86	70.2%	69.8%	(0.4%)
Ector	$26.0	$773.72	46.1%	47.6%	1.5%

Notes: Unreimbursed jail expenses were removed from unreimbursed health care expenditures. Because the analysis focused on county expenditures, UTMB's contributions to the healthcare of Harris County residents are not captured in this chart. A combined region was used for Dallas and Tarrant Counties.
Sources: Texas State Data Center; Texas Department of State Health Services.

Chapter 61 and whether patient income is above or below 21 percent of FPL.

OPTIONS TO ADDRESS DIFFERENCES IN COUNTY PROGRAMS

Recent legislative activities have focused on reducing the number of uninsured persons and the total amount of uncompensated care, but differences in the provision of healthcare at the county level remain which result in some counties assuming additional financial liabilities. Options for reform within Chapter 61 of the Texas Health and Safety Code include changing the CIHCP eligibility threshold, establishing a minimal county expenditure requirement, and establishing a reimbursement program for counties. Another option would be to provide state funds to groups of counties to foster innovative approaches to county healthcare challenges.

CHANGE THE CIHCP ELIGIBILITY THRESHOLD

The Legislature could increase the required threshold for counties to serve persons with family incomes up to 25 percent or 100 percent of FPL. This change could shift some of the costs of state teaching hospitals and counties that serve persons above 21 percent of FPL to counties that meet but do not exceed the current statutory requirement. This approach would increase county spending and state costs if the existing state matching program is maintained. DSHS estimated that when raising the threshold to 100 percent of FPL and maintaining the current statutory provision that counties are eligible once they expend 8 percent of their general revenue tax levy, an additional 107 counties would qualify for state assistance, with an expected cost of $50 million over the 2008–09 biennium. However, as counties provide more indigent care, it will also reduce the charity care provided by state hospitals. Some of the increased costs to the state to reimburse a greater number of counties could be offset by reduced needs at the state teaching hospitals. The Indigent Health Care Advisory Committee and the Task Force on Access to Health Care in Texas have supported this approach, and two bills proposed during the Eightieth Legislature, 2007, considered adjusting the eligibility threshold.

ESTABLISH A MINIMUM COUNTY EXPENDITURE REQUIREMENT

The Legislature could require counties to expend a certain percentage of their general revenue tax levy on indigent healthcare. This change could shift some of the costs of state teaching hospitals and counties that spend above the threshold to those that do not. A study by Morningside Research and Consulting, Inc., using fiscal year 2005 data, found that the average Texas county expends 4.5 percent of its general revenue tax levy on indigent care, and if counties were required to expend 8 percent, the threshold for state matching contributions, counties would spend $66 million more each year. It is likely that an 8 percent requirement

would not be feasible for many counties, but this example is illustrative of the amount of additional indigent care funds that could be raised by establishing a county requirement. An optimal threshold is likely between 4.5 and 8 percent. This requirement would also increase the state's liability unless the current matching program is altered but would likely reduce expenditures at state teaching hospitals.

ESTABLISH A REIMBURSEMENT PROGRAM FOR COUNTIES

DSHS is responsible for mediating disputes between hospital districts and counties or among counties over residency disagreements but lacks enforcement authority. In addition, no mechanism exists for counties to reimburse other counties for providing healthcare to their residents as exists for the state's teaching hospitals. The Legislature would need to provide DSHS with the authority to enforce such a reimbursement program for counties to increase the likelihood that counties that treat a large number of out-of-county residents would have a process for reimbursement. Counties could be required to reimburse other counties for caring for residents with incomes up to 21 percent FPL as Chapter 61 requires or another eligibility threshold. Florida provides an example of how this system could function. **Figure 136** describes Florida's reimbursement program.

FIGURE 136
FLORIDA'S HEALTH CARE RESPONSIBILITY ACT OF 1977

Florida does not require counties to provide indigent care, but the Health Care Responsibility Act (HCRA) (Chapter 154, Sections .301–.331, Florida statutes) requires counties to reimburse other counties for providing charity care to their residents up to 100 percent of FPL (pending certain conditions, e.g., the program does not apply in cases involving undocumented persons). Counties are required to reimburse other counties for caring for their residents, and if counties cannot come to agreement over payment, the paying county can seek compensation from the state. On balance, for fiscal years 2006 and 2007, counties reported $4.8 million in reimbursements to other counties, and $702,720 for in-county expenditures.

The statute redistributes indigent health care expenses among counties and encourages the efficient provision of health care; for counties with large indigent health care needs, it might be more cost-effective to establish indigent care programs; for others with minimal needs, it might be more cost-effective to reimburse other counties. The program's effectiveness could be limited by the fact that it does not address the health costs of undocumented persons.

Source: Legislative Budget Board.

An alternate approach to adjusting existing Chapter 61 requirements would be for the state to support pilot programs that leverage county and state funding to address the healthcare needs of an entire region. The Indigent Health Care Advisory Committee and the Task Force on Access to Health Care in Texas recently outlined approaches for regional pilots, which could involve partnerships between counties, hospital districts, and public hospitals. The state's role in the pilots could involve provision of additional funding for information technology infrastructure or funding to compensate the counties for the additional care provided.

Regionally-developed solutions to indigent and uncompensated healthcare issues have emerged nationwide and in Texas, and some have been highlighted by the National Association of Counties.

In Florida, the Hillsborough County Healthcare Plan provides managed care to indigent residents up to 100 percent FPL and serves 25,000 clients out of 28,000 eligible uninsured. The program is administered by the Hillsborough County Department of Health and Social Services and is financed through county sales tax revenue and property taxes. The county pays for administrative staff, and a community advisory board oversees the program. The focus of this program is to provide a medical home and decrease emergency visits through prevention, education, and integration of social services.

In North Carolina, Project Access is a network of volunteer healthcare providers. It has a high provider participation rate and serves almost all of the 15,000 eligible uninsured. The income threshold for participants is 200 percent FPL. The Buncombe County Medical Society administers the program and helps coordinate doctors and hospitals who donate their time and services. The project also tracks patient records, referrals, and the value of donated services. Physicians are asked to see 10 to 20 patients per year in their private offices or can volunteer time in safety-net clinics. The charity care is supplemented by private grants and $400,000 from Buncombe County, which is used for a prescription program and program staff.

In Michigan, Access Health is a three-share partnership between small employers and employees and the community, which serves approximately 300 businesses and includes 1,300 individuals. The plan is available to working uninsured who do not qualify for any federal, state, or employer-sponsored health coverage. Full-time and part-time employees and their dependents are eligible if they earn less than the median wage of $12 per hour. Enrollees are responsible for small co-pays. The program is financed by employers (30 percent), employees (30 percent), and

community match (40 percent) which includes DSH Federal Funds, state, and local funds. Access Health is an independent 501(c)(3) organization which accepts and disseminates public funds and administers the program.

If Texas wanted to facilitate similar regional approaches, it could provide additional supportive funds to encourage these programs, as it did in establishing the grant process for local three-share insurance programs during the Eightieth Legislature, 2007. The Legislature appropriated $750,000 to the Texas Department of Insurance to provide technical assistance and grants to local communities. Under this option, the Legislature could appropriate $1.8 million to DSHS to award up to three grants to regions proposing initiatives to address indigent healthcare challenges.

ADDITIONAL INFORMATION ON INDIGENT HEALTHCARE

Additional information on many of the topics discussed in this report is available in other Legislative Budget Board publications (**Figure 137**).

FIGURE 137
LEGISLATIVE BUDGET BOARD PUBLICATIONS RELATED TO INDIGENT HEALTHCARE, NOVEMBER 2008

SESSION	PUBLICATION	CONTENT	REPORT
Eighty-first Legislature	*Government Efficiency and Effectiveness Report*	State teaching hospitals	Federal Reimbursement to State-Owned Teaching Hospitals
Eightieth Legislature	*Government Efficiency and Effectiveness Report*	Characteristics of the uninsured	Socio-Demographic Overview of Texas' Uninsured Population
		Health Insurance Premium Payment	Increase Health Insurance Premium Payment Enrollment to Generate Medicaid Savings
		Federally Qualified Health Centers	Expansion of Federally Qualified Health Centers in Texas
		County indigent programs	Using State and Local Funds to Expand Healthcare Coverage
		Disproportionate Share Hospital Program, Upper Payment Limit Program, and Trauma funding	Maximize Federal Medicaid Reimbursement for Texas Hospitals
Seventy-ninth Legislature	*Staff Performance Report*	Trauma funding	Use Trauma Funds to Draw Down Federal Funds
Seventy-eighth Legislature	*Staff Performance Report*	School Health and Related Services	Maximizing Medicaid Reimbursement for School Health and Related Services

SOURCE: Legislative Budget Board.

REGULATE EMERGENCY CARE FACILITIES TO STANDARDIZE QUALITY OF CARE

Since the 1980s, various ambulatory (outpatient) healthcare facilities with a focus on emergent and minor-emergent conditions have developed nationally and in Texas. The continued growth of these freestanding emergency rooms and urgent care/minor emergency clinics is due to their convenience, and patient dissatisfaction with the speed and quality of care delivered by hospital-based emergency rooms.

Many states regulate these facilities, and Texas regulates similar ambulatory healthcare facilities. However, the state of Texas does not regulate certain freestanding emergency rooms or urgent care clinics, which results in a lack of standardization among facilities regarding staffing, equipment, and transfer agreements to other hospitals for advanced emergency and inpatient services. In addition, the state does not have information on the safety records of these facilities because no state entity collects or investigates complaints against them. Regulation could improve the quality of care delivered through greater standardization, and provide patients with a greater understanding of the level of care available in different care settings to assist in decision-making about where to seek care.

FACTS AND FINDINGS

- Demand for alternatives to hospital-based emergency rooms has grown nationwide and in Texas due to increased patient dissatisfaction with the rate and quality of care emergency rooms deliver and the need for new models of emergency care delivery in underserved areas.
- While the total number of freestanding emergency rooms that are independent of hospitals in the U.S. remains unknown, there are 189 freestanding emergency rooms that are affiliated with hospitals and approximately 8,000 urgent care clinics. Texas has nine hospital-affiliated freestanding ERs and approximately 210 ambulatory and emergency medical centers. However, determining the number of independent freestanding emergency rooms and urgent care clinics from this data is not possible.
- The state of Texas through the Department of State Health Services regulates some ambulatory healthcare settings including ambulatory surgical centers. The agency provides specifications for construction and design standards, qualifications for staff, equipment essential to the health and welfare of patients, and sanitary and hygienic conditions.

CONCERNS

- Aside from hospital-affiliated freestanding emergency rooms, Texas does not license independent freestanding emergency rooms and urgent care clinics. Independent freestanding emergency rooms and urgent care clinics are not required to meet federal Emergency Medical Treatment and Active Labor Act requirements, maintain specified staffing or equipment levels, or develop transfer agreements with local hospitals. The lack of standardization could cause patient harm because these facilities hold themselves out to the public as capable of providing various degrees of urgent and emergent care but may not be able to deliver the level of care patients expect.
- The Texas Department of State Health Services receives complaints about independent freestanding emergency rooms and urgent care clinics, but no entity investigates these complaints. Patients can file complaints with the Texas Board of Nursing or Texas Medical Board about the care provided by a practitioner in these facilities, but neither capture detailed facility type data to enable analysis.

RECOMMENDATIONS

- **Recommendation 1:** Amend Title 4 of the Texas Health and Safety Code to require the Texas Department of State Health Services to regulate independent freestanding emergency rooms and urgent care/minor emergency clinics, and the use of related terminology. Emergency rooms would be required to provide emergency care to all persons who present and suffer from an emergency medical condition, regardless of their ability to pay.
- **Recommendation 2:** Include a contingency rider to the 2010–11 General Appropriations Bill that

provides the Texas Department of State Health Services with the funding necessary to regulate independent freestanding emergency rooms and urgent care/minor emergency clinics.

DISCUSSION

Federal and state regulations provide a framework for distinguishing between the definitions and requirements of hospital-based emergency rooms (ERs) and emerging alternatives.

PROVIDER TYPES

For the purposes of Medicare reimbursement, federal law defines a dedicated ER as any department or facility of the hospital, regardless of whether it is located on or off the main hospital campus, which meets at least one of the following requirements:

- It is licensed by the state in which it is located under applicable state law as an emergency room or emergency department;
- It is held out to the public (by name, posted signs, advertising, or other means) as a place that provides care for emergency medical conditions on an urgent basis without requiring a previously scheduled appointment; or
- During the calendar year immediately preceding the calendar year in which a determination under this section is being made, it provides at least one-third of all of its outpatient visits for the treatment of emergency medical conditions on an urgent basis without requiring a previously scheduled appointment.

The federal Emergency Medical Treatment and Active Labor Act (EMTALA), passed under the Consolidated Omnibus Budget Reconciliation Act of 1986, requires dedicated ERs to provide emergency medical care to persons who present on-site with emergency medical conditions, regardless of their ability to pay. EMTALA sought to address patient "dumping" practices, or the transfer of uninsured patients from private to public hospitals. The act requires hospitals to perform a medical screening examination on such persons to determine if an emergency medical condition exists. Hospitals cannot delay the screening examination or care while inquiring about payment. If an emergency condition exists, the hospital must stabilize the condition or transfer the person to another hospital that could provide better care. Hospitals with specialized services are required to accept patient transfers if they have the capacity.

Texas Health and Safety Code, Chapter 222, provides the Texas Department of State Health Services (DSHS) with the authority to license hospitals. Rules developed by DSHS require licensed hospital locations to operate an ER or provide emergency services. Staffing requirements for hospital-based ERs include:

- employment of adequate medical and nursing staff qualified in emergency care under supervision of a medical/clinical director; and
- at least one person capable of initiating immediate appropriate lifesaving measures and one physician must be on duty and available at all times, though some exemptions exist for facility type (comprehensive medical rehabilitation hospitals, pediatric, and adolescent hospitals). Special hospitals, critical access hospitals, and general hospitals located in counties with fewer than 100,000 residents are required to have a physician on-call and able to respond in person or by telephone/radio in 30 minutes.

Supply requirements for hospital-based ERs include:

- equipment and supplies for the administration of intravenous medications, control bleeding, and splint fractures; and
- storage of blood and blood products.

Equipment requirement for hospital-based ERs include:

- emergency call system;
- oxygen;
- mechanical ventilatory assistance equipment including airways, manual breathing bag, and mask;
- cardiac defibrillator;
- cardiac monitoring equipment;
- laryngoscopes and endotracheal tubes;
- suction equipment;
- emergency drugs and supplies specified by medical staff;
- stabilization devices for cervical injuries;
- blood pressure monitoring equipment; and
- pulse oximeter or similar medical device to measure blood oxygenation.

General hospitals must participate in the local Emergency Management System based on their capabilities, with the exception of comprehensive medical rehabilitation hospitals and pediatric and adolescent hospitals.

In federal and state law, the operational requirements for hospital-based ERs are defined clearly. For independent freestanding ERs and urgent care clinics in Texas, requirements remain undefined. These facilities hold themselves out to the public as capable of providing some emergency or urgent care, but might not have the staff or equipment to deliver the level of care patients expect.

FREESTANDING EMERGENCY ROOMS

While there is no single freestanding ER model in terms of operations or regulation, there are common elements. These elements include physical separation from the hospital campus, provision of all emergency services including surgery and observation that are available in a hospital-based ER except trauma care, operation 24 hours per day/seven days per week, and provision of the ancillary services of a hospital emergency room. A primary difference between a freestanding ER and a hospital-based ER is that a freestanding ER must transfer patients requiring more extensive or inpatient care to other facilities. Independent freestanding differ from hospital-based and hospital-affiliated freestanding ERs in that they do not have to meet EMTALA requirements. From a regulatory perspective, there are two models of freestanding ERs including (1) those that are hospital-affiliated, and (2) those that are independent.

Freestanding ERs have existed for 40 years, and the American Hospital Association (AHA) estimates there were 189 hospital-affiliated freestanding ERs in calendar year 2006. The total number of independent freestanding ERs is unknown. At least 15 states have had at least one freestanding ER including Arizona, California, Delaware, Florida, Kansas, Maryland, Michigan, Nevada, North Carolina, Ohio, South Carolina, Texas, Virginia, Washington, and Wisconsin.

Texas has become a national leader in the development of "emergency-urgent care" models. In fiscal year 2006, DSHS reports that there were nine hospital-affiliated freestanding ERs in operation in six counties (Brazoria, Dallas, Harris, Henderson, Nueces, and Smith) and they handled approximately 390,000 ER visits and 1.1 million total outpatient visits. U.S. Bureau of Labor Statistics data from 2006 indicate there were 210 privately-owned ambulatory and emergency medical centers in Texas, but it is not possible to identify how many of these are freestanding ERs or urgent care clinics. Identification is not possible because the data are inclusive of freestanding ambulatory surgical centers, emergency medical centers and clinics, laser surgery centers, trauma centers, and urgent medical care centers and clinics. Anecdotal evidence suggests areas of activity for freestanding ERs include East Texas and the Houston and Dallas areas.

URGENT CARE/MINOR EMERGENCY CLINICS

In the service delivery continuum, the urgent care clinic provides an alternative to the primary care provider and ER. Urgent care clinics appeared in the 1980s, but much of the industry's growth began in the 1990s. Nationally, there are now 8,000 clinics according to a 2008 study by the Urgent Care Association of America (UCAOA). Key features of the urgent care clinic as defined by UCAOA include delivery of ambulatory medical care outside of a hospital ER (outpatient care) and no requirement for patient appointments (walk-in). An urgent care clinic provides some of the services of a primary care physician's office, but it is capable of responding to minor emergencies. Typical services provided include diagnostic testing, radiology, reparation of lacerations, provision of IV fluids, and occupational health/workers compensation care. The focus of urgent care differs from primary care; the focus of urgent care is provision of episodic care, not the management of chronic conditions or the provision of preventive healthcare such as immunizations. **Figure 138** shows a comparison of select features of each of these healthcare settings.

Despite differences in focus, capabilities, and regulation, in practice there are many similarities in the operation of these care delivery models. The entry of new care models into the healthcare market has increased competition and resulted in greater similarities in the provision of care. Urgent care clinics provide primary care at extended hours, but also some comparable care to that provided in ERs for patients with lower acuity. Some ERs now operate fast track units, which provide care that resembles care provided in urgent care clinics. Freestanding ERs attract patients from urgent care clinics and hospital-based ERs. Primary care offices are also expanding evening and weekend hours in response to the growth in urgent care and after-hours clinics.

DEVELOPMENT OF ALTERNATIVES TO HOSPITAL-BASED EMERGENCY ROOMS

Demand for alternatives to the hospital-based ER has grown due to increased patient dissatisfaction with the rate and quality of care, and the need for emergency and primary care delivery in underserved areas.

FIGURE 138
COMPARISON OF CURRENT HEALTHCARE SETTINGS IN TEXAS

	PRIMARY CARE PROVIDER	URGENT CARE/MINOR EMERGENCY CLINIC	INDEPENDENT FREESTANDING ER	EMERGENCY ROOM AND HOSPITAL-AFFILIATED FREESTANDING ER
Appointment required	Yes	No	No	No
Extended hours	No Some offer minimal after-hours access or hotlines.	Yes Most are open between 8 and 8.	Yes Most are open 24/7.	Yes Nearly all are open 24/7.
Must comply with EMTALA regulations	NA	No	No	Yes
Services provided	Preventive/wellness healthcare, care for chronic conditions	Episodic treatment for minor emergencies, capable of diagnostic testing, occupational health/workers compensation	Episodic treatment for minor emergencies and emergent conditions (aside from trauma), capable of performing surgery and patient observation	Episodic treatment for same cases as freestanding ER Advanced capabilities in provision of trauma care vary by hospital Some fast track areas to divert non-emergent patients
Admission capabilities	Many physicians have admitting privileges to local hospitals.	Many physicians lack admitting privileges and must send emergent patients to the ER.	Must admit to another facility.	Admit to parent hospital or within facility.

SOURCE: Legislative Budget Board.

The AHA found in a 2007 survey of 5,000 hospital CEOs for the calendar year 2006 that 48 percent of all hospital ERs and 65 percent of urban hospital ERs are at or over capacity. Nationally, ERs are strained for a variety of reasons, which include:

- *Increased ER utilization:* The Centers for Disease Control (CDC) reported that ER visits increased from 96.5 million in 1995 to 115.3 million in 2005 (20 percent increase). From fiscal years 1997 to 2006, Texas ER visits increased from 6.4 million to 8.5 million (32.8 percent increase). **Figure 139** shows the patient volumes for six major urban counties, and statewide.

  Nationally, population growth, population aging, growing complexity of medical problems, and an increase in the difficulty in obtaining care from other sources contribute to increased ER visits. These factors are compounded by the national decline in the number of 24-hour emergency rooms. From 1995 to 2005, the number of 24-hour ERs decreased from 4,176 to 3,795 (-9.1 percent), which increased the patient load for remaining ERs.

FIGURE 139
TOTAL ER VISITS FOR MAJOR URBAN COUNTIES IN TEXAS, FISCAL YEAR 2006

COUNTY	ER VISITS	POPULATION	VISITS PER CAPITA
Harris	1,287,055	3,830,130	0.34
Dallas	909,144	2,340,063	0.39
Tarrant	667,067	1,667,306	0.40
Bexar	449,203	1,550,160	0.29
Travis	381,501	928,037	0.41
El Paso	229,536	743,319	0.31
Statewide	8,415,363	23,507,783	0.36

SOURCES: Texas Department of State Health Services; Texas State Data Center.

- *Staffing shortages and hospital capacity:* The 2007 AHA survey reported that 55 percent of hospitals have gaps in specialty coverage in their ERs, and many experience hospital-wide shortages in therapists, registered nurses, pharmacists, and nursing assistants, among other positions. The nursing shortage is acute; the AHA estimates there were 116,000 vacant registered nursing positions in U.S. hospitals in December 2006. Staffing shortages and other hospital capacity issues often result in patient boarding in the ER, which the

American College of Emergency Departments has identified as the greatest cause of ER overcrowding. Some patients wait hours or days to obtain transfers to staffed beds in other parts of the hospital.

The strain on ERs results in increased wait times to receive care and patient diversion to other facilities. Several studies document increasing wait times. The Institute of Medicine reported that the median wait increased from 22 minutes in 1997 to 30 minutes in 2007, and for the group of patients requiring emergent care, the wait increased from 10 to 14 minutes from 1997 to 2004. The CDC reported no change in wait time only because hospitals have enacted strategies such as fast track areas. As the wait time increases, the average total time spent in the ER increases. The 2005 National Hospital Ambulatory Medical Care Survey reported that the average total time spent in the ER was 3.3 hours.

When hospitals are over-capacity in one or more departments, they can elect to enter "diversion" status and request that the EMS department transport some or all patients to other local hospitals. A request for diversion could be due to capacity issues across the hospital including a lack of critical care, acute care, or psychiatric beds; a lack of physical space in the ER or operating room; or staffing shortages. In AHA's 2007 survey, hospitals reported the time spent in a diversion status in the past 12 months. Approximately 36 percent of hospitals responding had spent some time on diversion, and 56 percent of urban and 64 percent of teaching hospitals had been on diversion status. Nationally in 2003, ambulances diverted 501,000 patients to other facilities. In Texas for fiscal year 2006, of 417 hospitals reporting to DSHS, 75 percent diverted a total of 1,636 patients. For-profit hospitals were responsible for 40 percent of diversions.

Some researchers link ER overcrowding, longer patient wait times, and increased patient diversion with a decreased quality of care. Several studies demonstrate the link between negative health outcomes and hospital crowding. Crowding typically reduces the amount of time physicians spend with patients, and resource constraints including a lack of space increase the risk of errors and poor outcomes. A 2006 Australian study found higher rates of mortality after ten days of inpatient care for patients who presented to the ER at a time of crowding, even accounting for other shift, day, seasonal, and annual factors. Delays in care due to increased wait times or diversion could put patients with conditions requiring swift responses at risk. Research links higher mortality rates with prolonged transport times. A 2007 study in the United Kingdom found that absolute mortality increased by 1 percent for each 10 kilometer (6.2 mile) increase in distance travelled to receive medical care.

In addition to the strain on hospital-based ERs, a secondary factor increasing the demand for freestanding ERs is the growing need for emergency medical care in areas that cannot support full hospitals such as new suburban growth areas. Many patients from these areas travel extended distances or times to obtain care. Some hospitals have opened freestanding ERs as a means to expand their market into new growth areas, with plans to open full-service hospitals when demand grows. While some have suggested the deployment of this model in suburban and rural areas, research suggests freestanding ERs are most promising in suburban areas. A 1999 study explored the applicability of this model to rural areas, and concluded that freestanding ERs were not a financially viable option.

The primary factor that has driven growth in the number of urgent care clinics is "consumer backlash" over the lack of convenience in obtaining care in hospital-based ERs and primary care practices. In addition to the lack of convenience of ER care as discussed, accessing primary care can be inconvenient for patients. Clinics operate during the week and standard business hours, and require patients to obtain appointments. The wait to see physicians could be several weeks. In a study ranking the U.S. and six other developed countries, the U.S. ranked lowest in after-hours primary care provider access.

PROS AND CONS OF FREESTANDING EMERGENCY ROOMS AND URGENT CARE CLINICS

Proponents of freestanding ERs argue that they benefit patients and hospital-based ERs by expanding system capacity. Patient benefits include reduced wait time for service and the extension of service to areas that could otherwise not support a hospital. Systematic evaluation of the wait times of freestanding ERs compared to hospital-based ERs has not been conducted, but anecdotal and self-reported evidence from freestanding ERs indicate that their wait times are shorter than hospital-based ERs. Proponents of freestanding ERs argue that they can reduce the amount of time rural and suburban residents have to travel to the ER and can serve as a temporary or permanent solution for communities not yet able to support a hospital.

Proponents also contend this model is beneficial by increasing the capacity of the healthcare system. Freestanding ERs provide an outlet for non-emergent patients who use the ER. The CDC found that at the point of triage, 5.5 percent of

patients needed to be seen immediately, 9.8 percent were considered emergent and needed to be seen within 1 to 14 minutes, and 33.3 percent were considered urgent, needing care within 55 to 60 minutes. Of patients using the emergency room, 51.3 percent were considered semi-urgent, non-urgent, or of unknown status and could be treated within 2 to 24 hours of arrival. Also, the majority of patients presenting in the ER do not require in-patient admission. For example, in Texas in 2006, 17.1 percent of ER visits resulted in hospital admission. As freestanding ERs serve more patients, supporters argue that they benefit hospitals by reducing the volume of patients in hospital-based ERs.

Some proponents of independent freestanding ERs support their operation, but oppose their current unregulated status, including the lack of application of EMTALA. Because freestanding ERs tend to be located in more affluent suburban areas and are not required to treat all patients, some contend that freestanding ERs “siphon” patients with insurance or the ability to pay for care from hospital-based ERs, leaving ERs with a patient mix of mostly uninsured and underinsured patients, threatening their financial viability. Additional concerns about the lack of regulation stem from the lack of standardization, inadequate staffing and equipment, the lack of transfer agreements with other facilities, and potential safety concerns.

Opponents of the independent freestanding ER model dispute proponents’ arguments that freestanding ERs provide the same level of care as hospital-based ERs. Critics contend that these facilities do not provide the same level of care as hospital-based ERs and that because they are held out to the public as the equivalent of an ER, patients could place themselves at risk by choosing to receive care in a freestanding ER. In the case of time sensitive conditions (e.g. a stroke or heart attack), any delay in the receipt of care could prove harmful. Furthermore, if a freestanding ER begins to treat a patient and runs diagnostic tests, but then must transfer the patient to another facility, the second facility might not accept the diagnostic tests performed by the freestanding ER and would perform duplicative tests, adding costs to the patient and delaying treatment. Critics are concerned with the possibility that patients, either out of confusion or due to promotional materials, will incorrectly choose where to obtain care. Many freestanding ERs promote themselves to the public as capable of responding to medical emergencies, but there is a lack of public awareness about the differences between care settings and the best place to receive treatment. This was a concern in a March 2008 certificate-of-need hearing in Tennessee. The state unanimously denied a freestanding ER’s application partially because of the facility’s advertising materials and the model’s dependence on the public correctly choosing when to seek care in the facility compared to a hospital-based ER.

Proponents of urgent care clinics maintain that they are beneficial to consumers while reducing overall health costs. They support expansion of the urgent care model because of its convenience to patients from extended hours, walk-in service, and reduced wait times. While systematic evaluations of the wait times of urgent care clinics compared to other healthcare studies have not been conducted, the self-reported wait times of urgent care clinics, as collected by UCAOA in 2007, average between 0 to 45 minutes for 35 percent of patients and 45 to 60 minutes for 28 percent of patients. Proponents also contend that the financing of urgent care clinics is cheaper than care delivered through the ER or freestanding ER so if urgent care clinics can divert patients from hospital-based or freestanding ERs, there will be a reduction in overall healthcare system costs.

Critics of urgent care raise concerns about the lack of standardization and regulation of urgent care clinics, and the negative effects of the provision of episodic healthcare. Aside from the states that have regulated the term’s use, facilities that do not meet UCAOA’s definition of “urgent care” can use the term. Because many states do not regulate urgent care clinics, there is a lack of standardization across clinics regarding staffing and equipment, which affect the range and quality of services provided.

Another range of concerns with urgent care clinics stem from their episodic focus that by nature limits patient follow-up and continuity of care. This focus facilitates patient fraud and gaming especially for those with addictions to prescription medication. Additionally, it exposes physicians to a greater risk of malpractice lawsuits, as some research argues that the stronger the relationship between a physician and patient, the less likely the patient will sue the physician over malpractice.

FEDERAL AND STATE REGULATION OF FREESTANDING EMERGENCY ROOMS AND URGENT CARE CLINICS

Authority for the regulation of healthcare organizations including hospitals is shared by the federal and state governments, and accrediting organizations. The states license hospitals, and regulations provide minimum operating standards for these facilities. The federal government establishes additional requirements hospitals and other

providers must meet in order to participate in the Medicare and Medicaid programs. Because up to 98 percent of hospitals participate in the Medicare program, these requirements affect the majority of hospitals and other health providers in U.S. Accrediting organizations such as the Joint Commission on Accreditation of Healthcare Organizations (Joint Commission) serve an additional regulatory function. The Centers for Medicare and Medicaid Services (CMS) designated the Joint Commission as an entity capable of accrediting hospitals for the purpose of participation in the Medicare program.

Included in the regulation of hospitals is regulation of ER services. States have taken two approaches toward the regulation of freestanding ERs and urgent care clinics. Several states including Florida and Illinois license hospital-affiliated freestanding ERs and regulate them using the parent hospital's license. Another approach, used by Delaware, Nevada, and Rhode Island, does not require freestanding ERs to be licensed under a parent hospital. These states have established licensing processes that could encompass freestanding ERs and urgent care clinics.

States that require freestanding ERs to operate as affiliates of parent hospitals require these ERs to meet the same regulatory standards as hospital-based ERs. In Florida, the Agency for Health Care Administration requires that freestanding ERs maintain the same accreditations, hours, and EMS transportation requirements as hospital-based ERs, and meet the same federal and state requirements. In Illinois, freestanding emergency centers must be located in a municipality with fewer than 75,000 residents, within 20 miles of the owning/controlling hospital, and within 20 miles of the hospital affiliated with the center as part of the EMS system. Illinois statute specifies the facility design, operation, and maintenance standards, equipment standards, and personnel requirements. Illinois also specifies how urgent-emergent care facilities can communicate with the public. Freestanding emergency centers cannot hold themselves out to the public as a full-service hospital or hospital emergency department. Any facility that is not regulated as a hospital or freestanding emergency center is prohibited from using the terms "urgent," "urgi," "emerge," or "emergent" in public advertising.

Delaware, Nevada, and Rhode Island maintain a separate licensing process for freestanding ERs and/or urgent care clinics. **Figure 140** compares the design features of the regulations in these states.

While some states have addressed urgent care clinics along with freestanding ERs, other states implemented distinct provisions relating to urgent care clinics. Arizona was the first state to license and regulate urgent care clinics, but UCAOA has argued that the licensing agency's rules were not uniform and that paperwork and other requirements proved challenging for urgent care clinics. Other states including Delaware, Illinois, New Jersey, and Rhode Island regulate the use of terms like "urgent care" and "emergent" to prevent public confusion of the facilities with ERs and have imposed various advertising requirements and directions for posting services rendered and hours of operation.

In Texas, DSHS regulates hospital-affiliated freestanding ERs under the licenses of parent hospitals. No licensing process exists for independent freestanding ERs or urgent care clinics, but the personnel working in these facilities are regulated under their professional licenses. Because they do not have to meet licensing standards, freestanding ERs and urgent care clinics do not have to meet staffing (e.g., staff trained in emergency medicine) or equipment requirements, and are not required to treat all patients that present and have an emergent medical condition, regardless of their ability to pay.

Because Texas does not license freestanding emergency facilities, there is no process to collect or investigate information about patient complaints against these facilities. DSHS has received complaints about freestanding ERs and urgent care clinics, but must direct patients to the Texas Medical Board or Texas Board of Nursing to file a complaint about a specific practitioner. The Texas Medical Board does not capture detailed facility data on complaints. Texas Board of Nursing does not track facility data on complaints, but its system does allow for creation of an action history on the files of nurses whose records are updated by board action. Some action histories include facility information. The action history records indicate that there have been 6 Licensed Vocational Nurses and 65 registered nurses who received disciplinary action from fiscal years 2003 to 2007 who were employed in a freestanding clinic. However, this category of freestanding facilities is broad and could include many types of clinics including urgent care clinics, rural health clinics, and clinics operated by hospitals.

The state of Texas does license ambulatory surgical centers, which like some freestanding ERs, perform surgery in an outpatient setting. Facilities are licensed for two years at a cost of $5,200. The renewal provides two years of licensure for an additional $5,200. DSHS provides specifications for

FIGURE 140
COMPARISON OF FEATURES OF STATE REGULATION

FEATURE	DELAWARE	NEVADA	RHODE ISLAND
Facility type and basic requirements	Any facility that uses "emergency" or "urgent care" in its name, and is capable of treating all life-threatening medical emergencies.	State licenses independent centers for emergency medical care. Facilities are required be located more than thirty minutes from a facility providing a higher level of emergency medical care, and be held out to the public as a facility that routinely provides limited emergency medical care.	State licenses "Freestanding Emergency Care Facilities" that are public or privately operated; structurally distinct and separate from a hospital; and are staffed, equipped, and operated to provide emergency medical care.
Staffing requirements	• Staff must be organized and supervised by physician/nurse 24 hours per day and at least one licensed nurse and physician must be present at all times. • Physicians must be licensed to practice medicine in Delaware and have a current Advanced Cardiac Life Support certification or American Board of Emergency Medicine certification. • Nurses must be licensed as professional nurses in Delaware and maintain a current CPR certification. At least one nurse must be certified in Advanced Cardiac Life Support.	Each facility is required to have an administrator, a physician medical director, and chief nurse.	• Each facility is required to have an administrator and a physician medical director (may be same person). • A licensed physician must be on duty for all hours of operation and must be board eligible for Internal Medicine, Family Practice, or Surgery boards, and must hold a certificate from the Advanced Coronary Life Support, Advanced Trauma Life Support, and Pediatric Life Support programs. • At least one licensed registered nurse must be on duty during all hours of operation and must have training/experience in emergency care.
Facility/equipment requirements	Facility is required to have the following equipment: • immediately available oxygen with flow meters and masks, or equivalent; • immediately available mechanical suction; • airway maintenance and resuscitation equipment to include resuscitation bags, laryngoscopes and blades of varying sizes and shapes, endotracheal tubes, cricothyerotomy tubes and adapters; ventilation devices must be capable of delivering 1,000 oxygen; • spine immobilization equipment to include sandbags and/or semi-rigid collars; • complete intravenous infusion sets and standards with a reserved supply of at least six liters PSS or RL; • cardiac monitors and defibrillators together with an effective cardiac pacing system;	Facility is required to have the following equipment: • lab; • radiological services; • storage/administration of blood and blood products; • treatment room specifications including sinks and restrooms; • device for monitoring the electrical activity of the heart with the capability of performing manual defibrillation and external cardiac pacing; • equipment for the advanced management of a patient's airway including a laryngoscope, and blades and endotracheal tubes in sizes for infants, children, and adults; • a sterile tray with tracheostomy tubes in sizes for infants, children, and adults necessary to create an emergency surgical airway;	Facility is required to have the following equipment: • clinical laboratory services; • diagnostic radiology services; • oxygen; • electrocardiograph; • cardiac monitor and defibrillator with battery pack; • pacemaker insertion set-up, external pacemaker; • central venous catheter set-up; • gastric lavage equipment; • suction device; • intravenous fluids and administration devices; • endotracheal intubation and tracheostomy trays; and • emergency obstetrical pack.

FIGURE 140 (CONTINUED)
COMPARISON OF FEATURES OF STATE REGULATION

	DELAWARE	NEVADA	RHODE ISLAND
Facility/equipment requirements (continued)	• equipment and supplies needed to empty and drain stomachs and bladders; • newborn and pediatric resuscitation equipment; • sterile suturing equipment and supplies; and • various specifications for treatment rooms, including sink and toilet access.	• sterile needles, tubing, and other equipment necessary to administer intravenous and intraosseous therapy for infants and children and specialized procedures to stabilize the vital signs of a patient; • apparatus for the suction of an airway with wide-bore tubing and rigid pharyngeal suction tips, and assorted sizes of sterile suction catheters; • devices to stabilize a patient's neck in sizes for infants, children, and adults; and • a sterile tray and equipment necessary to insert a tube into a patient's chest, appropriate for the age, size, and sex of the patient, for drainage of the chest cavity.	
Meet EMTALA or similar requirement	Yes	Yes	Yes
Transfer protocols	Written transfer agreements required with one or more hospitals to provide inpatient care as needed.	Required to have the following transfer protocols: • capacity to communicate with EMS; • written agreements with acute and trauma care providers for patient transfers; and • system to maintain patient information.	Required to have the following transfer protocols: • develop policy/procedures for transfer of severely ill or injured to another hospital; and • keep transfer records.

SOURCE: Legislative Budget Board.

construction and design standards, qualifications for staff, equipment essential to the health and welfare of patients, and sanitary and hygienic conditions.

Some freestanding ERs and urgent care clinics voluntarily pursued and attained national accreditation or certification in addition to meeting state requirements. Programs exist for ambulatory healthcare organizations and specifically, freestanding ERs and urgent care clinics, that are administered by the Joint Commission, the Accreditation Association for Ambulatory Health Care, the Urgent Care Association of America, the American Board of Urgent Care Medicine, and the National Association for Ambulatory Care. With exception of the Joint Commission's accreditation, most of these accreditations are not recognized by states, the federal government, or certifying boards. In addition, these organizations do not certify or accredit many facilities nationwide or in Texas.

PAYMENT FOR MEDICAL CARE

Insurance reimbursements for care in freestanding ERs and urgent care clinics may be less than reimbursements for similar care provided in hospitals or other settings. CMS establishes hospital reimbursement rules for the Medicare and Medicaid programs. In a 2008 memorandum regarding certification for Medicare, CMS indicated that when a Medicare-participating hospital opens an off-campus emergency department, services are covered under the Medicare Provider Agreement, provided that the facility complies with Medicare Conditions of Participation. These off-campus ERs are recognized as "dedicated emergency departments," meaning that EMTALA requirements apply. Patients are considered "outpatients" for reimbursement purposes. In 2007, CMS created a distinction for reimbursement purposes between emergency facilities that operate 24 hours per day, and those that maintain less than

24 hour per day service. ERs open 24 hours per day receive ER rates, and those that do not receive lower clinic rates.

CMS does not recognize independent freestanding ERs for Medicare participation unless they meet the Social Security Act's definition of a hospital, which indicates that a hospital must primarily provide inpatient services. CMS interpreted the requirement to mean that a hospital must devote 51 percent or more of its beds to inpatient care, but CMS may consider other factors when determining whether the facility meets the statutory requirement. Individual providers in independent freestanding ERs can participate in the Medicare and Medicaid programs if they have a provider number and meet all of the other program criteria. They can receive payment for professional services, but not facility fees. Some freestanding ERs do not accept Medicare or Medicaid patients, and are developing billing schedules with private insurers and fee schedules for self-paying patients.

Urgent care providers often use the same billing codes as primary care physicians. One practice is to bill using a flat-rate billing code, regardless of the amount of care provided. Generally, it is possible for individual physicians to participate in the Medicare/Medicaid programs. Some private insurers have developed tiered billing and carve-outs to account for different levels of care provided, or the provision of specific services such as X-rays. Across insurance settings, urgent care clinics bill for professional services, but their ability to bill for the facility fees like a hospital-based ER is uncertain.

In Texas, most independent freestanding ERs are not eligible for Medicare or Medicaid payment, or they are choosing not to participate in either program. Instead, they are attempting to contract with private insurers and establish fee schedules for self-pay patients. However, there can be obstacles in obtaining payment from private insurers. Some Texas insurers will only reimburse for services provided in freestanding emergency facilities that meet certain criteria. For example, one large Texas insurer requires that a facility (1) comply with EMTALA, (2) maintain transfer agreements, (3) contract with physicians with additional training in emergency medicine or that are board certified in emergency medicine, (4) operate 24 hours per day/7 days per week, (5) maintain suitable equipment and supplies, and (6) maintain a Joint Commission or AAAHC accreditation. No facilities in Texas currently meet these criteria.

APPROACHES FOR TEXAS REGULATION OF FXREESTANDING EMERGENCY ROOMS AND URGENT CARE CLINICS

During the Eightieth Legislature, 2007, several bills were introduced to regulate independent freestanding ERs including Senate Bill 1115/House Bill 3283 and Senate Bill 1358, but none were enacted. Senate Bill 1115 would have created a licensing process for an "independent emergency medical care facility," defined as a "facility, structurally separate and distinct from a hospital, that: (A) receives and treats individuals requiring treatment or stabilization of an emergency or immediate medical condition; (B) determines if an individual has an emergency or immediate medical condition; or (C) except for mass trauma preparation or planning, is fully capable of providing Level IV trauma care, as defined by the department." Based on the operational requirements imposed by the version of Senate Bill 1115 that passed the Senate, the licensing process would likely only apply to freestanding ERs, not urgent care clinics.

Recommendation 1 would amend Title 4 of the Texas Health and Safety Code to require DSHS to define and license "independent freestanding emergency rooms" and "urgent care/minor emergency clinics." The Texas Insurance Code and other statutes would be amended as needed to reflect independent freestanding ERs and urgent care clinics as entities that can provide different degrees of emergency care. The agency would be required to develop rules for design standards, staff qualifications, equipment requirements, and sanitary and hygienic conditions for each facility type, in addition to requiring transfer protocol for patients requiring advanced care as recommended by emergency physician and consultant organizations. DSHS should consider statutes and rules developed by other states as examples of how to address some of the concerns about the operation of both freestanding ERs and urgent care clinics through regulation.

To educate the public about alternatives to ERs, the statute would prohibit unlicensed facilities from using the terms "emergency" and "urgent," and their derivatives and require these facilities to post the services they provide at their entryways. Freestanding ERs should also be required to comply with federal EMTALA requirements, and provide emergency care to all persons who present with an emergency condition, regardless of their ability to pay.

Regulation could ensure greater standardization of the quality of care provided in these facilities, and provide patients with a greater understanding of the level of care provided in different care settings to assist in decision-making about

where to seek care. The rationale for this recommendation is three-fold. First, Texas is experiencing many of the trends that gave rise to freestanding ERs nationally, including increased ER visits and the need for healthcare in growing suburban areas. In addition, a growing number of patients are seeking ER care for non-emergent conditions or for conditions that do not require inpatient admission. These factors have increased the demand for urgent-emergent care alternatives and as a result, many urgent-emergent facilities are already in operation. Second, their unregulated status prevents the state from identifying the number in operation, standardizing the quality of care provided, and responding to complaints. Finally, other states have regulated these facilities and provide different models for consideration in Texas, and DSHS has experience licensing similar ambulatory healthcare settings.

FISCAL IMPACT OF THE RECOMMENDATIONS

The recommendations, if implemented, would result in a net gain of $177,354 in General Revenue Funds in the 2010–11 biennium. Since Recommendation 1 requires statutory change, Recommendation 2 would include a contingency rider to the 2010–11 General Appropriations Bill. **Figure 141** shows the five-year fiscal impact of the recommendation. The contingency rider would appropriate $1,074,136 in General Revenue Funds in fiscal year 2010, and $633,658 in fiscal year 2011.

The expected costs and revenue gain were calculated based on the assumption that a total of 375 facilities would be licensed, which includes 75 freestanding ERs and 300 urgent care clinics. As it does in its licensing of other healthcare settings, the agency would license all facilities in fiscal year 2010, issuing some one-year licenses and some two-year licenses to stagger the renewals for future years. The analysis used a licensing fee of $7,000 for freestanding ERs (one-year license $3,500) and $5,000 for urgent care clinics (one-year license $2,500), and a renewal fee of $6,000 for freestanding ERs and $4,200 for urgent care clinics.

The costs associated with implementing Recommendation 1 include staffing costs, technology costs, and a referral charge to send cases to the State Office of Administrative Hearings (SOAH). DSHS will require 19.5 full-time-equivalent (FTE) positions to implement the licensing and regulatory requirements of Recommendation 1 by December 1, 2010, assuming 375 entities to regulate. After the first year of implementation, the staffing need will decrease to 11 positions. Costs include salaries, benefits, travel, and other administrative expenses. DSHS will incur technology costs as a result of Recommendation 1. DSHS will need to make a one-time system modification to its existing health facility licensing integrated system and would encounter hardware and software costs for the additional FTE positions. The agency would also incur a minimal charge for cases referred to SOAH.

The expected revenue gain from licensing 375 entities on the fee schedule previously outlined will not exceed the expected costs for the first fiscal year of implementation, but will result in a gain in General Revenue Funds for the next four years, as shown in **Figure 141**.

The introduced 2010–11 General Appropriations Bill does not include these recommendations.

FIGURE 141
FISCAL IMPACT, FISCAL YEARS 2010 TO 2014

FISCAL YEAR	PROBABLE (COST) IN GENERAL REVENUE FUNDS	PROBABLE GAIN IN GENERAL REVENUE FUNDS	PROBABLE NET FISCAL IMPACT IN GENERAL REVENUE FUNDS AND GENERAL REVENUE–DEDICATED FUNDS	CHANGE IN FULL-TIME EQUIVALENTS FROM FISCAL YEAR 2009
2010	($1,277,308)	$1,221,500	($55,808)	19.5
2011	($782,839)	$1,016,000	$233,161	11.0
2012	($832,570)	$852,000	$19,431	11.0
2013	($832,570)	$858,000	$19,431	11.0
2014	($832,570)	$852,000	$19,431	11.0

SOURCE: Legislative Budget Board.

INCREASE THE USE OF E-PRESCRIBING TO IMPROVE PATIENT SAFETY AND PRESCRIBING SYSTEM EFFICIENCIES

E-prescribing is an electronic method of prescribing pharmaceuticals using current communications, data management, and web-based technology. The technology allows a medical professional to insure that the item being prescribed will not interfere with other medications the patient is taking and thus prevent costly medical errors. Also, a medical professional and pharmaceutical provider can use the technology to prevent fraud and billing errors by verifying that a prescription is not being duplicated or prescribed at multiple locations. The U.S. Centers for Medicare and Medicaid Services requires E-prescribing for all Medicare prescriptions by 2012. The federal government estimates that it will save taxpayers approximately $156 million over five years. In addition to improved patient care and provider efficiencies, the centers view E-prescribing as the nation's first major step to implement a standardized, integrated national health information technology and electronic medical record system. The federal government is therefore promoting the expansion of E-prescribing to state Medicaid programs, Children's Health Insurance Programs, other public pharmaceutical programs, and the private sector.

This report focuses on issues related to expanding E-prescribing through the Texas Vendor Drug Program for the Medicaid and Children's Health Insurance Programs. It describes the benefits of E-prescribing, state and national initiatives, federal requirements related to Medicare, and implementation challenges. Limited use of E-prescribing and electronic medical record technology by Texas physicians indicates the state is not prepared to take advantage of system efficiencies.

CONCERNS

- Although a private consortium of pharmaceutical industry businesses found that E-prescribing technology was available in 59 percent of Texas pharmacies in 2007, only 4 percent of Texas prescribers were using E-prescribing systems. The Texas Medical Association estimates that only one-third of physicians use any form of electronic medical record technology, impairing the ability of providers in Texas to effectively and efficiently make medical decisions based on comprehensive medical histories.
- The Texas Health and Human Services Commission is analyzing options to take advantage of E-prescribing efficiencies for the state's Medicaid and Children's Health Insurance Programs. Health information technology has not been fully developed to communicate formulary information and centralized access to electronic medical records for these programs. In fiscal year 2006, the Texas Medicaid program reimbursed 4,125 pharmacies for prescriptions written by 59,447 medical providers, posing a host of logistical problems to be resolved for E-prescribing.

RECOMMENDATION

- **Recommendation 1:** Include a rider in the 2010–11 General Appropriations Bill that directs the Texcas Health and Human Services Commission to develop an E-prescribing implementation plan, including relevant timeframes to improve patient safety and to standardize electronic prescribing systems in the state's Vendor Drug Program for the Medicaid and Children's Health Insurance Programs and submit a report, including any projected expenditures and cost savings per fiscal year, to the Legislative Budget Board and the Governor by December 1 of each year of the biennium.

DISCUSSION

Migrating from traditional prescribing methods to E-prescribing is being promoted by the U.S. Centers for Medicare and Medicaid Services (CMS) to improve patient safety, integrate electronic medical records into the healthcare system, and improve administrative efficiencies for providers. CMS is providing incentives to Medicare clinicians who implement E-prescribing in their practices. Pharmacy benefit managers, pharmacy chains, and information technology companies are offering software, hardware, and technical and financial assistance for physicians who want to install E-prescribing systems. The increase in E-prescribing transactions from 2006 to 2007 indicates growing acceptance of the new technology among providers The medical industry's overall experience indicates that, even though challenges remain, E-prescribing is a benefit to patient safety

and may also provide a cost benefit to providers, programs, and businesses that use it.

Through an E-prescribing system, a medical provider selects a medication electronically, consults a formulary, checks for drug interactions and allergies, and transmits the prescription via fax or electronically to a pharmacy. In 2006, the Institute of Medicine reported that preventable medication errors account for 7,000 deaths and 1.5 million preventable adverse drug events each year nationally. In addition to addressing patient safety issues, E-prescribing can be effective in reducing prescription fraud and abuse. **Figure 142** describes the benefits of E-prescribing, identified by major features.

Reports of cost savings related to E-prescribing vary greatly, ranging from $4 per prescription to $25 per prescription. While pharmacies and prescribers are expected to gain cost savings through E-prescribing efficiencies, those cost savings are offset by the prescribing providers' initial implementation costs. The average cost for physician office computer system changes is reported to be $20,000 to $40,000 per physician's practice. Additional costs of $0.20 to $0.30 per transaction may also be incurred if a provider subscribes to a commercial E-prescribing hub. Indirect cost savings for the state may occur when prescribing errors are reduced, thus limiting subsequent medical care related to accidental drug interactions or overdose. States can also capture savings through new contracts with pharmacies or pharmacy benefit managers as E-prescribing is implemented. In addition, improved tracking of provider and patient activity can reduce costs through better detection and control of fraud, abuse, and duplicate prescriptions.

Opportunities exist for states to partner with CMS and coordinate health and medical record system interoperability with Medicare intermediaries. The federal government may fund 90 percent of the cost of buying computer systems that process Medicaid claims. CMS can use that leverage when states apply for funds to upgrade their systems. CMS is beginning to push states toward a standards-based, modern Information Technology (IT) architecture that can link data

FIGURE 142
BENEFITS OF E-PRESCRIBING SYSTEMS

Warning and Alert Systems	Warnings or alerts provided at the point of prescribing enhance an overall medication management process. A clinical decision support system checks a new prescription against the patient's current medications to find drug-drug interactions, drug-allergy interactions, diagnoses, patient body weight and age, drug appropriateness, and correct dosing. The system alerts prescribers to contraindications, adverse reactions, and duplicate therapy.
Specialty Software	The system includes specialized drug reference software programs, such as *ePocrates Rx, Pro*, and the *Physician's Desk Reference*.
Access to Patient Medical and Medication History	Medical and medication history from all providers at the time of prescribing supports alerts related to drug inappropriateness and special medical conditions.
Patient Convenience and Compliance	Approximately 20 percent of paper-based prescription orders go unfilled by the patient—at least in part due to the hassle of dropping off a paper prescription and waiting for it to be filled. E-prescribing eliminates lost paper and reduces wait time.
Reduction in Phone/Fax Usage	E-prescribing can significantly reduce the volume of pharmacy call-backs related to handwriting legibility, mistaken manual prescription choices, formulary and pharmacy benefits, which improves workflow, efficiency, and productivity for the pharmacy and the prescriber, positively impacting office workflow efficiency and overall productivity.
Improved Surveillance and Recall Ability	E-prescribing systems enable automated analytical queries and reports that are not possible with a paper prescription system. For example, a provider could find all patients with a particular prescription during a drug recall, or check the frequency and types of medication prescribed to prevent fraud or abuse.
Improved Formulary Adherence and Reduced Drug Costs	E-prescribing improves provider ability to interact with the health plan/insurer formularies at the point of care. This facilitates generic substitutions or lower cost therapeutic equivalent medications, thereby reducing costs for patients. Lower costs for patients can also help improve medication compliance.
Greater Prescriber Mobility	Improved prescriber convenience can be attained when using a mobile device (laptop, PDA, etc.) and wireless network to write or authorize prescriptions. This allows prescribers to write prescriptions anywhere, even when not in the office.
Overall Cost Savings	Nationally, E-prescribing is estimated to save an average of $4.00 to $25.00 per prescription. This estimate is based on industry averages in the commercial market and may be less for Medicare and Medicaid.

Source: Centers for Medicare and Medicaid Services, *2008 Clinician's Guide to E-prescribing*.

from a variety of sources, including Medicaid claims, to provide a more comprehensive picture of patients' health. It is called the Medicaid IT Architecture. Such partnerships are also able to achieve local enhancements for state information and medical record technology programs in the process. There are also examples of private consortia banding together to provide technological, regulatory and financial assistance to providers.

Over the past few years, E-prescribing systems have undergone wide-scale testing and technical standards have gained universal support. According to SureScripts, a private consortium of pharmaceutical industry businesses, more than 35 million prescription transactions were sent electronically in 2007, and by the end of 2007 at least 35,000 prescribers were actively E-prescribing. SureScripts estimates there will be at least 85,000 active E-prescribers by the end of 2008. Although the number of participants has grown significantly, the proportion they represent of all prescribers is relatively small (3 percent in 2007 and 10 percent in 2008). Nationally, only 2 percent of eligible prescriptions were transmitted electronically in 2007. **Figure 143** shows the increase in E-prescriptions in Texas from fiscal years 2005 to 2007.

PHARMACY PROVIDER CHALLENGES

CMS estimates that E-prescribing technology is available at 97 percent of the nation's chain pharmacies and 27 percent of independent pharmacies, although 86 percent of independent pharmacies that have E-prescribing technology do not use it. Because E-prescribing provides administrative savings to pharmacies, acceptance is growing and technology improvements are occurring rapidly. CMS reports that E-prescribing also allows more time for patient counseling. **Figure 144** shows the number of community pharmacies in Texas that were ready for E-prescribing from fiscal years 2005 to 2007.

CLINICIAN IMPLEMENTATION CHALLENGES

The transition from a paper to an electronic system is challenging for many physicians and nurse practitioners. The Texas Medical Association (TMA) conducted a survey on electronic medical record implementation and released the results in May 2008. According to survey findings, only 33 percent of physicians are using some form of electronic medical record technology in Texas. This is up slightly from 27 percent reported in a similar survey conducted by TMA in 2005. However, about one-fourth of respondents said they still have no plans to implement electronic medical record technology in their practices.

Prompted by the low percentage of active E-prescribers, CMS released *A Clinician's Guide to Electronic Prescribing* in October 2008. The guide is designed to meet the needs of two target audiences: office-based clinicians who need a basic understanding of E-prescribing and its benefits and challenges; and office-based clinicians who are ready to bring E-prescribing into their practices but need information on steps to follow in planning for, selecting, and implementing an E-prescribing system. The two primary challenges listed in the report that limit widespread adoption of E-prescribing technology for clinicians are (1) Financial Cost and Return on Investment and (2) Work Procedure Changes and Change Management.

FIGURE 143
E-PRESCRIPTIONS IN TEXAS, FISCAL YEARS 2005 TO 2007

	FISCAL YEAR 2005	FISCAL YEAR 2006	FISCAL YEAR 2007
New E-prescriptions	77,294	143,694	681,407
E-Refill Requests	155,429	243,436	579,557
E-Refill Responses	145,551	221,796	498,058
Total E-prescription Transactions	**378,274**	**608,926**	**1,759,022**
Annual Growth in E-prescription Transactions		61%	189%

Sources: SureScripts Pharmaceutical Consortium; American Medical Association.

FIGURE 144
COMMUNITY PHARMACIES READY TO E-PRESCRIBE IN TEXAS

	FISCAL YEAR 2005	FISCAL YEAR 2006	FISCAL YEAR 2007
Community Pharmacies Ready to E-prescribe	1,827	2,346	2,639
Percentage of Total Community Pharmacies	46%	55%	59%
Annual Growth		28%	12%

Note: Community pharmacies is a term inclusive of both chain and independent pharmacies.
Sources: SureScripts Pharmaceutical Consortium; American Medical Association.

Prescribers, especially those in small practices and in inner city or rural settings, may believe they bear more than their fair share of the cost of E-prescribing, since other stakeholders also benefit from the savings and quality improvements that are achieved or receive fees from the use of E-prescribing. To participate in E-prescribing, physician practices have to invest in hardware and software, and cost estimates for those investments vary depending on whether an electronic medical record system is adopted or a stand-alone E-prescribing system is used. Even physicians receiving free E-prescribing systems may face financial costs in the areas of practice management interfaces, customization, training, maintenance, and upgrades as well as time and efficiency loss during the transition period. Large urban practices have been the sites of most successful implementations and can achieve a positive return on investment in as little as one or two years for E-prescribing and electronic medical record systems. It may take longer for small practices in rural and inner city settings to achieve a return on investment.

To gain efficiencies and time savings in the long run, practices require adequate planning, training, and support when introducing E-prescribing and electronic medical records management. **Figure 145** shows the growth trend in E-prescribers in Texas from fiscal years 2005 to 2007.

FIGURE 145
E-PRESCRIBERS IN TEXAS, FISCAL YEARS 2005 TO 2007

	FISCAL YEAR 2005	FISCAL YEAR 2006	FISCAL YEAR 2007
Total E-Prescribers	493	692	1,569
Percentage of Total Prescribers		2%	4%
Annual growth		40%	127%

SOURCES: SureScripts Pharmaceutical Consortium; American Medical Association.

RESTRICTIONS ON E-PRESCRIBING CONTROLLED SUBSTANCES

Restrictions related to prescribing controlled substances complicate the E-prescribing process and may discourage provider participation. Pursuant to a federal law effective April 1, 2008, the federal Drug Enforcement Administration (DEA) requires prescribing practitioners to use tamper-resistant prescription paper when issuing a written prescription for any drug for Medicaid recipients. This current regulation applies to all written prescriptions submitted for payment through the Texas Vendor Drug Program for all state Medicaid beneficiaries. The regulation does not apply to prescription orders transmitted to a pharmacy via telephone, fax, or electronic means. The purpose of tamper-resistant prescription pads is to reduce instances of unauthorized, improperly altered, and counterfeit prescriptions. If a Medicaid recipient presents with a non-compliant prescription, the pharmacist can obtain telephone verification from the prescriber and dispense the prescription in full (as written). The pharmacist must note the verification on the original written prescription. The pharmacist may also fill the prescription and obtain a compliant prescription by fax, electronic prescription, or as a rewritten prescription on tamper-resistant paper within 72 hours after the date the prescription was filled.

For a written prescription to be considered tamper-resistant by CMS, the prescription paper must meet the following three characteristics:

- prevent unauthorized copying of completed or blank prescription forms;
- prevent erasure or modification of information written on the prescription form; and
- prevent the use of counterfeit prescription forms.

Because the DEA currently prohibits electronic transmission of prescriptions for controlled substances, both physician practices and pharmacies are forced to use different work procedures to manage these prescriptions. This adds complexity to the prescribing process and is a barrier to adoption and use of E-prescribing, given that the American Medical Association estimates about 20 percent of all prescriptions are for controlled substances. Typically, the pharmacy vendor system requires prescriptions for controlled substances to be printed. A specific type of registered paper may be required and clinicians then must manually sign the form. This requires either a separate dedicated printer or a specialized printer that can switch to the specialized paper on demand. The printer must also be kept in a secure area. The prescriber can still use E-prescribing or electronic medical records system to generate and document all prescriptions.

In summer 2008, the DEA issued a proposed rule to allow controlled substances to be E-prescribed, and public comments on the proposed rule were due September 25, 2008. The effective date of implementation is unknown.

FEDERAL INITIATIVES

Based on the Medicare Modernization Act of 2003, CMS is requiring Medicare Part D providers to implement

E-prescribing by 2012. A qualified prescribing system must include the following capabilities:

- generate a medication list;
- select medications, transmit prescriptions electronically, and conduct contraindicating safety checks on medications;
- provide information on lower cost alternatives and formulary medications; and
- provide information on patient eligibility and health plan authorization requirements.

Most E-prescribing systems and electronic medical record systems offer these capabilities.

Medicare is also taking new steps to speed the adoption of E-prescribing by offering incentive payments to physicians and other eligible professionals who use the technology. Beginning in 2009, Medicare will provide incentive payments to eligible professionals who are successful E-prescribers. CMS defines successful electronic prescribers as eligible professionals who report E-prescribing in 50.0 percent or more of the applicable Medicare prescriptions issued by them. These prescribers will receive a 2.0 percent incentive payment in 2009 and 2010, a 1.0 percent incentive payment in 2011 and 2012, and a 0.5 percent incentive payment in 2013. Eligible prescribers who are not successful E-prescribers by 2012 will be subject to a penalty. For unsuccessful E-prescribers, CMS regulations state that fee schedule payments will be reduced by 1.0 percent in 2012, by 1.5 percent in 2013, and by 2.0 percent in 2014 and each subsequent year.

E-PRESCRIBING IN OTHER STATES

At least 21 states report some level of public health E-prescribing pilot project or implementation plan or progress. According to SureScripts, the top 10 E-prescribing states ranked by the number of prescriptions routed electronically in 2007 as a percentage of the total number of prescriptions eligible for electronic routing are Massachusetts, Rhode Island, Nevada, Delaware, Michigan, Maryland, North Carolina, Arizona, Connecticut, and Washington. Texas ranks 30th in the nation for E-prescribing. Progress on the status of the E-prescribing programs in three select states are described below.

Massachusetts was the first state to fully implement E-prescribing on a broad scale in its state health programs. A study conducted in 2007 by the Center for Patient Safety at the Dana-Farber Cancer Institute found that nearly 104,000 prescriptions flagged as potential problems during an ongoing E-prescription pilot project in Massachusetts helped prevent 724 bad drug interactions or drug-allergy issues. Although it would have been much more difficult to identify and avert these errors under the traditional pad-and-pen prescription system, the estimated $630,000 cost savings was less than expected. Massachusetts recently passed new healthcare cost-containment legislation, requiring hospitals and doctors to adopt a statewide electronic medical record-keeping system by 2015.

Florida's program, called ePrescribe, expanded statewide after July 2008 and received broad support from health plans and professional associations, which could make it a potential model for other states. Florida's E-prescribing pilot documented savings of $40 per patient per month in 2006. The program is estimated to save the state Medicaid program $2 million per month according to the Florida Agency for Health Care Administration. In October 2007, the agency signed a four and a half year agreement for an $11 million contract to provide the state's Medicaid program with Medicaid Drug Therapy Management services. The vendor is charged with developing solutions to improve quality of care while ensuring an overall cost reduction.

Contract deliverables include solutions and services in criteria development and analysis for the program, population health management, and two web-based electronic health record applications. *CyberAccess*(SM) will be a secure website where physicians will have access to the full medical and pharmacy details of patients, and which also provides patient care alerts based on best-practices guidelines. *DirectCAREPro*(SM) will provide pharmacists with complete medical and pharmacy claims profiles of patients at the point of service with actionable alerts. The agency believes that these products will assist physicians, pharmacies, and patients with information and resources on the cost-effective use of prescription drugs under the state Medicaid program.

Mississippi implemented a pilot program in 2005 that supplied personal digital assistants, commonly referred to as PDAs, to physicians in suburban and rural areas who needed convenient access to E-prescribing technology. Physicians liked the handheld devices because they were easy to carry and the same size as paper prescription pads. Among the pilot's findings was a reduction in prescribing errors and duplication, as well as a cost savings of $1.2 million per month.

TEXAS VENDOR DRUG PROGRAM INITIATIVES

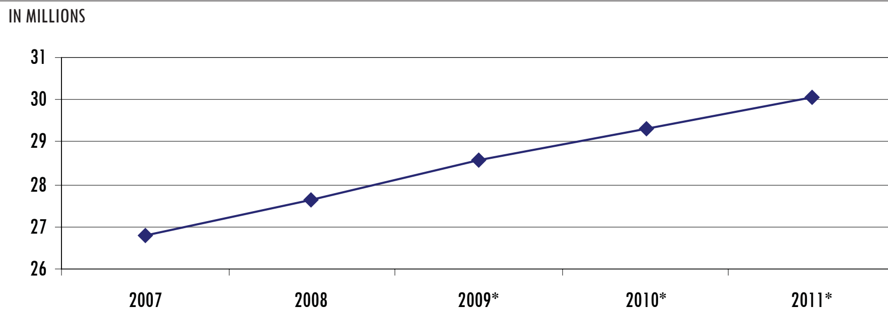
In fiscal year 2007, the Texas Vendor Drug Program operated by the Texas Health and Human Services Commission (HHSC) expended $1.8 billion in state and federal funds on 27 million Medicaid prescriptions and $85.4 million in state and federal funds on 1.4 million Children's Health Insurance Program (CHIP) prescriptions. **Figures 146, 147, and 148** show the number of prescriptions, clients, and expenditures per year for fiscal years 2007 to 2011 for all claims processed through the Texas Vendor Drug Program.

HHSC contracted for a feasibility study on developing electronic medical records and E-prescribing systems. The study will be completed and reported to the Eighty-first Legislature in January 2009. HHSC is researching E-prescribing initiatives in Medicare and in other states' Medicaid programs and is exploring options with E-prescribing network providers. Approaches to E-prescribing for the Texas Medicaid and CHIP programs and related fiscal impacts are also being examined by HHSC through the Texas Vendor Drug Program.

Electronic medical record systems that ensure accuracy, privacy, and security are essential to an effective E-prescribing system. HHSC plans to use drug manufacturer rebate funding to pilot an electronic medical records system project. The project requires drug manufacturers participating in the Texas Medicaid preferred drug list supplemental rebate program to provide funding equivalent to the manufacturer's cash rebate amount. Discussions are ongoing with a number of drug manufacturers to fund the project; however, the one-year timeframe for supplemental rebate contracts does not coincide well with the long-term involvement related to developing of an electronic medical records system. Questions linger related to the appropriate size of the project and whether the pilot would help the state meet its objectives.

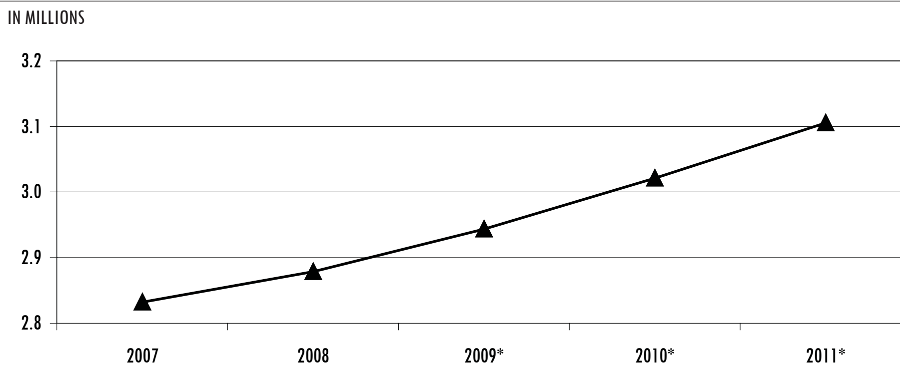
Currently, the Medicaid Drug Utilization Review program conducts prospective drug use reviews that occur at the point-of-sale and retrospective drug use reviews that examine claims data to identify patterns of inappropriate prescribing. The reviews seek to identify and monitor potential drug therapy problems that could lead to adverse outcomes, such

FIGURE 146
VENDOR DRUG PRESCRIPTIONS, FISCAL YEARS 2007 TO 2011



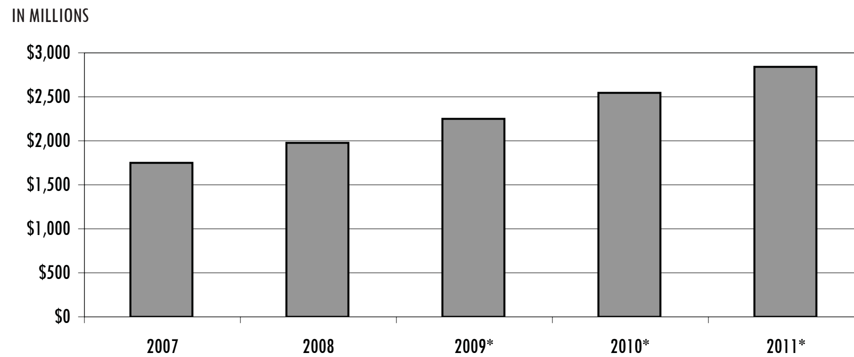
*Estimated.
Source: Texas Health and Human Services Commission.

FIGURE 147
VENDOR DRUG CLIENTS, FISCAL YEARS 2007 TO 2011



*Estimated.
Source: Texas Health and Human Services Commission.

FIGURE 148
VENDOR DRUG EXPENDITURES, FISCAL YEARS 2007 TO 2011



*Estimated.
SOURCE: Texas Health and Human Services Commission.

as drug interactions and incorrect drug dosages. Patient safety is greatly improved by the utilization review process and would be enhanced with E-prescribing technology by providing patient medical and drug information to the prescriber, pharmacy, and Medicaid system in real time. Medicaid drug utilization review is discussed in detail in another Government Effectiveness and Efficiency Report entitled, *Strengthen the Texas Medicaid Drug Utilization Review Program to Promote Safety and Contain Spending*.

Implementing an E-prescribing system in a state as large as Texas is a daunting task. HHSC must coordinate a diverse group of providers, contractors, and vendors for its public healthcare programs. In fiscal year 2006, the Texas Medicaid program reimbursed 4,125 pharmacies for prescriptions written by 59,447 medical providers. That same year the state's CHIP reimbursed 3,788 pharmacies for prescriptions written by 23,802 medical providers.

The largest programs, Medicaid and CHIP, have extensive provider networks that issue and process client prescriptions. Several prescribing systems are used by Medicaid/CHIP providers and all must have access to the appropriate medical records, formularies, and preferred drug lists used by these programs. The majority of clinicians and pharmacies have computers and faxes, but many still use paper prescriptions. Some rural providers may have limited access to Internet or wireless connectivity due to their remote locations. Even pharmacy and clinical providers with connectivity and up-to-date technology may not share software or have interoperability with all necessary communication systems. These technology gaps present the Texas Vendor Drug Program with a host of logistical problems related to sharing patient medical records and processing approvals and pharmacy claims before E-prescribing can be adopted as a standard method of issuing and approving prescriptions. Nevertheless, the promise of improved patient safety and improved cost efficiencies make it incumbent on HHSC to continue to examine E-prescribing. The 2010–11 General Appropriations Bill includes a rider that directs HHSC to develop an E-prescribing implementation plan (Recommendation 1).

FISCAL IMPACT OF THE RECOMMENDATION

Fiscal impact related to the development and reporting of an E-prescribing plan would not be significant. The introduced 2010–11 General Appropriations Bill includes a rider that directs HHSC to develop an implementation plan, including relevant timeframes, and to submit a report, including any projected expenditures or cost savings per fiscal year, to the Legislative Budget Board and the Governor by December 1 of each year of the biennium. The introduced bill does not include any other adjustments as a result of this recommendation.

EXPENDITURE AND CASELOAD TRENDS FOR LONG-TERM CARE IN THE TEXAS MEDICAID PROGRAM

"Long-term care" refers to a wide range of supportive and health services provided on an ongoing basis for persons who have limitation in functioning because of a disability or chronic condition. Long-term care is provided in two settings: (1) institutional settings, such as nursing facilities and intermediate care facilities for persons with mental retardation or related conditions (institution-based care); and (2) settings in the home or in the community (community-based care). Community-based care refers to a variety of non-institutional long-term care settings that may range from congregate living arrangements to a person's home. A shifting of long-term care resources from institution-based to community-based care settings has been spurred by consumer advocacy, judicial rulings, and encouragement and funding by government.

While most individuals prefer to receive care in a community-based setting, part of the economic rationale for expanding this type of care is it is less expensive, in many cases, than institution-based care on a per capita basis. Although community-based care can be cost-effective on an individual basis, funding this type of care does not ensure overall savings in state expenditures for long-term care. This report compares long-term care caseloads and expenditures for community- and institution-based care in the Texas Medicaid Program for the period of fiscal years 1999 to 2007.

FACTS AND FINDINGS

- ♦ Although the majority of Medicaid long-term care spending in Texas is directed to institution-based care, like the rest of the country, spending on community-based care has increased over time.
- ♦ Growth in community-based care caseload has outpaced that of corresponding long-term care target populations. Despite the higher rate of growth in the community-based care caseload, the percentage of the target population served has remained low.
- ♦ Spending on Medicaid community-based care has grown at a faster rate than spending on institution-based care.
- ♦ Despite growth in expenditures on Medicaid institution-based care, the number of clients receiving services in this setting has remained relatively unchanged.
- ♦ Because Medicaid community-based care expenditures have been less per person than Medicaid institution-based care, significantly more clients have been served in Medicaid community-based care settings at lower total expenditures compared to Medicaid institution-based care.
- ♦ The gap has widened between the expenditures per client in Medicaid institution-based care compared to community-based care settings.
- ♦ Among new waiver program clients from 1999 to 2007, 16 percent of clients with mental retardation or related conditions and 55 percent of aged and disabled clients could have been served in institutional settings without additional expenditures over that time. Had all of those clients been served in institutional settings, spending for long-term care services would have exceeded historical expenditures by $2.6 billion.

DISCUSSION

"Long-term care" refers to a wide range of supportive and health services provided on an ongoing basis for persons who have limitation in functioning because of a disability or chronic condition. A person typically needs long-term care services if he or she requires assistance with activities essential to daily self-care. These activities include bathing, dressing, grooming, toileting, housekeeping, shopping, and preparing meals. Persons requiring long-term care do so for various reasons, such as cognitive and developmental disabilities, childhood diseases, mental illness, spinal cord injuries, Alzheimer's, post-acute care, and other chronic diseases.

Both adults and children may require long-term care, some over a lifetime and others for only a limited period. While long-term care is sometimes associated primarily with the aged population, 37 percent of all long-term care recipients in the U.S. are individuals under age 65 with disabilities. Sixty percent of Americans who reach age 65, however, will need long-term care at some point in their lives.

Long-term care services are delivered in a range of settings that depend on the client's needs and preferences, the availability of informal support, and the sources of reimbursement for those services. Long-term care is commonly categorized into two settings: (1) institutional settings such as nursing facilities and intermediate care

facilities for persons with mental retardation or related conditions (institution-based care), and (2) settings in the home or in the community (community-based care). Community-based care refers to a variety of non-institutional long-term care settings that may range from congregate living arrangements to a client's home.

PUBLIC FUNDING OF LONG-TERM CARE

Medicaid is the primary payer of publicly funded long-term care services, accounting for approximately 48 percent of all long-term care expenditures in the U.S. in 2001. According to the federal Centers for Medicare and Medicaid Services, national Medicaid spending during the period from 2007 to 2017 is projected to increase at an average annual rate of approximately 7.9 percent. The long-term care population will contribute significantly to this increase.

Federal and state funding for long-term care services in Texas can be divided into the four categories shown in **Figure 149**.

Medicaid entitlement services must be provided to all persons who meet eligibility requirements. Medicaid entitlement services include both community- and facility-based services.

Medicaid community entitlement services include: Primary Home Care; Community Attendant Services; and Day Activity and Health Services. Medicaid facility entitlement services include Nursing Facilities and Intermediate Care Facilities for Persons with Mental Retardation or Related Conditions (ICF-MR/RC).

Waiver programs allow states the flexibility to limit the scope of eligibility, the area in which services are provided, scope and amount of services, and the number of people served. **Figure 150** shows the Medicaid 1915(c) waiver programs operating in Texas according to the type of institutional setting in which the waiver client would have otherwise received care.

State and federally funded non-Medicaid services include In-home and Family Supports, Residential and Community Care Services for Persons with Mental Retardation, Title XX Social Services Block Grant Program, and Older American Act Funding.

BALANCING THE CONTINUUM OF CARE

The array of long-term care services and settings described previously are often referred to collectively as a "continuum of care." This continuum includes an appropriate setting for persons to receive services based on their specific needs and the availability of informal support. The notion of a continuum of care has evolved, however, from one along which clients progress linearly along the continuum according to the acuity of their long-term care needs to one in which services are provided as an array from which individuals may choose; that services should be available and provided in almost any setting.

FIGURE 149
FEDERAL AND STATE FUNDING FOR LONG-TERM CARE IN TEXAS, 2006–07 BIENNIUM

CATEGORIES OF PUBLICLY FUNDED LONG-TERM CARE	2006–07 BIENNIAL EXPENDITURES PERCENTAGE OF TOTAL
Medicaid entitlement services	$7.6 billion or 75%
Medicaid 1915(c) home and community-based waivers (waiver programs)	2.2 billion or 22%
Non-Medicaid funded services – Federal Funds	151.8 million or 1%
Non-Medicaid funded services – State General Revenue Funds	199.5 million or 2%
TOTAL	**$10.2 billion**

Source: Texas Department of Aging and Disability Services.

FIGURE 150
MEDICAID 1915(C) WAIVER PROGRAMS, FISCAL YEAR 2007

NURSING FACILITY	ICF-MR/RC
Community-based Alternatives (CBA)	Home and Community-based Services (HCS)
Integrated Care Management 1915(c) (CBA equivalent)	Community Living Assistance and Support Services (CLASS)
Star+PLUS 1915(c) (CBA equivalent)	Deaf-Blind Multiple Disabilities (DBMD)
Medically Dependent Children Program (MDCP)	Texas Home Living (TxHmL)
Consolidated Waiver Program (CWP)	Consolidated Waiver Program (CWP)

Source: Texas Department of Aging and Disability Services.

Since the 1980s, public financing of long-term care has been allocated predominantly to institution-based care. In the U.S., 90 percent of total spending for Medicaid long-term care in 1987 was directed to institution-based care and the remaining 10 percent was directed to community-based care. By 2006, the share of Medicaid spending for institutional settings decreased to 63 percent and the share for Medicaid community-based care had increased to 37 percent. Most of this growth has occurred through expanding waiver programs. Spending on Medicaid community-based care waiver programs has increased from 31 percent of total Medicaid community-based care in fiscal year 1992 to 68 percent in fiscal year 2005.

The shifting of long-term care funding from institution-based care to community-based care has been spurred by consumer advocacy, judicial rulings, and increased public funding.

According to an AARP Public Policy Institute study (2008), persons with disabilities and their families prefer community-based care to institution-based care. A survey of persons age 50 and older with disabilities found that only 1 percent preferred to receive help with daily activities in a nursing facility, and even when 24-hour help was required, only 6 percent expressed a preference to receive care in a nursing facility.

Also key to the shifting of long-term care funding from institution- to community-based settings is the 1999 U.S. Supreme Court decision in Olmstead vs. L.C. (Olmstead). This ruling requires states to provide long-term care services in the most integrated setting appropriate to the needs and wishes of people with disabilities. Following this decision, failing to provide services to people with disabilities in a community-based setting rather than institution-based setting could constitute discrimination under the federal Americans with Disabilities Act.

COST-EFFECTIVENESS, COST SAVINGS, AND THE "WOODWORK EFFECT"

While most individuals prefer to receive care in a community-based setting rather than an institution-based setting, part of the economic rationale for the expansion of community-based care has been that for many individuals it is possible to provide lower per capita cost care in the community relative to care provided in an institutional setting. States must demonstrate to the federal government that providing long-term care services in community-based settings through waiver programs would cost the same or less than providing services to those clients in an institution-based setting for the federal government to approve the program.

Researchers at Harvard Medical School (2006) and the Lewin Group (2000) who have reviewed studies of the cost-effectiveness of community-based care provided via waiver programs have found that while average expenditures for waiver clients were less than for clients in an institution, it remains unclear whether waiver programs lower overall state Medicaid spending.

These analyses contend that it is possible that some number of waiver recipients would not have entered an institution, instead opting to continue to seek care from informal and other supports provided by family members and friends in the absence of the waiver. This induced demand for community-based care is referred to as the "woodwork effect" because those new recipients of publicly financed community-based care come "out of the woodwork" to apply for services.

The primary challenge becomes determining how many clients who receive community-based care would have entered the long-term care system (regardless of whether additional community-based services were made available) and received services in more costly institutional settings absent the availability of additional community-based care.

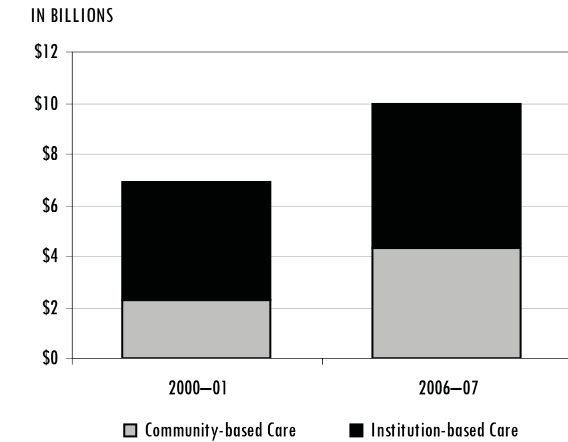
The differing components of cost among programs in both institution- and community-based settings further complicate analysis of cost-effectiveness. In the analysis of caseload and expenditures that follows, effort was made to make program expenditures comparable, but this challenge persists.

Policy makers, however, may prefer community-based programs regardless of cost-effectiveness as compared to institution-based care because the provision of community-based care increases contentment among patients and caregivers, and many have argued that this is reason enough for continued expansion.

TRENDS IN LONG-TERM CARE CASELOAD AND EXPENDITURES IN TEXAS

Although the majority of Medicaid long-term care spending in Texas is directed to institution-based care, as in the rest of the country, spending on home and community-based care has increased over time. Long-term care expenditures for the Texas Medicaid Program totaled approximately $9.8 billion in All Funds during the 2006–07 biennium. As shown in **Figure 151**, Medicaid community-based care increased from 34 percent of total Medicaid long-term care expenditures in

FIGURE 151
GROWTH IN LONG-TERM CARE EXPENDITURES FOR TEXAS MEDICAID PROGRAM, 2000–01 AND 2006–07 BIENNIA



SOURCE: Texas Department of Aging and Disability Services.

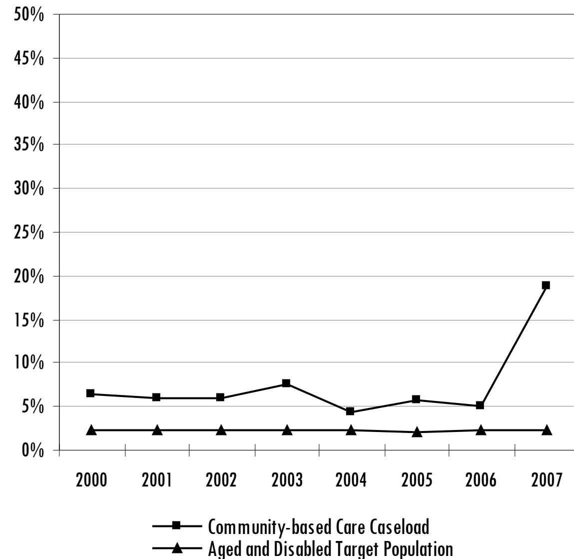
the 2000–01 biennium ($2.3 billion) to 44 percent in the 2006–07 biennium ($4.3 billion).

The rate of growth in community-based care caseload has outpaced the rate of growth of corresponding target populations. This trend is consistent for both the population of aged and disabled persons needing assistance with activities of daily living with income below 220 percent of federal poverty limits (aged and disabled target population) and the population of persons with moderate and severe/profound mental retardation and related conditions (target population of persons with mental retardation and related conditions). **Figures 152 and 153** show the rate of growth in the target populations and the rate of growth in the caseload served in Medicaid community-based care.

Despite the higher rate of growth in the community-based care caseload, the percentage of the target population served in any setting has remained low. **Figure 154** shows the percentage of the target population of persons with mental retardation and related conditions receiving long-term care services has ranged from 44 percent to 48 percent. The percentage of the aged and disabled target population who received long-term care services has ranged from 42 percent to 55 percent.

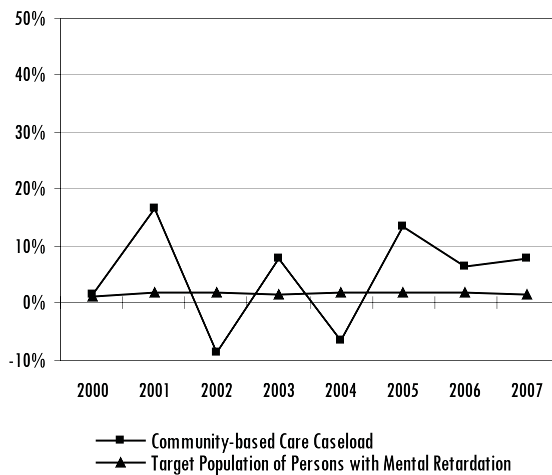
Figures 155, 156, and 157 show for the aged and disabled, persons with mental retardation and related conditions, and combined populations, the average annual client caseloads, total expenditures, expenditures per client, and the percentage change from the 2000–01 to the 2006–07 biennia in the Texas Medicaid Program.

FIGURE 152
RATE OF GROWTH IN TEXAS COMMUNITY-BASED CARE CASELOAD AND TARGET POPULATION FOR AGED AND DISABLED PERSONS, FISCAL YEARS 2000 TO 2007



SOURCE: Texas Department of Aging and Disability Services.

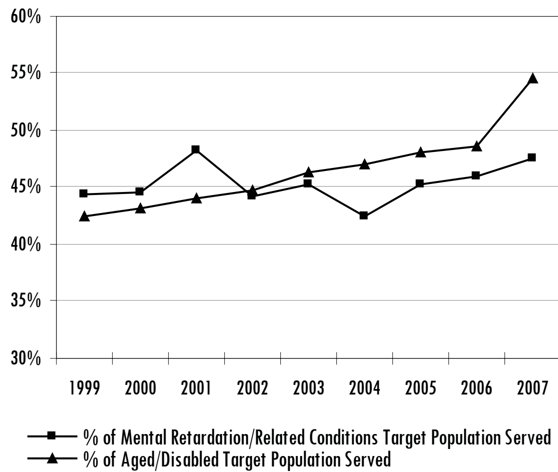
FIGURE 153
RATE OF GROWTH IN TEXAS COMMUNITY-BASED CARE CASELOAD AND TARGET POPULATION FOR PERSONS WITH MENTAL RETARDATION AND RELATED CONDITIONS, FISCAL YEARS 2000 TO 2007



SOURCE: Texas Department of Aging and Disability Services.

Expenditures on Medicaid community-based care increased at a faster rate than institution-based care. From the 2000–01 biennium to the 2006–07 biennium, spending on Medicaid institution-based care for the aged and disabled population increased 25.6 percent to $4.1 billion, while spending on Medicaid community-based care increased 81.3 percent to $3.2 billion. Similarly, spending on Medicaid institution-

FIGURE 154
PERCENTAGE OF TARGET POPULATION SERVED, FISCAL YEARS 1999 TO 2007



SOURCE: Texas Department of Aging and Disability Services.

based care for persons with mental retardation or related conditions increased 14.6 percent to $1.5 billion, while Medicaid community-based care increased 90.1 percent to $1.1 billion.

Despite increasing expenditures on Medicaid institution-based care, the number of clients who received services in this setting has remained relatively unchanged. From the 2000–01 biennium to the 2006–07 biennium, the number of aged and disabled clients in institutional settings increased by 2.2 percent to 69,522 clients, while expenditures for that care increased 25.6 percent to $4.1 billion. During this period, the number of persons with mental retardation and related conditions in institutional settings decreased by 10.7 percent to 11,654 clients, while expenditures for that care increased 14.6 percent to $1.5 billion.

Because Medicaid community-based care expenditures have been less per person than Medicaid institution-based care, significantly more clients have been served in Medicaid community-based care settings at less total expenditures compared to Medicaid institution-based care. Specifically, spending on all Medicaid community-based care totaled $4.3 billion to serve 253,238 clients during the 2006–07 biennium, compared to $5.7 billion to serve 81,176 clients in Medicaid institution-based care. This holds true, individually, in both the aged and disabled population and the population of persons with mental retardation and related conditions.

FIGURE 155
AVERAGE ANNUAL CLIENTS AND TOTAL EXPENDITURES FOR COMBINED LONG-TERM CARE POPULATIONS IN TEXAS MEDICAID PROGRAM, 2000–01 AND 2006–07 BIENNIA

	AVERAGE ANNUAL CLIENTS			EXPENDITURES, IN MILLIONS			EXPENDITURES PER CLIENT		
MEDICAID PROGRAM	2000–01	2006–07	PERCENTAGE CHANGE	2000–01	2006–07	PERCENTAGE CHANGE	2000–01	2006–07	PERCENTAGE CHANGE
Institutional Settings	81,080	81,176	0.1%	$4,518	$5,535	22.5%	$27,861	$34,093	22.4%
Community-based Settings	160,460	253,238	57.8%	$2,325	$4,263	83.4%	$7,245	$8,417	16.2%

SOURCE: Texas Department of Aging and Disability Services.

FIGURE 156
AVERAGE ANNUAL CLIENTS AND TOTAL EXPENDITURES FOR AGED AND DISABLED POPULATION IN TEXAS MEDICAID PROGRAM, 2000–01 AND 2006–07 BIENNIA

	AVERAGE ANNUAL CLIENTS			EXPENDITURES, IN MILLIONS			EXPENDITURES PER CLIENT		
MEDICAID PROGRAM	2000–01	2006–07	PERCENTAGE CHANGE	2000–01	2006–07	PERCENTAGE CHANGE	2000–01	2006–07	PERCENTAGE CHANGE
Institutional Settings*	68,034	69,522	2.2%	$3,247	$4,079	25.6%	$23,863	$29,336	22.9%
Community-based Settings (Entitlement)**	126,226	200,823	59.1%	$1,026	$2,034	98.2%	$4,064	$5,064	24.6%
Community-based Settings (Waiver)***	27,420	37,310	36.1%	$746	$1,178	57.9%	$3,603	$15,787	16.1%
All Community-based Settings	153,646	238,133	55.0%	$1,772	$3,212	81.3%	$7,667	$20,851	18.0%

*NF, SNF, Hosp, Star+ NF.
**PHC, CAS, DAHS, Star+ community (includes non-LTC caseload).
***CBA, MDCP, CW, PI, Star+ CBA.
SOURCE: Texas Department of Aging and Disability Services.

FIGURE 157
AVERAGE ANNUAL CLIENTS AND TOTAL EXPENDITURES FOR PERSONS WITH MENTAL RETARDATION AND RELATED CONDITIONS IN TEXAS MEDICAID PROGRAM, 2000–01 AND 2006–07 BIENNIA

	AVERAGE ANNUAL CLIENTS			EXPENDITURES, IN MILLIONS			EXPENDITURES PER CLIENT		
MEDICAID PROGRAM	2000–01	2006–07	PERCENTAGE CHANGE	2000–01	2006–07	PERCENTAGE CHANGE	2000–01	2006–07	PERCENTAGE CHANGE
Institutional Settings*	13,046	11,654	(10.7%)	$1,271	$1,456	14.6%	$48,712	62,471	28.2%
Community-based Settings (Waivers)**	6,815	15,105	121.7%	$553	$1,051	90.1%	$40,575	$34,790	(14.3%)

*ICF-MR, State Schools.
**HCS, CLASS, DBMD, TxHML.
Source: Texas Department of Aging and Disability Services.

The gap has widened between the expenditures per person in Medicaid institution-based care compared to community-based care settings. From the 2004–05 to 2006–07 biennia, the amount spent per person in Medicaid institution-based care settings increased 9.3 percent while the amount spent per person in Medicaid community-based care settings declined 2.5 percent. This also holds true, individually, in both the aged and disabled population and the population of persons with mental retardation and related conditions.

While we do not know how many "woodwork" clients have entered the long-term care system in Texas, we can estimate how many new waiver program clients could have been served, alternatively, in institutional settings. Among new waiver program clients from 1999 to 2007, 16 percent of clients with mental retardation or related conditions and 55 percent of aged and disabled clients could have been served in institutional settings without additional expenditures over that time. Had all of those clients been served in institutional settings, spending for long-term care services would have exceeded historical expenditures by $2.6 billion.

STRENGTHEN THE TEXAS MEDICAID DRUG UTILIZATION REVIEW PROGRAM TO PROMOTE SAFETY AND CONTAIN SPENDING

The Texas Health and Human Services Commission, through the Texas Medicaid Vendor Drug Program, provides outpatient prescription drugs to Medicaid recipients, including clients enrolled in traditional fee-for-service Medicaid and managed care. The Texas Medicaid Drug Utilization Review program, established in October 1992 in response to federal legislation, improves the quality of pharmaceutical care by ensuring that outpatient prescription drugs are appropriate, medically necessary, and not likely to result in adverse medical outcomes. The program also serves as a cost containment strategy by reducing spending associated with adverse medical outcomes and encouraging the use of cost-effective drugs. The program includes prospective drug use reviews, which occur at the point-of-sale, and retrospective drug use reviews, which examine claims data to identify patterns of inappropriate prescribing and result in educational outreach to physicians. These reviews identify and monitor potential drug therapy problems that could lead to adverse medical outcomes, such as drug interactions and incorrect drug dosages.

From fiscal years 2004 through 2007, retrospective drug use reviews conducted by the Texas Health and Human Services Commission resulted in an estimated savings of $50.8 million in General Revenue Funds. However, the agency arbitrarily limits the number of retrospective drug use reviews to an average of six per year. As a result, Texas is not maximizing its opportunity to implement reviews that could prevent adverse health outcomes and contain Medicaid spending. Furthermore, the state lacks information needed to regularly monitor prescription drug trends and evaluate the effectiveness of certain components of the Medicaid Drug Utilization Review program. Also, the advisory board that makes recommendations regarding the Medicaid Drug Utilization Review program is not explicitly prohibited from engaging in activities with pharmaceutical manufacturers that could call into question board members' impartiality when making recommendations on whether to implement drug use reviews.

Strengthening the Texas Medicaid Drug Utilization Review program by increasing the number and type of retrospective drug use reviews performed each year, improving Medicaid prescription drug data monitoring, improving the evaluation of program activities, and addressing conflict of interest provisions for program advisory board members could help improve the quality of pharmaceutical care and contain Medicaid spending in Texas.

CONCERNS

- The Texas Health and Human Services Commission arbitrarily limits the number of Medicaid retrospective drug use reviews to an average of six per year. As a result, Texas is not maximizing its opportunity to implement retrospective drug use reviews that could prevent adverse health outcomes and contain Medicaid spending. For example, the agency may not repeat successful reviews that address continuing drug therapy problems. Also, other states perform retrospective drug use reviews focused on additional disease-specific drug classes, and these types of reviews could potentially benefit Texas.

- The Texas Health and Human Services Commission does not regularly publish Medicaid prescription drug utilization and expenditure data that could help the agency, the Texas Legislature, and the Medicaid Drug Utilization Review Board monitor spending trends and improve efforts to contain prescription drug spending.

- Whereas the federally required Texas Medicaid Drug Utilization Review program annual report includes an estimate of cost savings resulting from retrospective drug use reviews, the report does not include cost savings estimates for prospective drug use reviews. As a result, the Texas Health and Human Services Commission, the Texas Legislature, and the Medicaid Drug Utilization Review Board lack information needed to evaluate program effectiveness and consider program improvements.

- The Medicaid Drug Utilization Review Board by-laws do not include a conflict of interest provision to prevent board members from having contractual relationships or other conflicts of interest with

pharmaceutical manufacturers that could call into question board members' impartiality when recommending that drugs or drug classes be subject to drug use reviews.

RECOMMENDATIONS

- **Recommendation 1:** Amend the Texas Government Code to direct the Texas Health and Human Services Commission to increase the number and type of retrospective drug use reviews performed each year as appropriate to allow the agency to (1) repeat reviews that have improved client outcomes and reduced Medicaid spending in previous years and address current drug therapy problems and (2) implement additional disease-specific reviews.
- **Recommendation 2:** Amend the Texas Government Code to direct the Texas Health and Human Services Commission to monitor Medicaid prescription drug use and expenditure patterns, including identifying the top therapeutic prescription drug classes and top prescription drugs based on total cost of paid claims and average cost per paid claim after any drug manufacturer rebates, and post this data on the agency's website on a quarterly basis.
- **Recommendation 3:** Amend the Texas Government Code to direct the Texas Health and Human Services Commission to include a detailed description of Medicaid drug utilization review program activities, including cost-savings estimates for both prospective and retrospective drug use reviews, in the federally required Medicaid Drug Utilization Review program annual report, and post the report on the agency's website.
- **Recommendation 4:** Amend the Texas Government Code to direct the Texas Health and Human Services Commission to amend the Medicaid Drug Utilization Review Board by-laws to include a conflict of interest provision to prevent board members from having contractual relationships or other conflicts of interest with pharmaceutical manufacturers.
- **Recommendation 5:** Include a rider in the 2010–11 General Appropriations Bill that directs the Texas Health and Human Services Commission to develop and submit to the Legislative Budget Board and the Governor by December 1 of each year of the biennium a report on strategies to strengthen the Texas Medicaid Drug Utilization Review program that were implemented after the effective date of the 2010–11 General Appropriations Act and any associated savings.

DISCUSSION

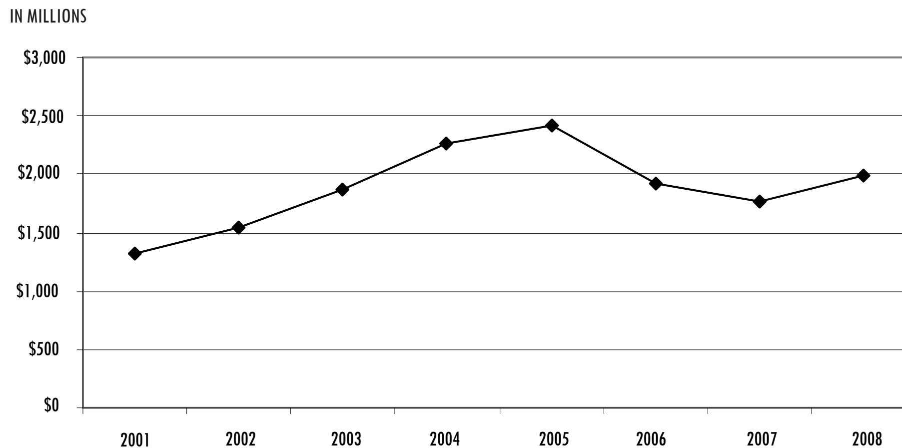
Medicaid, financed with both federal and state funds, is a healthcare program for low-income families, the elderly, and persons with disabilities. Individuals eligible for Temporary Assistance for Needy Families (TANF) or Supplemental Security Income (SSI) are automatically eligible for Medicaid. The Texas Health and Human Services Commission (HHSC), through the Texas Medicaid Vendor Drug Program (VDP), provides outpatient prescription drugs to Medicaid recipients, including clients enrolled in traditional fee-for-service Medicaid and managed care. Drugs administered in a doctor's office, inpatient hospital, outpatient hospital, or any location other than the client's home, nursing facility, or extended care facility are not covered by VDP, but are covered by other Medicaid programs.

Medicaid outpatient drug benefits vary by client group and service delivery setting. Specifically, children under age 21, nursing facility residents, adults eligible for a Medicaid 1915(c) long-term care waiver program, and adults enrolled in a capitated managed care organization or Integrated Care Management may receive unlimited outpatient prescription drugs. Medicaid adults who receive services through the non-capitated Primary Care Case Management model or on a fee-for-service basis are limited to three outpatient prescription drugs per month.

TRENDS IN MEDICAID VENDOR DRUG PROGRAM EXPENDITURES

As shown in **Figure 158**, in fiscal year 2007, Medicaid VDP expenditures totaled nearly $1.8 billion in All Funds, or 15 percent of total Medicaid spending. HHSC expects VDP spending to total nearly $2 billion in All Funds in fiscal year 2008. The average cost per Medicaid VDP prescription was $65.32 in fiscal year 2007 and is expected to be $72.14 in fiscal year 2008. Medicaid VDP spending increased from $1.3 billion in All Funds in fiscal year 2001 to $2.4 billion in All Funds in fiscal year 2005, an 83 percent increase. Due to implementation of the Medicare Part D program in January 2006, most clients who are dually eligible for Medicaid and Medicare now receive their prescription drugs through the Medicare program. As a result, Medicaid VDP spending decreased to $1.9 billion in All Funds in fiscal year 2006. However, states are required to make payments to the federal

FIGURE 158
TEXAS MEDICAID VENDOR DRUG EXPENDITURES, FISCAL YEARS 2001 TO 2008



NOTE: Expenditures for 2008 are estimated.
SOURCE: Legislative Budget Board.

government to help finance Medicare Part D drug coverage for dually eligible clients. The Texas payment to the federal government for prescription drug coverage for dually eligible clients is expected to total $298.4 million in All Funds in fiscal year 2008.

The Medicaid VDP expenditures shown in **Figure 158** are reduced by rebate payments received by drug manufacturers. The Medicaid VDP collects rebates through two programs: the federal Medicaid drug rebate program created by the federal Omnibus Budget Reconciliation Act of 1990 (OBRA 90) and the supplemental rebate program established in Chapter 531, Texas Government Code. The federal Medicaid drug rebate program requires drug manufacturers to enter into national rebate agreements for their drugs dispensed on an outpatient basis to be covered by Medicaid. Drug manufacturers who enter into supplemental rebate contracts with the Texas Medicaid program have their products considered for inclusion on the Medicaid Preferred Drug List (PDL). The PDL includes a list of preferred prescription medications that are safe, clinically effective, and cost-effective compared to other drugs in the same therapeutic class that Medicaid beneficiaries may receive without first obtaining prior authorization. In fiscal year 2007, the Health and Human Services Commission collected $637.1 million in All Funds in drug manufacturer Medicaid rebates—$517.3 million from the federal Medicaid drug rebate program and $119.8 million from the state supplemental rebate program. The Medicaid VDP shares the rebates collected with the federal government at the Federal Medical Assistance Percentage rate.

According to the Center for Medicare and Medicaid Services, growth in national Medicaid prescription drug spending is projected to be 7.4 percent in calendar year 2009. Annual growth is expected to average about 8.8 percent per year between calendar years 2010 and 2017. This rate is greater than the projected average annual growth in Medicaid hospital care (6.5 percent), Medicaid physician services (7.3 percent), and general Medicaid health care spending (8.0 percent). Three factors drive changes in prescription drug spending: (1) changes in the number of prescriptions dispensed (i.e., utilization), (2) changes in the types of drugs prescribed, and (3) changes in the prices of drugs.

HHSC has implemented initiatives in the Medicaid VDP to contain prescription drug spending. Three of those selected efforts are described below.

Medicaid Preferred Drug List (PDL) and Supplemental Rebate Program: Chapter 531 of the Texas Government Code directs HHSC to implement a PDL for the Medicaid program to control prescription drug spending. The PDL includes a list of preferred prescription medications that are safe, clinically effective, and cost-effective compared to other drugs in the same therapeutic class that Medicaid beneficiaries may receive without first obtaining prior authorization. Non-preferred prescription drugs require prior authorization. Drug manufacturers who enter into supplemental rebate contracts with the Texas Medicaid program have their products considered for inclusion on the PDL. As of March 2008, the Medicaid PDL includes 59 drug classes that represent about 68 percent of all Medicaid prescription drug

spending. Most of the remaining drug classes not included on the PDL include drug classes that are statutorily prevented from inclusion on the PDL (e.g., certain cancer drugs), and several small drug classes without multiple drug choices. PDL savings are generated from both supplemental rebates and from the shift in prescribing patterns toward less expensive preferred drugs. HHSC estimates that the PDL savings on a cash basis totaled $295.4 million in All Funds, or $115.9 million in General Revenue Funds, during fiscal year 2007. Of these savings, 40.6 percent is attributed to supplemental rebates and 59.4 percent is attributed to market shift.

Maximum Allowable Cost (MAC) Program: Although generic substitution is not required in the Medicaid VDP, the MAC program limits the use of brand name products when a generic equivalent is available. Specifically, the MAC program sets the reimbursement level for a drug at the median price of all generic products available. Pharmacies are reimbursed only the MAC amount for any prescription they dispense, brand or generic. As a result, pharmacies have a financial incentive to dispense the generic product. The pharmacy is only reimbursed the higher cost of the brand name product if the prescribing practitioner writes on the prescription drug order that use of a brand name product is necessary. The MAC payment level does not apply to all drugs. For example, in some cases the use of a brand name product is encouraged because it is less expensive than the generic equivalent due to the receipt of supplemental rebates.

Early Refill Claim Rejection: The VDP electronic claims processing system will reject a claim for a new or refill prescription drug order if less than 75 percent of the number of days' supply has elapsed on the previously filled prescription order for the same drug, strength, and dosage.

TEXAS MEDICAID DRUG UTILIZATION REVIEW PROGRAM

The Texas Medicaid Drug Utilization Review (DUR) program was established in October 1992 as required by OBRA 90. The purpose of the Texas Medicaid DUR program is to improve the quality of pharmaceutical care by ensuring that outpatient prescription drugs are appropriate, medically necessary, and not likely to result in adverse medical outcomes, such as illnesses caused by a drug interaction. Medicaid DUR programs also serve as a cost containment strategy in state Medicaid programs by reducing costs associated with adverse outcomes and encouraging the use of cost-effective drugs. Drug use reviews may apply to all Medicaid client groups. OBRA 90 requires that the Medicaid DUR program include two components: prospective and retrospective drug use reviews.

The Texas Medicaid DUR Board, which consists of five practicing physicians and five practicing pharmacists, is an advisory board that makes recommendations to HHSC regarding the DUR program. The HHSC Executive Commissioner appoints DUR Board members. HHSC contracts with the University of Texas College of Pharmacy (UTCP) and Affiliated Computer Services/Heritage Information Systems, Inc., (ACS Heritage) to carry out various components of the Medicaid DUR program. As shown in **Figure 159**, HHSC spent $2.3 million implementing the Medicaid DUR program in fiscal year 2007.

FIGURE 159
TEXAS MEDICAID DRUG UTILIZATION REVIEW PROGRAM: IMPLEMENTATION COSTS, FISCAL YEAR 2007

COMPONENT	EXPENDITURES
HHSC Staff	$181,428
Contract with University of Texas College of Pharmacy (UTCP)[1]	71,604
Contract with Affiliated Computer Services/Heritage Information Systems, Inc. (ACS Heritage)[2]	2,007,882
TOTAL	**$2,260,914**

[1]The contract with UTCP includes costs to develop, review, and update therapeutic criteria and standards for drug use.
[2]The contract with ACS Heritage includes costs to process prior authorization transactions associated with the Medicaid DUR program and the cost to implement retrospective reviews.
Source: Texas Health and Human Services Commission.

Federal regulations prescribe, at a minimum, the type of potential drug therapy problems that Medicaid DUR programs must screen or monitor. **Figure 160** lists potential drug therapy problems by type of drug use review.

Prospective Drug Use Reviews: Prospective drug use reviews occur at the point-of-sale and require pharmacists to review a patient's medication record and prescription drug order prior to dispensing all new and refill prescription medications. The purpose of prospective reviews is to identify potential drug therapy problems that could lead to adverse medical outcomes, such as drug interactions and incorrect drug dosages. The DUR Board, with assistance from UTCP, determines the therapeutic criteria and standards used in the prospective drug use reviews based on the compendia and peer-reviewed medical literature.

FIGURE 160
POTENTIAL DRUG THERAPY PROBLEMS CONSIDERED BY REVIEW TYPE

POTENTIAL DRUG THERAPY PROBLEM	DEFINITION	PROSPECTIVE DRUG REVIEW	RETROSPECTIVE DRUG REVIEW
	FEDERALLY REQUIRED		
Therapeutic Duplication	The use of two or more drugs from the same therapeutic class may result in an adverse medical outcome or additional program cost without additional therapeutic benefit.	X	X
Drug-Disease Contraindication	The potential for the dispensed drug to have an adverse effect on the patient's disease or the presence of the disease impacts the therapeutic effect of the drug.	X	X
Adverse Drug-Drug Interaction	The use of two or more drugs together may result in a clinically significant adverse medical outcome.	X	X
Incorrect Drug Dosage	The dosage lies outside the daily dosage specified in standards as necessary to achieve therapeutic benefit.	X	X
Incorrect Duration of Drug Treatment	The number of days of prescribed therapy differs from what is specified in standards.	X	X
Drug-Allergy Interactions	The use of a drug may result in an allergic reaction.	X	
Clinical Abuse/Misuse	The use of a drug that results in situations of abuse, gross overuse, overutilization, or underutilization.	X	X
Therapeutic Appropriateness	Drug prescribing and dispensing is in conformity with standards.		X
Overutilization and Underutilization	Use of a drug that is either greater than necessary or is insufficient to achieve desired therapeutic goal or may result in a clinically significant adverse medical outcome.		X
Appropriate Use of Generic Products	Use of generic products that conform to state guidelines.		X
	TEXAS SPECIFIC		
Monthly Dose Limitations	The dosage lies outside the monthly dosage specified in standards as necessary to achieve therapeutic benefit.	X	
Age or Sex Limitations	Specified drugs, such as prenatal vitamins, may have limits related to the patient's age or sex.	X	
Duration of Antifungal Products	Specified drugs are limited to 180 days of therapy each calendar year.	X	

Sources: U.S. Centers for Medicare and Medicaid Services; Texas Health and Human Services Commission.

Some drug therapy problems are screened by the VDP electronic claims processing system run by First Health Services Corporation while others are reviewed on site by the pharmacist. The VDP electronic claims processing system examines the client's prescription drug order and all of their paid Medicaid prescription drug claims across all pharmacies. Certain findings will cause the prescription drug claim to be rejected and may require the pharmacist to take additional steps before the claim can be processed. In other cases, the pharmacist may receive an educational message describing the alert. The pharmacist then exercises discretion in determining whether to take additional steps, such as consulting with the physician or counseling the client.

In November 2004, the Texas Medicaid DUR program implemented an additional type of prospective review, known as clinical edits, to target potential clinical, safety, or cost concerns among select drug classes. Whereas standard prospective drug use reviews examine only the patient's prescription drug history, clinical edits also review the patient's medical records by accessing paid claims data to determine whether the patient's status and medical condition match the established criteria for dispensing the requested

prescription drug. Clinical edits, which may exist for both preferred and non-preferred drugs on the Medicaid PDL, are administered through an automated point-of-sale prior authorization system known as SmartPA. If the criteria for the clinical edit are not met, the pharmacy will receive a message indicating that the prescriber needs to request prior authorization by calling the Texas Prior Authorization Call Center. Currently, there are clinical edits for 27 different drugs or drug classes.

HHSC contracts with ACS Heritage to provide SmartPA and call center services. HHSC pays ACS Heritage a fixed fee payment for each prior authorization transaction. Specifically, a prior authorization transaction may result from a request to use a non-preferred prescription drug on the Medicaid PDL, or to use a prescription drug screened with a clinical edit. In fiscal year 2007, there were 914,807 prior authorization transactions. Of these, 63.1 percent were for requests to use a non-preferred prescription drug on the Medicaid PDL, and 36.9 percent were for requests to use a prescription drug screened with a clinical edit.

Although not explicitly included in the contract, ACS Heritage also develops the clinical edits which are then reviewed and approved by the DUR Board and HHSC. HHSC also has an interagency contract with the UTCP to develop, review, and update therapeutic criteria and standards for drug use. UTCP may also review the clinical edits developed by ACS Heritage.

Retrospective Drug Use Reviews: In contrast to prospective drug use reviews that are conducted at the point-of-sale, retrospective drug use reviews occur after the prescription has been filled. Retrospective drug use reviews examine prescription drug claims data to identify patterns of fraud, abuse, gross overuse, or inappropriate or medically unnecessary prescribing. The examination may include an analysis of physician prescribing, prescription drug use by individual Medicaid clients, and pharmacy dispensing practices. The review involves comparison of prescription drug claims data to predetermined standards of drug use. OBRA 90 also requires states to conduct ongoing educational outreach programs targeted at practitioners identified in the claims data review to improve prescribing and dispensing practices. OBRA 90 requires that the educational outreach program provide practitioners with patient-specific or drug-specific information and suggested changes in prescribing or dispensing practices as well as face-to-face discussions between healthcare professionals who are experts in appropriate drug therapy and selected practitioners.

The DUR Board, with assistance from UTCP, determines the therapeutic criteria and standards used in the retrospective drug use reviews. HHSC then contracts with ACS Heritage to develop and conduct a minimum of six retrospective drug use reviews each fiscal year. **Figure 161** lists the 32 retrospective drug use reviews conducted during fiscal years 2004 through 2008. From fiscal years 2004 through 2007, there were 26 retrospective drug use reviews conducted with a total of 71,998 letters sent to physicians describing drug therapy issues, resulting in an estimated savings of $50.8 million in General Revenue Funds. Estimated savings for fiscal year 2008 was not available at the time of publication. ACS Heritage meets face-to-face with a subset of the physicians who receive intervention letters.

HHSC pays ACS Heritage a fixed rate for each retrospective drug use review conducted. In fiscal year 2008, HHSC paid ACS Heritage $67,469 in All Funds per review. However, per contract requirements, HHSC is guaranteed an All Funds cost savings equal to twice the amount paid to ACS Heritage, or $134,938 in All Funds per review. If the prescription drug claims data does not demonstrate this level of cost savings, ACS Heritage is required to reimburse HHSC the difference. ACS Heritage is required to follow a prescribed methodology for calculating cost savings attributed to the retrospective drug use reviews.

POTENTIAL BENEFITS OF DRUG UTILIZATION REVIEW PROGRAMS

DUR programs are expected to reduce Medicaid spending on prescription drugs by promoting the use of cost-effective medications. Some experts also believe that even greater spending reductions will occur for non-drug services (e.g., hospital services) through reductions in adverse health outcomes. Currently, there is limited national data available to demonstrate the effectiveness of prospective drug use reviews in the Medicaid program. However, some studies have shown that Medicaid retrospective drug use reviews are effective at modifying prescribing practices and reducing prescription drug expenditures. **Figure 162** summarizes these studies.

STRENGTHEN THE TEXAS MEDICAID DRUG UTILIZATION REVIEW PROGRAM

There are four steps HHSC should take to strengthen the Texas Medicaid DUR program to promote safety and contain spending: (1) implement additional retrospective drug use reviews; (2) monitor and publish prescription drug data; (3) improve the evaluation of DUR program activities; and

FIGURE 161
TEXAS MEDICAID RETROSPECTIVE DRUG USE REVIEWS, FISCAL YEARS 2004–2008

REVIEW TITLE	FISCAL YEAR IMPLEMENTED	ESTIMATED 12-MONTH GENERAL REVENUE SAVINGS
Atypical Antipsychotics	2004	$1,039,915
	2005	7,600,530
	2006	1,976,111
	2007	9,105,471
Antibiotic Prescribing	2004	702,552
	2006	247,957
	2007	1,720,624
Polypharmacy	2005	1,324,528
	2006	10,100,090
	2008	NA
Dose Consolidation	2004	3,001,502
	2007	1,249,037
Brand to Generic	2005	568,123
	2007	1,031,258
Gastrointestinal Drug Use Evaluation	2006	401,106
	2008	NA
Non-Steroidal Anti-Inflammatory Drug Use Evaluation	2006	735,264
	2008	NA
Attention Deficit Hyperactivity Disorder/Attention Deficit Disorder	2006	2,859,192
	2008	NA
Drugs of Abuse	2004	186,443
Falls in the Elderly	2004	982,507
Pediatric Antidepressants	2004	209,843
Improving Pharmacotherapy in the Elderly	2005	917,766
Anticonvulsants	2006	462,847
Hormone Replacement Therapy	2006	112,562
Migraine Medications	2006	163,238
Psychotropic Medication Utilization in Foster Children	2006	3,820,169
Allergic Rhinitis	2007	145,462
Tablet Splitting	2007	142,212
Advair/Symbicort Dual Action LABA/Steroid Combination Inhalers	2008	NA
Diabetes	2008	NA
TOTAL GENERAL REVENUE FUND SAVINGS 2004–08		**$50,806,309**[1]

[1]Estimated savings for fiscal year 2008 was not available at the time of publication.
Source: Texas Health and Human Services Commission.

(4) address conflict-of-interest provisions for the DUR Board.

HHSC arbitrarily limits the number of retrospective drug use reviews to an average of six per year. As a result, Texas is not maximizing its opportunity to implement retrospective drug use reviews that could prevent adverse health outcomes and contain Medicaid expenditures. For example, HHSC may not repeat successful reviews that address continuing

FIGURE 162
STUDIES ON THE EFFECTIVENESS OF RETROSPECTIVE DRUG USE REVIEWS, 1995–2000

RESEARCH ENTITY	DATE	FINDINGS
Louisiana State University Virginia Military Institute University of South Florida	2000	The study used an experimental and control group design to estimate the effect of retrospective drug use reviews on Medicaid prescription drug and non-drug spending. For the programs evaluated, letters were sent to physicians notifying them of potential drug therapy problems along with a brief medical record on the patient. These are findings from the study: • Retrospective drug use reviews produce cost savings in the Medicaid prescription drug budget. Specifically, total drug expenditures were 6.5 percent lower in states operating these reviews compared to states without these programs. • Retrospective drug use reviews do not result in higher or lower spending on other non-drug Medicaid services (e.g., inpatient hospital services).
Abt Associates, Inc., funded by the U.S. Center for Medicare and Medicaid Services	1998	The study used an experimental and comparison group design to estimate the effectiveness of retrospective drug use reviews on modifying prescribing practices. Three Medicaid retrospective drug use reviews implemented in Iowa and Maryland were used in the study. • All three retrospective drug use reviews achieved the expected effects—either a reduction or an increase in the use of a specified drug for patients identified in the intervention letters. • The improved rates of prescribing did not extend to patients of the targeted physicians who were not identified in the intervention letters.
University of Texas College of Pharmacy	1995	The study used an experimental and control group design to estimate the impact of a retrospective drug use review that included as a component sending letters to physicians participating in the Texas Medicaid program. The evaluation found that the retrospective drug use review resulted in a reduction in inappropriate prescribing.

Source: Legislative Budget Board.

drug therapy problems. A 1998 research study conducted by Abt Associates and funded by the Centers for Medicare and Medicaid Services concluded that retrospective letter interventions do not promote lasting, broad changes in prescribing practices; therefore, repeat reviews that include letter intervention to targeted physicians are needed.

In addition to the types of retrospective drug reviews already conducted in Texas, there are retrospective drug use reviews focused on disease-specific drug classes that are conducted in other states that could potentially benefit Texas. For example, two reviews conducted by the Louisiana Drug Utilization Review Program address potential overutilization of medications prescribed for sleep disorders (i.e., sedative hypnotic agents) and pain disorders (i.e., narcotic analgesics). Louisiana found that average per client expenditures for the medications targeted by these reviews were reduced by 17 percent for the sedative hypnotic drugs and 3 percent for the narcotic analgesics drugs after implementing the retrospective drug use reviews.

Recommendation 1 would amend the Texas Government Code to direct HHSC to increase the number and type of retrospective drug use reviews performed each year as appropriate to allow the agency to (1) repeat reviews that have improved client outcomes and reduced Medicaid spending in previous years and address current drug therapy problems and (2) implement additional disease-specific reviews. HHSC or its contractor should regularly examine Medicaid prescription drug claims data to identify the occurrence of potential drug therapy problems that could be addressed by repeating successful retrospective drug use reviews previously implemented in Texas and other states. The analysis of the claims data may identify potential drug therapy problems associated with prescriptions written by both new physicians and physicians who previously received letters.

HHSC does not regularly publish Medicaid prescription drug utilization and expenditure data. This information could help the agency, the Texas Legislature, and the Medicaid Drug Utilization Review Board monitor spending trends and improve efforts to contain prescription drug spending. Other states publish reports on Medicaid prescription drug use and spending. For example, since 2003, the Florida Agency for Health Care Administration has posted quarterly Medicaid drug utilization reports on its website. These reports include, among other elements, the number of claims and the amount paid for each Medicaid-covered drug.

Recommendation 2 would amend the Texas Government Code to direct HHSC to monitor Medicaid prescription

drug use and expenditure patterns, including identifying the top therapeutic prescription drug classes and top prescription drugs based on total cost of paid claims and average cost per paid claim after any drug manufacturer rebates, and post this data on the agency's website on a quarterly basis.

Federal law requires each state's DUR Board to submit an annual DUR report to the state Medicaid agency. The Medicaid agency must then submit an annual report to the federal government that incorporates the DUR Board's report and other federally required information. The report must include, but is not limited to, a description of the nature and scope of the prospective and retrospective drug use reviews, a summary of educational interventions used, an assessment of the effect of educational interventions on the quality of care, and an estimate of cost savings attributed to both prospective and retrospective drug use reviews.

Whereas the Texas Medicaid DUR program annual report submitted to the federal government includes an estimate of cost savings resulting from retrospective drug use reviews, the report does not include cost-savings estimates for prospective drug use reviews. As a result, HHSC, the Texas Legislature, and the Medicaid DUR Board lack information needed to evaluate program effectiveness and consider program improvements. The annual DUR reports submitted by other states, such as Louisiana and Arkansas, provide a detailed description of the types of prospective and retrospective drug use reviews implemented, including estimates of savings attributed to both prospective and retrospective drug use reviews.

Recommendation 3 would amend the Texas Government Code to direct HHSC to include a detailed description of Medicaid DUR program activities, including cost-savings estimates for both prospective and retrospective drug use reviews, in the federally required Medicaid DUR program annual report, and to post the report on the agency's website. Although HHSC may not be able to determine cost savings attributed to prospective reviews conducted on site by individual pharmacies, the agency should calculate cost savings attributed to prospective reviews performed through the VDP's electronic claims processing system and the SmartPA prior authorization system operated by ACS Heritage.

The by-laws for the Texas Medicaid DUR Board do not include a conflict of interest provision to prevent board members from having contractual relationships or other conflicts of interest with pharmaceutical manufacturers that could call into question their impartiality when recommending to HHSC that drugs or drug classes be subject to drug use reviews. In contrast, the Texas Medicaid Pharmaceutical and Therapeutics Committee, which makes recommendations to HHSC on PDL development and maintenance, is prohibited by state statute and committee by-laws from engaging in activities with pharmaceutical manufacturers that would call into question their impartiality when recommending prescription drugs to be included or excluded from the PDL. **Figure 163** cites the conflict of interest provision contained in the Texas Medicaid Pharmaceutical and Therapeutics Committee by-laws.

FIGURE 163
CONFLICT OF INTEREST PROVISION, TEXAS MEDICAID PHARMACEUTICAL AND THERAPEUTICS COMMITTEE BY-LAWS

Members must not have contractual relationships, ownership interest, or other conflicts of interest with a pharmaceutical manufacturer or labeler or with an entity engaged by the Commission to assist in the development of the PDL or the administration of the prior authorization system. They shall not entertain individual lobbying or marketing, or partake in any other activity/discussions with pharmaceutical manufacturers or their representatives that would call into question their impartiality in recommending drugs to be included or excluded from the PDL.

Source: Texas Health and Human Services Commission.

Similar to the Texas Medicaid Pharmaceutical and Therapeutics Committee, the Texas Medicaid DUR Board makes recommendations to HHSC on matters related to the use of prescription drugs in the Medicaid program. In the case of the Medicaid DUR Board, members make recommendations to HHSC on whether or not to implement prospective and retrospective drug use reviews that could lead to changes in the use of certain prescription drugs. Recommendation 4 would amend the Texas Government Code to direct HHSC to amend the Medicaid DUR Board by-laws to include a conflict of interest provision to prevent board members from having contractual relationships or other conflicts of interest with pharmaceutical manufacturers.

Recommendation 5 would include a rider in the 2010–11 General Appropriations Bill that directs HHSC to develop and submit to the Legislative Budget Board and the Governor by December 1 of each year of the biennium a report on strategies to strengthen the Texas Medicaid DUR program that were implemented after the effective date of the 2010–11 General Appropriations Act and any associated savings.

FISCAL IMPACT OF THE RECOMMENDATIONS

Recommendations 1, 2, 3, and 4 would amend the Texas Government Code to direct HHSC to implement strategies to strengthen the Texas Medicaid DUR program. Recommendation 5 directs HHSC to develop and submit a report on strategies implemented to strengthen the Texas Medicaid DUR program to the LBB and the Governor. The recommendations are intended to improve the quality of pharmaceutical care and contain Medicaid prescription drug spending. For example, increasing the number and type of retrospective drug use reviews performed each year may result in additional cost savings in the Medicaid VDP. Efforts to strengthen the Texas Medicaid DUR program may also reduce general Medicaid spending through reductions in adverse health outcomes.

These recommendations would have no significant cost because they could be implemented using existing resources. The cost to implement additional retrospective drug use reviews would be offset by savings realized up to one year after the review is completed.

The introduced 2010–11 General Appropriations Bill includes a rider that directs HHSC to develop and submit a report on strategies implemented by the agency to strengthen the Texas Medicaid DUR program to the LBB and the Governor by December 1 of each year of the biennium. The introduced bill does not include any other adjustments as a result of these recommendations.

IMPROVE PROCESSING OF SPECIAL IMMIGRANT JUVENILE STATUS FOR FOSTER CARE YOUTH TO MAXIMIZE FEDERAL FUNDS

Children in Texas may receive child protection and related services from the Texas Department of Family and Protective Services without regard to their immigration status. Federal law requires that foster care services provided to these children be financed with non-federal sources. In fiscal year 2008, about 1 percent of the 28,094 children in the Texas foster care system were undocumented immigrants. These children may be eligible for Special Juvenile Immigrant Status, which can lead to legal permanent status. Matching Federal Funds then become available to cover a portion of their medical and foster care costs. Although the Texas Department of Family and Protective Services has policies and procedures to identify children in the foster care system who are undocumented, and to submit Special Immigrant Juvenile Status petitions, improvements to the current process are needed to maximize Title IV-E Foster Care and Medicaid federal funding.

From fiscal years 2007 to 2008, the Texas Department of Family and Protective Services filed at least 68 Special Immigrant Juvenile Status petitions on behalf of foreign-born children who are in long-term foster care. The state could realize additional Federal Funds by decreasing the time preparing and submitting petitions and legal permanent status applications using specialized staff. By providing the Texas Department of Family and Protective Services with staff to support the Special Juvenile Immigrant Status and other immigration-related processes, the state could net an estimated revenue gain of $1.3 million in Federal Funds during the 2010–11 biennium.

CONCERNS

- The preparation of Special Immigrant Juvenile Status petitions and legal permanent status applications may take as long as 12 months for some children in Texas Department of Family and Protective Services' long-term foster care due to inadequate staffing and procurement procedures that impede the completion of these applications. As a result, matching Title IV-E and Medicaid Federal Funds are not accessed expeditiously to save General Revenue Funds.
- The Texas Department of Family and Protective Services does not systematically track the legal status of children whose petitions and applications are approved, instead relying on conservatorship caseworkers to update the immigration status of these children and inform eligibility workers, which delays the access of federal matching Title IV-E funding.
- While the Texas Department of Family and Protective Services saves state General Revenue Funds by submitting requests to the U.S. Citizenship and Immigration Services to waive filing fees of legal permanent status applications, this additional step delays the ability to match Title IV-E federal funding for eligible undocumented children in long-term foster care by several months.
- Since 2003, 160 children in the Undetermined Immigration Status category have been emancipated from state foster care. A number of these children could have achieved Special Immigrant Juvenile Status if the county court's or district court's jurisdiction was extended past the age of 18, until the Special Immigrant Juvenile Status petition and legal permanent status application were approved by the U.S. Citizenship and Immigration Services.

RECOMMENDATIONS

- **Recommendation 1:** Direct the Texas Department of Family and Protective Services to ensure all cases categorized as Undetermined Immigration Status are assigned to caseworkers who have experience with preparing Special Immigrant Juvenile Status petitions and legal permanent status applications.
- **Recommendation 2:** Direct the Texas Department of Family and Protective Services to work with the Health and Human Services Commission to require health maintenance organizations that provide care to children in foster care to contract with physicians approved by U.S. Citizenship and Immigration Services. The contracts should ensure access is provided to medical exams as needed to complete applications for legal permanent status filed on behalf of undocumented children in long-term foster care.
- **Recommendation 3:** Direct the Texas Department of Family and Protective Services to stop seeking fee waivers for filing fees associated with completing and filing legal permanent status applications.

- **Recommendation 4:** Decrease appropriations from General Revenue Funds to the Texas Department of Family and Protective Services for Strategy B.1.11, Foster Care Payments, by $282,179 in fiscal year 2010 and $279,965 in fiscal year 2011 and increase appropriations from Federal Funds to the agency for this strategy by $282,179 in fiscal year 2010 and $279,965 in fiscal year 2011. In addition, increase the number of full-time-equivalent positions by three to support the Special Immigrant Juvenile Status and other immigration-related processes at a General Revenue cost of $149,759 in fiscal year 2010 and $135,624 in fiscal year 2011 and a Federal Funds gain of $27,115 in fiscal year 2010 and $24,555 in fiscal year 2011 to Strategy B.1.1, CPS Direct Delivery Staff.
- **Recommendation 5:** Decrease appropriations from General Revenue Funds to the Health and Human Services Commission for Strategy B.1.2, TANF and Adults and Children, by $371,552 in fiscal year 2010 and $367,528 in fiscal year 2011 and increase appropriations from Federal Funds for this strategy by $371,552 in fiscal year 2010 and $367,528 in fiscal year 2011.
- **Recommendation 6:** Amend the Texas Family Code to extend the jurisdiction that county courts and district courts have over youth in foster care from age 18 to age 21, if Special Immigrant Juvenile Status petitions and legal permanent status applications have been filed.

DISCUSSION

Under federal law, any abused or neglected child is eligible for short-term emergency medical care, shelter, or other services (including placement in foster care services within the child welfare system) necessary to address an emergency regardless of immigration status. In Texas, children may receive child protection services and related benefits without regard to their immigration status.

The federal government provides Foster Care (Title IV-E) federal funding to assist states in providing safe, appropriate 24-hour substitute care for children who are under the jurisdiction of the administering state agency and need placement and care outside their homes. Title IV-E funds do not subsidize all children in foster care; rather eligibility is determined by a set of criteria, including immigration status and income eligibility. Foster care services provided to children who are undocumented must be financed with non-federal sources. According to the Texas Department of Family and Protective Services (DFPS), the state must meet specific standards and requirements to qualify for federal funding, including providing child welfare services statewide. DFPS reports that excluding a subset of the child population from protective services would not meet the federal requirement that Texas have a statewide system for child protection.

The Child Protective Services (CPS) Program at DFPS investigates reports of suspected abuse or neglect of children and takes action to protect abused and neglected children from further harm. Appropriations for child protective services for the 2008–09 biennium total $2.1 billion in All Funds. The appropriation includes $885.4 million in General Revenue Funds (42.6 percent). CPS relies heavily on Federal Funds from the Temporary Assistance for Needy Families (TANF) block grant program and the Title IV-E Foster Care and Adoption Assistance Programs, which together provide 49.3 percent of the appropriation.

FOREIGN-BORN CHILDREN IN THE TEXAS CHILD WELFARE SYSTEM

The Urban Institute reviewed the cases of about 30,000 children in Texas who had been removed from their home due to abuse or neglect and placed in out-of-home care as of March 2006. According to the authors of *Title IV-E Funding: Funded Foster Care Placements by Child Generation and Ethnicity, Findings from Texas*, the research completed from the Urban Institute review focused solely on Latino children, because the vast majority of immigrants in Texas are Latino. The groups of Latino children studied were (1) foreign-born, (2) U.S.-born children from immigrant parents, and (3) children born of U.S.-born parents.

The Urban Institute's review made the following findings regarding the demographics of foreign-born children in Texas placed in foster out-of-home care settings:

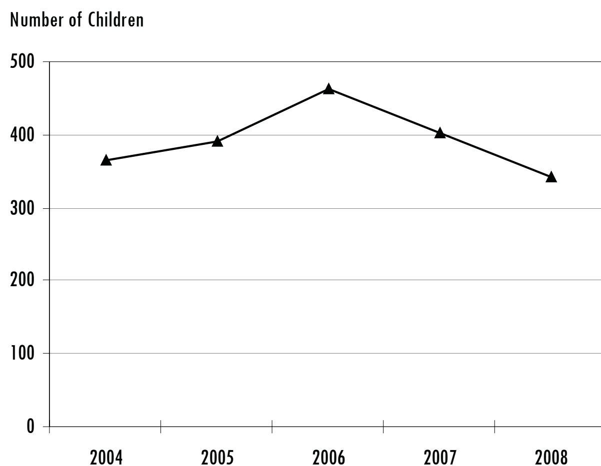
- In 2006, 1 percent of children in out-of-home care were foreign-born, compared with 7 percent in the state's general population.
- Only 5 percent of foreign-born children met eligibility requirements for Title IV-E funding.
- Foreign-born children in the Texas out-of-home care population were much older than other children. About three-quarters of the foreign-born children in care were adolescents (ages 11 to 18), compared with just one-third of U.S.-born children of immigrants.

- Fifty-nine percent of foreign-born children in the Texas out-of-home care population were female.

The review of placement settings and permanency planning in the child welfare case histories also determined differences between the groups of children. Children of immigrants in Texas were much less likely than children with U.S.-born parents to be placed with relatives, and their case goals were less likely to be associated with relatives. Only 8 percent of foreign-born children in care were living with relatives, compared with 20 percent of U.S.-born children of immigrants and 28 percent of children with U.S.-born parents. In addition, the report determined that foreign-born children were also significantly less likely to have a case goal of family reunification or relative adoption than other children. However, U.S.-born children with immigrant parents were just as likely to have these case goals as other children. The report concluded that foreign-born children are significantly more likely than other children to have a case goal of independent living.

In Texas, DFPS uses the Information Management Protecting Adults and Children in Texas (IMPACT) system as a case tracking and reporting system. Caseworkers are required to enter select identifying information, including a child's demographic information, which includes mandatory fields such as citizenship status. For fiscal years 2004–06, the agency's data shows an increasing number of children as having an Undetermined Immigration Status (see **Figure 164**). However, in fiscal year 2007 there was a decrease of 61 children with this status designation.

FIGURE 164
CHILDREN WITH UNDETERMINED IMMIGRATION STATUS IN DEPARTMENT OF FAMILY AND PROTECTIVE SERVICES CARE, FISCAL YEARS 2004 TO 2008



SOURCE: Texas Department of Family and Protective Services.

SPECIAL IMMIGRANT JUVENILE STATUS

The Federal Immigration Act of 1990 authorized a form of protection for children who are undocumented and who have been abused or neglected in the U.S. or abroad. These children can petition for Special Immigrant Juvenile Status (SIJS) which, if granted, prevents their deportation, provides immediate employment authorization, and begins the process for them to become U.S. citizens. Federal statute and regulations set out the eligibility requirements for SIJS. A child must meet the following criteria to be granted SIJS:

- be under the age of 21;
- be unmarried;
- be present in the U.S.;
- be declared dependent on a juvenile court located in the U.S. or placed under the custody of an agency or department of a state;
- be deemed eligible by the juvenile court for long-term foster care due to abuse, neglect, or abandonment; and
- be deemed by the juvenile court or administrative agency that it is not in their best interest to return to the home country.

A child who is in the custody of the U.S. Department of Homeland Security (DHS) must meet two other conditions to be granted SIJS. The Secretary of DHS must specifically consent to the jurisdiction of the juvenile court to determine the custody status or placement of a child. For children not in federal custody (the focus of this paper), express consent is automatically granted with the submission of an SIJS petition.

There are several conditions throughout the process a child must continue to meet to remain eligible for SIJS. The child must complete the entire process, including adjusting to legal permanent resident status before his or her 21st birthday. If the child does not adjust before his or her 21st birthday, the child will face the possibility of deportation. The child must remain dependent upon the juvenile court and eligible for long-term foster care until adjustment to permanent resident status is granted. In a situation where the court decides that the child is no longer dependent on the court or eligible for foster care (whether or not he or she is in foster care), the child will no longer be eligible for SIJS. The child cannot get married before adjustment of status is completed. Finally, the child must not get arrested, use illegal drugs, or leave the country.

BENEFITS OF SPECIAL IMMIGRANT JUVENILE STATUS

After petitioning for SIJS, the child is protected from deportation while the petition remains pending. Once SIJS is granted, eligible undocumented children in foster care may obtain a legal permanent resident card. These children are allowed to remain in the U.S. without the threat of deportation. Having a permanent resident card can enable children age 14 and older to work legally. Legal permanent residents are also eligible for some benefits provided by federal, state, and local governments. Additionally, legal permanent residents can apply for U.S. citizenship after five years. Children who have been in foster care or other residential care under the conservatorship of the DFPS are entitled to have their tuition and fees waived at any state-supported university, colleges, or vocational schools. However, other additional costs such as books, transportation, dormitory, lodging, or food expenses must be financed by the student. A student with legal permanent status may access federal financial assistance to pay for some of these expenses.

The State of Texas may be eligible for federal funds to support foster care for children who are legal permanent residents, but cannot claim federal reimbursement for them while they are undocumented. Foster care services for undocumented children must be paid with state and local funds. The federal government provides matching Title IV-E Foster Care Federal Funds to assist states in providing safe, appropriate, 24-hour substitute care for children who are under the jurisdiction of the administering state agency and need temporary placement and care outside their homes. Title IV-E funds may be used for payments on behalf of eligible children to individuals providing foster family homes, to child-care institutions, or to public or nonprofit child-placement agencies. Payments may include the cost of food, clothing, shelter, daily supervision, school supplies, personal incidentals, liability insurance (with respect to a child), and reasonable travel to the child's home for visitation. The federal-state match ratio for Title IV-E funds is the same as the Federal Medical Assistance Percentage (FMAP), which is 60.56 percent federal share in fiscal year 2008. The funding also provides for select administrative and training services, with a federal-state match ratio of 50:50 and 75:25, respectively. DFPS reported expenditures of $3.4 million in General Revenue Funds for foster care services provided to undocumented children in fiscal year 2008.

Texas also received an estimated $8 million in Federal Funds in fiscal year 2008 under the Chafee Foster Care Independence Program. These funds assist states in establishing and carrying out programs that help foster youth likely to remain in foster care until 18 years of age and youth who have left foster care to make the transition from foster care to self-sufficiency. DFPS supports Texas' Preparation for Adult Living Services (PAL) with Chafee Foster Care program funds. Youth who participate in PAL services may be eligible to receive financial assistance (Transitional Living Allowance and Aftercare Room and Board) to assist them with living expenses once they age out of the foster care system. Children must be U.S. citizens, permanent legal residents, or other qualified alien status to be eligible for PAL Transitional Living Allowance and the Aftercare Room and Board services.

DFPS must ensure that children in its conservatorship receive medical care. Medical care is defined in state statute as physical, dental, behavioral, vision, and allied healthcare services such as physical therapy, occupational therapy, speech therapy, dietetic, and other health-related services. Undocumented children who are in foster care are provided healthcare coverage paid with General Revenue Funds ($3 million in fiscal year 2008). Not only do children granted SIJS benefit from the status, but the State of Texas can also benefit by accessing federal Medicaid funding for those children. The Medicaid program provides basic healthcare for low-income citizens and people with chronic or long-term care needs, federally reimbursed at the FMAP rate.

ESTABLISHING SPECIAL IMMIGRANT JUVENILE STATUS

In most cases, three U.S. Citizenship and Immigration Services (CIS) applications must be filed for SIJS applicants (Form I-360, Petition for Special Immigrant; Form I-485, Application to Adjust Status; and Form I-765, Application for Employment Authorization). Although any person may complete the filings for an undocumented child seeking SIJS, the complexity of the documentation needed to support the applications requires an attorney or advocate with experience in immigration proceedings.

The I-360 Petition for Special Immigrant grants the child approval for a visa and must be determined before the child reaches the age of 21 and while the child is still dependent upon the juvenile court (in Texas, a child may remain dependent anywhere from age 18 to 21). The petition must include proof of the child's age and a copy of a juvenile court order finding that the following circumstances exist:

- The child is dependent on the state due to abuse, abandonment, or neglect.
- The child is eligible for long-term foster care.

- It is not in the child's best interests to return to their country of origin.

Once a SIJS petition is approved, the child is automatically eligible for legal permanent status. SIJS-eligible children must adjust their visa to legal permanent status while still dependent upon the juvenile court, or they will become ineligible for legal status. Both the I-360 and the I-485 forms must be adjudicated before the child turns 21 and while the child is still under the jurisdiction of the juvenile court, which in Texas may end before age 21.

Most filings for children who are not in removal proceedings submit the I-360 and the I-485 forms simultaneously. For children not in removal proceedings, CIS has jurisdiction over adjudication of the I-485 form. The I-765 Application for Employment Authorization Document (EAD) can be submitted along with the I-485 application. Once the I-485 request is granted, the work permit is no longer necessary, nor valid.

There are several filing fee costs and expenses associated with the application for SIJS. There are no filing fees for the I-360 form for SIJS applicants. The total cost for filing the I-485 application for a child under the age of 14 is $930, and $1,010 for all others. See **Figure 165** for a list of the additional costs and expenses for supporting documentation submitted with the I-485 form. Once an I-485 form is submitted, the I-765 filing fee of $340 is waived.

Federal law allows CIS to waive the filing fees of select applications based on an applicant's inability to pay. However, there is no standard waiver request form for applicants. The CIS has provided guidance to local CIS offices on what criteria are used to determine an applicant's inability to pay filing fees. Before the I-485 application can be reviewed, the fee waiver request must be approved by CIS. According to the Children's Services Department of the U.S. Conference of Catholic Bishops, waiver requests have been approved for SIJS applicants. However, the organization cautions that, depending on the local CIS office practice, waiver requests might delay the I-485 application approval process.

FIGURE 165
SPECIAL IMMIGRANT JUVENILE STATUS APPLICATION ADDITIONAL EXPENSES, FISCAL YEAR 2008

Native country passport
Medical exam
Original certified copy of juvenile court order
2 birth certificates or other evidence of his or her record of birth
2 certified English translations of birth certificate
4 passport-style photos
Certificates of disposition (if the child was ever arrested)
Transportation to and from attorney's offices, court dates, USCIS appointments

Source: Children's Services department of the U.S. Conference of Catholic Bishops/Migration and Refugee Services.

Although DHS I-360 application instructions direct that all I-360 petitions be mailed to a CIS secure post office box in Chicago, Illinois, some local CIS offices have their own procedures. For example, in Houston petitions may be filed at the local CIS office for children in removal proceedings, but all others are mailed to the Chicago address.

The local CIS office provides a notice of receipt and schedules an appointment to initiate an FBI background check with fingerprinting if an applicant satisfies the eligibility requirements for SIJS. The local CIS office staff then schedule an interview with the applicant to review the documentation and forms submitted. According to the Catholic Legal Immigration Network, the wait for the interview can vary from six months to three years depending on the local CIS office backlog or complexity of the case. The CIS staff may recommend approval of the case, request more information, or deny the case. Once the case is approved, the applicant receives a passport stamp that indicates temporary legal permanent status until they receive their permanent card. There is an appeal process in case of denial.

Federal law waives some requirements for SIJS applicants that other legal permanent status applicants must meet, such as the provision of proof that the applicant will not become a public charge. However, an SIJS applicant can be denied legal permanent status if he or she comes within grounds of inadmissibility (conduct-based actions). The SIJS applicant may request a discretionary waiver. Grounds of inadmissibility can be waived for certain immigrant juveniles:

- juveniles who have been involved in prostitution;
- juveniles who were convicted once as adults for possession of 30 grams or less of marijuana;
- juveniles who are HIV positive;
- juveniles who were deported and did not remain outside the U.S. for five years before returning;
- juveniles who committed fraud to enter the U.S. or to get a visa;

- juveniles who are alcoholics or have a mental or physical disorder that poses a risk to people or property;
- juveniles who are, or have been, drug addicts or drug abusers; and
- juveniles who helped other undocumented immigrants to enter the U.S. illegally.

There is a possibility that a waiver will not be granted. As a result, the SIJS application carries additional risk for children who fall under one of the above grounds of inadmissability. There are some nonwaivable grounds of inadmissability. A child who falls within one of these grounds and submits an SIJS application may be subject to deportation proceedings. There are two nonwaivable grounds of inadmissibility:

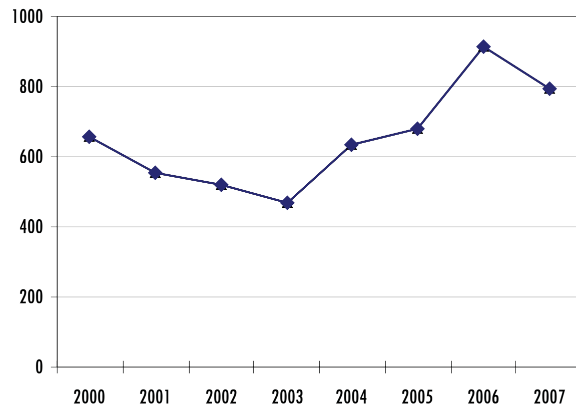
- if a person is convicted as an adult of a wide range of offenses or has made a formal admission of any drug offense; or
- if a person is considered by CIS to have been a drug trafficker.

The greatest risk to a child applying for SIJS is that if the petition is denied, DHS' Immigration and Customs Enforcement (ICE) might attempt to remove or deport the child from the U.S. When a child files for SIJS, immigration officials become aware of the fact that the child is present in the U.S. illegally. If the SIJS petition and adjustment of permanent status application are denied, CIS might transfer the file to ICE, which could use that information to place the child into removal proceedings for deportation.

Across the country a relatively small number of undocumented minors are granted legal permanent status pursuant to the SIJS statute. According to the *Yearbook of Immigration Statistics* published by DHS, nearly 1.1 million immigrants were admitted for legal permanent residence in the U.S. in 2007. While approximately 26 percent of those admitted were under the age of 21, only 796 minors, or less than three-tenths of 1 percent of the total, were admitted as legal permanent residents pursuant to the SIJS statute. **Figure 166** shows that the total number of minors admitted pursuant to the SIJS statute has remained relatively static for the five-year period preceding 2005; there was a slight increase in 2006.

Despite the fact that SIJS is an option, currently there is no data available on how well this option has been implemented by states. Information gathered from the Los Angeles County Special Immigrant Status Unit indicates that Los Angeles County is responsible for a significant number of the legal

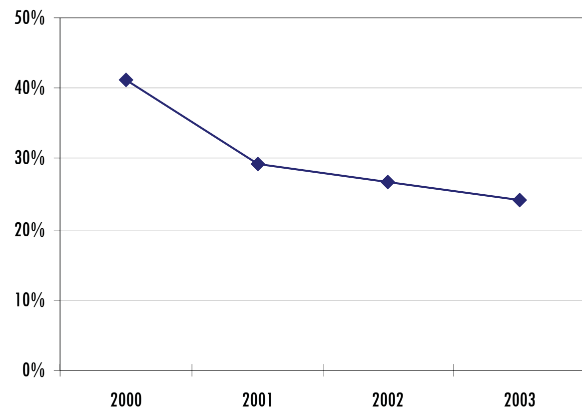
FIGURE 166
NUMBER OF ADJUSTMENTS TO PERMANENT LEGAL STATUS TO UNDOCUMENTED MINORS, FISCAL YEARS 2000 TO 2007



SOURCES: Legislative Budget Board; U.S. Citizenship and Immigration Services, Office of Immigration Statistics.

permanent residence approvals for the past several years. **Figure 167** shows that Los Angeles County made up as much as 41 percent of the total number of legal permanent residents admitted pursuant to the SIJS statute in fiscal year 2000.

FIGURE 167
PERCENTAGE OF ADJUSTMENTS TO PERMANENT LEGAL STATUS TO UNDOCUMENTED MINORS ATTRIBUTED TO LOS ANGELES COUNTY, FISCAL YEARS 2000 TO 2003



SOURCES: Legislative Budget Board; Los Angeles County Special Immigrant Status Unit.

According to an Annie E. Casey Foundation report published in 2006, *Undercounted. Underserved. Immigrant and Refugee Families in the Child Welfare System*, there is no reliable national data about the number of immigrant children who emancipate from the child welfare system without obtaining permanent residency. Most of the advocates interviewed by the authors claimed that local child welfare agencies, attorneys, and state juvenile courts have failed to inform

many eligible youth in a timely manner of the opportunity to apply for SIJS status.

SPECIAL IMMIGRANT JUVENILE STATUS MODELS IN OTHER STATES

There are a variety of models in other states of systems for pursuing Special Immigrant Juvenile Status for children in foster care on which Texas could base improvements to its approach.

The Department of Children and Family Services (DCFS) in Illinois administers the state-run child welfare system. Within the DCFS, there is an Immigration Services Unit that is responsible on a statewide basis for helping caseworkers obtain legal permanent status for eligible foster children in the Illinois child welfare system. The unit is responsible for seeking:

- legal permanent status for foreign-born children and youth;
- citizenship status for qualified youth who are legal permanent residents;
- replacement of Legal Permanent Resident Cards;
- refugee status adjustment, stay of deportation, asylum or removal of conditional status; and
- assistance in obtaining birth documents from foreign consulates.

Pro bono attorneys in Illinois also have access to a resource developed by the National Immigrant Justice Center titled *Special Immigrant Juvenile Status in Illinois, A Guide for Pro Bono Attorneys*. In coordination with the Illinois Task Force on Unaccompanied Immigrant Children, the center created a document that outlines how to prepare and file SIJS petitions and how to assist undocumented children in foster care achieve legal permanent status.

In 2005, the Florida Legislature enacted legislation which clarified the requirements for seeking SIJS and legal permanent status for undocumented children who are in foster care. This statute directed Florida's Department of Children and Families or a community-based care provider to determine whether a child is a citizen of this country by the time of the first judicial review for the child. This legislation also provided guidance to the department, community-based care providers, and the courts as to the findings necessary to support a petition for SIJS and an application for legal permanent status. The department or the community-based care provider must seek SIJS status and permanent residency within 60 days after the entry of a court order determining that such action is in the best interest of the child. The statute also authorized the courts to retain jurisdiction solely for the purpose of allowing time for the child's petition to be considered if filed before the child's eighteenth birthday.

A collaborative effort between child advocates, private practice law firms, and law school faculty made possible a resource on the SIJS process in Florida. The manual titled, *Florida: Special Immigrant Juvenile Status in Florida: A Guide for Judges, Lawyers, and Child Advocates*, provides an overview of the SIJS application process in Florida and highlights potential difficulties in the process.

The state of California is one of the 11 states that supervises a county-administered system of child welfare services. The Los Angeles Department of Children and Family Services is broken up into eight service planning areas. The Special Immigrant Status (SIS) Unit, which consists of one supervising children's social worker, four eligibility workers, and administrative staff, was started in 1988 and processed about 400 amnesty applications. In 1990, this unit began filing SIJS applications. The SIS Unit responsibilities include:

- processing all SIJS applications for the eight service planning areas in LA County;
- obtaining replacement of lost or stolen "green cards" for immigrant youth in the county;
- filing of USCIS work permits for children age 14 and older;
- filing for U.S. naturalization for eligible children; and
- assisting children to obtain a Social Security card and California ID under certain circumstances.

The SIS Unit has its own budget approved annually by LA County. The budget includes funding to pay for SIJS filing fees and associated expenses, which reduces the dependency on waivers that slow the process of approval of applications. The SIS Unit also receives funding to provide transportation for the children to attend meetings required by the CIS. In addition, each staff member in the SIS Unit is a county-certified translator. According to the director of the SIS Unit, having translators on staff reduces the reliance on securing outside translators for a variety of tasks related to SIJS petition filings (i.e., contacting foreign churches, schools, and governments). The SIS Unit has also used innovative tools to support SIJS petitions, such as bone scan tests to provide proof of age.

Since 2006, the SIS Unit has processed over 2,400 applications for legal permanent status which were approved by CIS, obtained over 300 replacement legal permanent status cards, filed over 200 applications for U.S. naturalization, and obtained over 600 CIS work permits.

There are some best practices that can be explored to improve the SIJS process at the Texas DFPS. The SIS Unit has fostered a relationship with the local CIS staff by holding quarterly meetings with CIS staff. SIS staff file SIJS applications in person at the local CIS immigration office. There is a one-day appointment for all SIJS cases where SIS Unit staff will take applicants and remain for their interviews.

LA County policies have also been developed to ensure that children are identified and assisted in achieving permanent legal status when they are in long-term care. The LA County SIS Unit must be notified when a permanency planning order is made, or if a permanency planning order has not been made but there is a great likelihood that it will be ordered in two to three months.

California state regulations require caseworkers to work with foster children on any concerns related to their immigration status. As part of a foster child's independent living plan, local child welfare caseworkers must teach an undocumented child how to acquire and receive a completed application for SIJS. In addition, state legislation was enacted requiring local child welfare agencies to submit reports before children age out of foster care that include verification that children have certain critical documents such as proof of citizenship or residence.

The SIS Unit provides systematic training of new case workers (Training Academy) on SIJS and other forms of immigration relief. The SIS Unit provides SIJS presentations at all regional offices and publicizes the SIJS process via email, flyers, and posters. To ensure that eligible foster children are identified, the SIS Unit reviews reports generated from the state Child Welfare Services/Case Management System that list the records of children born in other countries and cross-references this information with reports that list the children who are General Relief Ineligible (GRI). When a child is placed in foster care and is not eligible for Title IV-E Foster Care or for the Emergency Assistance Program funded by TANF, the child's foster care costs must be funded with county funds and are considered GRI.

In 2005, the California Legislature passed legislation requiring that a dependent child of the court who is not a legal permanent resident or citizen of the U.S. and for whom the court has determined parental reunification is no longer an option, be provided an attorney specializing in immigration law who may pursue legal permanent resident status or citizenship for that child. Although the bill was vetoed by the governor, it might serve as model legislation to ensure that undocumented children in foster care are provided the resources to access SIJS.

The New York City Administration for Children's Services (ACS) has addressed the issue of undocumented children in foster care by convening a special Immigrant Issues Subcommittee Advisory Board composed of ACS personnel, community-based service providers and advocates. In 2004, with a grant secured from the Annie E. Casey Foundation, ACS created a special Director of Immigrant Services position to oversee policy and practice issues regarding immigrant families and to whom the Immigrant Issues Subcommittee Advisory Board reports. This subcommittee developed a handbook, *Immigration and Language Guidelines for Child Welfare Staff*, that provides child welfare staff with information on immigration status and agency policy on eligibility for immigrants and lists resources for immigrant families. Included in this list of resources is a comprehensive list of all the advocacy and law organizations that will provide information and assistance to undocumented children in foster care. While pro bono immigration and law services are secured for undocumented children in foster care, NYC's ACS reimburses contract service providers for the costs associated with filing SIJS petitions. ACS also provides specialized training to caseworkers on immigration status.

Estimates provided by the ACS's Director of Immigrant Services indicate that there are approximately 100 to 150 children in foster care that are involved in the SIJS petition process at any one time. There are about 50 children in New York City's ACS Foster Care system who receive SIJS each year. The approval time for SIJS petitions has improved from up to four years to one year, due to ACS staff and advocates raising concerns and working with the local CIS office.

A website created by students at the Child Advocacy/Immigration Clinic at Columbia Law School in New York City also serves as a resource for information on SIJS. This website provides the public with information about SIJS, including distinct sections of information for eligible youth, caseworkers, pro bono attorneys, and law guardians. The website provides sample immigration forms, sample letters with information about SIJS for undocumented youth to bring to his/her law guardian (the equivalent of the attorney ad litem in Texas), and provides video clips that are narrated

by youths in the New York foster care system who have been through the SIJS process.

RECENT FEDERAL ACTIONS

Congress may consider legislation that would impact the SIJS process in the upcoming congressional session. House Resolution (HR) 6649, the Foster Children Opportunity Act, has been introduced and referred to the House Committee on Ways and Means. HR 6649 seeks to prevent undocumented children in the foster care system from missing the opportunity to change their immigration status by making the following state requirements:

- All children in the foster care system must be screened for eligibility under SIJS.
- Immigrant children must be assisted in obtaining legal permanent status under SIJS, or other appropriate provisions of immigration law.
- Juvenile courts and child welfare agencies must determine whether it is in a child's interest to file petitions or to appoint immigration counsel.

This proposed legislation would allow the use of Court Improvement Program funds training for judges and lawyers to assist SIJS-eligible foster children. Finally, technical assistance provided by the U.S. Department of Health and Human Services would be made available to child welfare agencies to carry out the provisions of this bill.

SPECIAL IMMIGRANT JUVENILE STATUS EFFORTS IN TEXAS

In order to comply with Title IV-E federal funding requirements, DFPS caseworkers must determine the immigration status of children. Caseworkers must follow a four-step process to determine the child's immigration status as part of the foster care Assistance Application. According to the CPS handbook, caseworkers must assign one of the following four immigration status categories in the case record:

- U.S. Citizen;
- Permanent Resident;
- Other Categories of Qualified Alien; or
- Undetermined Immigration Status.

Caseworkers must first determine if the child is a U.S. citizen by collecting documentation such as a birth certificate from one of the 50 states or U.S. territories. **Figure 168** shows the additional steps and documentation needed to support the category selected for the child.

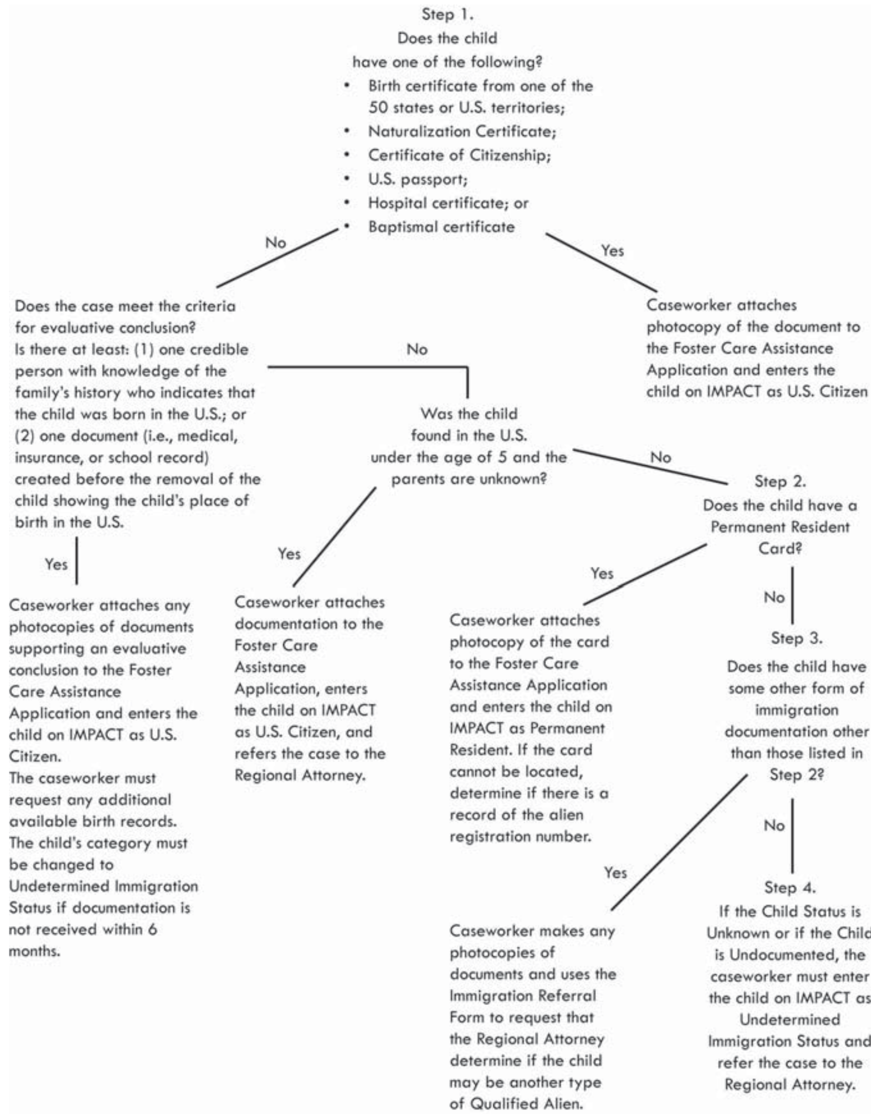
State policy directs caseworkers to monitor a child's immigration status to ensure that an eligible child has the opportunity to obtain legal permanent status. A caseworker must refer every case categorized as Undetermined Immigration Status to the Regional Attorney. DFPS caseworkers must also review the immigration status of every child with an Undetermined Immigration Status at every permanency planning meeting. The regional attorney must be immediately notified by the caseworker if the decision is made not to reunify a child with Undetermined Immigration Status with his or her family or the child turns age 16 or older (and the child will not be returning to the native country). Caseworkers must also assist in obtaining the information and documents needed for the SIJS petition and follow up the SIJS petition until is approved. Once the SIJS petition is approved and legal permanent status is granted, the caseworker is responsible for notifying the Eligibility Specialist to change the immigration status category of the child. **Figure 169** shows the current process for a SIJS filing in Texas for a child in long-term foster care.

DFPS regional attorneys are responsible for most of the SIJS petition filings, which are in addition to their duties to assist regional staff and represent DFPS in court when other arrangements cannot be made. One DFPS regional attorney is assigned in each DFPS region to address immigration cases. There is also an attorney in the state office that is assigned primarily to assist DFPS regional attorneys with immigration cases. There are two DFPS regions that have pro bono attorneys assisting undocumented children with SIJS filings. According to DFPS, when particularly complex cases arise, DFPS attorneys consult with local immigration attorneys or, occasionally, refer a case to a private immigration attorney. DFPS regional attorneys also provide an overview of the SIJS process and other immigration relief opportunities in the legal component of the Core Basic Skills Development training for caseworkers.

CHALLENGES TO ACCESSING SPECIAL IMMIGRANT JUVENILE STATUS FOR CHILDREN IN TEXAS FOSTER CARE

The SIJS process in Texas relies greatly on the caseworker to identify a child's immigration status, refer the case to regional attorneys, and monitor the child's immigration status improvements. Some DFPS staff and immigration advocates express concerns that this reliance on a caseworker who already carries caseloads exceeding nationally recommended levels might lead to failure to screen some children in foster care for SIJS eligibility or failure to update records regarding permanency planning outcomes. A review of Texas case

FIGURE 168
VERIFYING IMMIGRATION STATUS OF CHILDREN IN TEXAS FOSTER CARE SYSTEM, FISCAL YEAR 2008



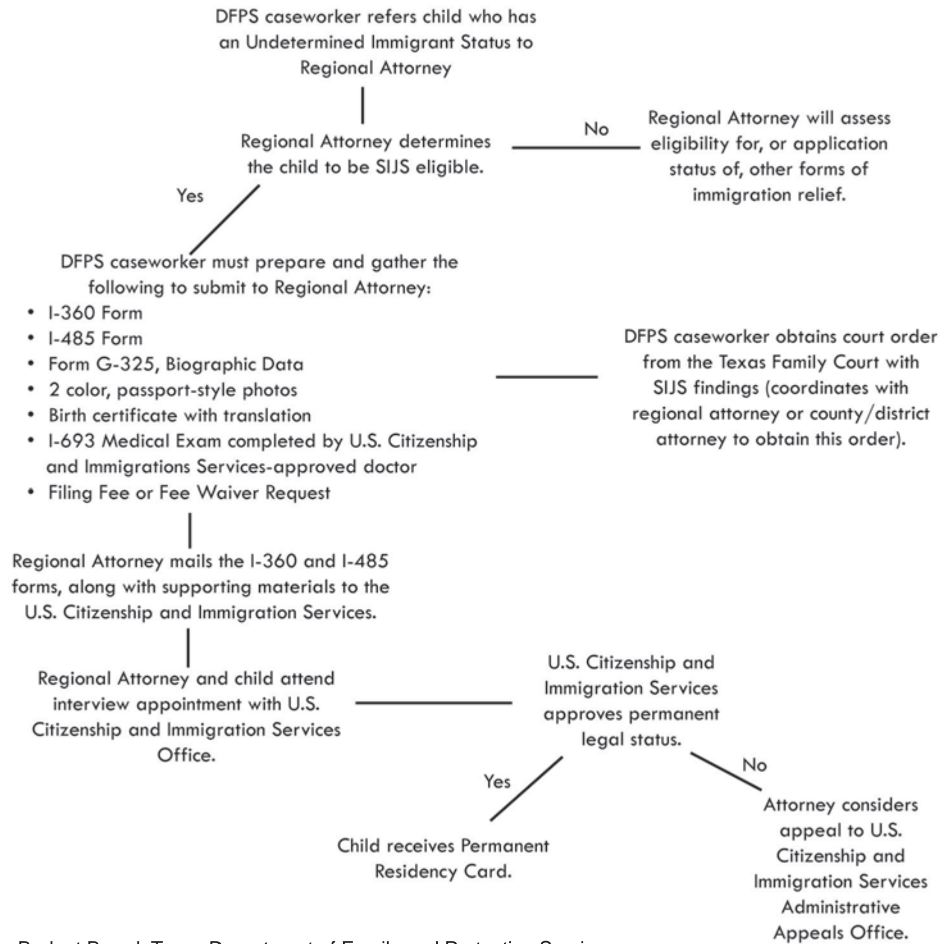
SOURCES: Legislative Budget Board; Texas Department of Family and Protective Services.

records by the Urban Institute in March 2006 shows that 24 percent of the case records of children in out-of-home placements did not include data for case goals, and this occurred primarily in counties with higher caseloads.

DFPS does not systematically track the number of children whose SIJS petitions are approved. The agency relies on the caseworker to update the child's immigration status to legal permanent resident. DFPS rules require the agency to reconsider a child's eligibility for foster care assistance whenever changes in the child's circumstances affect his eligibility for foster care assistance. According to DFPS, there are currently 259 foreign-born children in the conservatorship of DFPS who are classified as Undetermined Immigration Status. Not all these children are eligible for SIJS; **Figure 170** shows that 79 have a permanency goal of returning to the family. There are 76 children who do not have family reunification as a permanency goal. DFPS reported that applications for SIJS are in progress. A total of 38 children have SIJS petitions filed with CIS.

According to some DFPS regional attorneys, there are caseworkers who have experience in preparing SIJS petitions, but it is more likely that a caseworker with no experience with SIJS petitions will have to gather all the information and documents needed to file a SIJS petition. DFPS staff and

FIGURE 169
CHRONOLOGY OF A SPECIAL IMMIGRANT JUVENILE STATUS CASE IN TEXAS FOSTER CARE SYSTEM, FISCAL YEAR 2008



Sources: Legislative Budget Board; Texas Department of Family and Protective Services.

FIGURE 170
CHILDREN WITH UNDETERMINED IMMIGRATION STATUS
AUGUST 2008

STATUS	NUMBER OF CHILDREN
Permanency Goal of Returning to Family	79
Special Immigrant Juvenile Status Petitions Filed	38
Permanency Goal is not Family Reunification	76
Not Eligible for Special Immigrant Juvenile Status	5
On Runaway Status	6
Case Record needs to be updated to reflect Legal Permanent Residents or U.S. Citizens	15
Immigration Status Pending	40
TOTAL	**259**

Source: Texas Department of Family and Protective Services.

advocates reported that some caseworkers do not prioritize the gathering of supporting documents for SIJS petitions and in some instances will rely on a guardian ad litem or even the child to complete the applications. Survey results gathered by LBB staff indicated that the time it takes to prepare a SIJS petition or legal permanent status application varies from 3 months to 18 months. Recommendation 1 directs DFPS to ensure all cases categorized as Undetermined Immigration Status are assigned to caseworkers who have extensive experience with resolving immigration issues.

The SIJS process in Texas is also supported by DFPS border liaisons located in three DFPS regions. Border liaison responsibilities vary across regions but may include the following:

- coordinating with CPS' counterpart agency in Mexico, Sistema Nacional para el Desarollo Integral de la Familia (DIF);
- working with the U.S. Consulate in Mexico and the Mexican Consulate in Texas regarding child abuse or neglect and repatriation issues;

- assisting in locating children, parents and relatives in Mexico as part of a DFPS investigation;
- facilitating requests for home studies and psychological evaluations of Mexican nationals who are possible placements for children in DFPS care;
- requesting supervision from DIF for children placed in Mexico;
- assisting in acquiring birth, death and marriage certificates from Mexico; and
- assisting with making child abuse or neglect referrals to Mexico. Even if the reported victim of abuse/neglect child is now in Texas, a request is made to DIF to ensure safety of any other children in the care of the alleged perpetrator.

Border liaisons are not full-time staff positions, rather additional assignments to current staff. The border liaison for Region 11, which includes the Rio Grande Valley and Corpus Christi, is a program director with several CPS units under her supervision. The Region 10 (which includes El Paso) border liaison works part time and is available after hours to assist CPS staff with immigration issues. The Region 8 border liaison for the San Antonio area (which includes Eagle Pass and Victoria) also is responsible for carrying a workload of CPS investigations and may be called for after hours emergencies once every five weeks. DFPS staff involved in SIJS petition filings reported that the preparation of SIJS petition filings is hindered by having to balance these activities with other responsibilities.

Advocates have reported that another challenge that delays the submission of SIJS petitions and legal permanent status applications (I-485) is obtaining funds from DFPS for the filing fees and additional supporting documentation required by CIS (i.e, medical exam and biometric fees). Medical exams and fingerprinting fee expenses cannot be waived by CIS. A medical exam must be performed by a CIS-approved physician. The physician must complete the I-693 form after examining the child for any communicable diseases and ensuring that the child is up to date on vaccinations. Medical exam costs may range from $200 to $250; and if additional services (e.g., x-rays, vaccinations, etc.) or follow-up visits are required, the cost will be higher. DFPS advocates surveyed reported that in most cases a medical exam cannot be scheduled until the cost of the initial exam is paid to the physician. In one instance, a pro bono attorney had to seek a court order in order to receive the funds from DFPS. This delay prevented the submission of the I-485 application by four months. The cost for the biometric fees is $80, and the process to receive these funds may also take several months. DFPS staff must complete a purchase order in order to cover the costs of the medical exam, but the medical exam cannot even be scheduled without paying for the cost of a basic medical exam.

The Health and Human Services Commission (HHSC) has contracted with a Health Maintenance Organization (HMO) to implement a comprehensive statewide system to meet the medical and behavioral health needs of children in the foster care system. The STAR Health Program provides every child in foster care a primary care provider to oversee and coordinate his or her care. Recommendation 2 directs DFPS to work with HHSC to require the HMO to contract with CIS-approved physicians for providing access to medical exams that are needed as part of the legal permanent status applications filed on behalf of undocumented children in long-term foster care.

DFPS policy allows caseworkers to request court-related services if the service is legally necessary and appropriate for the well-being, safety, or permanency of the child. Included in the description of court-related services is providing for SIJS, U.S. Citizenship, or CIS fees. Caseworkers must verify with the regional attorney handling the immigration issue for the child that the fee is legally necessary for the SIJS process. The source of funds will be from the county welfare board or DFPS. According to agency staff, fee waivers are requested in most cases. CIS directs field office staff to adjudicate fee waiver requests within five business days of their receipt; however, the submission of a fee waiver request may add months to the I-485 application review process. In addition, a receipt notice from the CIS office is not available for I-485 applications if it is submitted with a fee waiver request. This makes it difficult for DFPS staff to contact CIS to determine the status of the I-485 application. Recommendation 3 directs the Texas Department of Family and Protective Services to stop seeking fee waivers for filing fees associated with completing and filing legal permanent status applications.

ENHANCE RESOURCES FOR SPECIAL IMMIGRANT JUVENILE STATUS AND IMMIGRATION-RELATED CASES

In recent years, CPS has hired subject matter experts to assist caseworkers conducting investigations. These subject matter experts include: child safety specialists with expertise in assessing risk and safety, law enforcement liaison staff, nurses, youth specialists, legal liaison staff, substance abuse experts,

and investigation screeners who provide additional review when CPS reports are received. Hiring subject matter experts in immigration (SIJS and other immigration reliefs) to support the SIJS and legal permanent status application process in the Texas foster care system would reduce some of the delays in preparing applications. In addition, directing DFPS to pay for the filing fees would expedite approval time of legal permanent status applications by the CIS and enable DFPS staff to follow up on pending applications.

The 3 full-time equivalents could be hired to replace part-time border liaisons, support the SIJS process, and make improvements such as the following:

- identify and foster relationships with local SIJS CIS officers to expedite approvals of SIJS petition and legal permanent status;
- develop agreements with more Central American consulates that would lead to lead to quicker turn around time for birth certificates, home studies, etc.;
- increase collaboration with immigration advocates, lawyers, and stakeholders who may volunteer pro bono services;
- review IMPACT reports on children who are listed as having an Undetermined Immigration Status and compare to reports of children who are funded by state-paid foster care assistance;
- provide in-depth training on SIJS and other forms of immigration relief; and
- develop a manual to distribute to family courts to increase awareness of SIJS petitions.

Recommendation 4 would decrease appropriations from General Revenue Funds to the Texas Department of Family and Protective Services for Strategy B.1.11, Foster Care Payments, by $282,179 in fiscal year 2010 and $279,965 in fiscal year 2011; and increase appropriations from Federal Funds to the agency for this strategy by $282,179 in fiscal year 2010 and $279,965 in fiscal year 2011. In addition, Recommendation 4 authorizes an increase in the number of full-time-equivalent positions for the agency by three to support the Special Immigrant Juvenile Status and other immigration-related processes at a General Revenue cost of $149,759 in fiscal year 2010 and $135,624 in fiscal year 2011, and a Federal Funds gain of $27,115 in fiscal year 2010 and $24,555 in fiscal year 2011, to Strategy B.1.1, CPS Direct Delivery Staff.

Recommendation 5 would decrease appropriations from General Revenue Funds to the Health and Human Services Commission for Strategy B.1.2, TANF and Adults and Children, by $371,552 in fiscal year 2010 and $367,528 in fiscal year 2011 and would increase appropriations from Federal Funds to the agency for that same strategy by $371,552 in fiscal year 2010 and $367,528 in fiscal year 2011.

In Texas, juvenile matters are heard in district or county courts across the state, making them the appropriate court that can make the findings of eligibility for long-term abuse, neglect, or abandonment. According to the Supreme Court Task Force on Child Protection Case Management and Reporting, there are over 350 judges in 254 counties that have jurisdiction to hear child protection cases. Although there is no specific state statute that terminates court jurisdiction of foster care children at the age of 18, many judges will end the court's jurisdiction when the child ages out of foster care (at the age of 18 or 21 in certain conditions).

According to DFPS staff, in fiscal year 2008 there were 30 children that had an undetermined status who aged out of foster care. **Figure 171** shows that a total of 160 of children aged out of foster care with Undetermined Immigration Status during the last six years. There are several reasons why these children might not have had their immigration status resolved before aging out of foster care. The reasons provided by DFPS staff include the following:

- The child's case record was never updated to reflect the most current immigration status (i.e., the child might not be undocumented or may have obtained SIJS status).
- The child's permanency planning goal still included family reunification.

FIGURE 171
CHILDREN WITH UNDETERMINED IMMIGRATION STATUS WHO EMANCIPATED, FISCAL YEARS 2003 TO 2008

FISCAL YEAR	TOTAL CHILDREN EMANCIPATED	CHILDREN WITH UNDETERMINED STATUS WHO EMANCIPATED
2003	947	25
2004	1,084	20
2005	1,189	24
2006	1,366	36
2007	1,411	25
2008	1,332	30

SOURCE: Texas Department of Family and Protective Services.

- The child is on runaway status.
- The child is ineligible for SIJS due to criminal offenses.
- The child's SIJS application is pending.

Federal law and regulation allow for a child to be granted SIJS and legal permanent status until the age of 21.

DFPS implemented rule changes in September 2006 to allow youth to stay in extended foster care from age 18 to the end of the month they turn 22, if they are enrolled in and regularly attending high school. Previously, youth had to graduate before turning 20. Rule changes also allow youth to remain in extended foster care from age 18 to the end of the month they turn 21, if they are enrolled in a vocational or technical education program. The age limit previously had been up to age 19.

Recommendation 6 proposes to amend the Texas Family Code to allow courts to extend foster care for children who have SIJS filings and legal permanent status applications pending with CIS. There might be a minimal fiscal impact to extending foster care past the age of 18 to children with pending applications. Eligibility for Title IV-E ends at age 18, unless a child is expected to graduate from a secondary educational institution (or an equivalent vocational or training program) by age 21. Thirty children aged out of care in fiscal year 2008 with Undetermined Immigration Status. Assuming a subset of these children may have filed SIJS petition and legal permanent status applications, matching Title IV-E federal funding would be available for those children under the age of 21 who were pursuing higher education degrees.

FISCAL IMPACT OF THE RECOMMENDATIONS

As shown in **Figure 172**, the recommendations in aggregate would result in a savings of $1 million in General Revenue Funds during the 2010–11 biennium. Recommendations 1, 2, and 3 would not have a fiscal impact, as they could be accomplished within DFPS' current agency resources.

Recommendations 4 and 5, combined, would result in a revenue gain of $1.4 million to Federal Funds during the 2010–11 biennium ($0.6 million in foster care and $0.8 million in Medicaid). This report assumes that the General Revenue Fund savings of $1.3 million for the 2010–11 biennium would be reduced by the costs required for the addition of two Program Specialists and one Attorney beginning in fiscal year 2010. Title IV-E federal funding would be available to cover a portion of these salary costs. The additional staff would decrease the time for preparing and submitting SIJS petitions and legal permanent status applications.

Ensuring access to medical exams under the STAR Health managed care system would enable DFPS staff to submit SIJS filings and legal permanent status applications more quickly to mitigate some of the delays in accessing Title IV-E funding.

Recommendation 6 would have minimal fiscal impact during the 2010–11 biennium. The fiscal impact of implementing Recommendation 6 cannot be estimated due to data limitations on the number of children with pending applications when aging out of foster care.

The introduced General Appropriations Bill for the 2010–11 biennium does not address these recommendations.

FIGURE 172
FIVE-YEAR FISCAL IMPACT OF RECOMMENDATIONS

FISCAL YEAR	PROBABLE SAVINGS IN GENERAL REVENUE FUNDS	PROBABLE REVENUE GAIN/ (LOSS) IN FEDERAL FUNDS	PROBABLE COST IN GENERAL REVENUE FUNDS	CHANGE IN FULL-TIME EQUIVALENTS FROM FISCAL YEAR 2009
2008	$653,731	$680,846	($149,759)	3
2009	$647,493	$672,048	($135,624)	3
2010	$647,493	$672,048	($135,624)	3
2011	$647,493	$672,048	($135,624)	3
2012	$647,493	$672,048	($135,624)	3

Source: Legislative Budget Board.

IMPROVE THE TRANSPARENCY AND ACCOUNTABILITY OF BEHAVIORAL HEALTH SERVICE DELIVERY IN MEDICAID HEALTH MAINTENANCE ORGANIZATIONS

Behavioral health services are available to Medicaid clients in both fee-for-service and managed care delivery models. Health maintenance organizations participating in Medicaid managed care may either subcontract part or all of their behavioral health services to a managed behavioral health organization or provide the services themselves. Managed care has the potential to improve the delivery of services by responding to client needs in a cost-efficient manner, such as controlling the use of inpatient and residential services. However, managed care approaches that emphasize cost control over quality of care may reduce access to care and ultimately increase costs in the long term. Nationally, the quality of care provided to individuals with behavioral health problems by managed care organizations remains poor. Evidence suggests that some Texas Medicaid clients with behavioral health conditions enrolled in STAR and STAR+PLUS health maintenance organizations may face problems with continuity of care.

State oversight can help ensure cost-efficiency while also ensuring appropriate access to high-quality behavioral health services in Medicaid managed care settings. Initiatives to assist with program monitoring and improvement could include publicly reporting on a range of behavioral health performance measures, attaching financial incentives to performance on some of these measures, and surveying Medicaid clients on their satisfaction with managed behavioral healthcare. By implementing additional efforts to improve the transparency and accountability of behavioral health service delivery in the Medicaid STAR and STAR+PLUS programs, Texas could help ensure that Medicaid clients enrolled in these programs receive appropriate high-quality services, thus reducing spending on more expensive care.

CONCERNS

- The performance data for the Medicaid STAR and STAR+PLUS health maintenance organizations regularly published by the Texas Health and Human Services Commission does not include certain key behavioral health indicators that could help the state monitor access to and quality of behavioral healthcare services, inform consumers, and incentivize health maintenance organizations to improve performance. Furthermore, the behavioral health performance data that is published is not available for current program monitoring because it is analyzed and reported several months after the end of the fiscal year.
- Financial incentives are not attached to STAR and STAR+PLUS Medicaid health maintenance organization performance measures that gauge the effectiveness of behavioral health service delivery.
- The Texas Health and Human Services Commission lacks a systematic process for evaluating which performance improvement strategies implemented by STAR and STAR+PLUS Medicaid health maintenance organizatons have improved performance on key behavioral health measures. Consequently, information on effective strategies that the health maintenance organizations could implement to improve behavioral health service delivery is not available for dissemination.
- The Texas Health and Human Services Commission does not have access to detailed consumer satisfaction data that could help the state monitor access to and quality of behavioral healthcare services provided to clients enrolled in STAR and STAR+PLUS Medicaid health maintenance organizations.

RECOMMENDATIONS

- **Recommendation 1:** The Texas Health and Human Services Commission should improve the tracking and reporting of behavioral health performance data for STAR and STAR+PLUS Medicaid health maintenance organizations by publishing additional behavioral health specific access, quality, and complaint indicators at the health maintenance organization level and statewide on the agency website on a quarterly basis.
- **Recommendation 2:** The Texas Health and Human Services Commission should use financial

incentives and disincentives to encourage STAR and STAR+PLUS Medicaid health maintenance organizations to meet performance expectations on indicators that measure the effectiveness of behavioral health service delivery.

- ♦ **Recommendation 3:** The Texas Health and Human Services Commission should identify strategies implemented by STAR and STAR+PLUS Medicaid health maintenance organizations that have demonstrated improved performance on key behavioral health measures and annually disseminate the information to encourage sharing and adoption of effective strategies.
- ♦ **Recommendation 4:** The Texas Health and Human Services Commission should contract with the External Quality Review Organization to conduct a biennial survey designed specifically to assess Medicaid STAR and STAR+PLUS consumer satisfaction with behavioral health services delivered through health maintenance organizations and behavioral health organizations and publish the survey results on the agency website.
- ♦ **Recommendation 5:** Include a rider in the 2010–11 General Appropriations Bill that directs the Texas Health and Human Services Commission to develop and submit to the Legislative Budget Board and the Governor by September 1, 2010 a report on strategies to improve the transparency and accountability of behavioral health service delivery in STAR and STAR+PLUS Medicaid health maintenance organizations that were implemented after the effective date of the 2010–11 General Appropriations Act.

DISCUSSION

Medicaid, financed with both federal and state funds, is a healthcare program for low-income families, the elderly, and persons with disabilities. Individuals eligible for Temporary Assistance for Needy Families (TANF) or Supplemental Security Income (SSI) are automatically eligible for Medicaid. Other persons who do not receive cash assistance may be eligible for Medicaid depending on age, family income, pregnancy, or disability (i.e., TANF-related or SSI-related groups). Texas Medicaid is administered by the Texas Health and Human Services Commission (HHSC).

Medicaid acute services are delivered primarily through two managed-care models: the fully capitated Health Maintenance Organization (HMO) model also known as the State of Texas Access Reform (STAR) program and the non-capitated Primary Care Case Management (PCCM) model. HMOs receive a monthly capitation payment for each person enrolled based on an average projection of medical expenses for the typical patient in exchange for assuming the risk of providing services that are medically necessary. Under the PCCM model, primary care providers receive a case management fee of $2.93 per member per month, and claims are paid on a fee-for-service basis. STAR HMOs operate primarily in urban areas whereas PCCM exists primarily in rural areas. There are also two Texas Medicaid managed care programs that integrate the delivery of acute and long-term care for certain client groups: the capitated STAR+PLUS program and the non-capitated Integrated Care Management (ICM) program. Each of these programs operates in select urban service areas.

TANF and TANF-related adults and children and certain SSI and SSI-related adults participate in Medicaid managed care on a mandatory basis. SSI and SSI-related clients under age 21 may participate voluntarily. Certain clients, including SSI and SSI-related clients under age 21, may receive Medicaid services on a fee-for-service basis. **Figure 173** shows the number of clients enrolled in each of the Medicaid delivery models by client type during June 2008.

DELIVERY OF BEHAVIORAL HEALTH SERVICES IN STAR AND STAR+PLUS MEDICAID HMOS

Behavioral health services, which provide treatment to persons with mental or chemical dependency disorders, are

FIGURE 173
MEDICAID CLIENTS BY DELIVERY MODEL, JUNE 2008

MEDICAID DELIVERY MODEL	TANF AND TANF-RELATED MEDICAID CLIENTS	SSI AND SSI-RELATED MEDICAID CLIENTS	TOTAL MEDICAID CLIENTS
Fee-for-Service	218,064	705,426	923,490
Managed Care: Primary Care Case Management	628,247	70,046	698,293
Managed Care: Health Maintenance Organization	1,093,092	7,135	1,100,227

Source: Texas Health and Human Services Commission.

available to Medicaid clients in traditional fee-for-service and managed care (i.e., STAR, STAR+PLUS, PCCM, ICM). Evidence suggests that some Texas Medicaid clients with behavioral health conditions enrolled in STAR and STAR+PLUS HMOs may face problems with continuity of care. Therefore, this report focuses on opportunities to improve the transparency and accountability of behavioral health services provided through Medicaid managed care, specifically STAR and STAR+PLUS HMOs. Improved accountability can help ensure individuals with behavioral health needs receive cost-effective, quality behavioral healthcare.

TYPE OF BEHAVIORAL HEALTH SERVICES

Medicaid HMO contractors are responsible for providing a benefit package to clients that includes all medically necessary services, including behavioral health services, covered under the traditional fee-for-service Medicaid program with the exception of certain services that are excluded from the HMO capitation rate. Services that are excluded from the HMO capitation rate are provided on a fee-for-service basis from Texas Medicaid providers. For most Medicaid HMOs, the behavioral health services excluded from the HMO capitation rate include specialty services administered by the Department of State Health Services (DSHS) and provided through local mental health authorities and out-of-office prescription drugs provided through the Vendor Drug Program. For Medicaid HMOs participating in the Dallas service area, all behavioral health services are excluded from the HMO capitation rate and are provided through the NorthSTAR program whereby the state contracts directly with a behavioral health organization (BHO) to deliver all publicly funded mental health and chemical dependency services except prescription drugs. **Figure 174** shows the behavioral health services available to Texas Medicaid clients enrolled in STAR and STAR+PLUS HMOs.

Medicaid HMOs, at their own discretion, may also provide behavioral health value-added services that provide additional coverage beyond those required by law or contract. HMOs may offer different value-added services and do not receive additional reimbursement for provision of these services. The most common value-added services offered by Medicaid STAR and STAR+PLUS HMOs include:

- partial hospitalization;
- intensive outpatient treatment;
- residential;
- crisis interventions; and
- off-site services.

MEDICAID SPENDING

Figure 175 shows the number of persons in Texas who received behavioral health services and reported spending for each program funded by Medicaid.

DELIVERY METHOD

HMOs participating in the Medicaid STAR and STAR+PLUS programs may subcontract part or all of their behavioral health services to a managed behavioral health organization (BHO) or may provide the services themselves. As shown in

FIGURE 174
BEHAVIORAL HEALTH SERVICES AVAILABLE TO TEXAS MEDICAID CLIENTS ENROLLED IN STAR AND STAR+PLUS HMOS, FISCAL YEAR 2008

	BASIC SERVICES IN HMO CAPITATION PAYMENT[1]						NON-CAPITATED SERVICES		
	INPATIENT MENTAL HEALTH SERVICES	OUTPATIENT MENTAL HEALTH SERVICES	OUTPATIENT CHEMICAL DEPENDENCY SERVICES	INPATIENT DETOXIFICATION RELATED TO THE TREATMENT OF AN ACUTE CONDITION	PSYCHIATRY SERVICES	ADULT COUNSELING SERVICES	TARGETED CASE MANAGEMENT	MENTAL HEALTH REHABILITATION	PRESCRIPTION DRUGS
STAR and STAR+PLUS Children (under age 21)	X	X	X	X	X		X	X	X
STAR Adults (age 21 and over)				X	X	X	X	X	X
STAR+PLUS Adults (age 21 and over)	X	X		X	X	X	X	X	X

[1]For Medicaid HMOs participating in the Dallas service area, all behavioral health services are excluded from the HMO capitation payment.
SOURCE: Texas Health and Human Services Commission.

FIGURE 175
MEDICAID SPENDING ON BEHAVIORAL HEALTH SERVICES IN TEXAS, FISCAL YEAR 2006

	MENTAL HEALTH		SUBSTANCE ABUSE	
PROGRAM	PERSONS SERVED (DUPLICATED ACROSS PROGRAMS)	SPENDING (IN MILLIONS)	PERSONS SERVED (DUPLICATED ACROSS PROGRAMS)	SPENDING (IN MILLIONS)
Medicaid Fee-for-Service and Primary Care Case Management[1]	243,004	$233.5	4,490	$3.70
Medicaid Health Maintenance Organizations[2]	28,753	9.9	275	0.09
Medicaid Vendor Drug[3]	547,756	492.9	--	--
NorthSTAR[4]	15,185	10.2	380	0.03
TOTAL	**--**	**$746.5**	**--**	**$3.82**

[1]Fee-for-service spending includes specialty behavioral health services, including targeted case management and rehabilitation services.
[2]Due to data limitations, spending data for health maintenance organizations is underreported.
[3]Data for the Vendor Drug Program is reported under mental health but may also include substance abuse services. Data for the Vendor Drug Program may include medications prescribed for a non-behavioral health condition.
[4]NorthSTAR data reflect only costs for Medicaid NorthSTAR clients.
Source: Texas Health and Human Services Commission.

Figure 176, as of fiscal year 2008, there were 15 HMOs participating in STAR or STAR+PLUS programs. Of these HMOs, eight contract with a BHO, four provide services in-house in all the service areas where they participate, two are not responsible for providing behavioral health services because services are provided by NorthSTAR, and one provides services in-house in all the service areas where they participate except Dallas where services are provided by NorthSTAR.

OVERSIGHT

HMOs participating in the Medicaid STAR and STAR+PLUS programs must adhere to federal regulations, state laws and rules, and contract requirements. First, Medicaid HMOs must adhere to federal regulations related to the operation of Medicaid managed care under Medicaid 1915(b) waiver authority. Specifically, Medicaid 1915(b) waivers allow states to implement managed care delivery systems, or otherwise limit individuals' choice of provider under Medicaid. Federal regulations specify various requirements, including but not limited to, quality assessment and performance improvement. Second, Texas state statute and administrative rules include requirements related to the implementation of Medicaid managed care, including required contract provisions and contract compliance. Medicaid HMOs must also adhere to rules promulgated by the Texas Department of Insurance. Finally, the most detailed listing of Medicaid HMO requirements is in the Uniform Managed Care Contract (UMCC) and the *Uniform Managed Care Manual* (UMCM). The UMCM contains policies and procedures required of all HMOs participating in the Medicaid STAR and STAR+PLUS programs and is incorporated by reference into the UMCC. The UMCC includes several requirements specifically related to the delivery of behavioral health services, including access and quality of care standards.

BENEFITS AND RISKS ASSOCIATED WITH MANAGED BEHAVIORAL HEALTHCARE

Managed care has the potential to improve the delivery of behavioral healthcare by increasing the number of individuals treated in less restrictive cost-effective settings. This approach reduces cost in part by shifting treatment from inpatient to outpatient settings, negotiating discounted hospital and professional fees, and limiting unnecessary services. Managed care approaches are designed to ensure that the levels and amounts of care are appropriate for the severity of the clinical condition and to inhibit the delivery of unnecessary amounts or types of services. Enrollees who can access care promptly and early in their illness may require less intensive care, and with appropriate continuing support, they may be less likely to relapse.

Critics of managed behavioral healthcare focus on the potential for managed care to reduce access and ultimately increase costs in the long term. According to the National Committee for Quality Assurance (NCQA), the quality of care provided in the United States by managed care organizations to individuals with behavioral health problems remains poor. This conclusion is based on NCQA's review of audited performance data voluntarily submitted to NCQA by more than two-thirds of HMOs and point-of-service health plans and some preferred provider organizations in the United States. Managed care approaches that emphasize cost control over quality of care may reduce access to care and lead to under-treatment. Sometimes the procedures used

FIGURE 176
METHOD FOR DELIVERING BEHAVIORAL HEALTH SERVICES FOR HMOS PARTICIPATING IN THE MEDICAID STAR AND STAR+PLUS PROGRAMS, FISCAL YEAR 2008

HMO	BEHAVIORAL HEALTH PLAN	SERVICE AREA	STAR	STAR+ PLUS
Aetna Medicaid	Magellan Behavioral Health	Bexar	✓	
		Tarrant	✓	
Amerigroup Community Care	Behavioral health services carved out to NorthSTAR	Dallas	✓	
	Behavioral health services provided in-house	Bexar		✓
		Harris	✓	✓
		Harris Expansion	✓	✓
		Nueces	✓	
		Tarrant	✓	✓
		Travis	✓	
Community First Health Plans	Behavioral health services provided in-house	Bexar	✓	
Community Health Choice	APS	Harris	✓	
		Harris Expansion	✓	
Cook Children's Health Plan	Corphealth, Inc.	Tarrant	✓	
Driscoll Children's Health Plan	Behavioral health services provided in-house	Nueces	✓	
El Paso First Premier Plan	Behavioral health services provided in-house	El Paso	✓	
Evercare of Texas	United Behavioral Health	Harris		✓
		Harris Expansion		✓
		Nueces		✓
		Travis		✓
FirstCare STAR	Magellan Behavioral Health	Lubbock	✓	
Molina Healthcare of Texas	CompCare	Bexar		✓
		Harris	✓	✓
		Harris Expansion	✓	✓
Parkland HEALTHfirst	Behavioral health services carved out to NorthSTAR	Dallas	✓	
Superior HealthPlan	Integrated Mental Health Services	Bexar	✓	✓
		El Paso	✓	
		Lubbock	✓	✓
		Nueces	✓	
		Travis	✓	
Texas Children's Health Plan	Behavioral health services provided in-house	Harris	✓	
		Harris Expansion	✓	
UniCare Health Plans of Texas	Behavioral health services carved out to NorthSTAR	Dallas	✓	
United Healthcare – Texas	United Behavioral Health	Harris	✓	
		Harris Expansion	✓	

SOURCE: Legislative Budget Board.

to manage costs are perceived as barriers to access rather than as mechanisms that facilitate efficient care. For example, plans may restrict the choice of providers to only those practitioners who are willing to accept discounted fees. Utilization management procedures may be used to restrict access to certain levels and types of care and to pressure practitioners to limit lengths of stay. Capitated health plans and practitioners may have financial incentives to reduce access to care.

Because of the risk of under-treatment of patients, it is important to monitor the quality and adequacy of health services delivered by capitated managed care. State oversight can help ensure cost-efficiency while also ensuring appropriate access and quality of care. According to the Institute of Medicine, the structure of the contract between a payer and

a managed care organization and the means for monitoring and enforcing the contract are among the most important ways to influence the quality of care. A purchaser of managed care can use a well-written contract to establish what standards of quality it expects from an HMO and to specify how quality will be defined, monitored, and managed. Specifications in law, regulations, or contracts are needed to ensure access to care, to maintain the quality of care, and to establish and protect consumers' rights.

There are two areas that are critical for state Medicaid programs to evaluate in their managed care programs—access and quality of care. The Institute of Medicine defines "access" as the extent to which those in need of behavioral healthcare receive services that are appropriate to the severity of their illness and the complexity of their needs. The U.S. Substance Abuse and Mental Health Services Administration indicates that one of the most important responsibilities of a public purchaser of managed care is to ensure that enrollees in managed care systems have prompt and easy access to network services. Similarly, the Institute of Medicine believes that access to care must be monitored carefully to ensure that individuals in need of mental health and substance abuse services receive prompt and appropriate care. "Quality of care" is defined as the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge. The interest in quality of care is partly driven by concern about the effects of financial incentives in managed care contracts for under-treatment and restricted access.

STAR AND STAR+PLUS MEDICAID HMO PERFORMANCE ON BEHAVIORAL HEALTH QUALITY OF CARE INDICATORS

States can use performance data to evaluate the performance of individual health plans and serve as a tool to improve behavioral healthcare within Medicaid managed care. Federal regulations require that states monitor managed care organization performance using standardized performance measures specified by the state and that HMOs submit necessary data. Furthermore, the federal government requires state Medicaid programs to have an ongoing independent external review of their managed care programs. HHSC contracts with the Institute of Child Health Policy in Florida to serve as the external quality review organization (EQRO) for the Texas Medicaid managed care program and the Children's Health Insurance Program. The EQRO evaluates access to care, satisfaction with care, and quality of care for Medicaid enrollees in all managed care programs.

Each year, the EQRO prepares annual chart books with quality of care measures for both the Medicaid STAR and STAR+PLUS programs. These reports provide an annual update on the quality of care provided to enrollees in the Medicaid STAR and STAR+PLUS programs. There are three performance measures contained in the annual chart books that relate to mental health. These measures are as follows:

- 7-day Follow-up after Hospitalization for Mental Illness;
- 30-day Follow-up after Hospitalization for Mental Illness; and
- Readmission within 30 days after an Inpatient Stay for Mental Health.

The 7-day and 30-day follow-up measures are contained in the Healthcare Effectiveness Data and Information Set (HEDIS) published by the NCQA. HEDIS is a tool used to measure performance on important dimensions of care and service. NCQA makes available to the public audited HEDIS performance data voluntarily reported to NCQA by more than two-thirds of HMOs and point-of-service health plans in the United States. The readmission within 30 days measure is not included in HEDIS. **Figure 177** and **Figure 178** show the Medicaid HEDIS mean and Medicaid STAR and STAR+PLUS HMO performance on the mental health measures tracked and reported by the EQRO for fiscal year 2007. These performance results suggest that some Texas Medicaid HMO enrollees with behavioral health conditions may face problems with continuity of care. Specifically:

- According to the EQRO, ensuring continuity of care and providing follow-up in the community after inpatient stays for mental illness have been shown to reduce enrollees' healthcare costs and to improve their outcomes of care. For most Medicaid STAR HMOs, results for the 7-day and 30-day follow-up measures are lower than the Medicaid HEDIS mean. Also, there is variability in STAR Medicaid HMO performance on these measures. For example, the percentage of clients who received follow-up within seven days after hospitalization for mental illness ranged from 7.0 percent for Cook Children's Health Plan to 46.9 percent for Molina Healthcare of Texas. Results for the 7-day and 30-day follow-up measures among Medicaid STAR+PLUS HMOs are comparable to the Medicaid HEDIS mean. The 7-day and 30-day follow-up performance measures reported for Medicaid STAR and STAR+PLUS include follow-up visits for a mental health diagnosis

FIGURE 177
MEDICAID STAR HMO PERFORMANCE ON MENTAL HEALTH MEASURES, FISCAL YEAR 2007

HMO	7-DAY FOLLOW-UP	30-DAY FOLLOW-UP	READMISSION
HEDIS 2007 Medicaid Mean	39.1%	57.7%	NA
All HMOs	24.9%	49.3%	17.5%
Aetna Medicaid	Data unavailable[2]	Data unavaiable[2]	Data unavailable[2]
Amerigroup Community Care[1]	26.0%	47.3%	15.5%
Community First Health Plans	26.4%	59.0%	21.7%
Community Health Choice	25.7%	41.7%	15.9%
Cook Children's Health Plan	7.0%	41.9%	35.8%
Driscoll Children's Health Plan	21.2%	62.9%	22.1%
El Paso First Premier Plan	12.0%	38.0%	23.5%
FirstCare STAR	20.5%	36.4%	5.6%
Molina Healthcare of Texas	46.9%	59.4%	Data unavailable[2]
Parkland HEALTHfirst[1]	--	--	--
Superior HealthPlan	20.0%	40.4%	14.3%
Texas Children's Health Plan	36.7%	66.5%	19.5%
UniCare Health Plans of Texas[1]	--	--	--
United Healthcare – Texas	Data unavailable[2]	Data unavailable[2]	24.3%

[1]Data on clients in the Dallas service delivery area are excluded because they receive behavioral health services through NorthSTAR. Data on these clients are included in the overall rate for all HMOs.
[2]The number of clients eligible for the measure is less than 30. Data on these clients are included in the overall rate for all HMOs.
SOURCE: Texas Health and Human Services Commission.

FIGURE 178
MEDICAID STAR+PLUS HMO PERFORMANCE ON MENTAL HEALTH MEASURES, FISCAL YEAR 2007

HMO	7-DAY FOLLOW-UP	30-DAY FOLLOW-UP	READMISSION
HEDIS 2007 Medicaid Mean	39.1%	57.7%	NA
All HMOs	35.3%	63.9%	24.9%
Amerigroup Community Care	31.6%	62.4%	24.8%
Evercare of Texas	42.5%	65.3%	25.6%
Molina Healthcare of Texas	32.9%	57.2%	20.7%
Superior HealthPlan	28.7%	67.0%	25.8%

SOURCE: Texas Health and Human Services Commission.

with any medical provider, not just a mental health provider. The HEDIS follow-up performance measure includes only follow-up visits with a mental health provider. Therefore, rates reported for Texas would be expected to be somewhat higher than the HEDIS mean.

- High readmission rates to inpatient psychiatric or substance abuse care may indicate an inappropriate discharge decision or the absence of adequate community services. There is variability in STAR Medicaid HMO performance on the readmission measure. Specifically, the percentage of clients readmitted to an inpatient facility within 30 days of discharge for STAR Medicaid HMOs ranged from 5.6 percent for FirstCare STAR to 35.8 percent for Cook Children's Health Plan.

IMPROVE THE TRANSPARENCY AND ACCOUNTABILITY OF BEHAVIORAL HEALTH SERVICE DELIVERY IN MEDICAID HMOS

There are four areas where HHSC should implement efforts to improve the transparency and accountability of behavioral health service delivery in the Medicaid STAR and STAR+PLUS programs: (1) performance reporting;

(2) financial incentives and disincentives; (3) evaluation of performance improvement activities; and (4) consumer satisfaction.

PERFORMANCE REPORTING

In the public sector, performance measurement is the primary tool of accountability for spending public funds on healthcare. Prior research has demonstrated the benefits of regularly tracking and publishing key behavioral health data. According to NCQA, managed care organizations that publicly report quality data routinely perform better than organizations that do not. Specifically, in 2006, publicly reporting Medicaid managed care organizations scored higher than their non-publicly reporting counterparts on 33 of 38 performance measures. Publicizing both achievements and poor performance can serve as a non-financial incentive for HMOs to improve performance and can inform consumers about specific HMO performance. According to HHSC, regularly publishing key behavioral health data is a necessary first step toward meaningful quality improvement.

HHSC uses the Performance Indicator Dashboard, a compilation of select performance items, to track STAR and STAR+PLUS Medicaid HMO performance by HMO, program, and service area. HHSC also uses the Performance Indicator Dashboard to assess HMO compliance with certain contract requirements. Data for the dashboard is based on HMO submissions, data from the EQRO, and other data available to HHSC. HMOs receive information on their individual performance and may receive information about the performance of their peers on an ad-hoc basis.

Reports prepared by the EQRO, including the annual chart books and Consumer Assessment of Healthcare Providers and Systems (CAHPS) Health Plan Survey Reports, are also used to monitor HMO performance and are available on HHSC's website. The annual chart books contain performance data and provide an update on the quality of care provided to enrollees in the Medicaid STAR and STAR+PLUS programs. The CAHPS program, which is funded and administered by the U.S. Agency for Healthcare Research and Quality (AHRQ), offers several surveys to assess the experiences of healthcare consumers. One of the surveys, the CAHPS Health Plan Survey, is a tool for collecting standardized information on enrollees' experiences with health plans and their services. The EQRO administers the CAHPS Health Plan Survey to adults and caregivers of children enrolled in Texas Medicaid managed care programs and prepares annual reports that summarize survey results.

The Medicaid STAR and STAR+PLUS HMO performance data regularly published by HHSC does not include certain key behavioral health indicators that could help the state monitor access to and quality of behavioral healthcare services, inform consumers, and incentivize HMOs to improve performance. HHSC now tracks seven behavioral health indicators on the Performance Indicator Dashboard. Four of these indicators are published in the annual chart books or the CAHPS Health Plan Survey Reports and are available on HHSC's website. The key behavioral health indicators that are not published by HHSC on a regular basis, which may or may not be currently tracked, include:

- **HEDIS Measures:** Two of the national HEDIS measures related to behavioral health are included in the Performance Indicator Dashboard and are published in the annual chart books; however, there are five additional HEDIS measures specific to behavioral health that are not regularly tracked or reported by HHSC. HEDIS, which includes data from more than 90 percent of managed care organizations in the United States, measures performance on important dimensions of care and service.

- **Data to Ensure Compliance with Contract Requirements:** Certain indicators that would help the state monitor compliance with behavioral health related contract requirements are not regularly published by HHSC. For example, HHSC does not regularly track or report on HMO compliance with the requirement that initial outpatient behavioral health visits be provided within 14 days of request. Performance indicators for two contract requirements, the rate of abandonment on the behavioral health hotline and the percentage of members with a mental health outpatient provider within 75 miles, are tracked by HHSC on the Performance Indicator Dashboard, but are not regularly published.

- **Consumer Satisfaction Data:** The Performance Indicator Dashboard and the CAHPS Health Plan Survey Report for Child Enrollees include an indicator to assess satisfaction with obtaining access to behavioral health treatment for children; however, a similar indicator for adults is not published. Data on adult satisfaction with access to behavioral health treatment is included in the CAHPS technical survey data, but is not included in either the Performance Indicator Dashboard or the CAHPS Health Plan Survey Report for Adult Enrollees.

- **Complaint and Appeal Data:** HHSC receives behavioral health complaint and appeal data from Medicaid HMOs. However, this data is not tracked separately on the Performance Indicator Dashboard and is not regularly published.

Furthermore, the behavioral health performance data that is published is not available for current program monitoring because it is analyzed and reported several months after the end of the fiscal year. For example, the quality of care indicators included in the annual chart books are calculated a minimum of eight months after the end of the fiscal year. As a result, performance data for the beginning of a given fiscal year is calculated nearly 20 months later.

Recommendation 1 would direct HHSC to improve the tracking and reporting of behavioral health performance data for STAR and STAR+PLUS Medicaid HMOs by publishing additional behavioral health specific access, quality, and complaint indicators at the HMO level and statewide on the agency website on a quarterly basis. Quarterly data should be published within a specified number of months after the end of the quarter. HHSC should report both the currently unpublished behavioral health indicators in the Performance Indicator Dashboard and should begin tracking and publishing additional behavioral health indicators. **Figure 179** shows the behavioral health measures currently published by HHSC for fiscal year 2008 and the indicators that HHSC should consider publishing on a quarterly basis.

FINANCIAL INCENTIVES AND DISINCENTIVES

Financial incentives and disincentives are used by states to shape HMO behavior in desired directions. In fiscal year 2006, HHSC implemented a value-based purchasing approach for Medicaid HMOs in STAR and STAR+PLUS. Under this new model, each HMO is at risk for 1 percent of their capitation rate dependent on the outcome of pre-identified performance measures. At the end of each rate period, HHSC evaluates if the HMO has demonstrated

FIGURE 179
CURRENT AND POTENTIAL BEHAVIORAL HEALTH MEASURES PUBLISHED BY HHSC, FISCAL YEAR 2008

BEHAVIORAL HEALTH INDICATORS CURRENTLY PUBLISHED BY HHSC
Percentage of caregivers of children reporting good access to behavioral health treatment or counseling
Percentage of members who received a 7-day follow-up after hospitalization for mental illness (HEDIS)
Percentage of members who received a 30-day follow-up after hospitalization for mental illness (HEDIS)
Percentage of individuals readmitted within 30 days after an inpatient stay for mental health
POTENTIAL BEHAVIORAL HEALTH INDICATORS TO PUBLISH
Behavioral health hotline abandonment rate
Percentage of members with one mental health outpatient provider within 75 miles
Percentage of children readmitted within 30 days after an inpatient stay for mental health
Percentage of adults readmitted within 30 days after an inpatient stay for mental health
Mental health utilization (HEDIS)
Antidepressant medication management (HEDIS)
Follow-up care for children prescribed ADHD medication (HEDIS)
Identification of alcohol and other drug services (HEDIS)
Initiation and engagement of alcohol and other drug dependence treatment (HEDIS)
Initial outpatient behavioral health visit provided within 14 days of request
Contact with members within 24 hours to reschedule missed behavioral health follow-up appointment
Adult member satisfaction with access to behavioral health treatment or counseling
Behavioral health member complaints per 1000 members
Behavioral health member appeals per 1000 members
Behavioral health member complaint resolution rate
Behavioral health member appeal resolution rate
Behavioral health provider complaints per 100 providers
Behavioral health provider complaint resolution rate

SOURCE: Legislative Budget Board.

whether it has met specified performance expectations for which the HMO is at risk. HMOs earn variable percentages up to 100 percent of the 1 percent at-risk amount. HHSC uses a set of performance measures, known as 1 percent at-risk performance measures, to determine the percentage of the 1 percent at-risk capitation rate that HMOs are able to earn. If one or more HMOs are unable to earn the full amount of the performance-based at-risk portion of the capitation rate, HHSC reallocates the funds through the Quality Challenge Award. HMOs that demonstrate superior performance on select performance indicators receive the Quality Challenge Award payment.

Financial incentives are not attached to STAR and STAR+PLUS Medicaid HMO performance measures that gauge the effectiveness of behavioral health service delivery. As of fiscal year 2008, there are seven 1 percent at-risk performance measures listed in the *Uniform Managed Care Manual* for Medicaid STAR and STAR+PLUS HMOs. One of the seven measures is specific to behavioral health. The one behavioral health related measure, Behavioral Health Hotline Abandonment Rate, is a process measure and does not gauge the effectiveness of behavioral health services provided to clients. As of fiscal year 2008, there are eight performance measures, four for STAR HMOs and four for STAR+PLUS HMOs, used to evaluate HMO performance for purposes of allocating Quality Challenge Award funds. None of these measures are specific to behavioral health.

Recommendation 2 would direct HHSC to use financial incentives and disincentives to encourage STAR and STAR+PLUS Medicaid HMOs to meet performance expectations on indicators that measure the effectiveness of behavioral health service delivery. HHSC should consider adding at least one indicator that measures the effectiveness of behavioral health service delivery to both the set of performance measures for the 1 percent at-risk premium and the set of performance measures used to evaluate HMO performance for purposes of distributing funds under the Quality Challenge Award program.

EVALUATION OF PERFORMANCE IMPROVEMENT ACTIVITIES

STAR and STAR+PLUS Medicaid HMOs participate in performance improvement activities and have implemented various strategies to improve access to and quality of behavioral health services. For example, HHSC has established three overarching performance improvement goals for Medicaid HMOs for fiscal year 2008 based on HHSC priority areas. Each Medicaid HMO is required to negotiate and implement customized sub-goals for all overarching goals, including measures and schedules for demonstrating that goals are met. One of the three overarching goals for both STAR and STAR+PLUS Medicaid HMOs is to improve access to behavioral health services for members.

HHSC lacks a systematic process for evaluating which performance improvement strategies implemented by STAR and STAR+PLUS Medicaid HMOs have improved performance on key behavioral health measures. Consequently, information on effective strategies that the HMOs could implement to improve behavioral health service delivery is not available for dissemination. Recommendation 3 would direct HHSC to identify strategies implemented by STAR and STAR+PLUS Medicaid HMOs that have demonstrated improved performance on key behavioral health measures and annually disseminate the information to encourage sharing and adoption of effective strategies.

CONSUMER SATISFACTION

According to the Institute of Medicine, consumer satisfaction measures must be included in the tools used to monitor quality of care. HHSC contracts with its EQRO to administer the CAHPS Health Plan Survey to adults and caregivers of children enrolled in Texas Medicaid managed care programs. The CAHPS Health Plan Survey for fiscal year 2007, administered to enrollees in STAR and STAR+PLUS Medicaid HMOs, includes sections designed to collect the following information:

- demographics;
- enrollees' satisfaction with their healthcare;
- enrollees' health status;
- care coordination services (STAR+PLUS adults only);
- child enrollees' special healthcare needs (STAR children only); and
- issues related to moving from pediatric to adult care for children with special healthcare needs (STAR children only).

The information collected by the EQRO during administration of the CAHPS Health Plan Survey includes a limited assessment of enrollee satisfaction with behavioral health service delivery. Specifically, adult enrollees and

caregivers of child enrollees in STAR and adult enrollees in STAR+PLUS were asked two questions related to their satisfaction with behavioral health services. Furthermore, the survey questions do not distinguish between behavioral healthcare delivered through the HMO or the BHO. As a result, HHSC does not have access to detailed consumer satisfaction data that could help the state monitor access to and quality of behavioral healthcare services provided to clients enrolled in STAR and STAR+PLUS Medicaid HMOs.

Medicaid programs in other states are using surveys that were specifically designed to evaluate Medicaid client satisfaction with behavioral healthcare received through managed care. According to AHRQ, these instruments are used by survey sponsors, including state Medicaid agencies, for quality improvement and monitoring purposes. Many of the states that evaluate Medicaid client satisfaction with behavioral health services use either the Mental Health Statistics Program's Consumer Survey (MHSIP) or modified versions of the Experience of Care and Health Outcomes (ECHO) Survey. In 2001, Texas health and human services agencies contracted with an external entity to assess Medicaid client satisfaction with behavioral healthcare received through managed care using the MHSIP and the Youth Services Survey for Families.

The ECHO survey, which is one of the free instruments offered by AHRQ through their CAHPS program, asks enrollees in adult health plans about their experiences with behavioral healthcare provided by either HMOs or BHOs. New Jersey, Vermont, and Minnesota have administered modified versions of the ECHO Survey as part of their Medicaid managed care quality oversight activities. Entities administering the survey can report information on 16 or 17 dimensions of the behavioral health treatment delivered by BHOs or HMOs, respectively. Some of the reporting dimensions for states administering the ECHO Survey include:

- getting treatment quickly;
- how well clinicians communicate;
- getting treatment and information from the HMO or BHO;
- perceived improvement;
- information about treatment options;
- information to manage condition;
- overall rating of counseling and treatment; and
- overall rating of health plan (HMO only).

Recommendation 4 would direct HHSC to contract with the EQRO to conduct a biennial survey designed specifically to assess Medicaid STAR and STAR+PLUS consumer satisfaction with behavioral health services delivered through health maintenance organizations and behavioral health organizations and publish the survey results on the agency website. The survey results should be reported on a statewide level and by HMO.

Recommendation 5 would include a rider in the 2010–11 General Appropriations Bill that directs HHSC to develop and submit to the Legislative Budget Board and the Governor by September 1, 2010 a report on strategies to improve the transparency and accountability of behavioral health service delivery in STAR and STAR+PLUS Medicaid HMOs that were implemented after the effective date of the 2010–11 General Appropriations Act.

FISCAL IMPACT OF THE RECOMMENDATIONS

Recommendations 1, 2, 3, and 4 would direct HHSC to implement efforts to improve the transparency and accountability of behavioral health service delivery in STAR and STAR+PLUS Medicaid HMOs. Recommendation 5 would direct HHSC to submit a report to the Legislative Budget Board and the Governor on strategies implemented by the agency to improve the transparency and accountability of behavioral health service delivery in STAR and STAR+PLUS Medicaid HMOs. The recommendations are intended to help ensure that Medicaid clients with behavioral health needs enrolled in HMOs receive appropriate high-quality services, thus reducing spending on more expensive types of care. It is estimated that the recommendations would have no significant fiscal impact because they could be implemented using existing resources.

The introduced 2010–11 General Appropriations Bill includes a rider that directs HHSC to submit to the Legislative Budget Board and the Governor by September 1, 2010 a report on strategies implemented by the agency to improve the transparency and accountability of behavioral health service delivery in STAR and STAR+PLUS Medicaid HMOs. The introduced bill does not include any other adjustments as a result of these recommendations.

STRENGTHEN THE DELIVERY OF INFORMAL CAREGIVER SUPPORT SERVICES

Most people who receive long-term care depend exclusively on family and friends, not on paid service providers or institutions. Identifying and meeting the needs of these informal caregivers often determines whether a care recipient can remain at home rather than enter an institutional setting. Yet, informal caregivers often do not identify themselves as caregivers and are unaware of caregiver support services in Texas, including services available through the local network of 28 Area Agencies on Aging.

Informal caregivers who seek services through the Area Agencies on Aging may receive a comprehensive assessment that identifies the assistance they need to support their own health and well-being and to remain in the caregiving role as long as appropriate. However, these agencies lack both a consistent protocol to determine when caregivers should receive this assessment and an automated standardized caregiver assessment tool. As a result, the state cannot collect and analyze statewide data necessary to evaluate the needs of assessed caregivers, measure the effectiveness of certain caregiver support interventions, improve existing programs, and develop new services to sustain informal caregivers.

Efforts to strengthen the current delivery of caregiver support services, such as improving the process for raising awareness about available caregiver support services and establishing a standardized assessment tool for use by Area Agencies on Aging, could help sustain the informal care system and avoid future Medicaid institutional spending. If individuals who are potentially eligible for Medicaid and are estimated to currently receive all of their long-term care from unpaid family and friends were instead to receive care in a nursing facility paid by Medicaid, the annual cost is estimated to range from $3.2 billion to $12.6 billion in state and federal funds.

CONCERNS

- Informal caregivers often do not identify themselves as caregivers and are unaware of available caregiver support services. Some local entities, such as the Area Agencies on Aging, have implemented efforts to raise awareness about the caregiving role and available support services. However, the lack of a coordinated statewide effort to raise awareness does not ensure that effective strategies are implemented in all areas and increases the possibility for duplication of effort.
- The process Area Agencies on Aging use to determine when caregivers should receive a comprehensive assessment and the tool they use to assess caregiver needs varies by location. As a result, the state cannot collect and analyze statewide data necessary to evaluate the needs of assessed caregivers, measure the effectiveness of certain caregiver support interventions, improve existing programs, and develop new services to sustain informal caregivers.

RECOMMENDATIONS

- **Recommendation 1:** The Texas Department of Aging and Disability Services should coordinate efforts implemented by Area Agencies on Aging and other community-based organizations to raise public awareness about the caregiving role and available support services to ensure statewide coverage and minimize duplication of effort.
- **Recommendation 2:** The Texas Department of Aging and Disability Services should add a caregiver status form into the existing functional eligibility determination process for Medicaid and other community-based long-term care programs as appropriate to identify informal caregivers and develop a protocol for referring caregivers identified through the caregiver status form to available support services, including those provided by the Area Agencies on Aging.
- **Recommendation 3:** The Texas Department of Aging and Disability Services should work with the Area Agencies on Aging to develop and implement an automated standardized assessment tool and protocol to evaluate the needs of certain caregivers accessing services through the Area Agencies on Aging.
- **Recommendation 4:** The Texas Department of Aging and Disability Services should analyze statewide caregiver data collected from the automated standardized caregiver assessment tool used by the Area Agencies on Aging and the caregiver status form included in the functional eligibility determination

process for Medicaid and other community-based long-term care programs as appropriate to inform system development and service redesign and report the findings biennially to the Governor and the Legislative Budget Board beginning in fiscal year 2011.

- **Recommendation 5:** Include a rider in the 2010–11 General Appropriations Bill that directs the Texas Department of Aging and Disability Services to develop and submit a report on strategies to strengthen the delivery of informal caregiver support services implemented after the effective date of the 2010–11 General Appropriations Act to the Legislative Budget Board and the Governor by September 1, 2010.

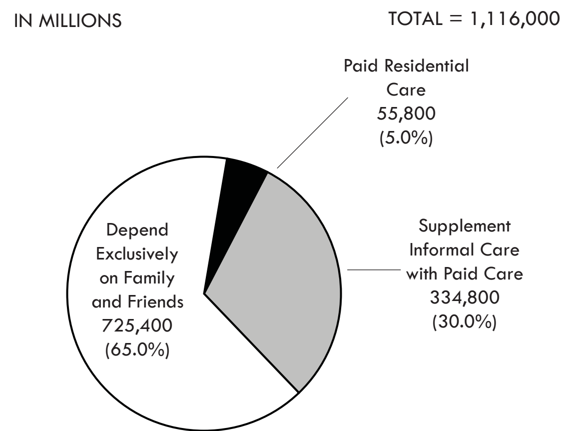
DISCUSSION

Long-term care refers to a wide range of supportive and health services for persons who have lost the capacity for self-care due to illness or frailty. Long-term care services include a continuum of health and social services provided in institutions, in the community and at home. Having a chronic illness or condition alone does not necessarily result in a person needing long-term care services. For many individuals, an illness or a chronic condition does not result in functional impairment or dependence, and they are able to conduct daily routines without assistance. Long-term care services may be required when the illness or condition limits a function or activity. Major groups of persons needing long-term care services and supports include older adults and non-aged persons with disabilities. Although persons with mental illness may need long-term care and could potentially benefit from the recommendations outlined in this report, the report does not focus on this population.

Most people who receive long-term care depend exclusively on family and friends, not on paid service providers or institutions. According to the U.S. Administration on Aging, among older people who need help with daily activities, 65 percent depend solely on family and friends, 30 percent supplement informal care with services from paid providers, and 5 percent rely exclusively on paid residential services. These national percentages were applied to the population of approximately 1.1 million older adults and non-aged persons with disabilities in Texas who need help with daily living to provide an estimate of the type of care received by these populations. **Figure 180** shows the type of long-term care that older people and non-aged persons with disabilities in Texas are estimated to receive based on the national percentages.

FIGURE 180
ESTIMATED TYPE OF CARE RECEIVED BY OLDER ADULTS AND NON-AGED PERSONS WITH DISABILITIES RECEIVING ASSISTANCE WITH DAILY LIVING IN TEXAS, 2008

IN MILLIONS TOTAL = 1,116,000

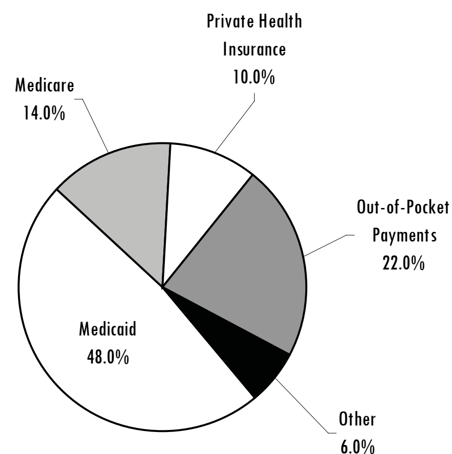


Source: Legislative Budget Board.

FORMAL LONG-TERM CARE SPENDING

Although family and friends provide most long-term care informally, the long-term care system includes thousands of formal care providers. They range from institutional providers, including nursing facilities and residential care facilities for persons with mental retardation or related conditions, to a variety of agencies and programs that provide a wide array of home and community-based services. **Figure 181** shows the public and private financing sources of formal long-term care in the U.S. Spending for long-term care financed under the federal Social Services Block Grant, the Older Americans Act, and state-only funded programs are not included. These

FIGURE 181
U.S. PUBLIC AND PRIVATE SOURCES OF FORMAL LONG-TERM CARE SPENDING, 2001



Source: U.S. House of Representatives, Committee on Ways and Means.

programs do not provide significant funding for long-term care relative to other public funding sources.

Medicaid is the single largest source of public financing for long-term care. In Texas, Medicaid long-term care spending totaled approximately $9.9 billion in All Funds during the 2006–07 biennium. Of this amount, 57 percent (or $5.6 billion) was spent on care provided in institutional settings and 43 percent (or $4.3 billion) was spent on home- and community-based services. Medicaid long-term care expenditures are expected to increase due in part to the increasing population of older adults, especially those who are in the oldest age categories. According to the Department of Aging and Disability Services (DADS), from 2000 to 2010, the age 60-plus population will grow by almost 30 percent and the age 85-plus population will grow by 11.9 percent. By 2040, older adults will compose almost one-quarter of the Texas population.

ROLE OF INFORMAL CAREGIVERS

The growth in the older population will also affect caregiving demands on families and friends who are the primary source of long-term care assistance. According to a National Conference of State Legislatures 2006 report, there are an estimated 1.9 million informal caregivers in Texas who provide help to older adults and non-aged persons with disabilities who need assistance with daily activities. These caregivers provide an estimated 2.1 billion hours per year of care with a market value of $18 billion. These amounts would be higher if persons providing care to children with long-term care needs were included. The provision of informal care and the use of caregiver support services can prevent or delay placement in more costly institutional settings. Specifically:

- **Importance of Care Provided by Family and Friends:** Care provided by family and friends can determine whether individuals with long-term care needs can remain at home and avoid placement in institutional settings, thus avoiding future Medicaid institutional expenditures. For example, according to the U.S. Administration on Aging, 50 percent of older adults who have a long-term care need, but no family available to care for them are in nursing facilities, while only 7 percent who have a family caregiver are in institutional settings. Furthermore, a review of current literature supports the conclusion that the availability of informal care helps prevent client transition to formal care, including institutionalization.
- **Caregiver Health Influences Institutionalization of Care Recipient:** Informal caregivers commonly face physical and mental health risks, financial pressures, and workplace issues due to their caregiving responsibilities, which affect their ability to provide care. Specifically, studies find higher levels of depressive symptoms and other emotional problems among family caregivers than among their non-caregiving peers. Other studies have also linked caregiving with negative affects on caregiver physical health. Finally, studies have concluded that caregivers whose health declined are more likely to end their caregiving role as compared to their healthy counterparts. The status of caregiver physical and mental health has been found to influence placement of the care recipient in institutional settings.
- **Caregiver Support Services May Delay Institutionalization of Care Recipient:** Research suggests that caregiver support services can help to reduce the strain of caregiving responsibilities, allow informal caregivers to remain in the workforce, and delay or prevent institutionalization of the care recipient. For example, researchers have found that providing support services to caregivers during the early stages of their role may delay institutionalization. Caregiver support services may include information about available services; assistance in gaining access to services; counseling, support groups, and training to assist caregivers in their roles; respite care to temporarily relieve caregivers from their caregiving responsibilities; and supplemental services to complement the care provided by caregivers.

DELIVERY OF CAREGIVER SUPPORT SERVICES IN TEXAS

DADS provides services funded under the federal Older Americans Act (OAA) through a statewide network of 28 Area Agencies on Aging (AAAs). Based upon the local needs within their service regions, AAAs use federal, state, and local funds to provide access and assistance, nutrition, and supportive services to persons age 60 and older. AAAs also provide services to informal caregivers through Title III-E of the OAA, also known as the National Family Caregiver Support Program (NFCSP). Other OAA funds may also serve caregivers. **Figure 182** shows the caregiving population eligible to receive services funded under the NFCSP.

NFCSP spending reported by DADS includes five categories of caregiver support services provided through AAAs and

FIGURE 182
NATIONAL FAMILY CAREGIVER SUPPORT PROGRAM: ELIGIBLE POPULATION

ELIGIBLE POPULATION	DEFINITION
Family Caregiver	An adult family member, or another individual, who is an informal provider of in-home and community-care to an individual age 60 and older or to an individual with Alzheimer's disease or a related disorder with neurological and organic brain dysfunction regardless of age.
Grandparents or older individuals who are relative caregivers	A grandparent or step-grandparent of a child or an individual with a disability, or a relative by blood, marriage, or adoption, who is 55 years of age or older and lives with the individual, is the primary caregiver of the individual because the biological or adoptive parents are unable or unwilling to serve as the primary caregiver, and has a legal relationship to the individual, such as legal custody or guardianship, or is providing care informally.

Source: Older Americans Act.

funded with Federal Funds, General Revenue Funds, Local Funds, and in-kind support. Service categories include access and assistance, caregiver education and training, caregiver information services, respite care, and supplemental services. As shown in **Figure 183**, total reported spending on NFCSP-funded caregiver support services totaled $12.7 million in All Funds in fiscal year 2007. Of total reported spending, 63 percent was Federal Funds.

In addition to OAA-funded services, DADS administers other programs that provide community-based long-term services and supports to older Texans and individuals with disabilities. These programs include Medicaid entitlement programs, Medicaid waiver programs, and non-Medicaid community-based programs. Services provided through these programs may ultimately benefit the caregiver by assisting the care recipient. Some of these programs include respite care for older adults and certain non-aged persons with disabilities as a funded service. Respite care, which gives caregivers a temporary short-term break, is the family support service most frequently requested by family caregivers to help them continue to provide care at home. **Figure 184** shows the number of persons who received respite services administered by DADS and reported spending by program. Individuals may receive services from more than one program to meet the needs of the caregiver.

Consumer demand for certain caregiver support services funded through DADS exceeds capacity. A review of the potential caregiving population and the number of persons receiving caregiver support services in Texas indicates limited provision of caregiver support services. Specifically, of the 1.1 million older adults and non-aged persons with disabilities who need help with daily living, approximately 655,000 are in the Medicaid long-term care target population (i.e., at or below 220 percent of the federal poverty level). Of this amount, an estimated 65 percent, or 425,750 persons, receive all of their long-term care from family and friends and could potentially benefit from caregiver support services. The total number of persons who received caregiver support services through programs administered by DADS is at most 61,281. However, the number is most likely lower since there is some amount of duplication in the number of persons served across programs. Furthermore, 11 of the 21 AAAs that responded to a survey administered by Legislative Budget Board (LBB) staff in 2008 indicated that consumer demand exceeds capacity for at least one caregiver support services provided in their area.

As funds are limited, AAAs are required by federal statute to target resources to caregivers who meet certain criteria. These criteria are intended to ensure that caregivers who are most in need of support receive services to continue in their caregiving role. DADS' rules require AAAs to target individuals in accordance with the OAA and to require that subcontractors and service providers adhere to the targeting policy implemented by the AAA. **Figure 185** shows the types of caregivers who are to receive priority for services funded under the NFCSP as outlined in the OAA. AAAs may also establish additional priority populations based on local needs. Caregivers who do not fall within a defined priority population and their care recipients may receive services provided through other funding streams.

LACK OF AWARENESS OF CAREGIVING ROLE AND AVAILABLE SUPPORT SERVICES

Caregiver support services can play a role in preventing institutionalization when accessed at the right time. Yet, there is general acceptance among researchers, advocates, and practitioners that the vast majority of family caregivers do

FIGURE 183
NATIONAL FAMILY CAREGIVER SUPPORT PROGRAM: PERSONS SERVED AND REPORTED SPENDING IN TEXAS, FISCAL YEAR 2007

SERVICE CATEGORY	DEFINITION	PERSONS SERVED (DUPLICATED ACROSS SERVICE CATEGORIES)	TOTAL REPORTED SPENDING (IN MILLIONS)	PERCENTAGE OF TOTAL SPENDING
Access and Assistance	Includes services that assist caregivers in obtaining access to the services and resources that are available within their communities.	16,788	$2.5	20.0%
Caregiver Education and Training	Counseling to individual caregivers, support groups, and training for individual caregivers and families to assist in making decisions and solving problems related to their caregiver roles.	4,233	$1.3	10.2%
Caregiver Information Services	Developing and disseminating information to informal caregivers and the public through publications, large group presentations, seminars, health fairs, and mass media.	---	$2.2	17.0%
Caregiver Respite Care	Temporary supports or living arrangements for care recipients in order to provide a brief period of relief or rest for caregivers, including in-home respite, respite provided by attendance of the care recipient at a senior center or other nonresidential program, and institutional respite provided by placing the care recipient in an institutional setting for a short period.	3,166	$4.0	31.6%
Supplemental Services[1]	Supplemental services are provided on a limited basis to complement the care provided by caregivers.	3,364	$2.7	21.2%
TOTAL		**----**	**$12.7**	**100.0%**

[1] Supplemental services may include homemaker services, personal assistance, chore maintenance, residential repair, and transportation.
SOURCES: Legislative Budget Board; Texas Department of Aging and Disability Services.

not self-identify and thus, it is difficult to reach this group with information, support, and education that could help prevent or delay institutionalization of the care recipient. As shown in **Figure 186**, there are seven stages in a caregiving career. Stage 2, or self-definition as a caregiver, is when individuals come to view themselves as caregivers and incorporate this activity into their social or personal identity. According to a survey commissioned by the National Family Caregivers Association, the most prominent benefit of self-identification is that caregivers become more proactive about seeking resources and skills they need to assist the care recipient. The Texas State Plan on Aging indicates it is important to help caregivers self-identify before the need for services becomes critical.

In Texas, surveys indicate a failure among caregivers to self-identify and a lack of awareness about available support services. Specifically, more than one-third of AAAs that responded to a survey administered by LBB staff indicated that caregivers failing to self-identify is a barrier to delivering caregiver support services. The 2005 DADS Aging Texas Well Indicators Survey found that approximately 44 percent of Texas caregivers are not aware of services provided through the AAAs, such as respite, support groups, and other caregiving tips and advice. Only 19 percent of Texas caregivers reported ever using these caregiving resources.

While DADS has developed general outreach materials, AAAs perform most efforts to help caregivers self-identify

FIGURE 184
TEXAS DEPARTMENT OF AGING AND DISABILITY SERVICES RESPITE SERVICES BY PROGRAM, FISCAL YEAR 2007

PROGRAM	PERSONS SERVED	TOTAL SPENDING (IN MILLIONS)	PERCENTAGE OF TOTAL SPENDING
Day Activity and Health Services – Medicaid Entitlement Service	22,753	$100.0	63.7%
Medicaid Home and Community-Based Services Waiver Programs	8,007	33.7	21.4%
Day Activity and Health Services – Social Services Block Grant	1,798	6.6	4.2%
Older Americans Act	3,166	4.0	2.5%
In-Home and Family Support Program	1,170	1.5	0.9%
Mental Retardation Authorities – Community Services	--	11.4	7.2%
State Mental Retardation Facilities	2	33.6	0.02%
TOTAL	**---**	**$157.3**	**100.0%**

Source: Texas Department of Aging and Disability Services.

FIGURE 185
NATIONAL FAMILY CAREGIVER SUPPORT PROGRAM: FEDERALLY DEFINED PRIORITY POPULATIONS, 2008

PRIORITY POPULATIONS:

- Family caregivers who provide care to individuals age 60 and older with Alzheimer's Disease or related disorders with neurological and organic brain dysfunction.
- Grandparents or older individuals who are relative caregivers who provide care to individuals with severe disabilities, including children with severe disabilities.
- Caregivers age 60 and older with greatest social need.
- Caregivers age 60 and older with greatest economic need.

Source: Older Americans Act.

and educate them about available services. Some AAAs have developed special initiatives to reach caregivers in their communities. However, one-third of AAAs responding to a survey administered by LBB staff in 2008 discussed the need for additional outreach and public awareness activities to reach caregivers. Specifically, AAAs wanted information about effective strategies for reaching caregivers. They stated a need for opportunities to share and receive best practice information related to raising awareness about caregiving and available services. Some also mentioned the need for a statewide marketing campaign to help caregivers self-identify. The lack of a coordinated statewide effort to raise awareness does not ensure that effective strategies are implemented in all areas and increases the possibility for duplication of effort.

USING ASSESSMENTS TO IDENTIFY AND SUPPORT THE NEEDS OF CAREGIVERS

Identifying and meeting the needs of informal caregivers is often a deciding factor in whether a care recipient can remain at home rather than enter an institutional setting. "Caregiver assessment" is the process of gathering information that describes a caregiving situation and identifies the particular problems, needs, resources and strengths of the informal caregiver. It approaches issues from the caregiver's perspective and culture, and focuses on what assistance the caregiver may need to support their own health and well-being. The assessment process allows service providers to better understand family needs and capacities, enables family caregivers to access support and remain in the caregiving role as long as appropriate, and contributes to optimal outcomes for the care recipient. In some cases, the assessment includes a comprehensive set of questions used to develop a care plan that includes services and supports for the informal caregiver. In other cases, an abbreviated assessment may be used to identify and refer caregivers to available support services in the community.

In addition to serving as a clinical guide to caregiver needs and serving as a basis for care plan development, states can use standardized caregiver assessments as a data collection

FIGURE 186
STAGES IN A CAREGIVING CAREER

STAGE 1 – PERFORMING CAREGIVING TASKS
When a dependency situation emerges in which a family member or close acquaintance performs tasks designed to assist an individual with routine activities previously performed without assistance.

STAGE 2 – SELF-DEFINITION AS A CAREGIVER
When individuals come to view themselves as caregivers and incorporate this activity into their social or personal identity.

STAGE 3 – PERFORMING PERSONAL CARE
When the caregiver begins providing personal care such as assistance with bathing, dressing, bladder and bowel evacuation, or other aspects of personal hygiene. Whereas the need for personal care marks the end of informal caregiving for many children, it often signals an unambiguous start of caregiving for spouses.

STAGE 4 – SEEKING ASSISTANCE AND FORMAL SERVICE USE
When the caregiver actively seeks out formal support services designed to assist informal caregivers. The frequent observation that many support services go unused likely reflects the fact that the services have been targeted to caregivers who have not yet reached this stage, which can be considered the "servable" moment.

STAGE 5 – CONSIDERATION OF INSTITUTIONAL PLACEMENT
When the caregiver seriously considers placing the care recipient in an institution as an alternative to informal caregiving. When caregivers fail to seek services prior to seriously considering institutional placement, there is little opportunity for services to play a preventive role.

STAGE 6 – INSTITUTIONALIZATION
When institutional placement occurs. As many care recipients die without ever residing in an institution, not all caregivers reach this stage.

STAGE 7 – TERMINATION OF THE CAREGIVING ROLE
When caregiving has an explicit end. There are three possible reasons:

(1) death of the care recipient (or caregiver); (2) recovery of the care recipient; or (3) termination of the caregiving role (i.e.; caregiver quits). The significance of this stage is that it acknowledges that care by informal caregivers continues to be provided after the care recipient has been institutionalized.

Source: University of Wisconsin at Milwaukee.

tool to provide information to policymakers and program administrators to improve long-term care service delivery. Statewide data can be analyzed and used to describe the caregiver population, measure caregiver needs, examine caregiver outcomes, evaluate program effectiveness, and modify existing programs or develop new services to improve the caregiver support system.

Other states have incorporated the following steps into the development and implementation of caregiver assessments:

- using caregiver assessments to legitimize the needs of informal caregivers as distinct from, but related to, the needs of the care recipient;
- involving key stakeholders in the development and implementation of assessment tools and protocols;
- using information technology, including automation of assessment forms and data, to improve management information systems;
- exploring valid and reliable caregiver measures before developing an assessment tool;
- incorporating measures of caregiver strain and burden;
- ensuring reassessment of caregiver needs to identify changes in the caregiver's and care recipient's situation over time;
- linking assessment and reassessments to a care plan for the caregiver; and
- continuous education and training of assessors.

Use of Caregiver Assessments in Texas: Caregivers who seek services through AAAs may receive a comprehensive assessment through Caregiver Support Coordination under the Access and Assistance service category. Caregiver Support Coordination is an ongoing process that includes assessing the needs of a caregiver and care recipient and effectively planning, coordinating, and following up on services that most appropriately meet the identified needs as mutually defined by the caregiver, the care recipient, and the access and assistance staff.

The process AAAs use to determine when caregivers should receive a comprehensive assessment and the tool they use to assess caregiver needs varies by location. Each AAA determines the type of caregiver eligible to receive a comprehensive assessment under Caregiver Support Coordination. The type

of caregiver that receives a comprehensive assessment may include all caregivers seeking services through the AAAs or only those with complex needs. The type of caregiver may also be characterized as a person caring for an older individual or a grandparent or other older relative caregiver caring for a child or an individual with a disability.

Assessment tools used by AAAs may include the Caregiver Self–Assessment Questionnaire developed by the American Medical Association, the Rosalynn Carter Caregiver Assessment, and the Zarit Stress Interview. Five AAAs have developed custom caregiver assessment tools, such as the Elder Service Network Assessment. For certain services funded under the NFCSP (i.e., Respite and Supplemental Services), AAA staff are required to assess the needs of individuals for whom caregivers are providing care. In these cases, most AAAs use the standardized Client Needs Assessment Questionnaire and Task/Hour Guide to assess the care recipient.

DADS rules require that AAAs maintain a confidential case record on each person served. Each case record is to include, among other items, documentation of assessments and reassessments. However, the systems used to track and maintain client data varies by AAA. Specifically, some AAAs use automated caregiver intake forms and assessment tools, while other AAAs rely on paper documents. The lack of an automated standardized tool to assess certain caregivers prevents the state from collecting and analyzing statewide data necessary to evaluate the needs of assessed caregivers, to measure the effectiveness of certain caregiver support interventions, improve existing programs, and to develop new services to sustain informal caregivers. Certain software products AAAs use to track and report client data could be modified to include a standardized assessment tool with a mechanism to report data back to DADS.

Use of Caregiver Assessments in Other States: Georgia, Michigan, Washington, and Minnesota are participating in a randomized control study to evaluate the use of an evidence-based instrument to assess informal caregivers. The project, known as the Tailored Caregiver Assessment and Referral (TCARE) process, is under development by academic researchers. TCARE is an example of a comprehensive assessment that provides care managers with tools and protocols for working with informal caregivers. The tools and protocols include an assessment form, forms that assist care managers with interpreting assessments, guides that assist care managers with identifying appropriate goals, strategies for meeting goals, and guides for developing family care plans.

Steps taken in other states to identify and refer caregivers to available support services in the community include adding a caregiver status form to the application process for publicly funded long-term care services, including Medicaid long-term care waiver services. Some states, including Minnesota, Washington, and Pennsylvania, have added an optional caregiver status form to the standardized tool used to assess care recipients applying to receive publicly funded long-term care services. The purpose of the status form, which takes about 10 minutes to complete, is to identify and refer caregivers to support services available through AAAs. Caregiver intervention strategies may also be included in the care recipient's care plan when appropriate. **Figure 187** describes the use of caregiver assessments in selected states.

IMPLEMENT STRATEGIES TO STRENGTHEN THE DELIVERY OF CAREGIVER SUPPORT SERVICES

Most people who receive long-term care depend exclusively on family and friends, not on paid service providers or institutions. Identifying and meeting the needs of informal caregivers often determines whether a care recipient can remain at home rather than enter an institutional setting. Local community-based organizations, including the local network of 28 AAAs that receive funding through DADS, provide an array of services to support informal caregivers.

Efforts to strengthen the current delivery of caregiver support services could help sustain the informal care system and avoid future Medicaid institutional spending. In Texas, there are approximately 655,000 older adults and non-aged persons with disabilities who need help with daily activities who are at or below 220 percent of the federal poverty level, or have monthly incomes below 300 percent of the monthly income limit for Supplemental Security Income (i.e., currently $1,971 per month), and are potentially eligible for Medicaid. Of this amount, it is estimated based on national percentages that 65 percent, or 425,750, receive all of their long-term care from unpaid family and friends. If these individuals were instead to receive care in a nursing facility paid by Medicaid, the annual cost is estimated to range from $3.2 billion to $12.6 billion in state and federal funds depending on the number of persons who meet Medicaid nursing facility medical necessity and asset test criteria. The cost could be even higher if some of these individuals received care in an intermediate care facility for persons with mental retardation or a state school because the average monthly cost per client

FIGURE 187
USE OF CAREGIVER ASSESSMENTS IN SELECTED STATES

STATE-LEVEL LEAD AGENCY	SUMMARY OF ACTIVITY
Minnesota Department of Human Services	Minnesota uses a uniform assessment tool known as the Long-Term Care Consultation Services (LTCCS) Assessment Form to evaluate the needs of persons applying to receive publicly funded long-term care services, including Medicaid long-term care waiver services. The LTCCS assessment form includes an optional 13-question caregiver status form. The caregiver status form or interview component includes: demographic information, availability and capability of informal support, willingness to provide care, care frequency and duration, self-reported health, emotional well-being, factors that may limit the caregiver, caregiver burden and exhaustion, and need for respite or other supports. The assessment also includes a question asking if the caregiver would like to be contacted by a community organization to receive more information and assistance on caregiving. Caregiver support services may be included in the care recipient's Medicaid waiver care plan or the caregiver may receive services through AAAs. Also, some AAAs in Minnesota are participating in the TCARE five-state research project to evaluate the use of an evidence-based tool to assess family caregivers. Use of TCARE may be expanded to all AAAs upon completion of the study.
Washington Aging and Disability Services Administration	Washington uses a uniform assessment tool known as the Comprehensive Assessment Reporting Evaluation (CARE) tool to evaluate the needs of persons applying to receive Medicaid long-term care waiver services. The CARE tool includes an optional 17-question caregiver status form used to identify caregivers with unmet needs so they may be referred to explicit caregiver support services available through the AAAs. The caregiver status form or interview component includes: demographic information, care duration, whether the caregiver is currently using caregiver support services, obstacles that might prevent continued care, and caregiver stress and burden. Also, Washington is participating in the TCARE five-state research project to evaluate the use of an evidence-based tool to assess family caregivers. Currently, four AAAs in Washington have been trained to use TCARE. Upon successful completion of the study in 2009, Washington intends to expand use of TCARE to all AAAs and to replace the current caregiver status form in the Medicaid CARE tool with TCARE as an online automated application. TCARE data will be used to inform the Washington Legislature and other stakeholders about whether the state is effectively serving the most burdened caregivers and thereby reducing institutional placement of the care recipient.
Pennsylvania Department of Aging	Since 1991, care managers at Pennsylvania's 52 AAAs have used standardized tools to assess both the care recipient and caregiver. When caregivers contact a AAA to request assistance for themselves or their care recipient, they are given the option of having their needs assessed during an in-home visit using the Level of Care Assessment (LOCA). The LOCA determines the level (nursing facility clinically eligible or nursing facility ineligible) and the locus of care (in-home or facility). The Care Management Instrument (CMI), which includes a caregiver status form designed specifically to assess caregiver needs, is the tool that is then used to establish a plan of care for AAA services. All information is entered into a laptop that automatically feeds into a statewide database maintained by the Pennsylvania Department of Aging. The caregiver components of the CMI include: demographic information, availability and capability of informal support, willingness to provide care, care frequency and duration, caregiver constraints (e.g., poor health), emotional concerns, caregiver strain, and family preferences. The LOCA and CMI data is used for a wide range of management and planning purposes, including measuring cost-effectiveness and comparing service utilization and outcomes to projected performance measures.

Source: Legislative Budget Board.

for these types of care, $4,077 and $7,477, respectively, is higher than for nursing facility care ($2,476).

Informal caregivers often do not identify themselves as caregivers and are unaware of available caregiver support services. Although some local entities, such as the AAAs, have implemented efforts to raise awareness about the caregiving role and available support services, the lack of a coordinated statewide effort to raise awareness does not ensure that effective strategies are implemented in all areas and increases the possibility for duplication of effort.

Recommendation 1 would direct DADS to coordinate efforts implemented by AAAs and other community-based organizations to raise public awareness about the caregiving role and available support services to ensure statewide coverage and minimize duplication of effort. Strategies that DADS could consider implementing to assist local entities with their outreach efforts include:

- using the Internet to raise awareness among the public by establishing a dedicated caregiving website that local entities, such as AAAs, can link to;

- establishing a process for local entities, including AAAs, to share best practice strategies used to raise awareness, including use of a dedicated website that local entities can use to post and access information on best practices; and
- creating template documents that local entities can adapt to their local area (e.g., Caregiving Resource Guides).

Some states have used their long-term care eligibility determination systems to identify and refer caregivers to support services available through AAAs. Specifically, these states include an optional 10-minute caregiver status form in the tools used to assess care recipients applying to receive publicly funded long-term care services, including Medicaid long-term care waiver services. Recommendation 2 would direct DADS to add a caregiver status form into the existing functional eligibility determination process for Medicaid and other community-based long-term care programs as appropriate to identify informal caregivers and develop a protocol for referring caregivers identified through the caregiver status form to available support services, including those provided by the AAAs. Currently, DADS staff and contractors use various paper-based forms to collect client information. For most programs, the information is then entered into the appropriate DADS' electronic reporting system. For example, several long-term care community-based programs use the Client Needs Assessment Questionnaire and Task Hour Guide. Information from this form, which is completed by a case manager, is entered into the DADS automated Service Authorization System. DADS should consider modifying appropriate forms to include a caregiver status form that includes a brief set of optional questions for the caregiver. The development of the caregiver status form should include consideration of questions included in similar tools used in other states.

Caregivers who seek services through the AAAs may receive a comprehensive assessment that identifies the assistance they need to support their own health and well-being and to remain in the caregiving role as long as appropriate. The process AAAs use to determine when caregivers should receive a comprehensive assessment and the tool they use to assess caregiver needs varies by location. As a result, the state cannot collect and analyze statewide data necessary to evaluate the needs of assessed caregivers, measure the effectiveness of certain caregiver support interventions, improve existing programs, and develop new services to sustain informal caregivers.

Recommendation 3 would direct DADS to work with the AAAs to develop and implement an automated standardized assessment tool and protocol to evaluate the needs of certain caregivers accessing services through the AAAs. The development of a standardized assessment tool should include consideration of evidence-based instruments under development and/or used in other states, such as the Tailored Caregiver Assessment and Referral process. The standardized protocol should provide guidance on the type of caregivers that should receive a comprehensive assessment, including when and how the assessment should be completed. DADS should include a requirement in their contracts with AAAs to require use of the automated standardized assessment tool and protocol. DADS should consider requiring AAAs to include the standardized assessment tool in the software products used to track and report client data.

Recommendation 4 would direct DADS to analyze statewide caregiver data collected from the automated standardized caregiver assessment tool used by the AAAs and the caregiver status form included in the functional eligibility determination process for Medicaid and other community-based long-term care programs as appropriate to inform system development and service redesign and report the findings biennially to the Legislative Budget Board and the Governor beginning in fiscal year 2011. DADS and the AAAs could use statewide caregiver data to evaluate the needs of assessed caregivers, measure the effectiveness of certain caregiver support interventions, improve existing programs, and develop new services to sustain informal caregivers.

Recommendation 5 would include a rider in the 2010–11 General Appropriations Bill that directs DADS to develop and submit a report on strategies to strengthen the delivery of informal caregiver support services implemented after the effective date of the 2010–11 General Appropriations Act to the Legislative Budget Board and the Governor by September 1, 2010.

FISCAL IMPACT OF THE RECOMMENDATIONS

Recommendations 1, 2, 3, and 4 would direct DADS to implement strategies to strengthen the current delivery of caregiver support services. Recommendation 5 would direct DADS to develop and submit a report on the status of implementing strategies to strengthen the delivery of informal caregiver support services to the Legislative Budget Board and the Governor. The recommendations are intended to help sustain the informal care system and avoid future Medicaid institutional spending. It is estimated that these

recommendations would have no significant fiscal impact because they could be implemented using existing resources. The introduced 2010–11 General Appropriations Bill includes a rider that directs DADS to develop and submit a report on the status of implementing strategies to strengthen the delivery of informal caregiver support services to the Legislative Budget Board and the Governor by September 1, 2010. The introduced bill does not include any other adjustments as a result of these recommendations.

IMPROVE THE OPERATION OF THE BUSINESS ENTERPRISES OF TEXAS PROGRAM

Federal statute authorized the Business Enterprises of Texas program to create jobs and increase business opportunities for persons who are blind or visually impaired. The program is a state-administered, federally sponsored program that gives persons who are legally blind training, support, and contracting priority in the operation of automatic vending machines, snack bars, cafeterias, and convenience stores on federal and state property. The Texas Department of Assistive and Rehabilitative Services administers the program and recruits, trains, licenses, and places blind individuals as operators of these facilities. Business Enterprises of Texas facility managers are private business owners who are responsible for the daily operations of the facility, which includes hiring, firing, training, and supervising all employees.

The program is not structured to maximize participation and lacks a formal mechanism to solicit customer feedback. Increasing the percentage of blind, disabled, and disadvantaged people employed by Business Enterprises of Texas facility managers and surveying state host agencies and customer populations annually on satisfaction of operational conditions would help improve the program's effectiveness.

Host agencies directly support the Business Enterprises of Texas program by supplying overhead costs such as rent, utilities, and maintenance. These costs are not accounted for in the program's budget or performance metrics. Accounting for and managing the total costs of operating the Business Enterprises of Texas program would increase the transparency of program operating costs.

FACTS AND FINDINGS

- At the end of fiscal year 2007, 123 Business Enterprises of Texas vending facilities were operated by blind licensed managers. These facilities employed over 1,300 employees.
- At the end of fiscal year 2007, the average income for Business Enterprises of Texas vending facility managers in Texas was over $96,000, and their average tenure was 8.5 years.

CONCERNS

- Texas statute requires blind licensees to give employment preference to blind, disabled, and other disadvantaged groups; however, from October 2006 to September 2007, less than 10 percent of employees hired by Business Enterprises of Texas facility managers who operated a vending facility on state property were blind or disabled.
- There is no formal process for collecting, maintaining, analyzing, or addressing customer feedback made to Business Enterprises of Texas facility managers or Business Enterprises of Texas program staff. Input on program operations such as product pricing, hours of operation, menu options, and product lines could help improve the quality of services in the program's vending facilities.
- Host agencies play a significant role in supporting the Business Enterprises of Texas program vending facilities by absorbing overhead costs such as rent, utilities, and maintenance, but these costs are not accounted for in the program's operating budget and are not reported as a benefit to the program's client population.

RECOMMENDATIONS

- **Recommendation 1:** Amend Rider 1 of the Texas Department of Assistive and Rehabilitative Services bill pattern in the 2010–11 General Appropriations Bill to include a new performance measure requiring the Texas Department of Assistive and Rehabilitative Services to report on the number of blind and disabled individuals employed by Business Enterprises of Texas facility managers to the Legislative Budget Board and the Governor.
- **Recommendation 2:** Include a rider in the 2010–11 General Appropriations Bill requiring the Texas Department of Assistive and Rehabilitative Services to survey state host agencies annually on satisfaction of operational conditions for the Business Enterprises of Texas program, such as pricing requirements, hours of operation, menu items, and product lines.
- **Recommendation 3:** Include a rider in the 2010–11 General Appropriations Bill requiring the Texas Department of Assistive and Rehabilitative

Services to submit a report by October 1st of each year of the biennium to the Legislative Budget Board and the Governor that provides an estimate of the total costs that are incurred by each state host agency for the operation of Business Enterprises of Texas cafeterias, snack bars, and convenience stores.

DISCUSSION

The federal Vending Facility Program was established by the Randolph-Sheppard Act (R-S Act) in 1936 to provide qualified blind individuals with employment and self-support by providing opportunities to operate vending facilities including cafeterias, snack bars, and automated vending machines. Federal law was amended in 1954 and again in 1974 to give contracting priority in the operation of vending facilities on federal property to blind and visually impaired individuals.

In fiscal year 2007, 2,545 blind vendors operated 3,031 vending facilities throughout the country, generating more than $710 million in revenue. During that year, the average vendor earnings were $46,753. Under the R-S Act, states are responsible for administering the Vending Facility Program. State licensing agencies recruit, train, license, and place blind individuals as operators of vending facilities on federal and other property.

Texas' vending facility program is the Business Enterprises of Texas (BET) program, which has been in operation since 1936. The R-S Act provided legislative authority for the BET program, and state statute defines the specific operations of the program within the limitations of the federal law. For example, in 1979, Texas extended the priority provision to include state property, giving individuals who are blind contracting priority in the operation of vending facilities on state property. Under Texas law, "vending facilities" refers to cafeterias, snack bars, vending machines, and convenience stores. These facilities are in office buildings, prison units, state schools, state hospitals, military facilities, highway rest stops, and post office buildings.

The Texas Department of Assistive and Rehabilitative Services (DARS) administers the program, and the program is funded with self-generated funds and federal grant funds. The BET program works closely with DARS Vocational Rehabilitation Services to recruit candidates to the program. A vocational rehabilitation (VR) counselor is responsible for determining and recruiting appropriate candidates for the BET program. An appropriate candidate for the program is age 18 or older and a resident of Texas. The individual must also be legally blind or visually impaired under federal standards (no more than 20/200 vision acuity in the better eye with correcting lenses) and must possess specific characteristics and skills deemed necessary to succeed as a vending facility manager. VR counselors identify appropriate candidates by assessing a candidate's performance in a series of diagnostic tests and comprehensive trainings.

Program candidates must complete a 16-week training course facilitated by BET program staff. Eighteen full-time state employees staff the BET program and are responsible for training, licensing, and assigning individuals who are blind to be operators of vending facilities located on federal, state, or private property. Once they are licensed and assigned to a facility, they are responsible for the daily operations of the facility including the hiring, firing, training, and supervision of all employees. According to Texas statute, DARS has the authority to establish the conditions for operation of a BET facility including pricing, menu selection, and product lines. Other ongoing duties of the BET program staff include providing the following:

- annual trainings on new BET developments;
- continuing education and training courses to enhance skills and productivity; and
- explanations of various rules, procedures, policies, and standards.

At the end of fiscal year 2007, 123 BET vending facilities were operated by blind licensed managers. These facilities employed over 1,300 employees. The average annual income of BET facility managers was over $96,000, and the average tenure was 8.5 years.

FEDERAL REVIEW OF THE RANDOLPH-SHEPPARD ACT PROGRAMS

In 2005, the U.S. Senate Committee on Health, Education, Labor and Pensions (HELP) completed a report on federal programs for employment of persons with disabilities, which included a review of the programs authorized by the R-S Act. The committee found that the purpose of the R-S Act was to help blind persons obtain competitive employment, but the program has succeeded in benefiting only a select few. Nationally, less than 5 percent of employees hired by R-S Act licensed blind vendors are blind, and less than 9 percent of the employees are blind or have another disability. According to the committee report, licensed blind vendors defend their right to hire as they see fit and claim that the purpose of the

R-S Act is to create blind "entrepreneurs;" however, the word "entrepreneur" is not in the statute, and no member of Congress has used the word "entrepreneur" in debating the R-S Act. The committee concluded that the R-S Act programs do not maximize the vocational potential of persons who are legally blind and unfairly produce large financial benefits for a few licensed blind vendors as opposed to encouraging the growth of jobs for the blind community.

The U.S. Senate considered reform legislation in June 2008, which included reforms to address the findings of the committee. The goal of the legislation was to create more and better jobs for individuals with disabilities by reauthorizing the R-S Act to extend opportunities to licensed vendors with disabilities and identifying new vending facility sites. The introduced legislation also transferred the R-S Act-related functions of the Commissioner of the Office of Special Education and Rehabilitative Services to the HELP Committee to restore accountability of the R-S Act Programs.

INCREASING THE NUMBER OF BLIND/DISABLED EMPLOYEES

The number of blind adults in Texas who are unemployed is unavailable, but nationally, 70 percent of blind adults are unemployed. Texas Human Resources Code requires an individual licensed to operate a vending facility on state property to give hiring preference to a qualified, visually handicapped person. If this is not possible, then a handicapped person whose disability is not of a visual nature must be given preference followed by a person who is socially, culturally, economically, or educationally disadvantaged. Individuals licensed to operate a vending facility on state property who refuse to comply with this section are subject to revocation of their license.

At the end of fiscal year 2007, 123 BET vending facilities were operated by blind licensed managers with over 1,300 employees; however, less than 10 percent of all BET vending facility employees in Texas were blind or disabled employees. DARS reported that because the federal R-S Act does not dictate that blind facility managers give employment priority to blind or disabled individuals, the program does not enforce the Texas statute requirements.

According to the American Council of the Blind, several states set hiring preferences and goals for R-S Act vendors to hire individuals who are blind or have other disabilities. Tennessee offers a credit towards an R-S Act vendor's set-aside fees as an incentive for R-S Act vendors to hire more individuals who are blind or have other disabilities. Set-aside fees are a percentage of the net proceeds of each vending facility that pay for program expenses such as management services and maintenance of equipment. Ohio statute requires vending facility managers to give hiring preference to people who are blind. The U.S. Senate HELP Committee reported concerns regarding the low percentage of employees hired through the R-S Act programs who are blind or disabled and stated that, nationally, the program is benefiting too few people. Enforcing current law in Texas would increase the number of blind and disabled individuals hired through the BET Program.

Recommendation 1 would amend Rider 1 of the DARS bill pattern in the 2010–11 General Appropriations Bill to include new performance measures requiring the DARS to report on the number of blind and disabled individuals employed by BET facility managers to the Legislative Budget Board and the Governor. The program should develop a strategy to increase the percentage of blind or disabled individuals who are employed by BET facility managers by 5 percent each year. This recommendation would help increase compliance with existing statute and increase the proportion of blind and disabled individuals hired by BET facility managers.

CUSTOMER SERVICE IN THE BET VENDING FACILITIES

Before being assigned to a facility, all licensed managers receive training on proper communication and customer service techniques, and BET program consultants are available to provide guidance and advice on issues related to the daily operations of vending facilities. Similar to other food service settings, most customer concerns are addressed immediately by the manager at the facility.

Texas Administrative Code requires DARS to establish the conditions for operation of a BET facility including pricing requirements, hours of operation, and menu items or product lines in accordance with rules and any requirements of the host entity; however, the BET program allows vending facility managers to determine certain operating conditions, such as menu items. If a vending facility host has questions or concerns about menu items, he or she is referred to the vending facility managers. Other issues related to operating conditions are directed to BET program staff by e-mail or telephone.

There is no formal process for collecting, maintaining, and analyzing data on complaints made to vending facility managers or BET program staff. DARS should establish the

operating conditions of a BET facility in accordance with its rules and any requirements of the host. Recommendation 2 would include a rider in the 2010–11 General Appropriations Bill requiring the DARS BET program to survey state host agencies annually on satisfaction of operational conditions such as pricing requirements, hours of operations, menu items, and product lines. The BET staff should use the results of the survey to evaluate customer satisfaction, identify trends, and determine if the host facility's needs are being accommodated.

IMPROVING THE TRANSPARENCY OF BET PROGRAM OPERATIONAL COSTS

At the beginning of fiscal year 2008, there were 120 BET-licensed vending facilities in Texas. **Figure 188** shows the listing of BET facilities by type.

FIGURE 188
TEXAS BET FACILITIES ON FEDERAL, STATE AND PRIVATE PROPERTY, FISCAL YEAR 2008

FACILITY TYPE	NUMBER OF FACILITIES	PERCENTAGE OF TOTAL
Vending Machines	66	55%
Snack Bars	24	20%
Cafeterias	23	19%
Convenience Stores	7	6%
TOTAL	**120**	**100%**

SOURCE: Texas Department of Assistive and Rehabilitative Services.

Cafeterias, snack bars, and convenience stores require a greater amount of space to operate compared to vending machines. These facilities require an average of 2,200 square feet to operate. Texas Government Code and Texas Human Resources Code require state agencies to provide space, utilities, janitorial support, and other related expenses in order for BET facilities to operate. These overhead costs are provided at no cost to the BET licensed businesses and are not accounted for in the operating budget for the BET.

During fiscal year 2006, BET licensees operated 24 cafeterias and snack bars on state property. The Texas Facilities Commission (TFC) and property-owning state agencies provided 54,860 square feet for the operation of BET cafeterias and snack bars. During this period, TFC and the property-owning agencies rented comparable space in buildings across the state at an average rate of $14.91 per square foot. Based on the average rental rate per square foot, the value of the space provided to BET cafeteria and snack bar businesses was $817,963. The value does not include the cost of maintenance, utilities, and janitorial support that state agencies also provide as hosts for BET cafeteria and snack bar businesses. These costs are incurred by state host agencies and are an additional way that the state supports the BET program. The BET program's operating budget does not account for these costs because there is no requirement to do so; however, accounting for these costs would increase the transparency of the BET program's operating costs.

Recommendation 3 would include a rider in the 2010–11 General Appropriations Bill requiring the DARS BET program to submit a report by October 1 of each year of the biennium to the Legislative Budget Board and the Governor that provides the total annual costs incurred by each state agency host for the operation of BET cafeterias, snack bars, and convenience stores. Reported costs should be fully inclusive of all costs incurred by the host agency and include, at a minimum, the value of the space used, maintenance costs, utility costs, janitorial costs, and the method of finance for each cost. An outline of the methodology used to determine the final cost should also be included in the report. The BET program should work with the host agencies and TFC to determine these costs and the report should be prepared in a format specified by the Legislative Budget Board and the Governor.

FISCAL IMPACT OF THE RECOMMENDATIONS

There is no fiscal impact associated with these recommendations. The recommendations require the BET program to implement process improvements and report on the results of these efforts. These efforts can be implemented using existing resources.

The introduced 2010–11 General Appropriations Bill includes a rider to implement Recommendations 1, 2, and 3.

EXAMINE THE EVIDENCE FOR CHRONIC DISEASE MANAGEMENT PROGRAMS FOR TEXAS BENEFICIARIES IN MEDICAID AND THE CHILDREN'S HEALTH INSURANCE PROGRAM

Individuals with one or more chronic diseases demand an increasing share of the nation's healthcare spending. Many governmental healthcare entities implemented disease management programs expecting improvements in the quality of healthcare that individuals with chronic diseases and conditions receive and reductions in healthcare costs. A key component of chronic disease management programs is the use of evidence-based practice guidelines. Their use has merit by improving decision-making regarding the appropriate level of care and fostering uniformity in the care individuals with chronic illness receive. This report examines chronic disease management programs that serve Texas beneficiaries in the Medicaid and Children's Health Insurance Programs. The report also highlights selected federal and state chronic disease management initiatives and the role of evidence-based practice guidelines in advancing appropriate and high quality healthcare for the individuals with chronic illnesses.

FACTS AND FINDINGS

- Nationally, the evidence that disease management programs are successful in improving the quality of healthcare patients with chronic conditions receive is well documented in the private health sector and is becoming increasingly so in the public sector. However, the evidence that disease management programs are successful in reducing the cost of healthcare and achieving significant return-on-investment is more compelling in the private sector than in the public sector.
- In general, challenges to effective disease management include issues regarding provider support and engagement, continuous review and revisions of clinical practice guidelines based on the latest evidence-based research, and mechanisms for accessing and disseminating clinical practice guidelines and best practices.
- The Texas Health and Human Services Commission implemented several disease management programs to address chronic illnesses. In general, programs are succeeding in informing patients and physicians about the benefits of disease management and in identifying and promoting the use of evidence-based practice guidelines and resources.
- The Texas Health and Human Services Commission reports that all Texas Medicaid managed care organizations, as well as the Medicaid Fee-for-Service and Primary Care Case Management programs, have implemented disease management programs for specified chronic illness and conditions.
- More time is needed before the disease management of chronic illness initiatives in Texas can be deemed successful in terms of significantly improving the appropriate use of healthcare resources, specifically the reduction in emergency room and hospital visits, and achieving true cost savings.
- The standardization of quality performance indicators across all disease management programs in Texas Medicaid Managed Care, Fee-for-Service and Primary Care Case Management programs would aid the evaluation process and may improve the outcomes of the performance assessments conducted by the External Quality Review Organization and others.
- Texas Medicaid Fee-for-Service/Primary Care Case Management is considering a transition to disease management focused on individuals with chronic illness who are at the highest level of risk for resource utilization rather than disease management focused on specific diseases or conditions. Medicaid programs in some states have already made this transition.

DISCUSSION

According to the federal Centers for Disease Control and Prevention (CDC), chronic diseases are the leading cause of deaths in the U.S. Seven of every 10 deaths each year in the U.S. are linked to chronic disease. In 2005, 133 million Americans had at least one chronic condition. Medical costs associated with chronic disease are more than 75 percent of the nation's total medical costs of $2 trillion.

National and state statistics highlight the challenges associated with severe chronic illness. With regards to diabetes, for example, CDC indicates that 14.6 million Americans were diagnosed with diabetes in 2005. The number of Texans diagnosed with diabetes grew from approximately 680,000 in 1994 to approximately 1.3 million in 2005. Similarly, the most common cardiovascular diseases—heart disease and stroke—account for 35 percent of all deaths in the U.S. Cardiovascular disease is the leading cause of death in Texas. CDC indicates that two of the 10 most expensive hospital treated conditions in Texas are heart related, with hospital charges for these conditions averaging $65,000.

DISEASE MANAGEMENT AND EVIDENCE-BASED PRACTICE

Many federal and state healthcare reform initiatives include disease management (DM) of specific chronic disease and complex conditions as one approach to address access, quality, utilization, and cost concerns. DM is categorized as a medical model for care coordination. Specifically, the Disease Management Association of America (DMAA) defines DM as "…a system of coordinated health care interventions and communications for populations with conditions in which patient self-care efforts are significant." According to DMAA, a full-service DM program should include all the following components:

- population-identification processes;
- evidence-based practice guidelines;
- collaborative-focused practice models including physician and support services providers;
- patient self-management education;
- process and outcome measurement, evaluation and management; and
- routine report and feedback with communication loops that may include patients, physicians, health plans, ancillary providers, and practice profiles.

Early DM programs were disease-specific and usually focused on specific chronic diseases, including diabetes, congestive heart failure (CHF), asthma, and chronic obstructive pulmonary disease (COPD). This approach presented operational challenges because many DM participants were often being cared for in multiple programs. More recently, the DM industry, focusing on the whole person, strives to address all of a patient's conditions in one program.

One report describes evidence-based medicine as "the conscientious, explicit, and judicious use of current best evidence in making decisions about the care of individual patients." A common way of implementing evidence-based medicine is the use of clinical practice guidelines, or a series of sequenced steps that based on the best evidence guide the decision-making in rendering specific and appropriate healthcare. Evidence-based medicine and the application of clinical practice guidelines are offered as solutions to rising healthcare costs, inequality in healthcare access, and variation in clinical practice. Variation in medical care is considered problematic because it is linked to overuse, underuse, or misuse, and to increased risk of medical error.

Although the evidence for DM is strengthening, some argue that the literature supporting the effectiveness of DM in addressing access, quality, and cost issues should be reviewed with caution. Supporters of evidence-based medicine are encouraged by its perceived benefits, such as a means of measuring the efficacy of medical practice to promote standardization. The increased efficacy in medical practice could produce greater efficiency because ineffective practices would not be employed. Greater uniformity could also be accomplished by limiting the use of some practices performed. Opponents of evidence-based medicine argue that practice standards can be detrimental at the local level by dismissing the benefit or effect that differences in technique and treatment have on patient outcomes. Standards could also diminish innovation and competition in medical practice and practitioners may lose their ability to contend with variation in patient populations. Skilled healthcare professionals could be replaced by less skilled workers without the competencies needed to handle diverse situations.

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 established the Citizens Health Care Working Group. The group's report notes that there is on-going activity to expand evidence-based healthcare through the efforts and support of federal and state programs, such as Medicaid and State Children's Health Insurance Programs, policy initiatives, federal entities such as the U.S. Preventive Services Taskforce, the Evidence-based Practice Centers, the Agency for Healthcare Research and Quality, and international entities such as the Cochrane Library. Entities like these provide updated evidence needed to support decisions on core benefits and services.

The group envisions a nonpartisan public/private entity, guided by evidence-based knowledge and expert consensus and within economic constraints, that is responsible for

making decisions regarding the core of cost-effective benefits and services offered. The workgroup suggests that if the evidence supporting two medical treatments is equal but one of the treatment costs more, then the lower cost treatment would be included in the core benefits and services. Medically ineffective treatments would not be covered. Individuals choosing alternative benefits and services not proven to be cost-effective would pay more to obtain this care.

The report notes that individuals with chronic disease are more likely to experience instances of poor or inconsistent quality of care. The poor management of chronic disease results in significant medical and administrative costs, increased absenteeism, and reduced worker performance.

The report suggests that a successful DM model is one that offers a patient-centered approach and provides data to patients and providers to promote positive action. Additionally, patients and providers, if necessary, are educated about the disease and available evidence-based treatment. Social and emotional support is provided to assist the patient in responding to the new information. The expectation is that the intervention should improve care and cause behavioral changes that lead to improved utilization of healthcare resources. This may not mean that fewer services are used but that the services are provided in more appropriate settings. Ultimately, it is the improvement in health status that would result in a better quality of life for individuals with severe chronic illness and a reduction in medical and non-medical costs.

MEDICAID AND CHRONIC DISEASE MANAGEMENT

In February 2004, CMS provided guidance on how states can cover DM in their Medicaid programs and identified several options that states have in the design and operation of DM programs. One option is that states offer DM as a medical service provided by licensed practitioners, with the intent of improving or maintaining beneficiaries' health. Medical assessment, medical self-management instruction, and dietary or disease education are examples of DM services that qualify as direct services and are reimbursed at the state's regular FMAP rate. DM models can be authorized through a Medicaid state plan amendment or a waiver provided through contracts with DM organizations, through Enhanced Primary Care Case Management (PCCM) programs, or through individual fee-for-service (FFS) providers. States may also offer DM services indirectly as an administrative function. For example, a state or contractor could work with providers to promote the use of evidence-based practice guidelines.

The Texas Medicaid Program offers DM services to beneficiaries in the Managed Care, FFS, and PCCM programs. The state Medicaid programs that offer disease management and the chronic diseases or conditions targeted are shown in **Figure 189**.

FIGURE 189
TEXAS MEDICAID PROGRAMS OFFERING CHRONIC DISEASE MANAGEMENT SERVICES AND CHRONIC DISEASES TARGETED AS OF JANUARY 2008

MEDICAID PROGRAMS REQUIRING DISEASE MANAGEMENT	DISEASE MANAGEMENT EFFECTIVE DATE	DIABETES	ASTHMA	CHRONIC OBSTRUCTIVE PULMONARY DISEASE	CORONARY ARTERY DISEASE	DEPRESSION	CONGESTIVE HEART FAILURE	OTHER CHRONIC DISEASES
Fee-for-Service	11/04/2004	X	X	X	X	X	X	
Primary Care Case Management	01/09/2005	X	X	X	X	X	X	
STAR	11/15/2005	X	X					
CHIP	11/15/2005	X	X					
STAR+PLUS	10/03/2006	X	X	X	X	X	X	X
Integrated Care Management	12/01/2007	X	X	X			X	X
STAR Health Program (Foster Care Model)	01/21/2008		X					

SOURCES: Legislative Budget Board; Texas Health and Human Services Commission.

DISEASE MANAGEMENT IN TEXAS' MEDICAID MANAGED CARE PROGRAMS

The Health and Human Services Commission's (HHSC) *Uniform Managed Care Manual* outlines the requirements regarding the provision of DM services. Texas Medicaid Managed Care Organizations (MCOs) are required to provide DM services to Medicaid beneficiaries with at least one targeted chronic disease or condition. (The MCOs are comprised of Health Maintenance Organizations (HMOs) and an Exclusive Provider Organization or provider network.) Effective October 3, 2006, MCOs participating in the State of Texas Access Reform (STAR) and STAR+PLUS programs and the Children's Health Insurance Program (CHIP) were required to provide a comprehensive DM program or coverage for DM services. Similarly, the Integrated Care Management program and the STAR Health Program for children in Foster Care, were required to provide DM services or coverage for these services effective December 1, 2007, and January 21, 2008, respectively. All of the programs are required to provide DM services or coverage for Medicaid or CHIP beneficiaries with specific chronic illnesses or conditions and to include the following components:

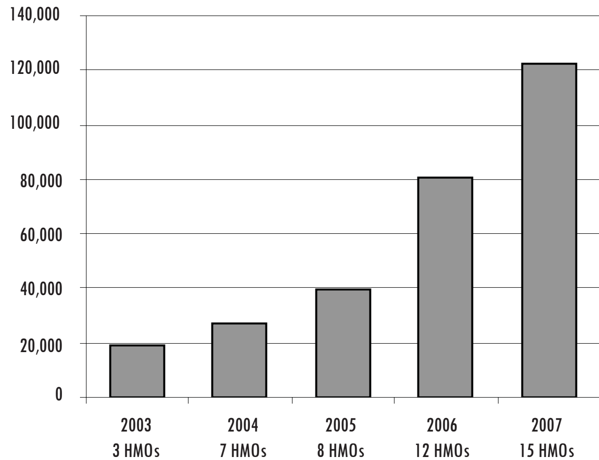
- intensive outreach including home visits for members without telephone service;
- methodology for determining the gap between actual and recommended prevention and treatment services members receive;
- methodology for ensuring that MCO members' medical care conforms to "nationally recognized evidence-based practice guidelines";
- assessment of members' adherence to medical care and instruction;
- methodology for identifying members at high-risk for not adhering to recommended care;
- adequate provider and service linkages to facilitate access to medically necessary services as well as other services such as pharmacy, rehabilitative therapies, transportation, and interpreter services;
- methodology for providing member and caregiver education regarding the members' medical condition and health care needs;
- development and circulation of appropriate educational materials to inform members about the DM project and relevant healthcare topics;
- methodology for communicating with local hospitals about member needs such as notification of hospital admissions, care coordination support, discharge planning, care plans, and on-site visits as needed; and
- comprehensive evaluation including initial assessment and periodic follow-up regarding members' health status including telephone contact and visitation for hard-to-reach members.

HHSC requires that MCOs participating in the STAR Health Program provide 24-hour call center access and service coordination, including program-related and local resources and services. Texas' Medicaid administrator, Texas Medicaid and Health Partnership, provides monthly claims and encounter data to the health plans. Analysis of the data is one way that health plans identify beneficiaries eligible for DM services.

In summary, MCOs are responsible for identifying persons eligible for DM services through pharmacy management records, claims and encounter data, and information provided on health plan member health surveys. Additionally, health plans encourage their providers to inform patients and encourage eligible patients to enroll in the DM program. The provider may refer the patient to the health educator or registered nurse generally responsible for outreach and enrolling patients into the DM program. The patient's risk level determines the level of services provided. Usually, patients with more complex or severe diseases and/or those with more frequent emergency room or hospital use receive intense outreach and follow-up and more frequent person-to-person encounters with the DM program's nurse, health educator, or case manager. These individuals also receive medical and social supports.

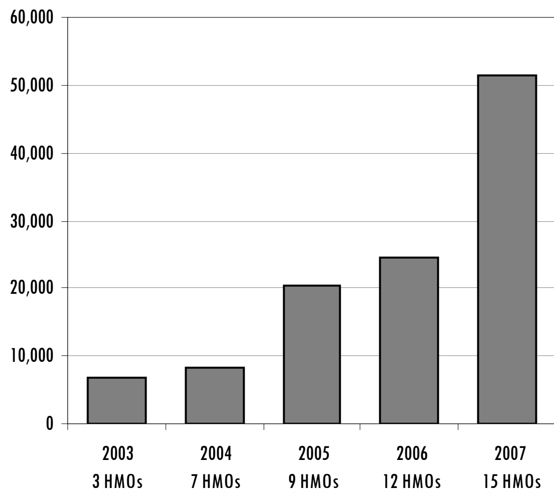
According to HHSC, all 17 Texas Medicaid HMOs now offer DM services. A total of 127,254 Medicaid Managed Care (MMC) and CHIP beneficiaries were identified with at least one targeted chronic disease or condition and, therefore, were eligible for DM services in HMO Reported Year 2007 (with 15 of the 17 HMOs reporting in the year). Of the total, 51,440 or 40 percent of MMC and CHIP beneficiaries identified as eligible for DM services received the services that year. The number of MMC and CHIP beneficiaries eligible for DM services and the number receiving DM services from 2003 to 2007 are included in **Figures 190 and 191**, respectively. The number of HMOs reporting in each year is also included.

FIGURE 190
NUMBER OF TEXAS MEDICAID AND CHIP MANAGED CARE BENEFICIARIES ELIGIBLE FOR THE DISEASE MANAGEMENT PROGRAM AND NUMBER OF HMOs REPORTING IN THE HMO REPORTED YEARS 2003 TO 2007



SOURCES: Legislative Budget Board; Texas Health and Human Services Commission.

FIGURE 191
NUMBER OF TEXAS MEDICAID AND CHIP MANAGED CARE BENEFICIARIES RECEIVING DISEASE MANAGEMENT SERVICES AND NUMBER OF HMOs REPORTING IN THE HMO REPORTED YEARS 2003 TO 2007



SOURCES: Legislative Budget Board; Texas Health and Human Services Commission.

According to HHSC, there are differences in the way the HMOs structure their DM programs resulting in some inconsistencies in the reported information. For example, some health plans submitted information based on their program year rather than the fiscal year.

CMS requires state MMC programs to contract with external quality review organizations (EQROs) to insure compliance with quality performance standards. The Texas MMC programs adopted a set of quality of care measures including measures related to asthma and diabetes management, among others. Regarding DM, the fiscal year 2005 EQRO report recommended that the next external review process should include an examination of the clinical practice guidelines in more detail and more fully define the elements of DM offered. Similarly, the fiscal year 2006 external evaluation the Texas Medicaid Managed Care STAR program cited a concern regarding the diabetes quality measures and concludes that improvements were needed in the medical management of beneficiaries with diabetes. The report suggests that HHSC continue to monitor the diabetes quality measures to assess the effectiveness of the DM programs for diabetes management.

DISEASE MANAGEMENT IN TEXAS' MEDICAID FEE-FOR-SERVICE AND PRIMARY CARE CASE MANAGEMENT PROGRAMS

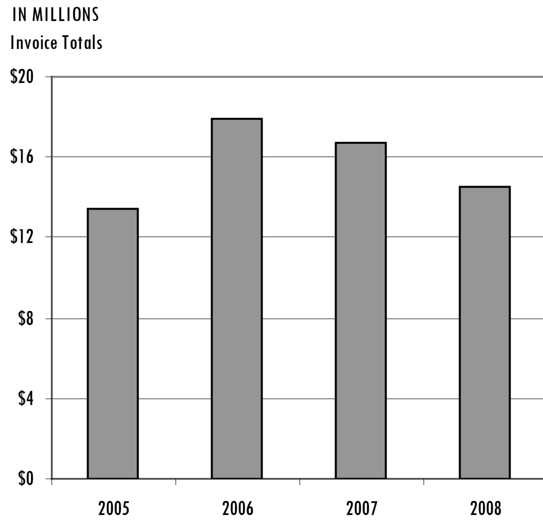
The Texas Medicaid program contracts with a DM organization to provide DM services for beneficiaries in the FFS and PCCM programs. Beneficiaries with chronic illnesses, including asthma, diabetes, COPD, CAD, and CHF are eligible to receive DM services. According to HHSC, the DM contractor identifies a Medicaid beneficiary eligible for DM services by certain diagnostic codes and by analysis of claims data for related diagnoses and other indicators. The individual is contacted, usually by a registered nurse. The contractor also employs community health workers, primarily in rural and south Texas communities, to provide disease-specific group education to eligible DM program participants

HHSC estimates that 40,000 to 45,000 Medicaid FFS/PCCM beneficiaries are eligible each month to receive DM services. Of those eligible for DM services, 8,000 or 9,000 beneficiaries actually participate in the DM program, with 20 percent to 25 percent of these individuals actively managed by DM nurses. The remaining beneficiaries receive community-based support. The level of DM services offered is based on the eligible beneficiaries' risk regarding severity of disease or condition and frequency of acute care utilization. Individuals assessed and identified as highest-risk receive more intense DM services, such as one-to-one sessions with a registered nurse to monitor symptoms and adherence to a medical plan.

HHSC payments for DM services based on invoice totals submitted by the contractor totaled $14.5 million in fiscal

year 2008. **Figure 192** shows the payment amounts from fiscal years 2005 to 2008.

FIGURE 192
HEALTH AND HUMAN SERVICES COMMISSION PAYMENTS TO DISEASE MANAGEMENT CONTRACTOR, FISCAL YEARS 2005 TO 2008



SOURCES: Legislative Budget Board; Texas Health and Human Services Commission.

HHSC contracts with an actuarial firm responsible for completing a year-end contract reconciliation to ensure that the DM contractor meets savings and performance targets. Two reconciliation reports have been completed. The DM services contractor assumed 100 percent risk related to the administrative fees the contractor received and agreed to a 5 percent savings in claims cost in Program Period I (October 2004 to September 2005). In Period II (October 2005 to September 2006), the DM contract was adjusted to 20 percent risk related to the administrative costs and 5 percent savings in claims cost. The reconciliation for each program year determined that the contractor payback amounts totaled $4.7 million in Program Period I and $1.4 million in Program Period II. The totals included amounts related to financial and quality performance.

HHSC indicates that the contractor agreed to use $2.3 million of the Program Period I payback amount to support the following additional program initiatives:

- Health and Wellness Program—a nine-month program targeting DM-eligible clients with CHF, CAD, and diabetes;
- DM Incentive Program—a 17-month program targeting DM-eligible clients who were not actively engaged; and
- Community Resource Additions—four additional nurses and three community health workers hired by the contractor to provide more community-based support services for the DM-eligible population.

The contractor also agreed to use $0.6 million of the Program Period II payback amount to implement a provider incentive pilot targeting providers with DM-eligible clients who were not actively engaged in the DM program. The pilot was implemented in four regions. There are 165 providers enrolled in the program, as of October 2008.

HHSC notes a shift in DM that emphasizes holistic or individual-focused intervention rather than disease-specific intervention. The holistic intervention focuses on patients at highest risk of over-utilizing medical resources. In July 2007, HHSC posted a request for information and plans to implement a statewide Health Management Program. This program will target clients who are expected to incur high costs based on inappropriate utilization patterns and clients with chronic illnesses and conditions considered at risk for future high costs. HHSC indicates that the current DM contract continues through October 2009.

DISEASE MANAGEMENT INITIATIVES IN SELECTED STATES

A survey of selected state Medicaid DM programs exemplifies their varied experiences and the lessons learned. **Figure 193** shows the Medicaid DM initiatives implemented in Florida, Virginia, Indiana, and Washington. In summary, service-related objectives, such as improving patient-provider relationships and increasing patient and provider awareness of the benefits of DM programs, are areas where the states have experienced more success in achieving their goals. The states' success in other service-related objectives, such as increasing the appropriate use of services and quality of services, are more difficult to assess because of concerns related to evaluation design, baseline determination, and quality outcome measurement. The experience these states had in achieving their specific financial goals related to cost reduction and cost savings demonstrate the need for additional evidence before financial success of Medicaid chronic DM programs is determined. Some states have modified their DM efforts to focus on beneficiaries with chronic illness at highest risk of service utilization.

FIGURE 193
DISEASE MANAGEMENT EXPERIENCE IN SELECTED STATES, NOVEMBER 2008

			SELECTED DM PROGRAM EVALUATION REPORTS		
STATES	DISEASES COVERED	MEDICAID PROGRAMS	MAJOR FINDINGS	RECOMMENDATION/ SOLUTIONS	LESSONS LEARNED
Florida	In 1997, targeted diseases and conditions included asthma, diabetes, HIV/ AIDs and hemophilia. In 1998 added hypertension, cancer, end-state renal disease, congestive heart failure and sickle cell anemia.	Managed Care and Fee-for-Service	2001 – Expected improvement in health outcomes and projected savings were not determined.	Redesign program from disease-specific to individual-focused; reduce number of DM contractors; establish methodology to determine cost savings and recover overpayments.	The program outcomes illustrate the importance of constructing baseline data for future comparison and evaluation of outcomes.
			2004 – Problems persisted in determining cost savings and assessing health outcomes and ensuing appropriate oversight. Other concerns regarding physician support of initiative and use of best practice guidelines.	Improve oversight and monitoring of vendor operations, recipient and provider services; develop strategies to improve provider participation; establish performance expectations; and remove risk-based provision from vendor contract.	The program illustrates the importance of developing effective oversight and monitoring strategies.
			2005 – Challenges include beneficiary contact information and updates and preference for emergency room care; provider participation; and political pressure to reduce costs in the short term.	Solicited community-based entities, physician offices, and clinics to update beneficiary contact information; provider education and provider encouragement to improve patient participation; involve hospital directors in promoting program; and educate policymakers on short- and long-term program benefits.	The program outcome suggests a different approach may be needed in implementing DM services in Medicaid due to the dynamics of a public program and characteristics of the population served.
Virginia	In 2006, targeted diseases and conditions included asthma, congestive heart failure, coronary artery disease, and diabetes. In 2007, added chronic obstructive pulmonary disease.	Managed Care and Fee-for-Service	2007 – Vendor reports DM program successful and majority of outcome measures were met. Improvement needed in claims-based clinical outcomes.	Initiated contract with external evaluator to develop validation strategy and required that vendor reports include financial information such as return-on-investment and expenditure data.	The program outcome illustrates the importance of including the external evaluation component in program design.
Indiana	In 2003, targeted disease conditions included congestive health failure and/or diabetes.	Fee-for-Service and Primary Care Case Management	2008 – Findings related to cost savings were consistent with similar DM studies. The program was successful in achieving cost savings due to DM intervention for congestive heart failure but less successful in diabetes. Finding that DM impact was more successful in low-risk beneficiaries receiving less intense services than in high-risk beneficiaries receiving more intense services was unexpected.	NA	The program was conducted as a random clinical trial. The program outcome illustrates the importance of increasing evidence-based knowledge regarding the impact of DM in the Medicaid population.

FIGURE 193 (CONTINUED)
DISEASE MANAGEMENT EXPERIENCE IN SELECTED STATES, NOVEMBER 2008

			SELECTED DM PROGRAM EVALUATION REPORTS		
STATES	DISEASES COVERED	MEDICAID PROGRAMS	MAJOR FINDINGS	RECOMMENDATION/ SOLUTIONS	LESSONS LEARNED
Washington	Beginning 2002, DM pilot targeted children with asthma and adults with end stage renal disease. Pilot ended 2006.	Beginning 2007, Fee-for-Service	2006 – In general, the pilot was successful in increasing the quality of services and improving provider-patient communications, but was not successful in achieving the anticipated cost savings.	Implemented new Chronic Care Management Program to serve high-risk beneficiaries with chronic disease and those with emerging chronic illness expected to become high-risk in the future if untreated or inappropriately treated.	The program outcome suggests achieving cost savings in Medicaid programs may be more significant in the long-term than in the short-term. Modifications may be warranted as more is learned about DM programs' impact on Medicaid.

SOURCES: Legislative Budget Board;The Florida Legislature; Duke University; Virginia Department of Medical Assistance Services; Washington Department of Social and Health Services; Indiana University School of Medicine.

FEDERAL INITIATIVE IN DISEASE MANAGEMENT

The effect of chronic DM in the Medicare programs is also an area of considerable interest and activity. The Dartmouth Atlas Project of the Dartmouth Institute of Health Policy and Clinical Practice examines the healthcare Medicare beneficiaries receive. The project found that there is considerable variation in the healthcare Medicare beneficiaries who have at least one of nine severe chronic illnesses receive in the last two years of life. Variation is more related to utilization of services than to other factors, such as the price of services or increase in the number of Medicare beneficiaries receiving services. Some of the variation is unwarranted and contributes to rising healthcare costs. Evidence-based systems of care could be more cost efficient and improve quality and access.

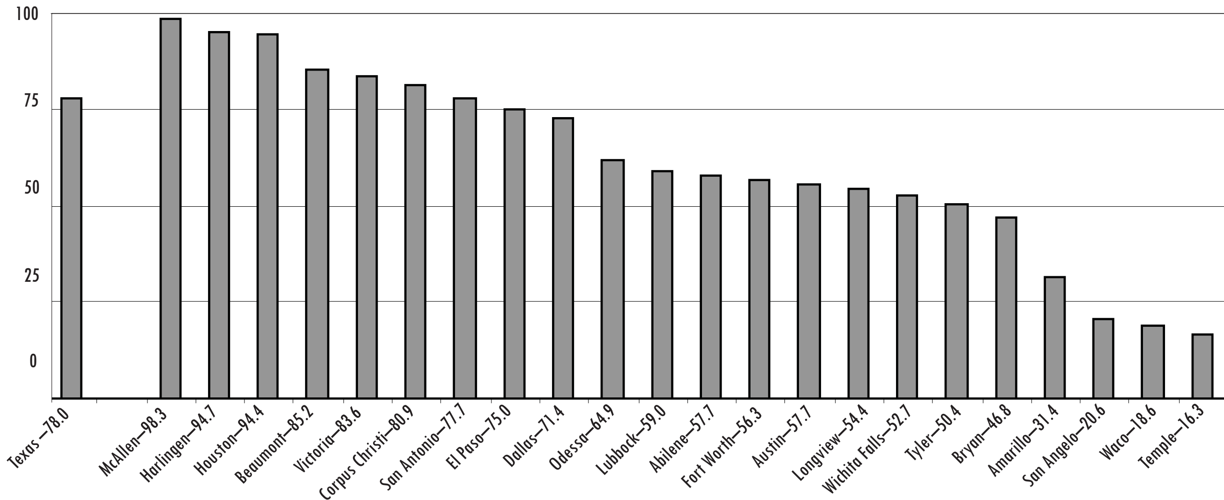
The Dartmouth Atlas Project developed the Hospital Care Intensity Index that captures the propensity to rely on inpatient hospital care in managing individuals with chronic illness. Texas has the twelfth highest score among the 50 states and the District of Columbia. A higher score indicates a greater propensity for relying on inpatient hospital care to manage chronic illness and represents more aggressive treatment; meaning it is more likely that Medicare beneficiaries with severe chronic illness will spend more days in a hospital and receive more visits from physicians during their hospital stays if they receive care in hospital referral regions with higher scores.

According to the Dartmouth Atlas Project, there are 15 hospital referral regions (HRRs) in Texas. The Texas regions and their respective scores are included in **Figure 194**.

The federal experience in implementing DM programs for beneficiaries with chronic illness is mixed. Chronic DM programs, pilots, and demonstrations implemented by the Medicare program and the U.S. Military exemplify the federal experience. The Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 authorized Medicare demonstrations to evaluate the financial and health effects of DM programs. The Medicare DM demonstration in the FFS program began in 2004 and provided DM services and comprehensive prescription drug benefits to beneficiaries who were diagnosed with advanced stage CHF, diabetes, or coronary artery disease. The three-year demonstration targeted Medicare beneficiaries in California, Arizona, and parts of Texas and Louisiana for participation and contracted with three entities providing DM services. The 2008 evaluation report indicates that the demonstration did not have an overall impact on Medicare FFS expenditures or service use. The report also indicates that the effect on quality of care was minor and only affected a few of the measures observed. The report concludes that major improvements in care quality and beneficiary well- being were considered unlikely.

The federal Medicare Prescription Drug Improvement and Modernization Act of 2003 required the U.S. Department of Health and Human Services to test and evaluate chronic care improvement interventions. Eight pilot sites were selected to provide chronic care services to FFS beneficiaries with CHF and/or diabetes and began between August 2005 and January 2006. In January 2008, CMS announced that Phase I of the program would end after three years of operation. A total of four reports to Congress on the pilot

FIGURE 194
TEXAS HOSPITAL REFERRAL REGIONS SCORES ON DARTMOUTH ATLAS HEALTH CARE INTENSITY INDEX, REPRESENTING THE PROPENSITY TO USE HOSPITAL CARE TO MANAGE CHRONIC ILLNESS IN MEDICARE, 2001 TO 2005



SOURCES: Legislative Budget Board; Dartmouth Institute for Health Policy and Clinical Practice.

program are statutorily mandated. The second report to Congress was released by CMS in December 2008. The interim analysis examines the first 18 months of the pilot program and updates the findings of the initial report regarding quality improvement, beneficiary satisfaction, health outcomes, and financial outcomes. The report notes that of the eight Medicare Health Support organizations participating in the pilot program, three organizations requested early termination of their programs by January 2008. The remaining organizations terminated their programs by August 2008. The key findings from the report include the following:

- Some of the more vulnerable Medicare beneficiaries eligible to participate in the pilot program were less likely to agree to participate.
- The interventions for the participating beneficiaries were not likely to produce significant behavioral change or savings.
- The first 18 months of the pilot provided limited improvement in self-management, physical and mental health functioning, beneficiary satisfaction, or care experience.
- Seven of the participating Medicare Health Support organizations had a positive impact in one or more process-of-care measures but no impact on the reduction of acute care utilization or mortality.
- Together, the Medicare Health Support organizations accrued fees that exceeded savings.

The report concludes that none of the Medicare Health Support organizations, at the midpoint of the pilot, met the statutory requirements regarding improvement in quality of clinical care, improvement in beneficiary satisfaction, and achievement of savings target. The report also concludes that the first 18 months of the pilot program did not support the use of the private disease management models as a cost-effective strategy for chronically ill Medicare beneficiaries. The third report to Congress will provide an assessment of the complete three years of the pilot program and include analyses of provider satisfaction, acute care utilization, and health and financial outcomes.

The federal John Warner National Defense Authorization Act of 2007 required the Secretary of the Department of Defense (DOD) to implement DM programs for certain diseases and conditions. The DOD was also required to submit an evaluation on the Military Health System's Disease and Chronic Care Management Program by March 2008. DM services were implemented in September 2006 for asthma and CHF and in June 2007 for diabetes. The DOD program targeted purchased care and direct care beneficiaries who were under 65 years of age with CHF, asthma, and diabetes to receive DM services. Other beneficiaries were eligible under a federal demonstration project scheduled for April 2007 through March 2009. Eligible beneficiaries were

identified based on prior emergency department visits and hospitalizations and medication usage. Some offsets to the cost savings were anticipated, such as administrative and medication costs and increased use of preventive, diagnostic, and other services. A scorecard will track and evaluate the progress of the DM program. As of March 2008, the external evaluation of the DM program had not been completed.

The Task Force on the Future of Military Health Care also examined DOD's DM program. The task force recommended that DOD standardize DM guidelines and case management guidelines in particular to optimize opportunities to improve care coordination.

DISEASE MANAGEMENT IMPLEMENTATION ISSUES

It appears that federal and state chronic DM initiatives are moderately successful in addressing quality, access, and utilization. The evidence that DM favorably impacts the appropriateness of healthcare that individuals with chronic diseases and conditions receive, fostered by adherence to evidence-based medical practice, is strengthening. It appears less likely that DM initiatives will have the expected effect on cost that state and federal healthcare programs seek, at least in the short-term (although DM may reduce inappropriate utilization of higher cost healthcare, namely emergency room and hospital care). It is likely that Texas and other states will find that the economic benefits derived from chronic DM programs are more significant in the long-term.

Achieving successful results in chronic DM programs that are supported by evidence-based practice may require addressing certain patient- and provider-related challenges. Patient-related challenges may include the need to address social and economic concerns of patients to achieve the expected medical outcomes. Provider-related challenges may include addressing provider resistance to practice protocols that include new screening and treatment technologies or electronic medical records, provider preference for traditional provider-patient relationships and conventional treatment practices, or lack of awareness about new treatments or interventions. Additionally, improvements in the evaluation of DM programs and the establishment of performance standards may be needed to accurately determine the impact of DM on healthcare costs, access, utilization and quality.

COORDINATE HOUSING AND HEALTH SERVICES TO MEET AGING POPULATION DEMANDS

Long-term care consists of two main components: housing and services. Older adults prefer to live in their own homes for as long as possible, and research demonstrates that people who age in place have favorable clinical outcomes when compared to similar individuals receiving long-term care services in a nursing home. To "age in place," an individual must have both housing and access to health services. Combining housing and services outside of institutional care is an opportunity to expand the long-term care continuum by creating more options between the two ends of the continuum: independent living and institutional care. Creating more alternatives allows more older adults and individuals with disabilities to age in place, resulting in better clinical outcomes for them and, in most cases, at less cost than nursing home care. Such alternatives are known as service-enriched housing.

"Service-enriched housing" is broadly defined as living arrangements that include health and/or social services in an accessible, supportive environment. The need for service-enriched housing is already here. In 2010, older Texans will represent 10 percent of the population or 2.6 million people, and by 2030, will increase to 15.6 percent of the population or 5.2 million people. The Texas Department of Housing and Community Affairs reports that there is a continuing need for affordable housing for seniors. To increase the number of service-enriched housing projects there are barriers that need to be overcome. Federal and state housing and services programs operate independently with little formal communication and coordination between them. This fragmentation is reflected in different and sometimes conflicting eligibility requirements, funding mechanisms, and regulations that can inhibit integrating housing and services and slow the creation of service-enriched housing developments. Establishing a state entity to develop and implement coordinated state policies that will increase state and local efforts to offer service-enriched housing could increase opportunities for more Texans to age in place.

CONCERNS

- The separation and lack of coordination between housing and health services creates barriers that prevent the development of service-enriched housing, which can prevent people from aging in place.
- Local, state, and federal government agencies, as well as private corporations and non-profit organizations, each have some level of involvement in the financing and delivery of affordable service-enriched housing; however, no one entity exists to coordinate and to reduce barriers created by the number of entities involved in developing service-enriched housing.

RECOMMENDATIONS

- **Recommendation 1:** Amend Texas Government Code, Chapter 2306, to create the housing and health services coordination council within the Texas Department of Housing and Community Affairs to be responsible for increasing state efforts to offer service-enriched housing through increased coordination of housing and health services.
- **Recommendation 2:** Include a contingency rider in the 2010–11 General Appropriations Bill to appropriate $600,000 for the biennium to the Texas Department of Housing and Community Affairs for activities of the housing and health services council.

DISCUSSION

According to the Joint Center for Housing Studies at Harvard University, government involvement in housing began in the 1930s and 1940s as a remedy to health and safety problems, like fire hazards and sources of disease, caused by substandard and overcrowded housing in the industrialized cities of the northeast. Once the federal government became involved in housing, the focus shifted from the public issues of general health and safety to more individual private concerns for the affordability and adequacy of individual housing units for individual households.

This shift erased the natural link between health and housing, and as a result housing and health agencies have diverged into separate systems. This separation can create barriers that prevent people from "aging in place." The National Aging in Place Council defines aging in place as the ability to continue to live in one's home safely, independently, and comfortably, regardless of age, income, or ability level. This means living in a familiar environment and being capable of participating in family and other community activities. Older adults prefer to live in their own homes for as long as possible, and research

demonstrates that people who age in place have favorable clinical outcomes when compared to similar individuals receiving long-term care services in a nursing home.

Individual health needs can create or compound problems for an aging housing stock, and housing needs can create or compound health problems for aging individuals. For example, health issues can delay or prevent home maintenance or repairs, and improper upkeep can lead to an unhealthy living environment. However, when a living environment is safe, affordable, and appropriate, an individual is more likely to maintain his health and independence and as a result will be able to maintain his living environment.

For this report, "service-enriched housing" is defined as living arrangements that include health and/or social services in an accessible, supportive environment. Service-enriched housing occurs on a continuum and includes various types of living arrangements with a variety of services offered to assist the resident with activities of daily living (ADL) and/or instrumental activities of daily living (IADL). **Figure 195** shows the differences in ADLs and IADLs.

FIGURE 195
A COMPARISON OF ACTIVITIES OF DAILY LIVING AND INSTRUMENTAL ACTIVITIES OF DAILY LIVING, 2008

ACTIVITIES OF DAILY LIVING	INSTRUMENTAL ACTIVITIES OF DAILY LIVING
• Bathing/showering	• Preparing meals
• Dressing	• Managing money
• Getting in/out of bed or chair	• Shopping for groceries/personal items
• Using the toilet	• Performing light or heavy housework
• Eating	• Using a telephone

SOURCE: U.S. Centers for Disease Control and Prevention.

Service-enriched housing fills the gap between independent living and facility care. **Figure 196** illustrates the continuum of care and shows examples of independent living, service-enriched housing, and facility care.

AGING DEMOGRAPHICS

The U.S. Census Bureau estimates more than 40 million Americans will be age 65 and older in 2010. By 2050, the estimate increases to 86.7 million. Next year 2.6 million Texans will be age 65 and older, and by 2030 older Texans will comprise 15.6 percent of the population or 5.2 million people. Senior or older Americans (defined here as age 65 and older) requiring health services will grow dramatically over the next two decades. Older adults, regardless of income, will face barriers to maintaining maximum independence due to many reasons. Crucial family supports will disappear as one spouse outlives another or children move to distant places and are no longer able to routinely help. For other seniors, limited financial resources will prevent them from identifying and purchasing needed services. Seniors of all incomes are at risk of institutionalization or neglect because of declining health and the loss or absence of support and timely interventions. According to the federal Commission on Affordable Housing and Health Facility Needs for Seniors in the 21st Century (Seniors Commission), the risk is greatest for those with lower incomes. According to the Kaiser Commission, disability and the need for long term services and supports are highest among older people—nearly 60 percent of people with long-term care needs are age 65 and older.

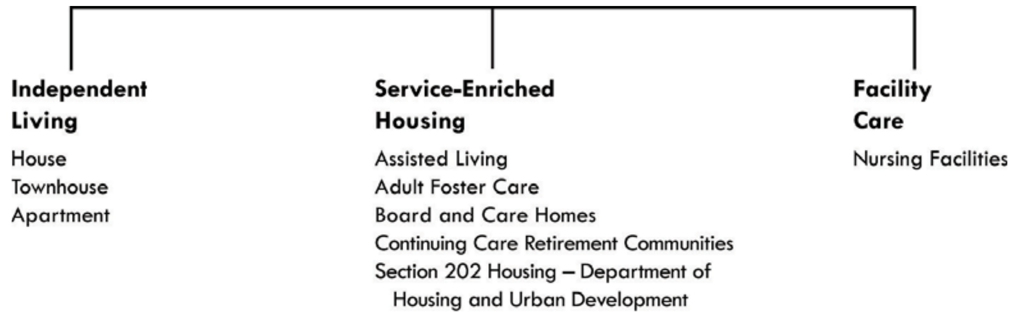
In addition to the growth of the older American population, trends for chronic disease and disabilities are increasing too. Research conducted in 2005 estimates 25 million Americans under age 65 with a chronic disability need help with an ADL. According to a 2005 report from the National Council on Disability, the rate of disability for individuals under age 65 is rising for diabetes, obesity, and mental illness; however, little data exist to accurately predict how this trend will impact the future use of long-term care services and cost.

NATIONAL SERVICE-ENRICHED HOUSING EFFORTS

State and local governments across the country are investing and developing service-enriched housing to meet the demands of older adults and persons with disabilities. Policy changes such as Medicaid waivers and the Olmstead decision are partly responsible for this trend. Medicaid waivers allow states to deliver in-home services to nursing home-eligible residents, and the Olmstead decision by the U.S. Supreme Court in 1999 requires states to create a comprehensive working plan for placing qualified people in the most integrated settings. The trend to allow seniors to age in place has been growing over the last 10 years, and there is greater acceptance that older persons do not necessarily need to relocate as their needs change, but can modify their environment by adding supportive services and reconfiguring their residences. **Figure 197** shows examples of Texas' and other states' service-enriched housing efforts.

Nearly all states have engaged in activities to develop service-enriched housing because it efficiently links services

FIGURE 196
CONTINUUM OF CARE



Key:

Independent Living: Self-contained houses, townhouses, or apartments which seniors either own or rent and where they function as members of the wider community. If supportive services are used, the resident organizes the support.

Service-Enriched Housing: Living arrangements that include health and/or social services in an accessible, supportive environment and allows an individual to participate in family and other community activities.

Facility Care: Living in a room, not a self-contained dwelling, and eating three meals a day communally. Typically bathrooms are shared and doors to residents' rooms cannot be locked. Facility care includes a full package of services, including nursing, housekeeping, laundry, and meal service. Facility residents are generally not members of a larger community.

SOURCE: Joint Center for Housing Studies of Harvard University.

FIGURE 197
SERVICE-ENRICHED HOUSING IN TEXAS AND OTHER STATES, 2008

FACILITY/ STATE	PROGRAM/ LICENSE	UNITS	SERVICES OFFERED	FUNDING	NOTES
Fowler Christian Apartments Dallas, Texas	Federal Section 202 Elderly Housing, Section 8, Assisted Living license	136	Meals, medication assistance, transportation, housekeeping, personal care	Medicaid, Private Pay	Campus offers continuum of care from independent apartment living to skilled nursing care
The Gardens at Osage Terrace Bentonville, Arkansas	Assisted Living license	45	24-hour supervision, social and recreational activities, housekeeping, meals	Medicaid	Services provided by local hospital through a management agreement
Helen Sawyer Plaza Miami, Florida	Public Housing/ Assisted Living	104	24-hours supervision, social, recreational activities, meals, transportation, medication assistance	Medicaid, Private Pay for a la carte services	Residents pay $685/month. Services subsidized through Optional State Supplement (state subsidy)
Project New Hope Los Angeles, California	Federal Section 202 Elderly Housing and Section 8 Low Income Housing	140	Social and recreational activities, case management, housekeeping, meals, health screening	Medicaid, Private Pay	Targets seniors with HIV/AIDS; uses outside resources for meal program

SOURCES: *Journal of Elderly Housing*; NCB Capital Impact.

with housing and provides alternatives to costly institutionalization. Moreover, its advantages include supporting resident communities by leveraging external resources. For example, facilities can establish connections with local governments to access existing services, including those provided by aging, social service, and health agencies. The addition of services can also help create more successful tenancies by increasing resident satisfaction and decreasing resident turnover.

This new view of the housing continuum stresses the elasticity of conventional housing in terms of its ability to accommodate a wider spectrum of older persons. Providing an array of service-enriched housing may lead to more efficient use of long-term care funding because offering a range of health

care services and housing options delivers only the care that is needed by the individual and maximizes an individual's capacity for self-help and independence. Current Medicaid spending in Texas indicates that it costs less on average to serve people on an individual level in the community compared to in an institution. In Texas, because Medicaid community-based care costs less per person than Medicaid institutional care, significantly more clients can be served in Medicaid community-based settings at less total expenditures compared to Medicaid institutional care. In the 2006–07 biennium, spending on all Medicaid community-based care totaled $4.3 billion to serve 253,238 clients compared to $5.7 billion spent to serve 81,176 clients in Medicaid institutional care.

Aging in place options can affect seniors and non-aged persons with disabilities of all income levels, including those who are not Medicaid-eligible, but could become eligible if their housing situation could not accommodate their health needs. Medicaid spending could be impacted if non-Medicaid-eligible populations also use service-enriched housing. Creating more options between independent living and institutional care may allow more non-Medicaid-eligible persons to age in place resulting in fewer people spending down their assets and transferring to institutionalized care provided by Medicaid. Over the last two decades, a limited number of evaluations have been conducted to assess the effectiveness of different approaches to creating service-enriched housing. Several of the evaluations have included an analysis of costs; however, none has directly addressed the issue of cost-effectiveness related to preventing or delaying institutionalization.

Research illustrates the benefits of service-enriched housing as well as the complexities and trade-offs involved. One study in 2002 compared the health outcomes of elderly, low-income residents of assisted living housing with a similar group of community-dwelling seniors. The findings showed the assisted living housing residents were more likely to maintain high functioning, and no more likely to experience death during the study period than their community-dwelling counterparts, despite being at higher health risk at the start of the study period.

The U.S. Department of Housing and Urban Development (HUD) established the federal Congregate Housing Services Program (CHSP) in 1959 as its first major effort to create service-enriched housing for frail older persons living in Section 202 and public housing. Services provided by CHSP included meals, transportation, homemaking, shopping, and service coordination. Evaluation of CHSP found that services were effectively provided to a targeted group of residents (average age 80) with significant ADL and IADL impairments. The evaluation also highlighted the importance of outside agencies and informal caregivers to this population. Despite the positive impact CHSP had on residents, in 1995 competing needs and a feeling that HUD should provide housing and not services resulted in no further funding for new grants. The U.S.Congress has since recognized the benefit of the currently operating programs and has financed their operation with annual extension funding.

While a key reason to pursue service-enriched housing is the aging of the baby-boomer population, national research indicates future increases of disability among the population younger than age 65. Both groups can benefit from the independence service-enriched housing offers.

BARRIERS SLOWING SERVICE-ENRICHED HOUSING EFFORTS

Agencies that administer housing and services programs operate as separate entities both at the federal and state levels. This fragmentation is reflected in different and sometimes conflicting eligibility requirements, funding mechanisms, and regulations that can inhibit integrating housing and services. **Figure 198** shows the differences in administration, funding, and other areas of federal housing and health services programs.

Similar fragmentation exists at the state level. The Texas Department of Housing and Community Affairs (TDHCA) is the primary agency responsible for the administration of federal and state funds for affordable housing and community services, and the Department of Aging and Disability Services (DADS) is primarily responsible for long-term care services. TDHCA's mission is to help finance affordable housing through the administration of tax deductions, tax credits, subsidies, and grants to individuals and municipalities, while DADS' mission is to provide aging and disability services and supports to older adults and persons with disabilities. Each agency has a different set of priorities, yet both agencies' programs impact older adults and persons with disabilities. Collaboration does occur on a limited basis among the agencies; however, no state agency is statutorily responsible for permanent policy and program coordination of service-enriched housing that will benefit older adults and persons with disabilities. **Figure 199** shows examples of state collaboration efforts.

FIGURE 198
PRIMARY POINTS OF FEDERAL LEVEL DISCONNECT BETWEEN HOUSING AND HEALTH SYSTEMS, 2008

HOUSING	HEALTH
Managed by the Internal Revenue Service and HUD.	**Managed** through the U.S. Department of Health and Human Services.
Funded as tax deductions, tax credits, subsidies, and grants to individuals and municipalities.	**Funded** as entitlements, subsidies, and grants to individuals and states.
Calculated as tax credits and deductions before the annual federal revenue projections. Budgetary programs calculated by appropriations.	**Calculated** as Medicare entitlements program by the Finance Committee before federal budget allocation. Medicaid, a budgetary program, requires states to match federal funding and is calculated by appropriations.
Administered by the locality.	**Administered** by the state.
Awarded to an individual or family meeting financial criteria; assistance is received when unit becomes available.	**Awarded** to any individual who meets physical and financial criteria; individual receives services upon qualifying (except for Medicaid waivers).
Operated under 30-year mortgages and affordability requirements ranging from 10–40 years in duration.	**Operated** using 1–2 year funding cycles.
Subsidy follows the housing unit.	**Subsidy** follows the individual.
Performance measured by production: number and affordability of units created.	**Performance measured** by need: number of individuals left unserved.
Regulated by construction and development standards.	**Regulated** by medical standards.

Source: Joint Center for Housing Studies at Harvard University.

FIGURE 199
EXAMPLES OF STATE LONG-TERM CARE COLLABORATION EFFORTS IN TEXAS, 2008

NAME	HOST AGENCY	CHARGE	NOTES
Children's Long Term Care Policy Council	Health and Human Services Commission	Assists HHSC to develop, implement, and monitor long-term service and support programs for children with disabilities and their families.	Focus is on children's long-term care issues.
Aging Texas Well Initiative	Department of Aging and Disability Services	Advises DADS on ways to improve state and local readiness for a growing aging population.	Broad-based effort limits in-depth focus on linking housing with services.
Promoting Independence Advisory Group	Department of Aging and Disability Services	Assists HHSC and other health and human service agencies develop a plan to ensure appropriate care settings for persons with disabilities.	Focus is on assisting persons receiving publically funded long-term care services.
Disability Advisory Group	Texas Department of Housing and Community Affairs	Assesses TDHCA housing programs and initiatives for special needs populations.	Focus is on persons with disabilities.

Source: Legislative Budget Board.

Barriers to creating affordable service-enriched housing can be divided into three main categories: organizational, financial, and regulatory. Initiating a service-enriched housing project involves a large numbers of agencies and entities that are governmental, profit, non-profit, and exist at the federal, state, and local levels. HUD regional offices, state housing finance authorities, community development groups, human service agencies, non-profit community organizations, and public housing authorities are some of the organizations that have some level of involvement in financing and delivery of affordable service-enriched housing. While it takes many partners to produce and maintain service-enriched housing projects, none of the entities involved is formally charged with or the resources to assume a permanent role in coordinating or integrating a complex pool of limited resources and organizing the multiple partners. Health and housing professionals and policymakers have different perspectives and timelines which accentuate the need for persons with multiple perspectives and expertise to view service-enriched housing from all sides.

Funding barriers can impede the progress of service-enriched housing projects. In 2005, the federal Government Accountability Office (GAO) found 23 federal housing programs administered primarily by HUD and the U.S.

Department of Agriculture (USDA) that target or have special features for the elderly. Each had their own eligibility and program requirements to meet which adds to the complexity of service-enriched housing financing. Additionally, GAO found that most of these housing assistance programs were not designed to provide supportive services for the elderly, which could prevent a person from aging in place. The *Journal of Housing for the Elderly* in 2004 states that financing service-enriched housing is often a complex and time-consuming enterprise that may require piecing together funds from numerous federal, state, and local sources, such as Section 202, Low Income Housing Tax Credits, Section 8 vouchers, Community Development Block Grants, redevelopment funds, and donated or discounted land from local entities. Securing funding for services adds an additional layer of complexity once the housing finance options are secured. Housing project developers are often concerned that funding for services may be unreliable and that service agencies cannot make long term commitments, 10 to 30 years, as some housing finance programs require of its investors.

Medicaid waivers can be used to fund the services portion of service-enriched housing; however, Medicaid waivers have state eligibility restrictions for income and assets as well as requirements for nursing home entrance, usually based on functional impairments. Layer these requirements on top of the housing finance requirements and the complexity and difficulty of obtaining financing and eligible residents for a service-enriched housing project becomes evident.

Due to many interpretations of what service-enriched housing means, regulatory requirements vary widely between states. For example, some states base assisted living licensure on service provision, while others use facility characteristics, and still others based it on level of care. While licensure is intended to ensure quality and maintain standards, it can lead to complications when coupled with housing finance requirements. In many states, a license for an assisted living facility cannot be obtained until the facility is built and operational, but failure to obtain a license in advance can cause a project to lose HUD funds. Moreover, states have varying housing requirements that may or may not overlap with Medicaid waiver requirements. For example, a client whose income meets HUD eligibility requirements may not qualify for Medicaid services either due to income and/or functional ability.

PARTNERSHIPS AND STATE COORDINATION PROMOTE SERVICE-ENRICHED HOUSING EFFORTS

To help states overcome these barriers, the Robert Wood Johnson Foundation (RWJF) created a demonstration project to create assisted living options that are affordable to Medicaid-eligible residents as a nursing home alternative. RWJF established the Coming Home Program in 1992 to address the needs of older persons who required affordable supportive housing, especially in rural and low income areas. The program goal was to identify and select a small number of rural communities and organizations to create models of affordable assisted living.

Thirteen states participating in the Coming Home Program received pre-development loans and technical assistance to assist them with feasibility, development, and operational consulting for selected projects. Additional technical assistance included fostering and facilitating partnerships between state agencies and projects to overcome regulatory obstacles, policy conflicts, and subsidy gaps in state housing and service programs. As of April 2006, Coming Home Program results included 98 projects in operation or development comprised of 3,445 affordable units: 45 affordable assisted-living facilities with 1,681 affordable units completed in 13 states and 53 projects in development with 1,764 units in nine states.

Through the Coming Home Program, the RWJF demonstrated public agencies, service providers, non-profit groups, and others interested in creating service-enriched housing could partner effectively to overcome difficult policy and financial barriers. Cross-agency partnerships were critical to the success of Coming Home projects. States with fully committed, ongoing, and effective cross agency partnership had better success in moving service-enriched housing projects to fruition. To create similar ongoing collaboration and cross agency coordination between Texas housing and health services programs, Recommendation 1 would amend Chapter 2306 of the Texas Government Code to create a housing and health services coordination council at the Texas Department of Housing and Community Affairs. The council's purpose would be to increase state efforts to offer service-enriched housing through increased coordination of housing and health services. The council's composition would include state agency staff and public members:

- one representative from the Texas Department of Housing and Community Affairs;
- one representative from the Office of Rural and Community Affairs;

- one representative from the Texas State Affordable Housing Corporation;
- one representative from the Health and Human Service Commission;
- one representative from the Department of Aging and Disability Services;
- one representative from the Department of Assistive and Rehabilitative Services;
- one representative from the Department of Agriculture knowledgeable in the Texans Feeding Texans and Retire Texas programs;
- one member from the Promoting Independence Advisory Committee;
- public member representative of financial institutions;
- public member representative of multi-family housing developers;
- public member representative of healthcare services;
- public member–non-profit representative;
- public member–consumer/advocate representative;
- public member–minority issues representative; and
- public member–rural community representative.

Public members would be appointed by the governor to serve staggered six-year terms. The executive director of TDHCA would chair the council. State agency staff and public members would have substantial knowledge or experience in creating, implementing, or participating in projects that integrate housing and health services and/or have knowledge or experience about the needs or services used by older adults and non-aged persons with disabilities, the populations most likely to utilize and benefit from service-enriched housing models. State agency staff members must have administrative responsibility for programs for older adults and non-aged persons with disabilities or related services provided by the agency that the member represents and have the authority to make decisions for and commit resources of the agency, subject to the approval of the administrative head of the agency.

The council's responsibilities would include:

- development and implementation of coordinated state policies to increase state efforts to offer service-enriched housing;
- identification of barriers preventing or slowing service-enriched housing efforts. The barriers to be examined should include, but not be limited to regulatory, administrative, funding, and coordination;
- development of a system/plan to cross-educate selected staff in both housing and health services agencies to increase the number of staff with expertise in both areas. The system/plan would go beyond merely placing agency staff on other agencies' workgroup or committees; it would create new and effective ongoing coordination between housing and health services agencies;
- identification of opportunities state housing and health service agencies can provide technical assistance and training to local housing and health service entities about cross education of staff, cross agency coordination, and opportunities to increase local efforts to create service-enriched housing;
- development of suggested performance measures to track progress in: (1) the reduction or elimination of barriers in creating service-enriched housing; (2) increasing the coordination between housing and health services agencies; (3) the number of state housing and health services staff cross-educated and/or with expertise in both housing and health services programs; and (4) the provision of state housing and health services staff providing technical assistance to local communities to increase the number of service-enriched housing projects; and
- development of a biennial plan to implement the above goals and to track the progress of their implementation. The plan would include any needed statutory changes to pursue the above goals. The council would issue a biennial report on the progress of these efforts to the Legislative Budget Board and the Governor by August 1 of each even-numbered year.

The cost of Recommendation 1 would be $300,000 in General Revenue Funds annually. This funding would pay for the salary, benefits, and training of 3 full-time-equivalent (FTE) positions at TDHCA to support the council in carrying out its statutory responsibilities.

Recommendation 2 creates a contingency rider to appropriate funds to TDHCA for 3 FTE positions to assist the council

with its statutory responsibilities and for travel expense reimbursement of council members.

FISCAL IMPACT OF THE RECOMMENDATIONS

Recommendations 1 and 2 would cost $600,000 in General Revenue Funds for the 2010–11 biennium. **Figure 200** shows the fiscal impact of these recommendations. The council and its supporting staff would be responsible for increasing state efforts to coordinate housing and health services. Coordinated state policies and increased staff with expertise in housing and health services could lead to more housing developers, non-profit organizations, and service providers working together to increase the number of service-enriched housing projects statewide. Service-enriched housing has the potential to delay or prevent premature institutionalization of older adults and non-aged persons with disabilities.

FIGURE 200
FIVE–YEAR FISCAL IMPACT

FISCAL YEAR	PROBABLE GAIN/(LOSS) IN GENERAL REVENUE FUNDS	CHANGE TO FULL-TIME-EQUIVALENT POSITIONS COMPARED TO 2007–08 BIENNIUM
2010	($300,000)	3
2011	($300,000)	3
2012	($300,000)	3
2013	($300,000)	3
2014	($300,000)	3

Source: Legislative Budget Board.

The introduced 2010–11 General Appropriations Bill does not address these recommendations.

PROVIDE BETTER INFORMATION TO PROSPECTIVE PURCHASERS OF LONG-TERM CARE INSURANCE

The Texas Health and Human Services Commission estimates that Texas paid $3.5 billion from All Funds for Medicaid long-term care for the elderly in fiscal year 2005, and that those costs will quadruple by fiscal year 2040, even if spending per recipient is held at current levels. The federal government and the states are promoting long-term care insurance as one strategy to supplant a portion of future Medicaid expenditures. Most recently, Texas implemented a long-term care Partnership, a program that allows individuals who pay for long-term care with private insurance to access Medicaid while protecting some or all of their assets. Despite these efforts, the number of long-term care policies purchased remains low.

Long-term care insurance is complicated. Potential buyers face a bewildering array of considerations and choices. Policies are not standardized. Some policies have as many as 360 possible combinations of options. As a result, it is difficult for consumers to evaluate and compare policies. A recent survey indicated that 40 percent of potential purchasers who decide not to buy long-term care insurance cite the complexity of the policies or the inability to choose among policies as an important reason for their decision. Providing better information to consumers would reduce barriers that limit sales of long-term care insurance, potentially increasing the number of private long-term care policies purchased.

CONCERNS

- It is difficult for consumers to compare long-term care insurance prices, features, and options.
- There is no readily available information allowing consumers to assess the likelihood that premiums on a policy will increase.

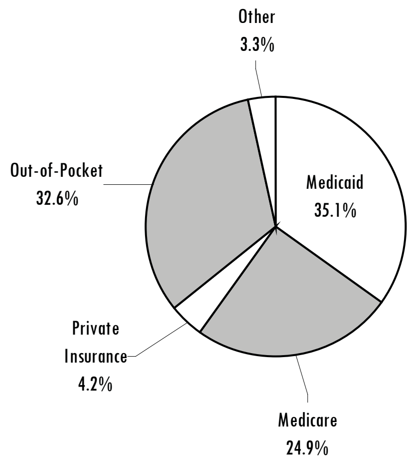
RECOMMENDATIONS

- **Recommendation 1:** The Texas Department of Insurance should improve the rate comparison section of its website by including Partnership policies and representative long-term care group policies, adding policies with different durations of coverage and daily benefits, and including loss ratios with the rate data. In addition, the agency should investigate the possibility of putting the rate comparison data in a menu-driven format in which the potential consumer chooses among desired options and features to select policies for comparison.
- **Recommendation 2:** The Texas Department of Insurance should update the rate increase histories each time a rate increase is approved in the state, and the rate history information should include information on pending rate increase filings.
- **Recommendation 3:** Amend Texas Insurance Code, Section 1651.053, to allow insurers to enter into binding agreements with the Texas Department of Insurance to maintain loss ratios higher than the loss ratios otherwise required by agency rule.
- **Recommendation 4:** The Texas Department of Insurance should amend its rules to require insurance carriers to disclose estimated loss ratios for long-term care policies to prospective customers.
- **Recommendation 5:** The Texas Department of Insurance should add links on its website to companies that evaluate the financial stability of long-term care insurers and should provide on its website and printed materials the toll free numbers for those companies.
- **Recommendation 6:** The Texas Department of Insurance should include a suitability worksheet on its website and in appropriate printed materials, as well as provide a suitability worksheet to the Texas Department of Aging and Disability Services for use in benefits counseling.

DISCUSSION

Long-term care is personal assistance given over a sustained period for persons who are unable to perform certain routine activities of daily living or who suffer from mental impairment. Care can be provided in many different settings, including nursing homes, assisted living facilities, adult day-care centers, or private homes. Persons over age 65 account for about 60 percent of those requiring long-term care. According to a 2004 federal Congressional Budget Office (CBO) study, approximately 36 percent of long-term care for the elderly is provided on an informal, unpaid basis. **Figure 201** shows the funding sources for

FIGURE 201
FUNDING SOURCES FOR LONG-TERM CARE FOR THE ELDERLY, 2004



Source: U.S. Congressional Budget Office.

paid long-term care for the elderly in 2004 as estimated in the CBO study. According to CBO estimates, national expenditures for long-term care services for the elderly in 2004 totaled $134.9 billion.

Medicaid was the largest source of funding for long-term care services for the elderly, accounting for $47.3 billion, or 35.1 percent of U.S. spending in 2004. Medicaid pays a large portion of nursing home care because, unlike Medicare, Medicaid covers chronic conditions, and there is no limit on the duration of care provided by Medicaid. To qualify for Medicaid, a person must meet certain income and asset limits. Many recipients meet the asset requirements only after spending down their assets; others use estate planning to shelter assets to be eligible for Medicaid.

Out-of-pocket spending was the second largest source of long-term care funding for the elderly, contributing 32.6 percent of spending in 2004. Out-of-pocket spending is typically funded from the income of the person receiving care, including retirement and social security income, or by that person spending down assets.

Medicare was the third largest source of funding for long-term care, at 24.9 percent of total 2004 expenditures. Medicare is not designed to cover care for chronic conditions; payments are made in limited circumstances and for a limited duration. Typically, to qualify for Medicare nursing home payments, a person must require skilled care after discharge from a hospital stay and require treatment for the condition for which the patient had been hospitalized. In these cases, Medicare pays the cost of a skilled nursing facility for 20 days and a portion of costs for days 21 to 100. Medicare pays for home healthcare for part-time or intermittent skilled nursing care and certain home health aide services. It also pays for some physical therapy, occupational therapy, and speech-language therapy ordered by a doctor and provided through a certified home health agency.

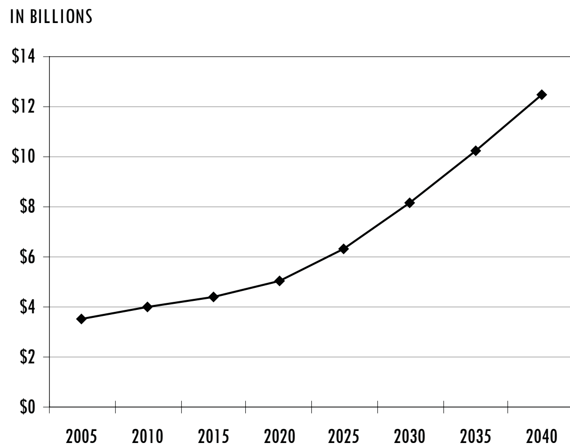
According to the CBO study, private health insurance paid $5.6 billion, or 4.2 percent, of long-term care costs in 2004. The insurance payments could be from long-term care insurance, health insurance, or Medicare supplement insurance. Long-term care insurance pays for only a small portion of long-term care. In 2007, the American Association for Long-Term Care Insurance reported that long-term care insurance paid $3.3 billion in claims for recipients of all ages in 2006. The percentage of care paid by long-term care insurance is expected to increase in the future as the holders of policies purchased during the prior two decades reach the age group most likely to need care.

The Medicaid portion of long-term care costs directly affects Texas' budget. Medicaid is funded through a mix of state and federal dollars. In state fiscal year 2008, the mix consisted of 39.4 percent state funds and 60.6 percent federal funds. The Texas Health and Human Services Commission (HHSC) estimates that Medicaid paid $3.5 billion from All Funds for long-term care for the elderly in Texas in fiscal year 2005. HHSC projects that the number of Texans eligible for Medicaid long-term care will increase by 370 percent between fiscal year 2005 and fiscal year 2040. As shown in **Figure 202**, growth in the number of persons who are Medicaid eligible could nearly quadruple the Texas Medicaid long-term care costs for the elderly to $12.5 billion by 2040, even if spending per recipient is held at 2004 levels. According to the CBO, Medicaid's national average reimbursement rates for nursing facilities grew at an annual rate of 6.7 percent from 1979 to 2001.

A study published in the healthcare journal *Inquiry* (2005/2006) estimated the lifetime distribution of use and cost of long-term care. The findings show an uneven distribution of lifetime demand and cost. The study estimates that 31 percent of people turning age 65 in 2005 will not need long-term care in their lifetime. At the other extreme, one in five persons (20 percent) in that age group will need more than five years of care. The distribution of years of care is shown in **Figure 203**.

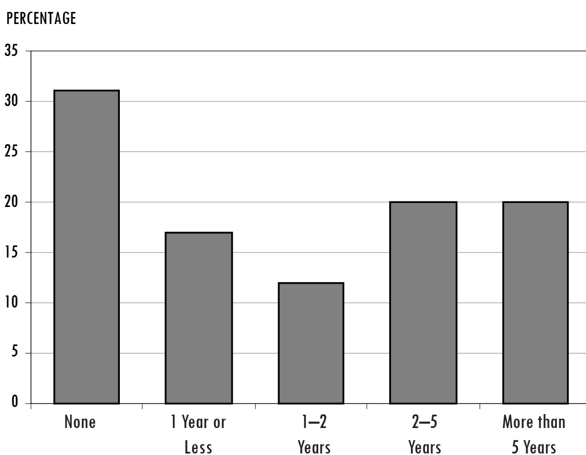
As shown in **Figure 204**, the study estimates that 42 percent of Americans turning age 65 in 2005 will require no paid

FIGURE 202
TEXAS PROJECTED MEDICAID LONG-TERM CARE SPENDING FOR THE ELDERLY ASSUMING NO CHANGE IN COST PER RECIPIENT, FISCAL YEARS 2005 TO 2040



SOURCE: Texas Health and Human Services Commission.

FIGURE 203
PROJECTED LONG-TERM CARE NEED FOR AMERICANS TURNING AGE 65 IN 2005, DISTRIBUTION OF YEARS OF CARE BY PERCENTAGE OF SPECIFIED POPULATION



SOURCE: *Inquiry*, 2005/2006.

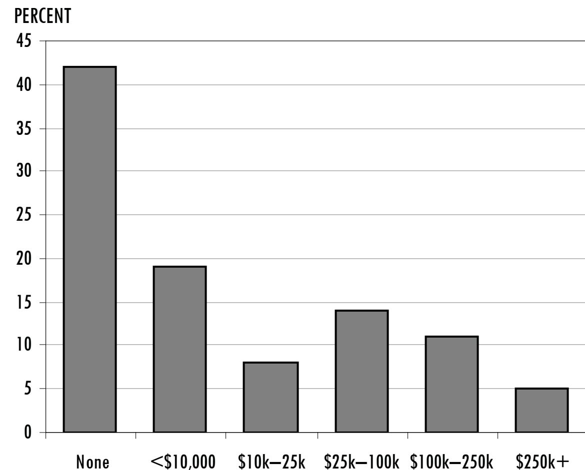
long-term care. On the other extreme, 5 percent of the cohort is expected to incur $250,000 or more in long-term care expenses.

The uneven distribution of long-term care costs across the population, especially the potentially catastrophic costs for a portion of the population, would seem to create an ideal situation for risk sharing through insurance.

LONG-TERM CARE INSURANCE

Long-term care insurance is a relatively new type of insurance developed specifically to cover the costs of long-term care. The product is sold in the individual and group markets with

FIGURE 204
DISTRIBUTION OF PRESENT DISCOUNTED VALUE OF LIFETIME LONG-TERM CARE EXPENDITURES FOR AMERICANS TURNING AGE 65 IN 2005 BY PERCENTAGE OF SPECIFIED POPULATION



SOURCE: *Inquiry*, 2005/2006.

individual policies accounting for 76 percent of policies sold between 1984 and 2004.

Long-term care insurance policies are not standardized. The purchaser, usually with help from an insurance agent, constructs each policy by selecting from a menu of benefits and options. When all of these options are considered, some policies have as many as 360 possible combinations of options.

The consumer's initial choice in selecting a policy is of critical importance. Unlike automobile insurance or homeowner's insurance, the policyholder cannot readily switch long-term care insurance companies without substantial financial loss. In some cases, the purchaser will never need or access the benefits covered by the long-term care policy, and in other cases, the consumer may pay premiums for 20 to 30 years before receiving benefits. The consumer must evaluate his ability to pay premiums, including an unknown amount of potential premium increases, over a long time period. The consumer must also consider the financial stability of the company selling the insurance, the changing long-term care delivery system, and the availability of public programs for funding long-term care over that same time span. A potential purchaser must consider these features, options, and issues: type of coverage, daily benefit, elimination period, duration of coverage, Partnership or Non-Partnership policy, inflation protection, non-forfeiture provisions, waiver of premium, underwriting standards, expense incurred or indemnity policy, when to buy, and premiums.

Type of Coverage. Comprehensive policies cover a wide range of services from home care to nursing home care. Other policies cover only nursing home care. Most policies sold today have both nursing home and home care coverage.

Daily Benefit. The daily benefit is the maximum amount the policy will pay per day. A 2007 survey by America's Health Insurance Plans (AHIP) found that the average daily nursing home benefit purchased in 2005 was $142 and the average home care daily benefit was $135 per day.

Elimination Period. The elimination period is the number of days between the time the policyholder satisfies the policy's disability requirements and when the policy starts paying claims. In the AHIP survey, two-thirds of 2005 policies had 90 to 100 day elimination periods, while only 1 percent had no elimination period. Policies may differ in the way days are counted toward the elimination period.

Duration of Coverage. The duration of coverage is the period of time that the policy will pay benefits. Most policies specify a number of years of coverage, but lifetime coverage is also available. Some policies have separate durations of coverage for different long-term care services. Many policies have a pre-established maximum lifetime benefit. Some policies offer a pool of money that can be spent on any covered services. In the AHIP survey, the average duration of coverage for nursing homes chosen by insurance purchasers in 2005 was 5.4 years. Twenty-three percent of the purchasers surveyed selected lifetime coverage, while 22 percent chose three-year coverage.

Partnership or Non-Partnership. Long-term care Partnership policies allow those paying for long-term care with insurance to protect some or all of their financial assets while qualifying for Medicaid. Under provisions of the Texas Partnership plan, for every dollar of long-term care paid through a Partnership policy, the state will disregard one dollar of the policyholder's assets in determining Medicaid eligibility. Insurance payments in excess of protected countable assets can be used as a dollar-for-dollar offset against Medicaid estate recovery.

Inflation Protection. The consumer may purchase inflation protection in two forms: automatic inflation adjustment or future purchase option. The automatic inflation adjustment increases the maximum daily benefit by a specified percentage each year. Under the future purchase option, the insurer guarantees the policyholder the opportunity to purchase increased benefits periodically without having to undergo underwriting. Texas Department of Insurance (TDI) rules require insurers to offer inflation protection, but the purchaser may decline the inflation protection on non-Partnership policies. Federal regulations require inflation protection for Partnership policies sold to persons younger than 77 years of age. Inflation protection can be expensive; the CBO estimates that buying 5 percent compound inflation doubles the premium for 55-year-old purchasers.

Non-forfeiture Provisions. Many policies are voluntarily lapsed because the policyholder stops paying premiums. The purchaser of a long-term care insurance policy may buy a non-forfeiture benefit to protect against some of the financial loss from a lapse. If the purchaser declines to purchase non-forfeiture protection, the insurer must provide contingent non-forfeiture protection that applies if cumulative premium increases reach a certain threshold percentage. In the event of such premium increases, the policyholder may pay the higher premium for the same level of coverage, pay the existing premium for a reduced level of benefits, or stop paying premiums and receive a shortened benefit period.

Waiver of Premium. Some policies allow the policyholder to stop paying premiums when the insured starts drawing benefits. Other policies require the continuation of premium payments while the policyholder is receiving benefits.

Underwriting Standards. The stringency of underwriting practices varies among companies. These variations can affect the stability of premiums. In theory, if two policies have the same benefits and premiums, all other factors being equal, the policy with the stricter underwriting should be the better value.

Expense Incurred or Indemnity. Expense incurred policies pay the lesser of the actual cost of care and the daily benefit. Indemnity policies pay the daily benefit even if the actual daily cost of the long-term care service is less than the daily benefit.

When to Buy. The older the person is at the time of initial purchase, the higher the initial premiums and the less likely that the person will meet the health standard for purchasing long-term care insurance. The younger the person is at the time of purchase, the longer that person will have to pay premiums, the less he knows about his future physical and financial condition, and the less he knows about future long-term care delivery systems and government financed programs. The younger the purchaser, the more important inflation is, and the more concerned the purchaser must be about any gap between the policy's inflation protection and the rate of increase in long-term care costs.

Premiums. Premiums are set according to the age of the policyholder at the time of the initial purchase of the policy. A 2007 survey prepared by LifePlans, Inc., for America's Health Insurance Plans (AHIP) reports that annual premiums for comprehensive long-term care insurance averaged $1,973 nationally in 2005. Average premiums by age at the time of purchase are shown in **Figure 205**. While premiums cannot be increased on any individual policyholder, insurers may increase the premiums on an entire class of policyholders. Premium increases, especially on many older policies, have been common and sometimes quite substantial. Increases can occur if the insurer's actual experience differs from what the insurer estimated. Lower than expected lapse rates, higher than anticipated usage rates, or lower than predicted returns on investment can cause increases in insurance premiums.

FIGURE 205
AVERAGE ANNUAL PREMIUMS OF LONG-TERM CARE POLICIES PURCHASED IN 2005

AGE AT TIME OF PURCHASE	PREMIUM
Less than 55	$1,740
55–64	$1,877
65–69	$2,003
70–74	$2,341
75+	$2,604

SOURCE: American Health Insurance Plans.

GOVERNMENT PROMOTION AND MARKET PENETRATION

The federal government is promoting long-term care insurance in several ways including providing tax deductions for the purchase of long-term care insurance, enacting a long-term care insurance plan for federal employees, authorizing the states to create Medicaid long-term care Partnerships, and creating the "Own Your Future" campaign to promote awareness of the need for long-term care planning. The State of Texas has an employee long-term care insurance plan administered through the Employees Retirement System of Texas (ERS). The state recently enacted a long-term care Partnership plan and is participating in the "Own Your Future" campaign.

Despite federal and state promotion of long-term care insurance, the number of long-term care insurance policies purchased has remained low. According to a 2007 Georgetown University study, only 7.8 percent of Americans age 50 and older had long-term care insurance in 2005. The statistics for Texas are similar to the national numbers. In 2006, there were about 5.9 million Texans age 50 or older. According to TDI, 388,000 Texans of all ages had long-term care insurance.

Research cites several reasons why so few long-term care insurance policies are purchased: misinformation, complexity of the policies, cost, the value of policies, rate stability, overlap with Medicaid, underwriting, and lack of confidence that the insurer will pay claims.

Many people erroneously believe that Medicare and Medicare supplements cover long-term care for chronic conditions for extended periods, and some people believe that they have long-term care insurance when they do not.

The 2007 AHIP survey of potential buyers indicated that 40 percent of potential purchasers who decide not to buy long-term care insurance cite the complexity of the policies or the inability to choose among policies as an important reason for their decision.

The National Association of Insurance Commissioners (NAIC) suggests that buyers spend no more than 7 percent of their income on long-term care insurance and that people with fewer than $35,000 in assets do not purchase long-term care insurance. According to a 2003 Kaiser Foundation study, under the NAIC guidelines, only 20 percent of couples ages 35 to 59 could afford long-term care insurance and have adequate protection against other financial risks. As shown in **Figure 206**, the same study estimated that 21 percent of households headed by someone age 60 to 79 could afford a mid-range policy. In the age range 60 to 64, a mid-range policy was affordable to 39 percent of households. The mid-range policy used in the study was the federal employee insurance policy with a $125 daily benefit, a 90-day elimination period, and 5 percent compound inflation protection. Because the federal employee plan premiums are lower than the average premiums for the five largest carriers,

FIGURE 206
PERCENTAGE OF HOUSEHOLDS THAT COULD AFFORD LONG-TERM CARE INSURANCE UNDER NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS GUIDELINES, 2003

AGE OF HEAD OF HOUSEHOLD	PERCENTAGE THAT COULD AFFORD A MID-RANGE POLICY
60–64	39%
65–69	27%
70–74	17%
75–79	5%
TOTAL	**21%**

SOURCE: Kaiser Family Foundation.

the study may actually overstate the number of households that could afford individual policies.

A loss ratio is the present value of the total expected claim payments divided by the present value of the total expected premiums over the life of a set of policies. The higher the loss ratio, the more favorable to the consumer. In a 2006 report, the federal Government Accountability Office (GAO) estimated the loss ratio for individual long-term care policies to be 59 percent. GAO found that 41 percent of total premiums collected were expected to go to profits and administrative costs, including agent commissions which averaged 17 percent of premiums on a discounted basis. The GAO estimates that the loss ratios on group policies average 68 percent. A 2007 National Bureau of Economic Research paper found that the loss ratio for a typical individual long-term policy was substantially lower than loss ratios that have been estimated in other private insurance markets.

According to a 2004 National Health Policy Forum paper, many policies had rate increases of 10 percent to 20 percent, a few have seen 40 percent premium hikes over the life of the policy, and some North Dakota policyholders saw cumulative rate increases of 700 percent. Many of the rate increases have affected older, pre-rate stabilized policies; however, lower than expected lapse rates and interest rates may lead to more premium increases in the future.

A 2004 National Bureau of Economic Research paper estimated that 60 percent to 75 percent of the expected discounted value of benefits a median-wealth individual would receive from a typical long-term care insurance policy duplicates benefits that Medicaid would have provided had the individual not purchased insurance. Long-term care Partnership policies eliminate much of this overlap.

Long-term care insurance policies are subject to underwriting, that is, insurance companies screen prospective buyers for certain medical conditions. Applicants who fail the screening are either denied coverage or required to pay higher premiums. The 2006 GAO study estimates that about 25 percent of applicants for individual policies and 16 percent of applicants for group policies do not pass underwriting. The percentage of applicants estimated by the 2003 Kaiser Foundation study who would pass underwriting by age and gender is shown in **Figure 207**.

FIGURE 207
PERCENTAGE OF APPLICANTS ESTIMATED TO PASS SPECIFIED UNDERWRITING SCREENS, BY AGE AND SEX, 1996

AGE GROUP	MEN	WOMEN	TOTAL
40–44	93%	85%	89%
45–49	92%	81%	86%
50–54	89%	79%	84%
55–59	87%	73%	80%
60–64	84%	75%	79%
65–69	74%	71%	72%
70–74	69%	67%	68%
75–79	61%	63%	62%

Source: Kaiser Family Foundation.

In the 2007 AHIP survey, 42 percent of non-purchasers surveyed cited concerns that insurance companies will not pay benefits as an important or very important reason for not purchasing. There have been media reports of companies not paying benefits. The most notable of these articles appeared in the New York Times in March 2007. The article dealt primarily with the insurers Penn Treaty American, Conseco, and Conseco's subsidiary, Banker's Life. The article reported that these companies had an inordinate number of claims denials and had created unnecessary delays and bureaucratic complexities to prevent policyholders from receiving benefits. NAIC reported that the number of consumer complaints about claim denials increased by 74 percent between 2001 and 2006. NAIC also reported that more than 70 percent of claim denials were overturned in favor of the policyholder upon appeal. According to NAIC, this is a pattern of error not typically found in other lines of health-related insurance. In Texas, TDI received 87 complaints on long-term care insurance related to denial or delays in claims handling in calendar year 2005, 57 in 2006, and 84 in 2007.

AVAILABILITY OF INFORMATION TO THE CONSUMER

Information on long-term care and long-term care insurance is available from state and federal agencies, consumer organizations, public policy think tanks, scholarly publications, trade organizations, and insurance companies. A 2004 study by Georgetown University found that consumers had access to an abundant quantity of information about long-term care insurance. However, the study concluded that much of the information was too general to be of much use in helping the consumer make specific choices. The report noted that information provided was sometimes vague, and information from different sources was often contradictory. In particular, the study suggested that consumers need a tool for comparing policies and policy options. A 2006 study from the American Association of

Retired People (AARP) found that there is little independent and objective guidance on this topic and nothing that would allow consumers to compare one policy with another. The AARP study also found that there is no readily available information that would allow the consumer to predict future rate increases.

The Texas Department of Insurance (TDI) provides a substantial amount of long-term care insurance information on its website and through printed publications. Information includes general background guides on long-term care insurance, rate comparisons for a limited number of sample policies, and rate increase histories for long-term care insurance companies.

The TDI website provides rates for six sample policies with a $100 maximum daily benefit for nursing home care and a $50 maximum daily benefit for home care. Other features, benefits, exclusions, and limitations may vary by company and policy. There is a wide variance in the annual premiums for the sample policies. For example, the TDI sample tax-qualified policies with a $100 daily nursing home benefit, a $50 daily home care benefit, and a 90- to 100-day elimination period have annual premiums ranging from a low of $404 to a high of $1,104 for a person age 55. With such a wide variation in rates, it is difficult for a consumer to determine if the policies are actually comparable without additional information contained in the policy itself.

The rate comparison guide is not very flexible. Sample policies do not include inflation protection. Since new long-term care Partnership policies must have inflation protection for most purchasers, the policies in the current selection of sample policies are not particularly helpful to someone shopping for a Partnership policy or wishing to compare a Partnership policy to a non-Partnership policy. The TDI website also does not include group policy prices, which would provide the potential consumer a frame of comparison with individual policies.

In addition to the six standard policies, the TDI website provides information on each company's most popular policy. Information on the benefit amounts, elimination period, benefit period, and other features included in the policy are shown. However, this feature is of limited benefit to the consumer as a comparison tool, because the benefits and features vary widely among different policies.

Recommendation 1 addresses these concerns by directing TDI to update its rate comparison section to include long-term care Partnership policies, representative group policies, additional sample policies with different durations and daily benefits, and estimated loss ratios for policies. The recommendation would direct TDI to determine the plausibility of putting the rate comparison data in a menu-driven format in which the potential consumer selects among a limited number of desired options and features.

Including Partnership policies would help address the Medicaid overlap problem because the asset protection provided by the Partnership policies eliminates most of the overlap. Including group policies is expected to have three beneficial effects: (1) increase awareness of group policies; (2) put downward pressure on premiums because group policies generally have higher loss ratios than individual policies; and (3) increase the number of potential purchasers who pass underwriting because the average issue age of group policy purchasers is lower than the average issue age of individual polity purchasers. Showing the loss ratios would also allow for better comparison of policies and perhaps lower prices. Including policies with different options would be helpful to people considering Partnership policies. Inclusion of a menu-driven tool would be particularly helpful to potential purchasers of Partnership policies if it allows the consumer to work from the amount of assets to be protected to a policy design providing that level of benefits.

The TDI website has a 10-year history of rate increases for each insurance company. The purpose of this information is to help the potential buyer assess the likelihood that the insurer will raise rates in the future. As of July 2008, the rate increase history page was out of date. The page indicated that it was last updated in October 2006. The rate history page does not include information on pending rate increase filings in Texas or other states.

Recommendation 2 addresses concerns about the rate history data by directing TDI to update the rate history any time an insurance carrier increases a long-term care premium in the state. The recommendation also directs TDI to include pending rate increase filings with the rate increase histories.

TDI rules require that insurers filing for rate increases for pre-July 1, 2002 policies demonstrate the policies will have a loss ratio of at least 60 percent after the rate increase. Policies issued on or after July 1, 2002 must meet requirements designed to ensure that initial premiums are actuarially adequate and that premium increases are justified. These policies are referred to as "rate stabilized policies." Before an insurer increases premiums on a rate stabilized policy, TDI rules require the insurer to demonstrate that, on a present

value basis, claims will be no less than the sum of 58 percent of initial premiums, 85 percent of premiums resulting from regular rate increases, and 70 percent of premiums from rate increases due to a change in regulation or from a factor affecting all insurers. In addition, TDI rules require the insurer to show that any rate increase requested is sufficient to make future rate increases unnecessary.

Recommendation 3 would amend statute to allow insurers to enter voluntarily into binding agreements with TDI to maintain loss ratios at higher levels than required by TDI rule. Entering into such an agreement would not impose an absolute cap on premiums but could eventually increase the actuarial value of policies' value to consumers. Information on agreements to maintain higher ratios should be included in both the rate comparisons and the rate increase history. Recommendation 4 directs the Texas Department of Insurance to amend its rules to require insurance carriers to disclose estimated loss ratios for long-term care policies.

A factor influencing the decisions of prospective buyers not to purchase long-term care insurance is concern that the insurance company will not be in business when the policyholder needs long-term care. Several sources advise the potential consumer to check the financial stability of their prospective insurer. Ratings agencies such as A. M. Best, Moody's, Standard and Poor's, and Weiss Research monitor the financial condition of long-term care insurers.

Recommendation 5 directs TDI to provide links to companies that rate the financial stability of long-term care insurers and to provide the toll free numbers for those companies both on the TDI website and in appropriate printed material.

TDI rules require insurers to supply each purchaser with certain information, including an outline of coverage, notice on rating practices, and notice on consequences of replacement. The agent must also supply the purchaser with a pamphlet entitled *Shopper's Guide to Long-Term Care Insurance*, plus contact information for TDI and the Texas Department of Aging and Disability Services (DADS). In many states the agent is required to provide a personal worksheet to determine suitability of coverage. Proposed TDI rules would add this requirement in Texas.

DADS supports free benefits counseling for Texans over age 60 through 28 Area Agencies on Aging (AAA). Benefits counseling includes counseling on long-term care insurance policies. While there is no official count of the number of these counseling sessions that involve long-term care insurance, according to DADS, the number is low. The counseling sessions are not structured; the topics covered are the ones the client is interested in covering. Medicaid eligibility is the most counseled benefit. There are no specialized materials or checklists in use at this time regarding long-term care insurance. If the client is not eligible for counseling from the AAA, the AAA refers the client to TDI for assistance.

Recommendation 6 would require that TDI post a suitability worksheet on its website and provide the worksheet to DADS for use in benefits counseling.

FISCAL IMPACT OF THE RECOMMENDATIONS

The recommendations would have no significant fiscal impact.

The introduced 2010–11 General Appropriations Bill does not address any of the six recommendations.

REQUIRE HEALTH PLANS THAT RANK PHYSICIANS TO MEET NATIONAL STANDARDS

Health insurers have begun to develop ways to measure the quality and efficiency of physicians, which allows health plans and consumers to choose higher quality and more efficient providers. These measures have been controversial with physicians and consumer groups, who fear that they have focused on cost over quality. These groups have also had concerns about the rankings because the methodology used has not always been transparent, physicians have not always been able to examine and validate the data, and consumers have found the rankings too complex to be useful.

Recently proposed national standards for physician performance measures are gaining acceptance among health insurers and physician groups as the basis of a system that is fairer, more consistent, and more efficient than any current alternatives. Several heath insurers have committed to following the national standards. Texas could help ensure the fairness, consistency, and efficiency of physician ranking systems by requiring all health plans to meet certain national standards when adopting physician ranking or tiering systems.

CONCERN

- ♦ Although several health plans operating in Texas have developed systems for ranking physicians, they are not required to meet any standards to ensure that their rankings are fair to physicians and clear to consumers.

RECOMMENDATION

- ♦ **Recommendation 1:** Amend the Texas Insurance Code to require all insurers adopting physician ranking systems to meet the standards detailed in the Consumer-Purchaser Disclosure Project's Patient Charter for Physician Performance Measurement, Reporting and Tiering Programs.

DISCUSSION

Health plans develop physician rankings to measure the quality and efficiency of care, which allows consumers to choose higher quality and more efficient providers. However, quality and efficiency have both been historically difficult to define and measure. Such rankings have led to physician resistance and, in a few cases, lawsuits.

Several nationwide insurers, including Blue Cross and Blue Shield, Cigna, Aetna, and Humana, established internal physician quality measures in the recent years that proved controversial with physician groups and consumer advocates. Physicians were concerned that the measures were primarily based on patients' claim data, which emphasized the cost of care over the quality of care and reflected patients' decisions rather than physicians' advice. Some health plans have not allowed physicians to review data or to appeal decisions.

In 2008, the AARP Public Policy Institute noted that "for reporting of efficiency measures to have the intended effect, the public must feel assured that 'inefficiency' means additional care that provides no marginal benefit." A September 2007 study by George Washington University found that physician ranking raises a number of legal issues when the standards and weights used are secret, the methodology is not transparent, and physicians cannot examine and validate the data.

PHYSICIAN RANKINGS IN OTHER STATES

Other states have recently seen a number of lawsuits related to physician rankings:

- In November 2006, the Washington State Medical Association filed suit against Regence BlueShield over its ranking plan. This suit was settled in August 2007 with an agreement for Regence to develop a new ranking system with physician input.
- Also in 2006, the Fairfield County Medical Society in Connecticut filed suit against United Healthcare and Cigna, claiming that the health plans' ranking systems was based on claims data and did not accurately represent quality of care.
- In May 2008, the Massachusetts Medical Society filed suit against Unicare, the Tufts Health Plan, and the Group Insurance Commission, a quasi-independent state agency covering state employees and certain other public sector workers, over its physician tiering plan. The society claimed that the plan's rankings were based on claims data.

In July 2007, the New York Attorney General threatened suit against CIGNA Healthcare, Inc., Aetna Health, Inc., and UnitedHealthCare, Inc., over their physician ranking programs. All three insurers, plus Empire BlueCross and a few others, have agreed to accept the Attorney General's ranking model code, which is similar to the Patient Charter developed by the Consumer-Purchaser Disclosure Project.

THE CONSUMER-PURCHASER DISCLOSURE PROJECT

In 2002, the Institute of Medicine (IOM), part of the National Academy of Sciences, called for uniform public performance measure standards that recognize and reward physicians who deliver high-quality care. In early 2003, a coalition of business organizations, consumer advocates, and labor interests formed the Consumer-Purchaser Disclosure Project (CPDP) to develop a fair and comprehensive measurement system for physicians. Among the supporters and participants are the AARP, AT&T, IBM, the March of Dimes, Motorola, the National Business Coalition on Health, the Robert Wood Johnson Foundation, and the U.S. Chamber of Commerce.

In April 2008, CPDP proposed a set of standards for health plans adopting physician performance measures. These standards are part of the CPDP's Patient Charter for Physician Performance Measurement, Reporting and Tiering Programs (Patient Charter), which is a voluntary agreement to adopt certain criteria for ranking physicians and to have those criteria reviewed by an independent organization. The Patient Charter has widespread acceptance among national insurers and provider groups as a system that is fairer, more consistent, and more efficient than any current alternatives. Several health plans, including Aetna, Cigna, WellPoint, and UnitedHealthcare, have already committed to following the guidelines of the Patient Charter. In April 2008, the American Medical Association stated that although additional work was necessary to accurately and fairly evaluate the individual work of physicians, it supported the Patient Charter and offered assistance in ensuring that the criteria were appropriate and measurable.

The Patient Charter has two primary requirements of health plans. Health plans must:

1. Retain, at their own expense, the services of a nationally recognized, independent healthcare quality standard-setting organization to review their physician ranking programs. This review should include a report detailing the measures and methodologies used by the health plan. The scope of the review should encompass all elements described in the Criteria for Physician Performance Measurement, Reporting, and Tiering Programs, comparing some of these elements to national standards.
2. Adhere to the CPDP's Criteria for Physician Performance Measurement, Reporting, and Tiering Programs. These criteria and their elements are shown in **Figure 208**.

By having an independent review of ranking programs and public disclosure of the results, health plans can promote the consistency, efficiency, and fairness of the ranking programs and make physician performance information more accessible and easier for consumers to understand. In August 2008, the CPDP named the nonprofit healthcare quality organization National Committee for Quality Assurance (NCQA) as the first CPDP-approved independent reviewer that can certify the first requirement. The Utilization Review Accreditation Commission is in the process of revising its Provider Performance Measurement and Reporting Standards to align with the Patient Charter with the intent of being a second independent reviewer.

STANDARDIZING VOLUNTARY RANKING SYSTEMS IN TEXAS HEALTH PLANS

Aetna Health Inc., Cigna Healthcare of Texas Inc., UniCare Health Plans of Texas Inc. (which is owned by WellPoint), and United Healthcare of Texas Inc., are among the Texas health plans that are part of national plans which have publicly announced their intent to adopt the measures of the Patient Charter. All four of these were among the top 20 largest health maintenance organizations in Texas in 2006, based on the number of written premiums. BlueCross BlueShield of Texas (BCBSTX), which has the largest network in the state, worked extensively with the Texas Medical Association in 2007 and early 2008 to refine its ranking program, BlueCompare. BCBSTX is now reviewing the national standards.

The Patient Charter is designed to balance standardization and innovation, thus ensuring better performance reporting. Recommendation 1 would amend Texas Insurance Code to require all insurers adopting physician ranking systems to meet the standards detailed in the Patient Charter. This standardization would level the playing field for insurers and help to ensure rankings that are fairer, more consistent, and more efficient for providers and consumers. While the standards would ensure similarities in any physician ranking systems adopted by a health plan, the Patient Charter is

FIGURE 208
THE CONSUMER-PURCHASER DISCLOSURE PROJECT CRITERIA FOR PHYSICIAN PERFORMANCE MEASUREMENT, REPORTING, AND TIERING, 2008

CRITERIA	ELEMENTS
Measures should be meaningful to consumers and reflect a diverse array of physician clinical activities.	• Measures should consider the six aims of the IOM to the extent possible: care should be safe, timely, effective, efficient, equitable, and patient-centered. Whenever feasible, health plans should measure patients' experience. • All information provided to the consumer should take the consumer's health needs and particular areas of care into account. • Performance reporting for consumers should include both quality and cost-efficiency information.* • A health plan must disclose any weighting it gives to different measures to clarify how quality and cost-efficiency are interrelated in the ranking. • A health plan must seek input on its measures from consumers or consumer organizations.* • Ranking programs must include a clearly defined process for receiving and resolving consumer complaints.* • Performance information for consumers must include context, a discussion of the limitation of the available data, and guidance on other factors in physician choice.
Those being measured should be actively involved.	• As health plans must contact consumers or consumer organizations, health plans should also reach out to physicians and their organizations for input on their ranking programs.* • Health plans must give physicians reasonable prior notice before releasing their individual performance results.* • Health plans must establish a clearly defined appeals process that allows a reasonable time frame for physicians to review their own performance results and gives them the opportunity to refute results they believe to be inaccurate.*
Measures and methodology should be transparent and valid.	• Any information about physician performance needs to be accessible and clear to consumers, physicians, and other clinicians. • Health plans must disclose any information that might limit the usefulness of results. • Health plans should publish measures and methodology used to assess performance. Health plans should assess some measures against national standards, including risk and severity adjustment, minimal observations, and statistical standards. Health plans should fully disclose measurement elements such as data used, how the patients were identified, specification and methodologies, known limitations of the data, and how episodes are defined.* • The rationale and methodologies supporting the unit of analysis reported should be clearly articulated. • Sponsors of physician measurement and reporting should collaborate to aggregate data and promote consistency. These activities should be publicly reported. • The program should be regularly evaluated for effectiveness and unintended consequences.
Measures should be based on national standards to the greatest extent possible.	• Any measures adopted by a health plan should be endorsed by the National Quality Forum (NQF) to the extent possible. If a health plan adopts a non-NQF measure because the NQF measures do not exist or are unduly burdensome, the health plan should plan to adopt comparable NQF-endorsed measures when available.* • When NQF-endorsed measures do not exist, health plans should search for substitutes endorsed by another national accrediting organization.* • Health plans may adopt supplemental measures if part of a pilot program to determine necessity. Supplemental measures should adhere to the NQF measure criteria of importance, scientific acceptability, feasibility, and usability and may include sources such as medical specialty society guidelines.*

*These elements must be compared to national standards.
Source: The Consumer-Purchaser Disclosure Project.

permissive enough to allow for further innovation in measures and methodologies. Four of the largest health plans operating in the state are now modifying their ranking systems to align with the Patient Charter. Therefore, any health plan in Texas that establishes a physician ranking should meet those same standards, but still have the freedom to innovate and modify as necessary.

FISCAL IMPACT OF THE RECOMMENDATION

The recommendation would not have a fiscal impact to the state. The recommendation would provide a level playing field for health plans that establish a ranking system for physicians, but no health plan is required to establish such a system.

The introduced 2010–11 General Appropriations Bill does not include any adjustments as a result of this recommendation.

REDUCE THE PRISON POPULATION BY REDUCING PAROLE PROCESS DELAYS

Texas prisons operate close to maximum capacity. The total prison operating capacity of 157,264 includes 1,916 beds that the Texas Department of Criminal Justice uses under contract with county jails. A recent projection by Legislative Budget Board staff shows a slight decrease in the prison population during fiscal year 2009, followed by small annual increases during subsequent years. This projection considers new trends in direct court sentences to prison, a decrease in technical parole and probation revocations, an increase in parole approval rates, and the expansion of treatment programs for offenders and prison diversion initiatives made possible by a $201.8 million All Funds appropriation by the Eightieth Legislature, 2007.

While these efforts have slowed the growth of the prison population, the Texas Department of Criminal Justice's costs continue to be high with a total of $5.9 billion in All Funds appropriation for the 2008–09 biennium. Delays in releasing offenders approved for parole limits bed capacity and results in the use of contracted beds. In fiscal year 2008, the Texas Department of Criminal Justice spent approximately $28 million for contracted capacity.

Data shows that of the 64,744 offenders released from prison from September 2006 to March 2008, the release of almost 14,000 was contingent upon completion of a specified rehabilitation program. During this period, 56 percent of offenders awaiting parole pending completion of a specified program were released at least two weeks beyond their target release date. Inefficiencies in the parole release process create delays in an offender's release and limits bed availability. Allowing the Texas Department of Criminal Justice to release offenders upon rehabilitation program completion would reduce the prison population by more than 1,000 offenders and potentially save $13.6 million in General Revenue Funds for the 2010–11 biennium.

FACT AND FINDING

- Offenders who are required by the Texas Board of Pardons and Paroles (the Parole Board) to complete a treatment program as a condition of release are assigned a program start date that determines when an offender should be enrolled in a program to satisfy the conditions of release. The Parole Board's target release date is calculated from the estimated program start date based on the length of the particular program.

CONCERNS

- Offenders sometimes complete the requirements for release earlier than the estimated target release date set by the Parole Board. The Texas Department of Criminal Justice is not authorized to release offenders prior to the target release date. From September 2006 to March 2008, 6,456 offenders completed their assigned rehabilitative program earlier than anticipated but were ineligible for release because their target release date had not been reached.

- Because the completion of an offender's case summary is the beginning of the parole process, inefficiencies in preparing case summaries delay the review and release process. The Texas Department of Criminal Justice reports that not all institutional parole officers can type or have computers with the capability to prepare case summaries. Furthermore, the transport of files to and from institutional parole officers, the typing pool, and the Texas Board of Pardons and Paroles adds unnecessary time to a process that can be improved by technology and automation. Any inefficiency in the process results in increased costs to the state through the delayed release of offenders.

RECOMMENDATIONS

- **Recommendation 1:** Amend Texas Government Code, Chapter 508, to allow the Texas Department of Criminal Justice to release offenders upon completion of a Parole Board specified rehabilitation tier program and meeting all other requirements set by the Texas Board of Pardons and Paroles.

- **Recommendation 2:** The Texas Department of Criminal Justice should automate forms currently completed by institutional parole officers as a part of the case summary file used by the Board of Pardons and Paroles to review an offender for release.

- **Recommendation 3:** The Texas Department of Criminal Justice should require all new institutional parole officer hires to have typing abilities. Current

institutional parole officers without typing skills should be provided keyboarding training to help address inefficiencies in case summary completion. The typing pool consisting of administrative clerks whose sole responsibility is to transcribe institutional parole officers' case summaries should be phased out within four years, and the number of officers increased as funds are available.

DISCUSSION

Texas prisons operate close to maximum capacity. Total prison operating capacity of 157,264 beds includes 1,916 beds that the Texas Department of Criminal Justice (TDCJ) uses under contract with county jails. These county beds cost the state approximately $28 million in fiscal year 2008.

While increased parole approval rates and the expansion of treatment programs for offenders and prison diversion initiatives made possible by a $201.8 million All Funds appropriation by the Eightieth Texas Legislature, 2007, have slowed the growth of the prison population, TDCJ's costs continue to be high and are expected to increase with the cost of increasing fuel and food prices. In total, TDCJ was appropriated $5.9 billion in All Funds for the 2008–09 biennium.

Maximizing the use of technology in the preparation and delivery of an offender's case summary and expediting the release of offenders who have fulfilled their rehabilitative program requirements would help the Parole Board and TDCJ contain the cost of incarcerating and paroling offenders.

PREPARING AN OFFENDER FOR BOARD REVIEW

In fiscal year 2006, the Parole Board considered over 71,000 offenders for parole and approved 18,967 offenders. Of those approvals, 8,905 votes for parole release were contingent on the offender completing a rehabilitation program, otherwise known as a Further Investigation-Rehabilitation (FI-R) vote. Data for fiscal year 2007 through March 2008 shows that 14,000 offenders were approved for release contingent upon completion of a specified rehabilitation program. This represents approximately 21.6 percent of all offenders released during this time period. It is significant to note that the majority of offenders approved for parole are FI-R votes because these cases not only involve the development of a case summary, but also require TDCJ to place the offender in a rehabilitation program that can add months and cost to an offender's release.

Several steps take place before the Parole Board considers an offender for release. Upon entering the prison system, an offender is assigned a custody level and appropriately incarcerated. An offender's parole eligibility date (PED) is calculated based on the offense committed, the amount of time served, and the laws in place at the time of the offense. This date legally satisfies the minimum time requirements an offender needs to serve to be paroled.

The process for being paroled or released on discretionary mandatory supervision begins six months before an offender's PED. At this point, an offender is identified through a weekly report as eligible for review by the Parole Board, and an institutional parole officer (IPO) is assigned to develop an offender's case summary. The regional review panel (one parole board member and two parole commissioners) bases its vote on the case summary that contains the offender's criminal, social, medical, psychological, and institutional adjustment history, and support letters from friends and family. Victims are also given an opportunity to submit letters or present their case in front of the parole review panel.

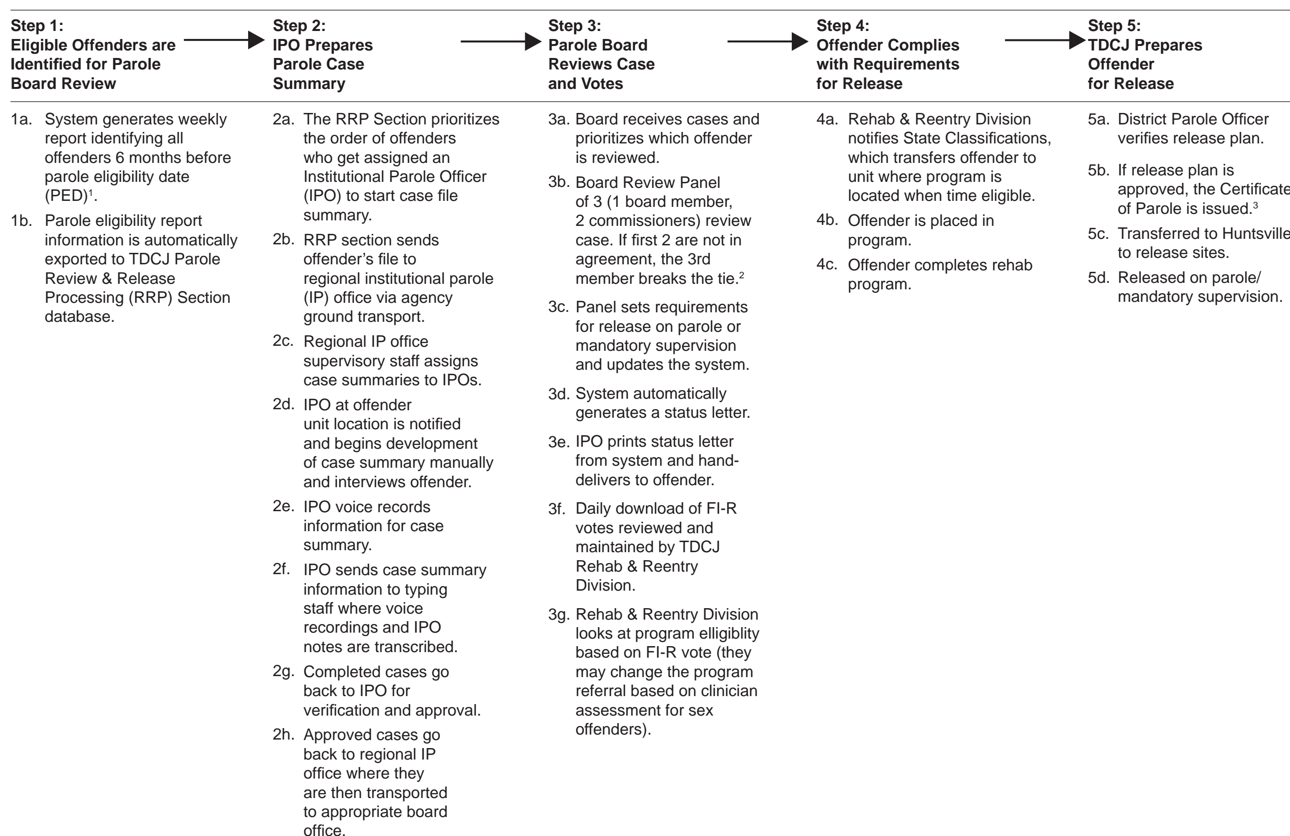
When a parole decision has been reached, the information is entered into the TDCJ computer system. An offender is notified of the Parole Board's decision and given a subsequent review date if denied. On average, subsequent reviews are set for a year later. If an offender receives an FI-R vote, arrangements are made to place the offender in the appropriate institutional program. Upon successful program completion, TDCJ issues a certificate of parole, and an offender is released if he has an appropriate place of residence (which includes halfway houses).Those with no options for residence cannot be released.

Figure 209 shows the parole review and release process, the person in charge at a particular step, and details on how information is disseminated among the agencies and divisions involved.

DELAYS IN CASE SUMMARY PREPARATION

Although the weekly report, shown in **Figure 209** as the first step in the parole process, identifies offenders approaching their PED or next review date, the resources to complete the case summaries (required for parole review) in a timely fashion are lacking. Of the offenders who were released from September 2006 to March 2008 contingent upon program completion, 48 percent had their respective case reviewed late by the Parole Board. Therefore, the date of the Parole Board's vote was after the offender's PED. Delays on the

FIGURE 209
PAROLE REVIEW AND RELEASE PROCESS



[1]Offenders who have been previously denied parole are identified four months prior to next review date established by the Parole Board.
[2]In certain cases, the full board must vote.
[3]Once a release plan is approved, a certificate of parole can be issued when an offender has completed 90 percent of the program.
Source: Legislative Budget Board.

front-end of the review process cause delays in an offender's release from prison. This delay may be that the number of IPOs is not sufficient to prepare case summaries for the number of offenders who are pending Parole Board review. **Figure 210** shows that the number of completed case summaries increased in the last few fiscal years, while the number of IPOs remained constant. This trend has required IPOs to work overtime to prepare case summaries for offenders who are approaching their PED. TDCJ data provided in **Figure 210** shows that overtime hours worked by IPOs from September 2006 to April 2008 exceeded the total overtime worked in fiscal year 2007.

Despite an increase in the number of completed case summaries and overtime worked by IPOs and clerks, as of September 2008, according to TDCJ there were approximately 6,632 offenders identified for parole review pending assignment to an IPO for case summary completion. Furthermore, there were 820 case summaries completed and

FIGURE 210
NUMBER OF INSTITUTIONAL PAROLE OFFICERS AND CASE SUMMARIES COMPLETED, FISCAL YEARS 2006 TO 2008

FISCAL YEAR	AUTHORIZED POSITIONS	FILLED POSITIONS	SEPARATIONS	IPO TURNOVER	OVERTIME HOURS WORKED	CASE SUMMARIES COMPLETED
2006	197	189	26	10.1%	7,026	73,841
2007	201	193	16	8.8%	10,889	75,940
2008*	196	186	11	5.9%	12,706	53,027

*As of 4/30/08.
Source: Texas Department of Criminal Justice.

waiting to be typed by clerical staff, and routed to the appropriate regional Parole Board office to be reviewed. This large number of cases represents offenders whose release is delayed due to delays in getting their case considered by the Parole Board.

OTHER FACTORS CAUSING DELAYS IN AN OFFENDER'S RELEASE

There are some cases where delays are inevitable. For example, short-sentence offenders who enter the prison system with good-time credits earned while incarcerated at the county level are eligible for parole immediately. These types of cases take precedence over other offenders who have already been identified for Parole Board review, but whose PEDs are after that of the offender who just came into the system. Resources must be devoted to the development of these new arrivals' case summaries regardless of whether another offender's PED has passed.

Another reason for delays can be in the way the parole review panel calculates an offender's target release date. Currently, the Parole Board specifies a program start date that determines when an offender should be enrolled in a program to satisfy the conditions of the Parole Board vote and a target release date that guides when an offender is released from prison. The Parole Board gives TDCJ a standard period to enroll an offender in a program based on the FI-R vote. There are several rehabilitation programs of varying length, which satisfy an FI-R vote as provided in the Texas Administrative Code (the number preceding the "R" refers to the length of the program in months). The available programs are shown in **Figure 211**.

FIGURE 211
REENTRY PROGRAMS USED TO SATISFY FI-R VOTES, FISCAL YEAR 2008

TIER VOTE	PROGRAMS	DESCRIPTION	NUMBER OF UNITS OFFERING PROGRAM	PROGRAM CAPACITY
FI-3R	Changes/ Lifeskills	A 180-hour program offered by Windham School District that offers a life skills curriculum to prepare offenders for release. The program content includes: family relationships and parenting, civic and legal responsibilities, victim sensitivity, health maintenance, employability, money management, and other related life skills.	93	There is not a specific program capacity for each unit.
	Voyager	This program is offered through the Chaplaincy Department and offers a faith-based, non-denominational curriculum. The program is voluntary and is normally three months in length. Teachings include: life skills for understanding one's self, developing self-esteem, being responsible for one's actions, understanding values, overcoming bad habits, managing emotions, and building and maintaining healthy relationships.	67	There is not a specific program capacity for each unit.
FI-6R	Pre-release Substance Abuse	This is a six-month modified therapeutic community treatment program for offenders with serious substance abuse dependence and antisocial characteristics. Programming consists of five months of intensive structured treatment and one month of after-care treatment.	1	1,008 beds and 216 Pre-treatment beds
	Pre-release Therapeutic Community	This is a six-month modified therapeutic community treatment program designed to provide pre-release services to offenders who may have a combination of needs. The Rehabilitation and Reentry Programs Division, Windham School District, and Parole Division work together to provide the following: vocational training, educational classes, substance abuse treatment, life skills classes, cognitive intervention, employment training, and release planning.	1	600 beds and 511 Pre-treatment beds

FIGURE 211 (CONTINUED)
REENTRY PROGRAMS USED TO SATISFY FI-R VOTES, FISCAL YEAR 2008

TIER VOTE	PROGRAMS	DESCRIPTION	NUMBER OF UNITS OFFERING PROGRAM	PROGRAM CAPACITY
FI-7R	Serious and Violent Offender Reentry Initiative	The program is made up of two phases. Phase I, is an in-cell pre-release program that will utilize PC-based equipment to deliver a wide variety of programming. It begins six months prior to an offender's release. Phase II begins upon release to supervision and is managed by the Parole Division. Phase II provides a continuum of care upon transition from Phase I for twelve months. The offender will receive cognitive intervention, substance abuse education, housing assistance, mental health services, employment resources, etc., through the Parole District Resource Center.	1	63 beds
FI-18R	InnerChange	TDCJ and Prison Fellowship Ministries developed the InnerChange Freedom Initiative Program, which is designed to reduce recidivism. This program is a voluntary faith-based program, which uses Biblical principles to emphasize the importance of taking ownership for one's life and for developing good decision-making skills and actions.	1	378 beds
	Sex Offender Treatment Program	This 18-month program is based on Cognitive-Behavioral therapy in a relapse-prevention framework. Therapists work with offenders to change errors in thinking.	3	484 beds

SOURCE: Texas Department of Criminal Justice.

As shown in **Figure 212**, the time allowed by the Parole Board to enroll an offender in a designated program is in excess of what TDCJ needs for shorter rehabilitative programs. In some cases, TDCJ placed offenders before the specified program start date. As a result, offenders completed the program and satisfied the terms of the Parole Board vote earlier than anticipated, but were ineligible for release because they had not met their target release date. This is especially problematic in the case of FI-3R and FI-6R votes, which are the majority of all FI votes.

FIGURE 212
AVERAGE TIME ALLOWED BY PAROLE BOARD TO ENROLL OFFENDER IN REHABILITATIVE PROGRAM FROM THE DATE OF BOARD VOTE, SEPTEMBER 2006 TO MARCH 2008

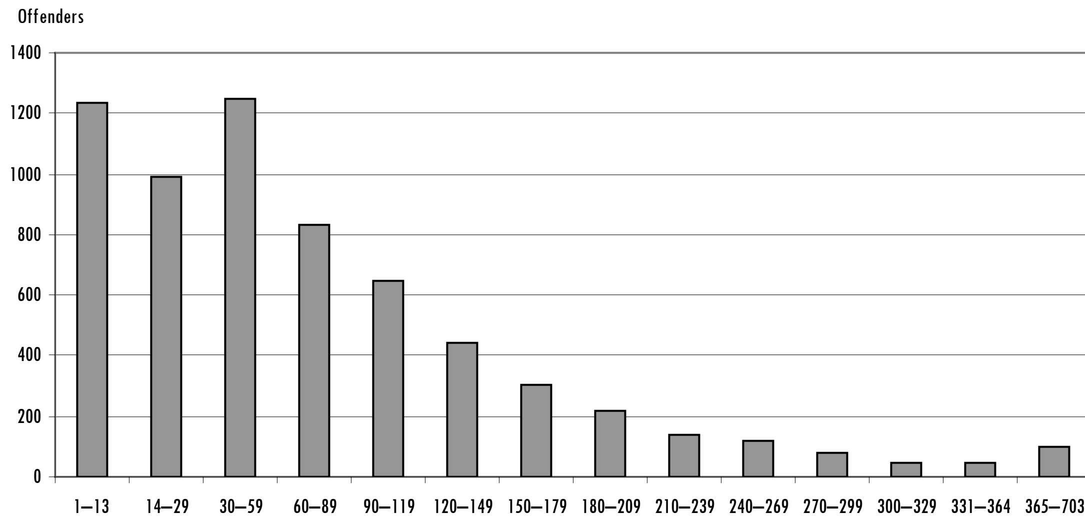
BOARD VOTE	AVERAGE TIME GIVEN TO ENROLL OFFENDER (IN MONTHS)	AVERAGE TIME NEEDED TO ENROLL OFFENDER (IN MONTHS)
FI-3R	3.1	1.4
FI-6R	3.7	3.5
FI-7R	3.1	3.0
FI-9R	7.7	8.9
FI-18R	4.7	16.4

SOURCE: Legislative Budget Board.

This delay occurs because the target release date as provided in TDCJ's Parole Division Policy and Operating Procedures Manual is calculated based on the Parole Board's estimated program start date. For example, if an offender with an FI-3R vote (required to take three-month rehabilitative program) has a specified program start date of June 1, the Parole Board estimates that the offender's release date is three months (the length of the program) after the specified program start date on September 1. However, if TDCJ can place the offender in the program on April 1 and the offender completes it by July 1, the offender cannot be released before September 1, his/her target release date. TDCJ lacks the authority to release an offender before the offender meets his/her target release date. As a result, the offender must either wait in the rehabilitation program taking up limited capacity or be transferred to the general population where the benefits of the program treatment may be diminished. Either way, the time offenders wait to reach their release date results in an unnecessary cost to the state. From September 2006 to March 2008, over 6,700 offenders were released after their target release date; 6,456 of which completed their program before this period. The majority of these offenders were released within two months after their target release date as shown in **Figure 213**.

Some of these offenders may not have approved housing options and so may not be able to be released even once their target release date is met. For example, the majority of the 209 offenders released one year after their target release date were not released because they did not have an approved

FIGURE 213
NUMBER OF DAYS OFFENDERS WAIT TO REACH TARGET RELEASE DATE AFTER PROGRAM COMPLETION, SEPTEMBER 2006 TO MARCH 2008



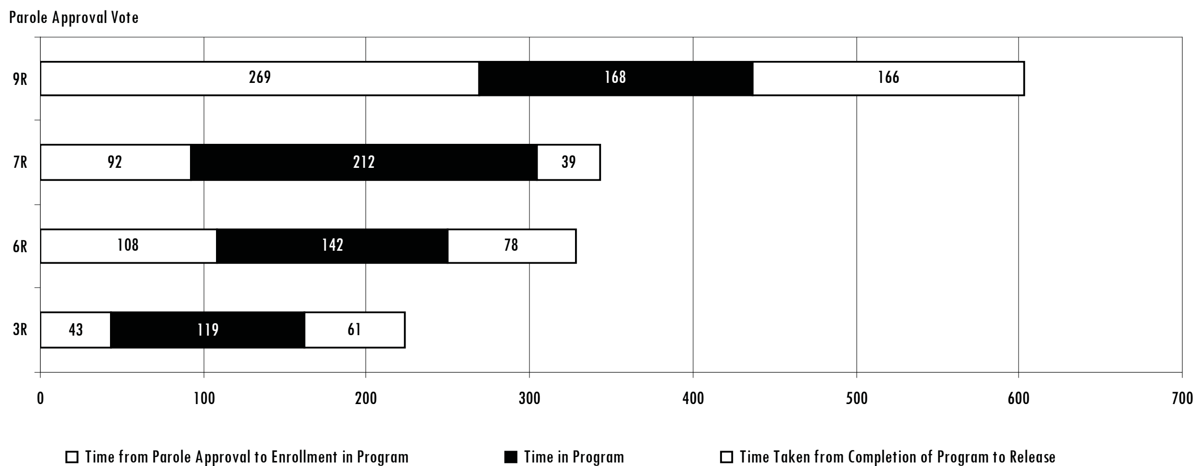
SOURCE: Legislative Budget Board.

housing option or were waiting to be placed in a halfway house. This data shows that there continues to be a lack of halfway house beds and other housing options for paroled offenders. As of August 2008, there were 256 offenders waiting to be placed in a halfway house.

While the process for preparing an offender for Parole Board review, program placement, and release is the same for the various FI-R votes, the period between these events is different for each FI-R type, as shown in **Figure 214**. **Figure 215** shows that on average from the time the Parole Board votes on a particular case, it takes 7.3 months to release an offender with an FI-3R and 10.8 months for an offender with an FI-6R vote. The difference in duration is due not only to varying program lengths and target release dates set beyond the actual program completion dates, but also to process inefficiencies.

The Offender Information Management System Reengineering (OIMS) project was introduced in 1997 and was to provide a single system that would contain all offender information. The parole supervision component,

FIGURE 214
AVERAGE TIME BETWEEN PAROLE APPROVAL AND RELEASE BY TYPE OF PAROLE VOTE FOR OFFENDERS RELEASED BETWEEN SEPTEMBER 2006 AND MARCH 2008



SOURCE: Legislative Budget Board.

FIGURE 215
AVERAGE AMOUNT OF TIME TO RELEASE AN OFFENDER FROM BOARD VOTE TO RELEASE, SEPTEMBER 2006 TO MARCH 2008

BOARD VOTE (PROGRAM LENGTH)	AVERAGE TIME BETWEEN VOTE AND RELEASE
FI-3R (90-day program)	223 days (7.3 mos.)
FI-6R (180-day program)	328 days (10.8 mos.)
FI-7R (210-day program)	343 days (11.3 mos.)
FI-9R (270-day program)	603 days (19.8 mos.)
FI-18R (540-day program)	916 days (30.1 mos.)

Source: Legislative Budget Board.

which allows parole officers to process the offender supervision contacts and other forms electronically, was implemented in September 2004. The second component of OIMS relating to the prerelease of an offender was implemented in September 2006, but was discontinued in March 2007 to address Parole Board and TDCJ Parole Division needs encountered during implementation, and because of problems with inadequate equipment and slow system performance. However, during this period, IPOs processed and the Parole Board reviewed 3,200 offenders through the prerelease OIMS system. Since March 2007, the OIMS prerelease component has been used only for those offenders in the system who were given subsequent parole review dates. The thousands of remaining offenders approaching Parole Board review all continue to be processed through the legacy system consisting of paper-based files.

Transporting paper files to and from the four regional institutional parole offices and five satellite offices adds days to an already lengthy process. This affects the three regional institutional parole offices and satellite offices that are located outside of Huntsville more because TDCJ stores its offender files in Huntsville. Depending on the length of an offender's criminal history, there can be boxes of information that must be delivered for the IPO to review. The ground transport of these files can be delayed depending on how often the agency mail truck travels to the regional institutional parole office. For example, if the agency mail truck has weekly runs to a regional institutional office every Wednesday, an IPO who completed a case summary on Thursday must wait five days before the case summary is retrieved and delivered to the appropriate Parole Board office. These five days multiplied by thousands of offenders, and a daily prison rate of $40 can be costly.

Once IPOs receive an offender's file, they must manually sort through information to prepare the required forms and assessments that make up the offender's case summary. This part of the process can be very time consuming, involving many staff, and delaying the completion of a case summary and Parole Board review of an offender. IPOs must complete an offender's "Parole Guidelines" risk assessment form, which contains current and historical information that is available in TDCJ's system. The risk assessment instrument is used to determine an offender's parole guideline score. In 1985, the legislature mandated use of guidelines in parole decision-making. The parole guideline scores on the form are processed by three staff members—the IPO, and two clerical staff. The IPO completes the form, one clerical person enters a portion of the scores in the system, and another enters the scores on an Excel spreadsheet and submits the scores monthly to TDCJ's Central Office. Requiring three persons perform different duties with the same scores increases the rate of error and duplicates work. If the system screen were modified to include all data elements, the IPO could enter the data onto the form in the system, and save time and improve data reliability.

The lack of adequate computer equipment and the limited typing abilities of some IPOs requires TDCJ to employ clerical staff to type and transcribe the information the IPOs have gathered to develop the case summaries. As of the beginning of January 2008, 46, or 36.5 percent, of all Clerk IIs within the TDCJ's Parole Division are in the typing pool. Like IPOs, TDCJ data shows that clerks, whose sole responsibility is to type case summaries, have also worked a substantial amount of overtime in fiscal year 2008. As of April 30, 2008, the overtime hours worked in fiscal year 2008 had already exceeded the total overtime hours worked in fiscal year 2007. Clerks and IPOs are compensated for their overtime with pay.

Some steps have been taken to prepare IPOs for the implementation of the OIMS prerelease component. The distribution of refurbished computers and laptops to IPOs in fiscal year 2008 is expected to address slow system performance and provide IPOs with reliable equipment needed to retrieve data from the system. OIMS aims to eliminate inefficiencies and to improve the prerelease process. However, until changes to OIMS have been made and approved by all users, process improvements must be achieved in other ways.

OPTIONS TO REDUCE PROCESS INEFFICIENCIES

The authority given to the Parole Board in the Texas Constitution is broad and does not require any specific release protocols as it relates to FI-R votes. Instead, the Parole Board is allowed discretion to set its own rules relating to the

parole process, action upon board review, and release dates. The Texas Administrative Code provides that all offenders with FI-R votes can be released "to parole only after program completion and not earlier than [the] specified date." Therefore, TDCJ cannot release an offender who has completed their assigned program if their completion date is before the Parole Board's estimated target release date. Recommendation 1 would amend Chapter 508 of the Texas Government Code to allow TDCJ to release offenders upon completion of a Parole Board specified rehabilitation tier program even if the target release date set by the Parole Board has not been met, provided all other requirements are met. This could help avoid delays that occur due to miscalculated specified program start dates and target release dates. The Parole Board would be required to adopt new rules to reflect the new statutory language.

Recommendations 2 and 3 would help address some delays in the case summary production process, reduce the duplication of work, and decrease the risk of errors that result from multiple staff involved. Recommendation 2 would require TDCJ to automate forms currently completed by IPOs as a part of the case summary file used by the Parole Board to review an offender for release. This would include, but not be limited to, the offender "Parole Guidelines" risk assessment form. If the information from the system were pre-programmed into the form, the IPO could verify the validity of the information. Taking advantage of automation can improve the case summary completion process and allow IPOs to focus time and resources on other activities that can lead to a more expedited disposition of offenders.

In anticipation of full implementation of OIMS, which will require case summaries to be processed electronically, Recommendation 3 would require new IPOs to have typing abilities. Current IPOs without typing skills should be provided keyboarding training to help decrease the reliance on clerks to type data onto forms required in the case summary. The typing pool made up of administrative clerks whose sole responsibility is to transcribe IPO case summaries should be phased out within four years. Any cost savings from eliminating these positions could be used to hire additional IPOs to decrease the overtime worked by current IPOs.

FISCAL IMPACT OF THE RECOMMENDATIONS

Amending the Texas Government Code as provided in Recommendation 1, and automating certain case summary development processes as provided in Recommendations 2 and 3, is expected to decrease the number of days an offender with a FI-R vote is incarcerated. Currently, the average number of days from program completion to release for an offender with an FI-3R vote is 61 days; an offender with an FI-6R vote 78 days; and an offender with an FI-7R vote 39 days. This analysis assumes that implementation of Recommendations 1 and 2 would decrease the time between program completion and release by an average of 25 days. Specifically, it would decrease the number of days in prison for an offender with an FI-3R vote by 35 days, an offender with an FI-6R vote by 20 days, and an offender with an FI-7R vote 10 days. The reduction in days would result in a shift of offenders from prison to parole supervision, with the largest impact in the first year of implementation and decreasing impact in subsequent years.

Assuming that sentencing patterns and release policies not addressed in this proposal remain constant, the probable impact of allowing the release of offenders upon completion of a Parole Board specified rehabilitation tier program even if the target release date has not been met is estimated as shown in **Figure 216**.

FIGURE 216
FIVE-YEAR FISCAL IMPACT OF RECOMMENDATIONS, FISCAL YEARS 2010 TO 2014

FISCAL YEAR	PROBABLE SAVINGS/ (COST) IN GENERAL REVENUE FUNDS	PROBABLE DECREASE IN PRISON POPULATION
2010	$8,303,087	619
2011	$5,274,639	393
2012	$3,620,727	270
2013	$3,564,852	266
2014	$2,302,067	172

SOURCE: Legislative Budget Board.

The reduction in the prison population would result in a savings of $13.6 million in General Revenue Funds for the 2010–11 biennium. Estimated savings to General Revenue Funds also include the increased cost of parole supervision for the offenders who would be shifted from prison to parole supervision as a result of Recommendation 1.

Recommendation 3 would have no fiscal impact. Cost savings of $782,000 (not including overtime) derived from eliminating the typing pool supporting the IPOs could be used to train IPOs in keyboarding and hire additional IPOs to reduce the overtime worked.

The introduced 2010–11 General Appropriations Bill does not include any adjustments as a result of these recommendations.

THE IMPACT OF CORRECTIONAL OFFICER WORKFORCE SHORTAGES ON PRISON OPERATIONS AND SECURITY

The Texas Department of Criminal Justice is responsible for controlling and caring for more than 140,000 incarcerated offenders in state run prisons. Approximately 23,000 correctional officers supervise these offenders on a 24-hour basis. At the end of fiscal year 2008, 23 of the 98 Texas Department of Criminal Justice correctional units had a vacancy rate of 20 percent or more. Correctional officer turnover has averaged 22 percent since 2000, and the Texas Department of Criminal Justice reported 3,025 correctional officer vacancies (or 11.5 percent of all correctional officer positions) at the end of fiscal year 2008.

Unable to hire enough correction officers to meet the prison system's needs, the Texas Department of Criminal Justice uses overtime hours to cover staff shortages. Hiring more correctional officers would reduce the need for overtime and allow units to operate as designed. However, various factors prevent the agency from retaining enough appropriately qualified individuals to fill the unmet need. The combination of pay, work environment, and the location of some prison units contribute to correctional officer turnover and increase the likelihood of future security lapses in the system. The agency has thus far effectively managed the correctional officer shortage and maintained unit security by mandating overtime and limiting offender movement. By implementing new strategies to select correctional officers better suited for the job, improving the work environment, and extending the career ladder, the agency could reduce turnover, its reliance on overtime, and decrease the risk of adverse security events.

FACTS AND FINDINGS

- Nationally, correctional officers are dissatisfied with their jobs because of stressful working conditions, unsatisfactory relationships with supervisors, and limited job autonomy and variety, which contribute to high correctional officer turnover rates.
- The Texas Department of Criminal Justice's annual correctional officer turnover reached a 10-year high in fiscal year 2007 of 24.3 percent. Fiscal year 2008 correctional officer turnover was 24.1 percent, but correctional officer turnover at the prison units ranged from 5.9 percent to 42.2 percent.
- The Texas Department of Criminal Justice uses best practices in workforce planning, recruitment, and training. However, the agency is not selecting the most appropriate applicants from those who qualify for employment, because 32 percent of correctional officers hired in fiscal year 2008 left employment with the agency for a reason that may indicate they were ill suited for the profession.
- The Texas Department of Criminal Justice recruits a large number of correctional officers compared to other states; however, in fiscal years 2007 and 2008, the agency had almost an equal number of new hires and terminations.
- Only 26 percent of a cohort of newly hired correctional officers from 2004 remained continuously employed at the Texas Department of Criminal Justice as a correctional officer over four years.
- The correctional office career ladder is based on months of service. Fiscal year 2008 pay ranged from $26,016 to $34,620 annually until the Texas Board of Criminal Justice modified the correctional officer career ladder, effective May 1, 2008, to increase pay for officers with up to 20 months of service and adjusted the months of service needed to qualify for Correctional Officer III, IV, and V. This change increased the salary for officers with fewer months of service and compressed the time to advance to the highest level of the career ladder, Correctional Officer V, from 97 months to 91 months, but it did not increase pay for tenured officers.
- Correctional officers earn the maximum salary for their job at 7.5 years of service, which is approximately 12.5 years before they can retire. Most states offer a broader range of pay for correctional officers.
- The agency paid $82 million in overtime pay in fiscal year 2008 to correctional officer and other unit staff, which is equivalent to paying an additional 2,668 correctional officers at an average correctional officer salary of $30,756 per year. Analysis indicates there is a relationship between high levels of overtime and both high turnover rates and increased uses of force.
- Overtime worked by correctional officers covered 50 percent of the average reported vacancies, which indicates the Texas Department of Criminal Justice

fills one-half of vacancies with overtime to maintain staffing levels. However, there is still a gap between the number of shifts covered each month and the staffing level the agency determined appropriate for each unit.

- Units with higher turnover did not have more security issues than units with lower turnover. This may be attributed to the Texas Department of Criminal Justice's ability to manage the correctional officer shortage while maintaining unit security. It is uncertain if vacancies and turnover will result in prison operations being susceptible to future adverse security events.

DISCUSSION

The safety of the prison staff and the offenders is a priority for prison administration. Correctional officers (CO) perform the critical public safety function of securing prisons, often under challenging circumstances. A CO is responsible for the care and custody of offenders; maintaining the daily schedule; enforcing rules and regulations; settling disputes; and preventing disturbances, assaults, and escapes. State and federal government employers seek individuals for correctional officer positions who have the ability to supervise others, communicate well, and react in crises. COs duties include: providing assistance, guidance, and direction; counseling, supervising, and instructing; and persuading individuals to listen and comply with rules.

DUTIES OF A CORRECTIONAL OFFICER

COs monitor the activities and supervise the work assignments of offenders. General population offenders leave their cells in the housing unit each day to go to the mess hall, programs, work assignments, infirmaries, libraries, commissaries, and indoor and outdoor activities and recreation. At different points in the day, one CO may be responsible for moving or securing up to 144 offenders. COs conduct searches, restrain and secure assaultive offenders, and transfer and transport offenders. They also search offenders living quarters for contraband like weapons and drugs.

A CO is at risk of assault or injury in his/her work environment, therefore, must be constantly alert. COs respond to emergencies, which may include climbing stairs and ladders while searching for unaccounted for offenders, hearing calls for and calling for help, giving first aid at the emergency site, carrying an injured or unconscious offender or staff to safety. They are prepared for and occasionally are required to use force or deadly force, chemical agents, or firearms to control offenders and maintain security in the prison.

At the Texas Department of Criminal Justice (TDCJ), a CO is scheduled either five 8-hour days or four 12-hour days. Officers rotate to different posts during their shifts. Each CO receives one 30-minute break per 8- or 12-hour shift. The CO may receive two additional 15-minute breaks if there is sufficient staff. Understaffed units report that additional breaks are rarely an option.

There are 103 CO posts, but not every unit uses each post. TDCJ maintains post orders which are written procedures that describe the tasks to be completed by the CO assigned to the post. COs are trained to work most of the posts in the unit, and they work a variety of posts. COs may start their shift as a rover (a CO who walks the cellblock and escorts offenders), and then rotate to the picket (a post in a guard tower on the perimeter of the unit or at a stationed position inside the unit). Only a few posts require officers to log the duties they completed while at the post. Not every post's tasks will be completed if there is a shortage of officers. If COs on the next shift do not arrive for duty, other COs must cover their posts. If no one volunteers to work an open shift, the warden can mandate another CO to remain and work overtime.

Figure 217 shows examples of four common CO posts and gives a brief description of the types of tasks the CO assigned to the post should complete.

DEMOGRAPHICS OF THE CURRENT CORRECTIONAL OFFICER POPULATION

At the end of fiscal year 2008, TDCJ had 23,275 filled positions, 3,025 less than the number of authorized positions. **Figure 218** shows the demographics of the agency's CO population employed during fiscal year 2008. The average age of a CO was 40.6, and most often COs are white males.

ELIGIBILITY CRITERIA, HIRING, AND PRE-SERVICE TRAINING

Each state determines the minimum requirements for someone to become a correctional officer. States' minimum age requirements vary from ages 18 to 21. All states require COs to have a high school diploma or an equivalency credential while a few require additional experience, certification, or college credit. According to a study conducted in 2000 by the National Institute of Corrections on recruitment, hiring, and retention practices in jails, retention rates tend to be higher among employers committed

FIGURE 217
SELECTED CORRECTIONAL OFFICER POSTS, FISCAL YEAR 2008

POST TITLE	BRIEF DESCRIPTION OF DUTIES OF THE POST
Front Gate Picket Officer	Secure the perimeter, prevent unauthorized entrance and exits, observe activities near the post, properly identify persons entering and exiting, and maintain and use a firearm as necessary.
Cellblock Rover Officer	Monitor the housing area and prepare and move offenders to activities. Secure the cellblock, count offenders, and conduct random housing searches.
Visitation Officer	Greet, identify, and register visitors; search visitors, offenders, and the visitation room; and ensure no contraband is brought into the unit.
Mobile Patrol Office	Patrol outside the perimeter fence; investigate, record, and report all unusual activity; and maintain and use a firearm as necessary.

Sources: Legislative Budget Board; Texas Department of Criminal Justice.

FIGURE 218
CORRECTIONAL OFFICER DEMOGRAPHICS, FISCAL YEAR 2008

RACE				
BLACK	HISPANIC	WHITE	OTHER	TOTAL
7,310	4,506	11,442	286	23,544
31.0%	19.1%	48.6%	1.2%	100.0%

GENDER		
MALE	FEMALE	TOTAL
13,944	9,600	23,544
59.2%	40.8%	100.0%

AGE		
AGE GROUP	AVERAGE HEADCOUNT	PERCENTAGE
18 to 21	1,043	4.4%
22 to 29	4,778	20.3
30 to 39	5,383	22.9
40 to 49	5,906	25.1
50 to 59	4,592	19.5
60 to 69	1,711	7.3
70+	132	0.6
TOTAL	**23,544**	**100.0%**

Sources: Legislative Budget Board; Texas Department of Criminal Justice.

to identifying and hiring only the strongest applicants. Employers with screening processes designed to weed out weaker applicants have higher retention rates.

New York, California, and Arizona applicants must be at least age 21 and undergo extensive testing and evaluation. The selection process in these states includes all-day testing, written examinations, psychological evaluations, oral exams, physical screenings, background investigation, and fingerprinting. States with very strict hiring criteria struggle to qualify enough officers.

Texas' criteria are lenient compared to other states which allows TDCJ to qualify more applicants for hire. In Texas, individuals must meet the following criteria to be eligible to be hired as a CO at TDCJ:

- be a U.S. citizen;
- be at least age 18;
- have a high school diploma or equivalent;
- pass the pre-employment test and a drug test; and
- not be convicted of a felony, a drug-related offense, any offense involving domestic violence, a Class A or B misdemeanor conviction within the past five years, be on probation for any criminal offense, and not have any criminal charges pending or have an outstanding warrant.

Before being interviewed, applicants must pass a 100-question multiple-choice test. The pre-employment test is a general knowledge test used to evaluate an applicant's memory, verbal skills, situational and deductive reasoning, reading comprehension, and math skills.

The pre-employment screening test was developed in 1988 with assistance from Rice University to identify strength areas determined to be predictors of successful performance as a CO. TDCJ has used the same pre-employment screening test for 20 years. Applicants who pass the pre-employment test are interviewed and evaluated using a standard set of scoring guidelines. Lastly, TDCJ conducts a criminal history background check and requires drug and alcohol screening. Those not offered employment are most often disqualified because of their former TDCJ employment record or a criminal history.

Once selected, COs attend a 200-hour (approximately five-week) training academy that prepares them to work in a unit. Academies begin about once a week and special unit-based academies are held periodically throughout the state in areas

that are distant from one of the six regional academies. The CO training is accredited and based on guidelines established by the American Corrections Association (ACA). TDCJ reported spending more than $2 million on pre-service training in fiscal year 2007. Since a 2001 audit conducted by the State Auditor's Office, TDCJ has increased its focus on training. Trainees surveyed after training have indicated that the training properly prepared them for work on the unit.

From July 2005 to March 2008, 3,363 applicants who had been offered employment as a CO did not report to training as originally scheduled. The show-up rate increased from an average of 68 percent in fiscal year 2004 to an average of 77 percent in fiscal year 2007. In fiscal year 2008, an average of 77 percent of new hires showed up for training, and 92 percent of those who started training graduated.

After completing pre-service training at the academy, a new CO is assigned to a unit and continues training under the guidance of an experienced CO-mentor for 104 hours (approximately 2.5 weeks). TDCJ tries to assign new COs to the unit they request as their preferred work location, but this is not always possible, because the agency must balance CO work unit preference with unit need. As a result, some COs commute to their assigned unit and live in on-campus housing if it is available. Of the 23 units that are less than 80 percent staffed, 8 have employee housing. TDCJ included an exceptional item in its 2010–11 biennial legislative appropriations request to build three new housing quarters near understaffed units for employees.

In November 2007, TDCJ began offering a higher starting salary to three types of applicants: (1) those with a bachelor's degree, (2) two years of military service, or (3) COs returning to employment within three years. Those with additional education or experience are hired at the CO III level, or $2,429 a month, $261 more a month than the standard CO I hiring rate.

TDCJ began offering a $1,500 recruitment bonus in April 2008 to encourage newly hired COs to accept work assignment at understaffed units (select units less than 80 percent staffed). As of October 2, 2008, TDCJ agreed to pay 1,139 recruitment bonuses. Since the inception of the recruitment bonus program in April 2008, the number of new hires increased from 595 to 697 a month, and the number of trainees accepting work assignments at understaffed units has increased from 29 percent to 38 percent of academy graduates. Of the 1,139 COs who were paid a recruitment bonus, 114 have left employment with the agency and are now required to pay some or all of the bonus back to TDCJ.

TDCJ is able to qualify a sufficient number of applicants for hire. Alternatively, states with very strict hiring criteria have a limited supply of eligible applicants, and though they may have lower turnover, they have fewer eligible applicants and struggle to hire enough COs to meet their needs. Wrong initial selection, or employees not suited to the job, is a common cause of turnover. Thirty-two percent of COs hired in fiscal year 2008 left employment with TDCJ for a reason that indicated they were likely ill suited for the profession. TDCJ could strengthen its hiring and screening requirement to increase the number of appropriate hires and reduce the cost of hiring and training over 6,000 COs a year, many of whom do not stay with the agency for more than one year.

TDCJ could update its pre-employment screening tool and refine the assessment and selection process to hire fewer correctional officers overall, but more correctional officers who are suited to the job. This could reduce the number of COs hired and reduce unnecessary turnover. Some turnover is expected, but unnecessary turnover costs the agency in recruiting, hiring, and training.

STAFFING, TURNOVER, AND VACANCIES

TDCJ's staffing levels are established in compliance with ACA guidelines and with best practices outlined in the *Staffing Analysis Workbook for Jails, 2003* produced by the National Institute of Corrections. Unit staffing levels are determined for each unit based on unit design, mission, offender population, custody level, posts in the unit, activities, and established relief factors. Unit rosters have three categories of staffing, and units that are not fully staffed typically only staff Category I positions. Staff categories include:

- Category I staffing (minimum mandatory staffing)–has a highest priority; generally those include offender housing, perimeter security, and primary gate control posts.
- Second Level Category I staffing (mandatory plus)–allows more movement and relief and meets security staff requirements for programs like vocational education, recreation, and law library access.
- Category II (full operation)–allows movement, relief, and all community and education programs including community work projects and the field force

Staffing decisions must balance offender needs, ensure staff and public safety, and work within available resources.

Wardens and CO supervisors prepare the schedule by filling each category post on the roster with available staff. If there are not enough officers to fill the Category I posts, a supervisor will ask for volunteers from any unit to work overtime. If there are not enough volunteers, a warden may mandate overtime or limit movement to secure the unit. TDCJ prefers to staff rosters to Category II to ensure secure movement to programs, community work, and activities.

Like other states, TDCJ struggles to retain COs and fully staff its prisons. TDCJ CO turnover has averaged 20 percent since 2000, while state employee turnover averaged 15 percent during the same period. TDCJ hires COs who do not succeed in the profession. Thirty-eight percent of COs who leave TDCJ are in their first year of service. Turnover results in a less experienced staff. **Figure 219** shows the retention of COs hired during a two-month period in 2004. This cohort includes 1,248 COs hired from March 1 to May 30, 2004. In June 2008, only 323, or 26 percent, of the group had been continuously employed as a CO since their hire. This attrition suggests that for every 6,000 new COs hired each year only 26 percent or 1,560 officers will still be employed in a security position four years later. In fiscal year 2008, there were 9,423 COs with less than four years of service.

Along with high turnover, the agency has struggled to fill its authorized positions. Slightly more than 11 percent of TDCJ's authorized CO positions were vacant at the end of fiscal year 2008. The vacancy rate, the difference between the number of COs on staff and the agency's ideal staffing level, is listed in **Figure 220** for units with vacancy rates greater than 20 percent. TDCJ considers units with less than 80 percent staffed as critically understaffed units.

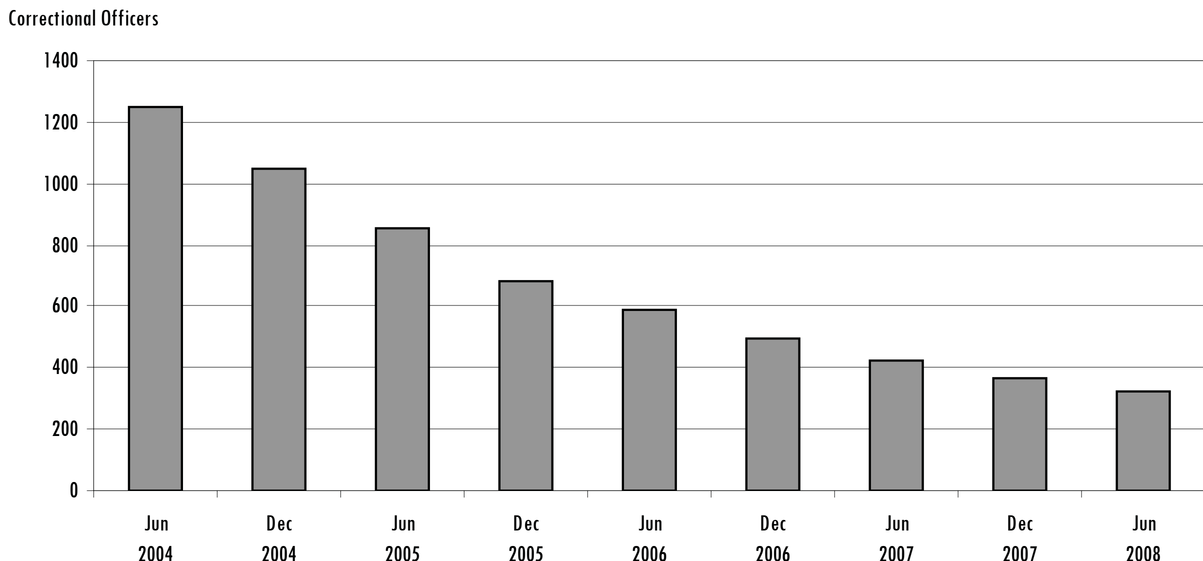
LOCATION, UNEMPLOYMENT RATE, AND LABOR SUPPLY

A unit's location contributes to its staffing shortage because in some areas demand for workers exceeds the labor supply. Statistical analysis conducted by Legislative Budget Board (LBB) staff evaluating 2007 census data and turnover showed a relationship between high CO turnover and low population in the county where the unit is located. There are 52 counties in Texas with a prison unit and 22 of those counties have more than one unit. **Figure 221** shows the eight counties with three or more units and their staffing needs.

Typically, counties with lower populations have greater difficulty staffing multiple units. One exception is Coryell County, which has an unemployment rate of over 6 percent, is near a large military base, and has few employers competing for individuals with the same qualifications.

High turnover rates trend with low unemployment rates. National statistics indicate that when unemployment is low, turnover rates among corrections officers are high because there are more job options. In a labor market with an unemployment rate of 4 percent, those with employable skills are employed, and the 4 percent of unemployed individuals are those more difficult to match with an employer. In fiscal year 2007, the unemployment rate in Texas counties with a prison unit ranged between 4 percent

FIGURE 219
CORRECTIONAL OFFICER ATTRITION FOR A COHORT OF OFFICERS



SOURCE: Legislative Budget Board.

FIGURE 220
UNITS WITH THE HIGHEST VACANCY RATE, END OF FISCAL YEAR 2008

UNIT	TDCJ OPTIMUM STAFFING LEVEL (FTES)	NUMBER OF VACANT POSITIONS	PERCENTAGE VACANT
Ft. Stockton	85	38	44.7%
Dalhart	201	87	43.4%
Daniel	210	83	39.5%
Ware	167	64	38.0%
Ferguson	505	185	36.5%
Coffield	750	267	35.6%
Lynaugh	193	68	35.3%
Wallace	211	75	35.3%
Eastham	543	190	35.0%
Smith	438	144	32.8%
Beto	435	139	31.9%
Ellis	464	146	31.4%
Jordan	174	51	29.4%
Wynne	482	141	29.3%
Connally	537	155	28.8%
McConnell	551	147	26.6%
Stiles	536	140	26.1%
Polunsky	570	132	23.2%
Michael	600	134	22.3%
Pampa	65	14	21.5%
Garza East	382	81	21.2%
Holliday	322	68	21.1%
Estelle	735	149	20.2%

Source: Legislative Budget Board.

and 6 percent. As a result, the CO labor pool in these counties was further limited by low unemployment.

According to the U.S. Bureau of Labor Statistics, the Texas unemployment rate increased in 2008 to 4.7 percent from 4.3 percent a year earlier, and the real wage in the U.S. has fallen every month in 2008. Decreases in wage and employment rate result in an increased labor supply for jobs like correctional officers because more people are seeking employment, and the pay for COs becomes more competitive. As a result, the current labor market should be more favorable to TDCJ, making it easier for the agency to retain correctional officers.

USE OF AND NEED FOR OVERTIME

TDCJ reported 2,792 vacancies at the end of fiscal year 2005, which grew to 3,978 at the beginning of fiscal year 2008. The agency ended fiscal year 2008 with just over 3,000 vacancies. Units manage staffing shortages with overtime. Overtime worked by correctional officers covered approximately 50 percent of the average reported vacancies which indicates TDCJ is maintaining staffing levels with overtime. However, there is still a gap between the number of CO shifts covered each month and the staffing level TDCJ determined appropriate for each unit.

COs worked an average of 36 hours of overtime a month in fiscal year 2008. Some officers work little or no overtime in a month while others work as much as 140 overtime hours a month. Officers sometime work overtime at units other than their assigned unit to cover shifts at units that are severely understaffed. In fiscal year 2008, TDCJ paid approximately $816.4 million in salaries and $82.0 million in overtime to correctional officer and other unit staff. The $82 million paid

FIGURE 221
STAFFING NEED FOR CORRECTIONAL OFFICERS BY COUNTY, FISCAL YEAR 2007

COUNTY	NUMBER OF UNITS	COUNTY POPULATION	CO STAFFING NEED	NUMBER OF VACANCIES	VACANCY RATE
Walker	7	63,902	2,638	431	16.3
Coryell	6	72,156	1,738	81	4.7
Brazoria	6	294,233	1,369	280	20.4
Anderson	5	56,760	2,353	633	26.9
Fort Bend	5	509,822	781	54	7.0
Bee	3	32,689	1,000	262	26.2
Jefferson	3	241,975	824	120	15.0
Liberty	3	75,434	495	59	12.0

Source: Legislative Budget Board.

in overtime is equivalent to paying an additional 2,668 COs at the average CO salary of $30,756 per year.

TDCJ's overtime policy has changed a few times over the years to adjust to staffing needs and budget constraints. TDCJ began paying COs on a monthly basis for the overtime they work beginning in January 2007. Previously, COs banked overtime and were paid overtime hours once the officer's overtime hours exceeded 240 hours. **Figure 222** shows the amount of overtime paid monthly in fiscal year 2008.

FIGURE 222
OVERTIME PAID FOR CORRECTIONAL SECURITY OPERATIONS, FISCAL YEAR 2008

MONTH	AMOUNT (IN MILLIONS)
September	$6.9
October	6.0
November	7.0
December	7.2
January	6.2
February	7.0
March	6.4
April	6.5
May	7.1
June	7.1
July	6.9
August	7.6
TOTAL	**$82.0**

SOURCE: Legislative Budget Board.

Every unit accumulated some paid overtime hours in fiscal year 2008; however, 38 units used much more than the average, approximately 30,000 hours a year, to fill gaps created by CO vacancies. **Figure 223** lists the top 20 units that used substantially more overtime than other units.

Other states also struggle to keep a full complement of COs on staff resulting in increasing overtime costs. In Wisconsin, overtime rose 27 percent between 2005 and 2006, largely due to an unanticipated 1,200 increase in the prison population. California's overtime costs increased by 35 percent between 2005 and 2006 as the state struggled to keep its 33 prisons staffed despite nearly 4,000 vacancies. Overtime costs in California reached nearly $500 million in 2006, with 15 percent of COs earning at least $25,000 in overtime that year. Six employees earned more than a $212,179 annual salary—more than triple the average CO salary in California.

FIGURE 223
OVERTIME BY UNIT, FISCAL YEAR 2008

UNIT (LOCATION)	ESTIMATED PAID HOURS OF OVERTIME
Clements Unit (Amarillo)	266,449
Estelle Unit (Huntsville)	200,034
Eastham Unit (Lovelady)	188,341
Polunsky Unit (Livingston)	183,501
Coffield Unit (Tenn Colony)	151,990
Allred Unit (Wichita Falls)	148,977
Darrington Unit (Rosharon)	147,744
Montford Unit (Lubbock)	131,502
Stiles Unit (Beaumont)	123,503
Michael Unit (Tenn Colony)	114,043
Lyncher Jail (Harris Co)	109,567
Smith Unit (Lamesa)	108,431
Beto Unit (Tenn Colony)	101,887
Wynne Unit (Huntsville)	99,747
Ferguson Unit (Midway)	97,510
Clemens Unit (Brazoria)	96,355
Connally Unit (Karnes Co)	93,565
McConnell Unit (Beeville)	91,955
Wallace Unit (Colorado City)	90,262
Robertson Unit (Abilene)	85,483

NOTE: Estimated.
SOURCE: Legislative Budget Board.

CAUSES AND RISKS OF TURNOVER

Based on a 2003 survey conducted by ACA, correctional officers leave employment for four main reasons: inadequate pay; demanding hours and shift work; stress and burnout; and wrong initial selection or employees not suited to the job. The U.S. Bureau of Labor Statistics finds that working in a correctional institution can be stressful and hazardous. Every year, correctional officers are injured in confrontations with offenders. Some correctional institutions are well lit and ventilated, but others are old, overcrowded, hot, and noisy. None of Texas' offender housing units are air conditioned, which makes the work environment particularly uncomfortable in the summer months and often results in higher turnover during the hot summer months. Because prison security is required around the clock, officers work day and night, weekends, and holidays.

Employees who leave employment are asked to complete the State Auditor's Office exit survey indicating their reason for leaving, and separately TDCJ tracks the circumstances of an employee's termination. According to TDCJ, of the COs who left the agency in fiscal year 2008, 1,549 or 25 percent

left while on disciplinary action, under investigation, or in lieu of being terminated. Another 3,100 or 51 percent left for reasons not related to the job. Among the other voluntary separation reasons "insufficient pay" and "dissatisfaction with supervisor/coworker" were second and third. Twenty-six percent of the 522 TDCJ employees who completed the State Auditor's Office exit survey cited "better pay/benefits" as the primary reason for leaving employment with the agency.

The calculation used to determine Texas state employee turnover is the annual number of separations divided by the average number of filled positions on the last day of each quarter. TDCJ's annual correctional officer turnover reached a 10-year high in fiscal year 2007 of 24.3 percent. Fiscal year 2008 correctional officer turnover was 24.1 percent; however, turnover rates vary greatly by TDCJ unit. The unit with the lowest turnover was Jester III in Richmond with 5.9 percent turnover, and the highest turnover unit is at Stiles in Beaumont with 42.2 percent turnover. Both are located in TDCJ region III (Beaumont, Galveston, and Houston).

Stress and burnout is more severe among officers who work in understaffed conditions and those who work more overtime. Units with high vacancy rates also tend to have higher turnover rates; this may suggest that COs working in fully staffed units are more likely to stay with the agency. **Figure 224** shows that there is a relationship between units with high turnover rates and a high percentage of vacancies. The state appropriation for operating prisons is based on the prior year's level of filled positions to avoid over-appropriating salary funds to the agency. As a result, if TDCJ were to fill all 3,025 currently authorized CO vacancies, the agency would need approximately $167 million more in General Revenue Funds for the 2010–11 biennium to cover the cost of salaries.

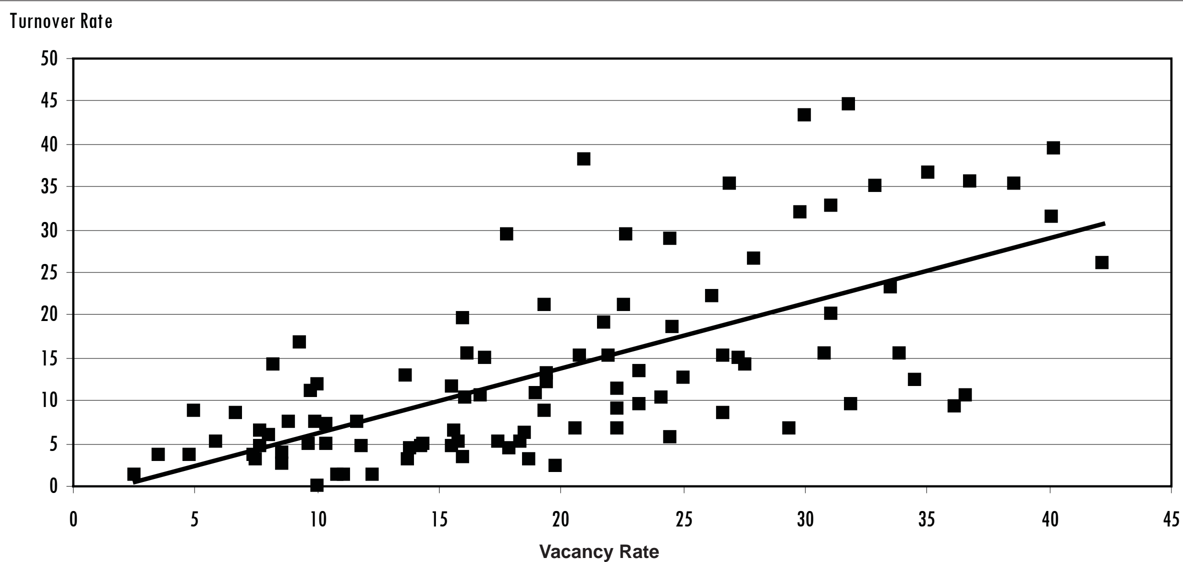
EFFECTS OF PAY

Higher pay is generally associated with lower turnover rates. There has been significant research in other shortage occupations that predicts turnover is most often related to low pay and relationships between staff and supervisor. In a comparable occupation, nursing assistance, low pay ranked as the top source of job dissatisfaction.

The *Corrections Compendium*, the journal published by the ACA, collected data from 46 states on a variety of CO workforce factors, including pay. In the May 2007 issue, the journal published the salary for COs at various points in their tenure. **Figure 225** shows the starting pay, median pay, and pay ranges for COs in states comparable to Texas. Arizona, Florida, Georgia, North Carolina, and Oklahoma share qualities with Texas that result in challenges retaining COs, such as location, population, economy, and union representation.

CO duties are comparable among states, but the cost of living makes it difficult to compare CO salaries and the effect salary has on turnover in each state. The Council for Community and Economic Research surveys cities to collect

FIGURE 224
RELATIONSHIP OF VACANCY RATE TO TURNOVER RATE, FISCAL YEAR 2007



Source: Legislative Budget Board.

FIGURE 225
STATE-BY-STATE COMPARISONS OF CORRECTIONAL OFFICER MEASURES, PUBLISHED MAY 2007

MEASURE	ARIZONA	CALIFORNIA	FLORIDA	GEORGIA	NEW YORK	NORTH CAROLINA	OKLAHOMA	TEXAS
State Population (In Millions)	6.2	36.5	18.1	9.4	19.3	8.9	3.6	23.5
Offender Population	31,079	157,000	89,551	57,571	63,124	37,878	17,000	152,625
Adult Units	10	33	104	67	63	78	40	98
Correctional/Security Staff	6,686	22,900	17,277	14,640	19,636	11,280	2,005	26,322
Turnover Rate Correctional Staff	16.3%	5.6%	17.6%	26.2%	4.4%	12.0%	16.9%	24.0%
Starting Pay	$31,957	$45,288	$30,808	$23,614	$31,704	$26,105	$24,605	$22,446
Top Pay	$50,111	$73,728	$45,034	$41,402	$57,236	$40,779	$28,040	$33,280
Median Pay for COs and Jailers in the State	$32,950	$64,090	$34,990	$28,800	$46,630	$28,590	$24,690	$29,530
Median Pay for All Other Jobs in State	$28,650	$34,040	$27,670	$28,660	$35,170	$27,980	$25,840	$27,570
Union Representation	Yes	Yes	Yes	No	Yes	No	No	No

SOURCES: American Correctional Association; U.S. Bureau of Labor Statistics.

grocery, housing, utility, transportation, healthcare, and miscellaneous goods price information from voluntary participants to derive the cost of living index for each state. In the first quarter of 2008, New York was indexed as the fifth most costly and Texas was indexed as the forty-eighth, making it one of the three least costly states. Using this index, the average CO salary in Texas ($30,756) is equal to a salary of $37,750 in New York, $31,313 in Florida, and $31,584 in Arizona.

It is difficult to make general comparisons about CO salary with other similar jobs because pay ranges vary across professions, states, and within the state, although in most states, the median CO pay is comparable with the median pay for the general population employed in the state. The average annual pay for a CO in Texas in fiscal year 2007 was $29,292. At the same time, the average pay for the general population employed in Texas was $28,150, $1,142 less than the average correctional officer's pay.

Average salaries vary greatly among counties. In 2007, average county wages ranged from $2,076 a month in Swisher County to $4,390 in Harris County. With an average monthly CO salary of $2,441, CO pay is more competitive in some areas of the state and less so in others. There is also a variety of employers recruiting employees from the same labor pool as TDCJ; therefore, it is difficult to determine how competitive CO salaries are with competing employers in various parts of the state.

Texas has the twelfth most compressed CO pay range among all states that responded to the 2006 ACA survey. Texas' salary range from the first to last step on the correctional officer career ladder is $8,608. Rhode Island reported the smallest range, $1,140, and Pennsylvania has the largest range, $29,989. The average range was $14,028.

Correctional officers who are employed for 7.5 years reach the maximum possible pay for their career as a CO, $2,885 a month or $34,620 annually in fiscal year 2009. At this point, COs are likely to still have at least 12.5 years until they are eligible to retire and receive a pension. Pay increases steadily in the early years of service (a change of $8,608 in 7.5 years), but there is limited incentive for experienced officers to stay employed with the agency. Once an officer reaches CO V, he or she must choose one of the following:

- remain employed as a CO and get periodic raises when the legislature authorizes an across-the-board increase or CO pay raise; or
- move to a different job within TDCJ, such as a CO supervisor or non-security position; or
- leave TDCJ.

Pursuing a supervisory position is an option for COs who would like to increase their salary. The salary for a CO Supervisor Sergeant is $2,985 a month or $35,815 annually, which is an increase of $1,190 a year over the highest CO career ladder pay level. CO supervisors have less opportunity to work overtime; as a result, supervisors could earn the same or less pay than they did as a CO. With limited opportunities for advancement, COs may not see their job as a career or profession. **Figure 226** shows that COs leave at a higher rate than other state employees with the same months of service, but turnover decreases at a similar rate for each group.

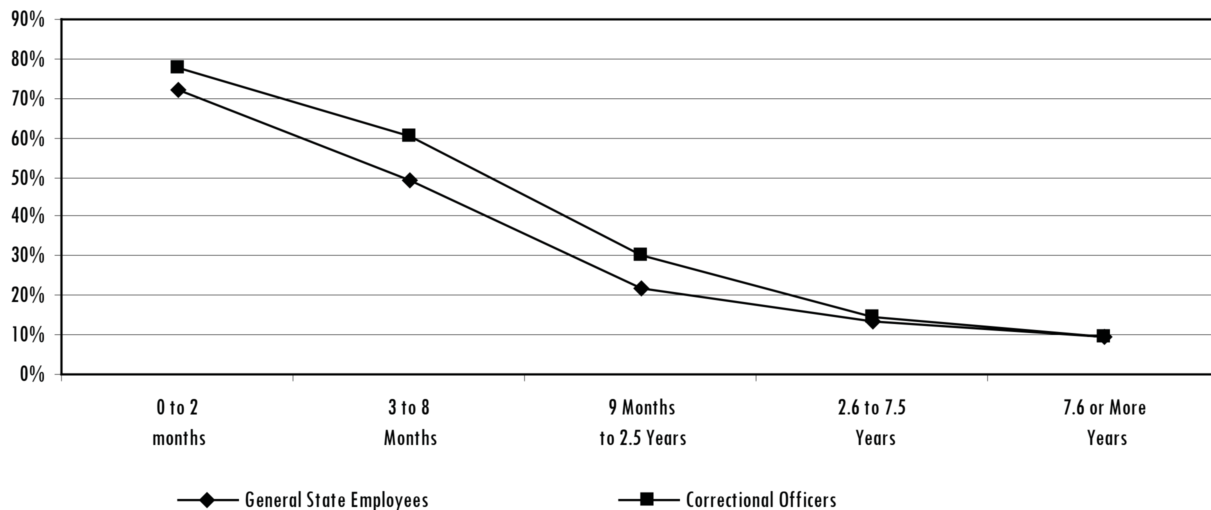
In fiscal year 2001, the career ladder topped out at a CO IV with 37 months of service and $2,365 in monthly pay. Effective September 1, 2001, the career ladder changed significantly. CO IV became a three-step series for officers with 37 to 96 months of service, and CO V was added for officers with 97 or more months of service. Incremental salary increases were included at every level; starting pay increased from $1,577 a month to $1,716 a month and maximum pay increased from $2,365 a month to $2,589 a month. The career ladder was unchanged in fiscal years 2002 to 2005.

COs received pay increases from fiscal years 2006 to 2009 as a result of the across-the-board state employee salary increases. **Figure 227** shows changes to the correctional officer career ladder adopted by the Texas Board of Criminal Justice, effective May 1, 2008. TDCJ increased pay for COs with up to 20 months of service, and adjusted the months of service for CO III and CO V, which compressed the time to advance to a CO V from 97 months to 91 months of service. The increase in pay shown in **Figure 227** from May to September is the result of the fiscal year 2009 state employee salary increase.

There is a relationship between high pay and low turnover; therefore, it is likely that pay is partly responsible for staff turnover, but it is not the only factor influencing a CO's decision to remain with or leave the agency. It is difficult to quantify the amount of additional pay that would be necessary to reduce turnover to an acceptable rate. If CO pay were increased by $50 a month, the cost would be $32.3 million in General Revenue Funds for the 2010–11 biennium. In Texas, COs earn the maximum salary for their job at 7.5 years, but most states offer a broader range of pay for COs. **Figure 228** is an example of an expanded career ladder that would create a broader CO pay range similar to the average range in other states of $14,000. The cost of implementing the expanded career ladder would be $75.6 million in General Revenue Funds for the 2010–11 biennium.

To maintain equity, the CO supervisor job series would need to be adjusted to ensure CO supervisor pay starts at a sufficiently higher rate than CO Vs to encourage the most qualified COs to move into the supervisor series. The average CO works three days of overtime each month adding approximately $350 per month to their pay. Correctional officer supervisors are rarely needed for overtime; therefore, to make CO supervisor pay competitive, the monthly pay

FIGURE 226
TURNOVER TREND FOR GENERAL STATE EMPLOYEES AND CORRECTIONAL OFFICERS BASED ON THE LENGTH OF SERVICE ON THE CORRECTIONAL OFFICER CAREER LADDER, FISCAL YEAR 2007



Source: Legislative Budget Board.

FIGURE 227
CORRECTIONAL OFFICER CAREER LADDER CHANGES MAY 1, 2008 AND FISCAL YEAR 2009 CAREER LADDER

TDCJ CAREER LADDER	SERVICE IN MONTHS	SALARY MAY 1, 2008	SALARY SEPTEMBER 1, 2008
CO I	0 to 2	$2,118	$2,168
CO II	3 to 8	$2,245	$2,295
CO III	9 to 14	$2,379	$2,429
CO III	15 to 30	$2,517	$2,567
CO IV	31 to 42	$2,590	$2,642
CO IV	43 to 54	$2,665	$2,718
CO IV	55 to 90	$2,745	$2,800
CO V	91+	$2,829	$2,885

Source: Texas Department of Criminal Justice.

FIGURE 228
EXAMPLE OF EXPANDED CORRECTIONAL OFFICER CAREER LADDER, 2010–11 BIENNIUM

TDCJ CAREER LADDER	SERVICE IN MONTHS	SALARY SEPTEMBER 1, 2008	OPTION FOR EXPANDING RANGE
CO I	0 to 2	$2,168	
CO II	3 to 8	$2,295	
CO III	9 to 14	$2,429	
CO III	15 to 30	$2,567	
CO IV	31 to 42	$2,642	
CO IV	43 to 54	$2,718	
CO IV (new)	55 to 73		$2,800
CO IV (new)	74 to 90		$2,885
CO V (new)	91 to 115		$3,005
CO V (new)	116 to 136		$3,125
CO V (new)	137 to 150		$3,245
CO V (new)	151+		$3,434

Source: Legislative Budget Board.

should be more than the highest level on the CO career ladder.

EFFECTS OF WORK ENVIRONMENT

High rates of turnover among COs can result from pay issues, but the work environment also affects turnover. Units with higher rates of overtime, officer disciplinary hearings, inexperienced officers, and fewer officer grievances have higher turnover rates. Stressful working conditions, unsatisfactory working relationships with supervisors, and limited job autonomy and variety contribute to a work environment that makes officers less satisfied with their job and more likely to leave employment.

Work environment includes working conditions and characteristics of the job. Working conditions are both the physical surroundings and the culture of the organization. Job characteristics are represented by the job variety, job satisfaction, job stress, and other intrinsic job attributes. Most studies confirm a negative relationship between work stress and job satisfaction among correctional employees. Demanding hours, shift work, stress, and burnout are partially responsible for turnover. A positive work environment is necessary to retain staff.

Legislative Budget Board (LBB) staff identified a set of variables associated with work environment and collected and analyzed the data. The variables represent different aspects of what makes the prison work demanding and what influences a CO's decision to stay with or leave the agency. Using regression analysis, LBB staff determined the relationship between several independent variables. Four variables related to work environment had a significant relationship with turnover at units. These variables are shown in **Figure 229**.

There is a relationship between units with high turnover and a negative work environment, and these four variables had a statistically significant relationship to turnover. Units with high turnover had more CO disciplinary hearings and more overtime. Turnover results in understaffed units and the need to staff units with newer COs who have fewer years of experience. Units with insufficient staff and inexperienced staff are more vulnerable to security risks.

The higher turnover units had lower rates of employee grievances. This trend suggests that employees do not choose to pursue resolution of problems, but instead leave the agency. Low grievance rates may also suggest that employees at units with high turnover rates and a low number of employee grievances do not trust the process for complaint resolution or that they will be treated fairly. **Figure 230** represents, in order of correlation strength, each variable that was considered in the analysis of CO turnover. The variables with significance are above the line in **Figure 230**. Those below the line did not have a significant influence on CO turnover. Other variables were considered but were either not quantifiable or the data was not readily available.

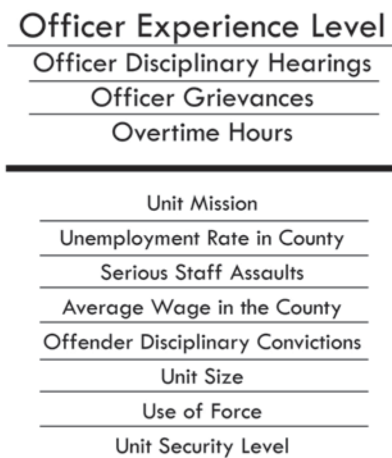
This analysis confirms that units with greater turnover have lower overall CO experience levels, more disciplinary hearings, and require more overtime hours to maintain

FIGURE 229
DEFINITION OF WORK ENVIRONMENT VARIABLES SIGNIFICANT IN THE ANALYSIS

VARIABLE	DEFINITION
Officer Experience Level	Experience level of COs based at each unit. The LBB assigned an indexed number to represent the years of experience based on the distribution of CO II – CO Vs at each unit.
Officer Disciplinary Hearing	The number of hearings conducted to review and address CO behavior or noncompliance with employee polices or procedures
Officer Grievances	The number of grievances filed by a CO with TDCJ. TDCJ encourages employees and supervisors to attempt to resolve any employment related disagreement one-on-one, but employees who believe they have not been treated fairly have a right to submit a grievance.
Overtime Hours	Hours a CO works beyond their normal scheduled hours

Source: Legislative Budget Board.

FIGURE 230
WORK ENVIRONMENT FACTORS RELATED TO TURNOVER IN ORDER OF SIGNIFICANCE



Source: Legislative Budget Board.

operations. These factors may be the result of turnover but may also cause additional turnover.

STRATEGIES TO IMPROVE CORRECTIONAL OFFICER WORK ENVIRONMENT

Turnover results in higher recruitment needs, hiring and training costs, more expensive pay to staff units with COs through overtime, a negative work environment, and lower morale. Leadership, well-trained supervisors, effective employee-supervisor relationships, and high quality of staff are qualities of a positive work environment that can significantly increase retention. TDCJ could implement additional retention programs to improve the work environment and improve morale among tenured correctional officers. Prisons benefit operationally from retaining experienced correctional officers.

Texas does not require COs to be certified. Making an occupation more professional is the process of setting standards and requiring greater education, skill, or certification. Professionalization provides an opportunity for corrections to improve its image among potential employees and instill pride in those who work in the field. The ACA has instituted a Corrections Certification Program that allows COs to voluntarily gain recognition as qualified professionals. Encouraging COs to seek a certification could improve skill level, commitment, and promote ethical behavior.

Another strategy to improve the work environment is by further improving CO supervisor skills. TDCJ's Internal Audit division held workshops with newly promoted CO supervisors in January 2007. Internal Audit found that COs reported one of the negative aspects of working for TDCJ was dissatisfaction with CO supervisors. The auditors recommended that the agency require all current and future CO supervisors attend training. The agency implemented the recommendation creating a one-week sergeant's academy for new CO supervisors. The agency has promoted the training to current CO supervisors, and approximately 83 percent of all CO supervisors have attended the training. TDCJ should continue to improve supervisor training and require all supervisors to attend to address concerns COs voiced about problematic relationships with supervisors and the culture of the unit.

The National Institute of Corrections survey respondents recommended the adoption of management policies that empower staff, making them feel invested in a mission and providing room for their own judgment and discretion to help them engage at work. Fairness, openness, and honesty are necessary to support a positive work environment. The agency could offer additional pay to high performing officers who have special skills. Some COs work as recruiters, mentors, or certified bilingual officers for no extra pay. The

agency should offer additional pay to officers willing to take on these additional duties. These duties are important programs for both new and current staff.

All new officers are assigned to a mentor when they arrive at the unit to complete pre-service training. Mentors serve as role models, guides, and career coaches to other employees. Mentoring and other on-the-job training programs integrate new CO staff with tenured staff. Mentoring programs can help bring new COs into the fold and make the CO feel like they belong and can succeed at the unit. Better trained COs are more likely to remain with the agency and are better at securing units and completing their duties. Allowing tenured COs to earn additional pay performing duties such as mentoring would improve CO job satisfaction by increasing job autonomy and job variety.

TDCJ has the authority to offer retention bonuses but has not. A state agency can enter into an agreement with an employee to pay the employee a bonus of up to $5,000 for remaining employed for 12 months. The agency could use targeted retention bonuses to retain experienced COs at understaffed units. Retention bonuses could also be used to encourage experienced COs to relocate to understaffed units.

EFFECT OF TURNOVER ON UNIT SECURITY

According to ACA, high turnover contributes to diminished security and risk of an adverse event, because units with high turnover have insufficient and overworked staff. LBB staff selected variables that are commonly used to evaluate prison security and collected data on those variables to determine the relationship between those variables. The variables are shown in **Figure 231**.

Correctional officers have the authority to use force in any correctional setting as necessary to achieve the compliance of an offender or to maintain a safe and secure environment for offenders and staff. Uses of force are categorized as minor, major, or deadly and are controlling measures taken during a confrontational situation in an effort to cause an offender to do anything involuntarily. It is also efforts by staff to control disruptive or violent offenders and restore order in the unit.

LBB staff selected use of force as the dependent variable to measure which other factors had an effect on use of force and security risk in TDCJ prisons. There was no relationship between the variables identified to determine unit security risk and CO turnover, and there was no significant relationship between use of force and unit mission, unit size, unit security level, officer experience level, officer disciplinary hearings, officer grievances, and time the unit is limiting movement (locked down). Therefore, units with higher turnover did not have more security issues than units with lower turnover.

There was a small relationship between units with increased uses of force and higher amounts of overtime. **Figure 232** shows the relationship of uses of force to overtime. This likely indicates that TDCJ is effectively managing the workforce shortage and turnover with overtime. It is possible that the overtime is a predictor for increased stress, burnout, and unit safety. Although TDCJ is effectively managing risks, the increased stress on the system increases the risk of adverse security events. Without changes to improve the system, it is possible that these management efforts will not work in the long term.

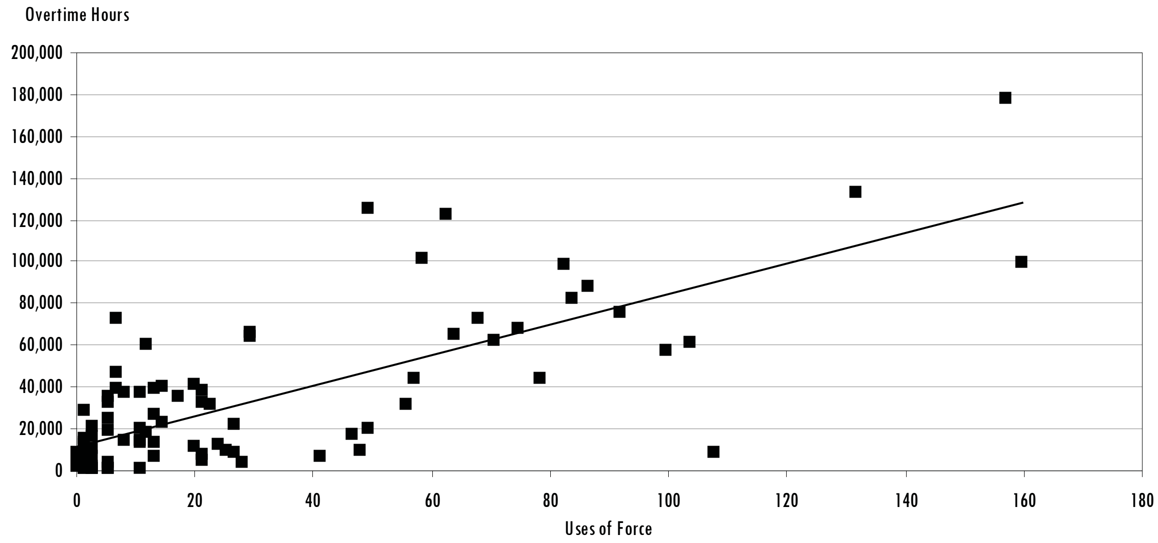
Because units vary, a unit-by-unit analysis would be necessary to identify the workforce and retention programs appropriate to improve staffing and security concerns at each unit. A unit-by-unit analysis would require evaluating the factors causing the unit to have higher than acceptable turnover. Combinations of secondary factors unique to a unit cause certain units to struggle with staff retention.

FIGURE 231
DEFINITION OF SECURITY RISK VARIABLES

VARIABLE	DEFINITION
Escapes	Absconding from custody
Offender Disciplinary Convictions	Number of hearings conducted to review and address offender behavior or noncompliance with polices or procedures
Serious Staff Assaults	Number of assaults of a CO by an offender that required more attention than first-aid
Use of Force	A controlling measure taken during a confrontational situation in an effort to cause an offender to do anything involuntarily. Uses of force are categorized as minor, major, or deadly.

SOURCE: Legislative Budget Board.

FIGURE 232
RELATIONSHIP OF USE OF FORCE TO OVERTIME, FISCAL YEAR 2007



SOURCE: Legislative Budget Board.

IMPROVE COMPLIANCE WITH THE DRIVER RESPONSIBILITY PROGRAM

The Driver Responsibility Program, which is administered by the Texas Department of Public Safety, assesses a surcharge on drivers convicted of certain driving offenses in Texas. Failure to pay these surcharges results in driver license suspension. The program applies to offenses committed after September 1, 2003 and has assessed and collected surcharges since September 2004. At the end of fiscal year 2008, 4 million offenders have been convicted of violations under the Driver Responsibility Program. Only 38.5 percent of these offenders are complying with the program. The program billed almost $1.3 billion for these offenses since its inception but has collected only 35.8 percent by the end of fiscal year 2008. Of all surcharges billed, 57.5 percent resulted in driver license suspension.

Many offenders are low-income or indigent Texans, drivers with income below the federal poverty guidelines, who cannot afford to pay the assessed surcharges. Poor compliance with the Driver Responsibility Program leads to a greater number of unlicensed and uninsured drivers on Texas roads. To improve collection rates and reduce the number of unlicensed drivers in the state, the Texas Department of Public Safety should establish a needs-based program that reduces surcharges for indigent offenders. This program would not have any fiscal impact to the state, but would improve program compliance and road safety.

FACTS AND FINDINGS

- There are four categories of Driver Responsibility Program violations: (1) Points, (2) Driving while Intoxicated, (3) Driving while License Invalid or without Financial Responsibility, and (4) Driving with No License. Compliance with the four categories of violations varies greatly.
- The only statutory penalty for not complying with the Driver Responsibility Program is driver license suspension.

CONCERNS

- The Texas Department of Public Safety has not implemented the indigency program for the Driver Responsibility Program authorized by Senate Bill 1723, Eightieth Legislature, 2007. Many Driver Responsibility Program offenders tend to be low-income or indigent Texans who may be unable to comply for financial reasons.
- Many offenders may be unaware that the Driver Responsibility Program surcharge is typically assessed separate from court fees and fines, leading them to fail to plan for the bill or to believe that the bill is in error.
- Since an estimated one-half to three-quarters of drivers with suspended licenses will occasionally drive anyway, poor compliance with the Driver Responsibility Program leads to a greater number of unlicensed and uninsured drivers on Texas roads. While compliance with points violations is over 70 percent, compliance with the other three types of violations is at 42 percent or less.
- Some offenders are low-income Texans who are not indigent. These individuals may face similar difficulties in paying surcharges that indigent offenders face, but may be able to comply with the law at a lower surcharge level.

RECOMMENDATIONS

- **Recommendation 1:** Amend Texas Transportation Code, Chapter 708, to require the Texas Department of Public Safety to establish an indigency program for offenders under the Driver Responsibility Program. The indigency program should include a provision requiring the Texas Department of Public Safety to reduce an offender's surcharges upon receiving proof of indigency. The Texas Department of Public Safety should report indigent offenders as a separate compliance category in its weekly overview on the Driver Responsibility Program.
- **Recommendation 2:** Amend Texas Transportation Code, Chapter 708, to require courts to issue a statement to defendants informing them of surcharges to be paid under the Driver Responsibility Program.
- **Recommendation 3:** Amend Texas Transportation Code, Chapter 708, to permit the Texas Department of Public Safety to adjust surcharges to maximize compliance among offenders.

DISCUSSION

The Driver Responsibility Program (DRP) became effective on September 1, 2003. Under the DRP, certain traffic offenders pay an annual surcharge for three years, following final conviction of certain traffic offenses, if committed on or after September 1, 2003. The program includes the following categories for traffic violations:

- Points: accumulating six or more points from specific moving violations;
- Driving while Intoxicated (DWI): failing a blood alcohol test;
- License Invalid/No Insurance (LINI): either driving while license invalid (DWLI), meaning that the license is suspended or revoked, or failing to maintain financial responsibility (having no insurance); or
- No License (NL): driving with no license or an expired license.

Figure 233 shows each type of violation and applicable surcharges.

PROGRAM REVENUE ALLOCATION AND COLLECTIONS

Of the revenue DRP collects from surcharges, 1 percent is directed to the General Revenue Fund for program administration. The remainder (99 percent) is divided equally (49.5 percent) between the Designated Trauma Facility and EMS Fund (General Revenue–Dedicated Funds) and the General Revenue Fund. If combined deposits to the General Revenue Fund from DRP funds and $30 State Traffic Fine funds meet an annual $250 million limit, any additional funds would be directed to the Texas Mobility Fund. **Figure 234** shows this relationship.

Total cumulative surcharges collected as of the end of fiscal year 2008 were $455.1 million of $1.27 billion assessed. As **Figure 235** shows, the Texas Comptroller of Public Accounts' Biennial Revenue Estimate (BRE) for DRP collections has increased from $76.4 million in fiscal year 2006 to $131.4 million in fiscal year 2008. Actual DRP collections have met or exceeded the BRE in each year of operation.

IMPROVEMENT OF COLLECTIONS

Senate Bill 1723, Eightieth Legislature, 2007, allowed the Texas Department of Public Safety (DPS) to improve collection efforts through several new methods DPS implemented these changes in February 2008. The new collection methods include:

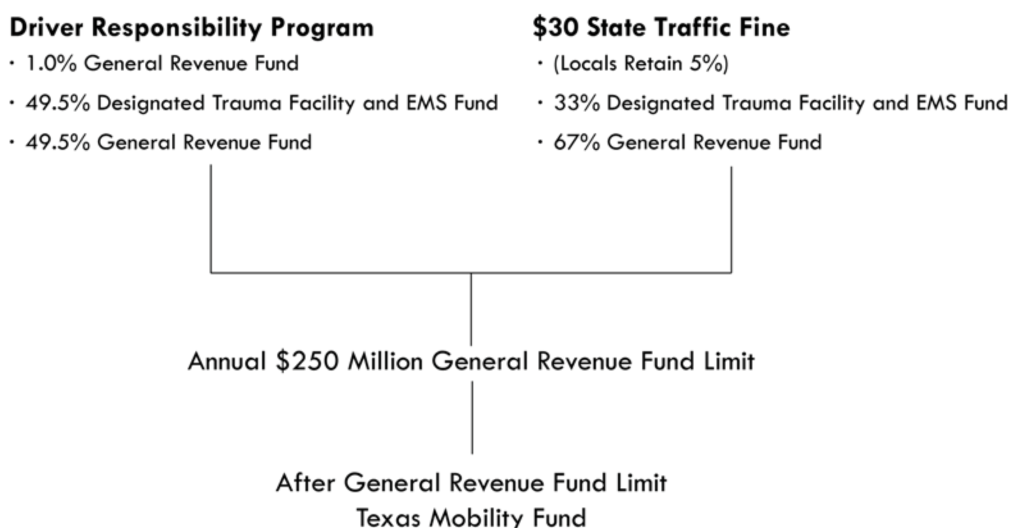
- Reestablishing installment plans that were suspended for failure to pay. Offenders may now reestablish an installment agreement and request a change of the due date. Each of these actions may only be taken once.
- Pursuing additional collection efforts. The vendor now attempts additional notifications and pursues

FIGURE 233
VIOLATIONS RESULTING IN DRIVER RESPONSIBILITY PROGRAM SURCHARGES, 2003 TO PRESENT

VIOLATION	DETAIL	SURCHARGE (PER YEAR FOR THREE YEARS)
6 or more points (Points)	2 points per moving violation;	$100 for 6 points
	3 points per moving violation resulting in an accident;	$25 for each additional point
	Exempt: speeding less than 10 percent over posted speed limit, unless in school zone; and	
	Also exempt: other specific traffic infractions	
Driving while Intoxicated (DWI)		$1,000 for first offense
		$1,500 for subsequent offense
		$2,000 for offense with blood alcohol test of 0.16 or more
License Invalid/No Insurance (LINI), includes: • Driving while License Invalid (DWLI) • Driving without Financial Responsibility (No Insurance)	DWLI is driving with a suspended or revoked license.	$250
Driving without a License (NL)	Not having a license or driving with an expired license	$100

SOURCE: Legislative Budget Board.

FIGURE 234
DRIVER RESPONSIBILITY PROGRAM FUND ALLOCATION



SOURCE: Legislative Budget Board.

FIGURE 235
ALLOCATION OF DRIVER RESPONSIBILITY PROGRAM COLLECTIONS, FISCAL YEARS 2006 TO 2008

	FISCAL YEAR 2006 (IN MILLIONS)		FISCAL YEAR 2007 (IN MILLIONS)		FISCAL YEAR 2008 (IN MILLIONS)	
FUND	ACTUAL	BRE*	ACTUAL	BRE*	ACTUAL	BRE*
General Revenue Fund	$49.7	$38.6	$80.0	$61.5	$84.6	$66.4
Designated Trauma Facility and EMS Fund	$48.7	$37.8	$78.5	$60.3	$81.1	$65.0
TOTAL	**$98.4**	**$76.4**	**$158.5**	**$121.8**	**$165.7**	**$131.4**

*BRE (Biennial Revenue Estimate).
SOURCE: Legislative Budget Board.

current addresses for offenders through various new database hosts. The vendor also uses outbound telephone calls and message campaigns to contact delinquent offenders. The vendor may accept check-by-phone payments and electronic-fund-transfer payments when speaking with a client.

- Establishing random amnesty periods. Offenders who have neglected to pay surcharges but incurred no additional DRP-related surcharges will be eligible to pay an amount equal to the initial year surcharge without penalty. The amnesty period will be open for 90 days and scheduled at the discretion of DPS.
- Reducing surcharges due as an incentive to pay timely. Offenders who pay surcharges and comply with driving laws can receive a reduction in surcharges to 75 percent of the initial surcharge in the second year of payment and 50 percent of the initial surcharge in the third year of payment.

Figure 236 shows assessments and collections by category of offense for fiscal years 2007 and 2008. In the points category, assessments were up in fiscal year 2008 over assessments in fiscal year 2007; but in all other categories, assessments were lower than in the prior year. However, in all categories, collections in fiscal year 2008 had improved over collections in the prior fiscal year. The collection rates show that points collections remained nearly constant from fiscal year 2007 to

FIGURE 236
ASSESSMENTS AND COLLECTIONS BY CATEGORY OF OFFENSE, FISCAL YEARS 2007 AND 2008

	FISCAL YEAR 2007			FISCAL YEAR 2008		
CATEGORY	ASSESSMENTS (IN MILLIONS)	COLLECTIONS (IN MILLIONS)	COLLECTION RATE	ASSESSMENTS (IN MILLIONS)	COLLECTIONS (IN MILLIONS)	COLLECTION RATE
Points	$5.2	$3.5	67.6%	$7.6	$5.1	67.7%
DWI*	$170.2	$61.8	36.3%	$152.6	$68.1	44.6%
LINI*	$208.7	$79.1	37.9%	$173.3	$79.9	46.1%
NL*	$43.3	$11.2	25.8%	$40.9	$13.4	32.9%
TOTAL	**$427.5**	**$155.6**	**36.4%**	**$374.3**	**$166.6**	**44.5%**

*DWI (Driving while Intoxicated; LINI (License Invalid/No Insurance); NL (No License).
SOURCE: Legislative Budget Board.

fiscal year 2008. In all other categories though, the collection rate jumped roughly seven to eight percentage points.

Figure 237 shows the compliance and suspension rates by category of offense both for the life of the program since inception and for fiscal year 2008 alone. As of the end of fiscal year 2008, the overall compliance rate was 38.5 percent; but the overall compliance rate for fiscal year 2008 alone was 43.6 percent, indicating that DPS has improved compliance among offenders in recent years. Within categories, overall compliance ranges from 28.2 percent to 70.9 percent, but the compliance rates within fiscal year 2008 alone also skew higher, from 32.1 percent up to 73.7 percent. The overall collection rate is 35.8 percent, up from 28.3 percent at the end of fiscal year 2006. The rates of suspension for noncompliance have also tended to decrease. The overall suspension rate for the program is 57.5 percent, but the suspension rate for fiscal year 2008 alone was 55.8 percent. Within the categories, suspension rates for fiscal year 2008 tend to be lower than overall suspension rates for the program with the exception of NL violations. However, it should be noted that these rates reflect only the differences in the final week of fiscal year 2008 from the final week in fiscal year 2007. Since the actual compliance and suspension rates fluctuate from week to week throughout the year, the fiscal year 2008 rates should be taken as indicators of a trend rather than as definitive numbers for the year.

In 2005, the National Highway Traffic Safety Administration estimated that one-half to three-quarters of drivers with suspended licenses may occasionally drive anyway. Even with suspension rates generally decreasing, more than half of all offenders in the DWI, LINI, and NL categories—almost 2.3 million offenders—have had their driver licenses suspended. Poor compliance with the DRP leads to a greater number of unlicensed and uninsured drivers on Texas roads, which is a hazard for all Texas drivers.

INDIGENCY PROGRAM FOR OFFENDERS

Senate Bill 1723, Eightieth Legislature, 2007, authorized DPS to establish an indigency program for offenders. This program is not required, and DPS has not implemented it, citing a lack of the necessary tools and resources to determine whether offenders are indigent. As **Figure 237** shows, compliance rates in fiscal year 2008 are less than 50 percent for DWI and LINI offenders and less than 33 percent for NL

FIGURE 237
COMPLIANCE AND SUSPENSION RATES BY CATEGORY OF OFFENSE, FISCAL YEARS 2003 TO 2008 AND FISCAL YEAR 2008 ONLY

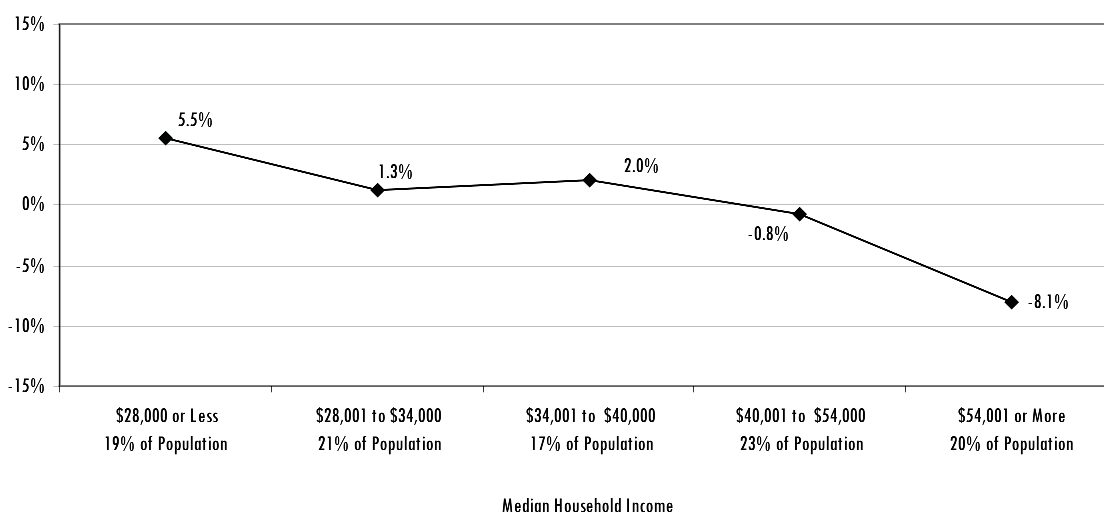
	COMPLIANCE RATES		SUSPENSION RATES	
CATEGORY	2003 TO 2008 FISCAL YEARS	2008 FISCAL YEAR	2003 TO 2008 FISCAL YEARS	2008 FISCAL YEAR
Points	70.9%	73.7%	22.7%	21.7%
DWI*	41.6%	47.7%	54.0%	49.8%
LINI*	40.8%	46.3%	55.7%	52.8%
NL*	28.2%	32.1%	66.9%	69.1%
TOTAL	**38.5%**	**43.6%**	**57.5%**	**55.8%**

*DWI (Driving while Intoxicated; LINI (License Invalid/No Insurance); NL (No License).
SOURCE: Legislative Budget Board; Texas Department of Public Safety.

offenders. A January 2007 Legislative Budget Board report found that offenses in the LINI and NL categories tended to occur disproportionately in lower income areas of the state. Lower income areas of the state tend to have higher rates of indigency in the population. The higher rate of indigency in lower income areas of the state contributes to the low compliance rate for these categories, as shown in **Figures 238 and 239**.

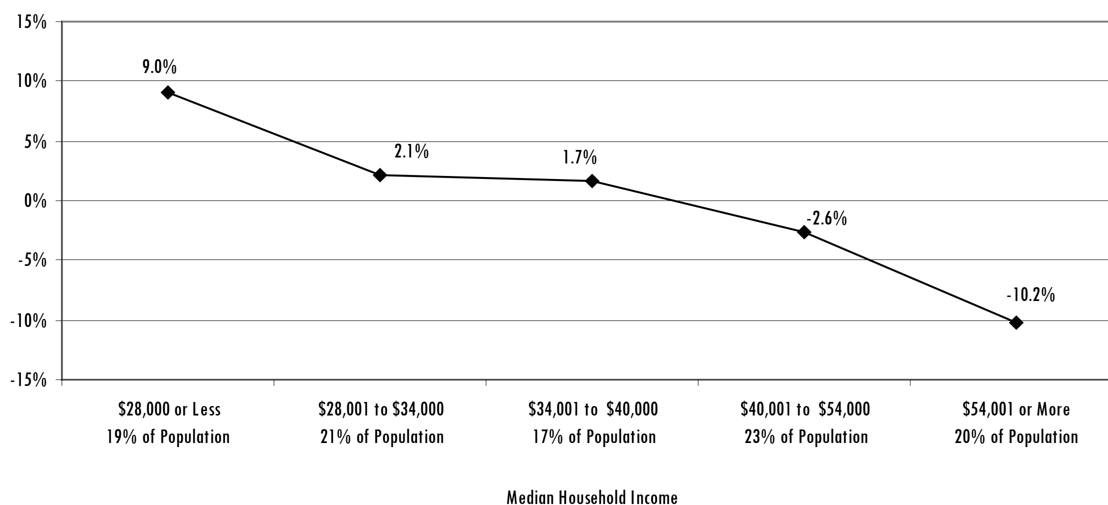
DPS reduces handgun license fees when the applicant submits proof of indigency. The enabling statute for this program defines indigence as not more than 100 percent of the applicable income level established by the federal poverty guidelines. **Figure 240** shows the federal poverty guidelines for 2008 as established by the U.S. Department of Health and Human Services. Applicants for these licenses are required to submit a copy of their federal tax receipts with their applications. A program operating at DPS that determines indigency based on the federal poverty guidelines indicates that DPS can establish a similar needs-based program for DRP offenders. However, DPS does not have

FIGURE 238
PERCENTAGE POINT DIFFERENCE BETWEEN DISTRIBUTION OF LICENSE INVALID/NO INSURANCE OFFENDERS AND POPULATION, FISCAL YEARS 2003 TO 2006



SOURCE: Legislative Budget Board.

FIGURE 239
PERCENTAGE POINT DIFFERENCE BETWEEN DISTRIBUTION OF NO LICENSE OFFENDERS AND POPULATION, FISCAL YEARS 2003 TO 2006



SOURCE: Legislative Budget Board.

the authority to reduce DRP surcharges for offenders the agency determines to be indigent.

FIGURE 240
HEALTH AND HUMAN SERVICES POVERTY GUIDELINES, 2008

PERSONS IN FAMILY OR HOUSEHOLD	HOUSEHOLD INCOME
1	$10,400
2	$14,000
3	$17,600
4	$21,200
5	$24,800
6	$28,400
7	$32,000
8	$35,600
For each additional person, add	$3,600

Source: U.S. Department of Health and Human Services.

Recommendation 1 would amend Texas Transportation Code, Chapter 708, to require DPS to establish an indigency program for DRP offenders. A needs-based program would allow DPS to identify offenders who may be unable to pay surcharges. DPS should establish a process similar to the process used by the handgun license division in which indigent offenders may file paperwork establishing their income level as within 100 percent of the federal poverty guidelines. DPS should be allowed to direct its vendor to process the paperwork.

Recommendation 1 would furthermore authorize DPS to reduce surcharges for offenders it determines to be indigent. DPS should have administrative authority to establish the appropriate action by rule. DPS should also report indigent offenders as a separate compliance category in its weekly DRP collection reports. This would allow DPS to show a more accurate measure of its collection, compliance, and suspension rates by distinguishing between indigent and nonindigent offenders.

STATEMENT OF OFFENDER RESPONSIBILITY

Although information about the DRP and its requirements is included on the traffic ticket as well as the DPS website, some offenders are reporting that they were unaware of the DRP surcharges. These offenders claim that they were under the impression that they had discharged their entire penalty when they paid their court fines and fees. Courts are not required to provide additional information about DRP surcharges beyond what is included on the traffic ticket.

Recommendation 2 would amend Texas Transportation Code, Chapter 708, to require courts to issue a statement to defendants informing them of their responsibility under the DRP and surcharges to be paid. Such an admonishment would help ensure that individuals understand their obligation to pay surcharges under the program and allow them to plan for payment of these assessments. Defendants should sign this statement, and the courts should retain a copy. This recommendation is similar to the language offered in House Bill 3669, Eightieth Legislature, 2007, which was not enacted.

MODIFY SURCHARGES

As **Figures 238 and 239** show, some offenders in the DRP are low-income Texans who are not indigent. Even with an income above the federal poverty level, these offenders may face similar difficulties in paying surcharges as those faced by indigent offenders. These offenders may also be more able to comply with the law if the surcharge were lower. Greater compliance among offenders would reduce the number of driver licenses that DPS must suspend in any given year. The National Highway Traffic Safety Administration estimated in 2005 that one-half to three-quarters of all drivers with suspended licenses may occasionally drive anyway. If DPS could reduce the number of driver license suspensions, DPS can reduce the number of unlicensed drivers on Texas roads.

Recommendation 3 would amend Texas Transportation Code, Chapter 708, to authorize DPS to change category surcharges to maximize compliance among offenders. The economic theory of marginal utility holds that any decrease in the surcharge would have an accompanying increase in the number of offenders who pay their required fines. Since the overall compliance rates for most of the violation categories have been well below 50 percent, Recommendation 3 would allow DPS to test the marginal rate of change at various surcharge levels with the goal of maintaining revenue-neutrality. This statutory change would give DPS a range of potential surcharges and the administrative authority to modify those surcharges to maximize achievement of the program objectives. If compliance does not improve within a reasonable amount of time after a modification, DPS should have the authority to modify the surcharge again.

Figure 241 shows the potential impact of several across-the-board modifications to the statutorily set surcharges based on collection and compliance rates as of the end of fiscal year

FIGURE 241
NECESSARY COMPLIANCE RATES FOR REVENUE-NEUTRALITY WITH POTENTIAL DRP SURCHARGE REDUCTIONS

	DWI	LINI	NL
Surcharge/year	$1000/$1500/$2000	$250	$100
Total violations at the end of fiscal year 2008	485,765	2,257,746	1,109,111
Percentage in compliance at the end of fiscal year 2008	41.6%	40.8%	28.2%
Surcharges billed to offenders in compliance	$213,183,994	$250,513,732	$36,216,221
10 percent cut in surcharge/year	$900/$1350/$1800	$225	$90
Compliance rate needed for revenue-neutrality	46.3%	45.3%	31.4%
30 percent cut in surcharge/year	$700/$1050/$1400	$175	$70
Compliance rate needed for revenue-neutrality	59.5%	58.2%	40.4%
40 percent cut in surcharge/year	$600/$900/$1200	$150	$60
Compliance rate needed for revenue-neutrality	69.4%	68.0%	47.1%
50 percent cut in surcharge/year	$500/$750/$1000	$125	$50
Compliance rate needed for revenue-neutrality	83.3%	81.5%	56.5%

Source: Legislative Budget Board.

2008. A 40 percent cut in surcharges by category would be revenue-neutral if compliance for DWI and LINI violations increased to almost 70 percent and compliance for NL violations increased to almost 50 percent. Since current compliance among points offenders is at just over 70 percent, any cut in surcharges over 40 percent might require an unrealistic level of compliance to achieve revenue-neutrality.

FISCAL IMPACT OF THE RECOMMENDATIONS

It is assumed that all recommendations would be revenue-neutral, although they will improve compliance. DPS should be able to implement Recommendation 1 within its current budget. Recommendation 2 may increase revenues slightly, but will more likely reduce efforts to collect from offenders who are able to pay but uninformed about the requirements of the program. Recommendation 3 should be revenue-neutral.

The introduced 2010–11 General Appropriations Bill does not include any adjustments as a result of these recommendations.

IMPROVE TRAFFIC SAFETY BY BANNING THE USE OF WIRELESS COMMUNICATION DEVICES WHILE DRIVING

Recent studies have found that drivers using wireless communication devices (e.g., cell phones, personal digital assistants, etc.) are distracted to a level of impairment equal to intoxicated drivers. Preliminary data from the Texas Crash Records Information System show 6,473 accidents involving cell phones in fiscal years 2007 and 2008, 55 of which were fatal. Texas could save lives, reduce the risk of accidents, reduce traffic congestion, and generate an estimated net $1.9 million in revenue to the state for the 2010–11 biennium from fines and surcharges paid by individuals using wireless communication devices while driving.

FACTS AND FINDINGS

- Texas has banned all cell phone usage for bus drivers when a passenger age 17 or younger is present and for intermediate license holders in the first six months of their licensure.
- The National Highway Traffic Safety Administration estimated that 5 percent of all drivers were using a cell phone at any given time in 2006. The agency noted that drivers observed manipulating hand-held devices, which includes text-messaging, doubled from 2005 to 2006.
- Five states and the District of Columbia have banned the use of hand-held cell phones while driving, and five states and the District of Columbia have banned text-messaging while driving.
- The Public Policy Institute of California estimated that California's 2008 law banning the use of hand-held cell phones while driving will reduce the number traffic deaths by at least 300 annually.

CONCERNS

- Drivers using cell phones are four times more likely to have accidents than other drivers, are impaired to a level equal or greater than intoxicated drivers, cause greater traffic congestion, and contribute to driver aggression in other drivers.
- Changes in driving laws intended to improve public safety, such as seat belt laws, are ineffective unless there is a strategy to inform the public of the law.

RECOMMENDATIONS

- **Recommendation 1:** Amend Texas Transportation Code, Section 545, to prohibit use of all wireless communication devices while driving, except in cases of emergency use.
- **Recommendation 2:** Amend Texas Transportation Code, Section 545, to require the Texas Department of Public Safety to make violations involving wireless communication devices a surchargeable offense under the Driver Responsibility Program.
- **Recommendation 3:** Include a contingency rider in the 2010–11 General Appropriations Bill to appropriate collections not to exceed $500,000 per year in General Revenue Funds for the 2010–11 biennium to the Texas Department of Public Safety to inform drivers of the ban on wireless communication devices.

DISCUSSION

Drivers of motor vehicles who use a cell phone are four times more likely to have a serious accident than undistracted drivers. Researchers have found no significant difference in decreased driver performance when comparing hand-held and hands-free cell phone use. As cell phone use has increased, the number of drivers using a cell phone has also increased. Although cell phone use is not the most dangerous distraction that a driver may face on the road, the prevalence of cell phone use while driving makes it the most common cause of crashes and near-crashes related to distracted driving.

EVIDENCE OF DRIVER IMPAIRMENT AND INCREASED ACCIDENTS

Numerous studies have concluded that wireless communication device use while driving impairs drivers and increases the risk of accidents. **Figure 242** shows a listing of recent studies supporting these conclusions.

INCREASED TRAFFIC CONGESTION

In addition to the increased risk of accident, other studies have found that drivers who use wireless communication devices while driving increase traffic congestion. Studies supporting this finding include:

FIGURE 242
STUDIES ON DRIVER IMPAIRMENT AND RISK FROM THE USE OF A WIRELESS COMMUNICATION DEVICE WHILE DRIVING, 2003 TO 2008

RESEARCH ENTITY	DATE	FINDINGS
Insurance Institute for Highway Safety	2005	Drivers in Australia that use cell phones are four times as likely to be involved in a car crash serious enough to injure themselves or others.
University of Utah	2003	• Cell phone drivers exhibited greater impairment than intoxicated drivers when controlling for driving difficulty and time on task. • Drivers on both hand-held and hands-free cell phones had sluggish reactions and attempted to compensate by driving slower and increasing the following distance from the vehicle immediately in front of them. • The intoxicated drivers, however, were more aggressive, following the vehicle in front of them more closely and applying more force when braking. • There was no significant difference in driving impairment between drivers using hand-held cell phones and those using hands-free devices.
University of Utah	2007	• Drivers talking on hands-free cell phones were less likely to create a durable memory of directly seen objects than other drivers, even other drivers having an in-vehicle conversation with another person. • Inattention persisted for objects of both high and low relevance to the driver.
Accident Analysis and Prevention	2008	In a meta-analysis of 33 studies, researchers found that the reaction time of drivers using both hand-held and hands-free cell phones was greater than the reaction time of other drivers.
University of Maryland	2007	• Drivers who use a cell phone also tend to engage in more dangerous driving behavior in general than drivers who do not use a cell phone.
Liberty Mutual Research Institute for Safety	2008	• Drivers using cell phones, whether hand-held or hands-free, tend to be unaware of the corresponding decrease in their driving performance. • In some cases, the drivers tested while using cell phones estimated their own level of distraction inversely with their performance, meaning that they thought they were least distracted when engaging in the most dangerous behavior.
National Highway Traffic Safety Administration (NHTSA) and the Virginia Tech Transportation Institute	2005	• Nearly 80 percent of all crashes and 65 percent of all near-crashes involved driver inattention within 3 seconds of the incident. • Other in-car distractions, such as reaching for a falling cup, increase the risk of an accident to a greater extent than cell phone use while driving; cell phone use while driving was much more frequent than other in-car distractions. • Because of the frequency of cell phone use while driving, it was the primary cause of driver inattention associated with crashes and near-crashes.
Center for Cognitive Brain Imaging at Carnegie Mellon University	2008	• Listening to any conversation in a car environment decreases mental resources associated with driving attention by 37 percent. • Cell-phone conversations are socially different from in-car conversations, in that evidence holds that passengers and drivers will suppress conversation in response to driver demands, while not attending to a cell-phone conversation can be seen as rude and insulting behavior.

Source: Legislative Budget Board.

- A 2007 study from the University of Utah found that drivers using hands-free cell phones make fewer lane changes, lower the overall traffic speed, and increase their travel time in medium and high-density driving conditions, leading to greater traffic congestion.
- *Science* magazine reported in January 2008 that drivers talking on a cell phone have a drive time that is 5 percent to 10 percent greater than undistracted drivers.
- A 2006 study from Dickinson State University in North Dakota found that drivers who are inconvenienced by a driver on a cell phone tend to show more aggression than drivers who are inconvenienced by a driver who is not on a cell phone.

Increases in traffic congestion have an indirect cost to the state in terms of wasted fuel and time and greater vehicle-related emissions. The Texas Transportation Institute's *2007*

Urban Mobility Report measures the inefficiencies of congestion in terms of wasted fuel and time, showing a growth in national cost related to congestion from $15 billion in 1982 to $78 billion in 2005 (in constant 2005 dollars). Researchers at the University of California at Riverside found in 2007 that strategies to mitigate start-and-stop traffic and low speeds associated with traffic congestion can each lead to a 7 percent to 12 percent decrease in carbon dioxide emissions.

MORE DRIVERS USING WIRELESS COMMUNICATION DEVICES

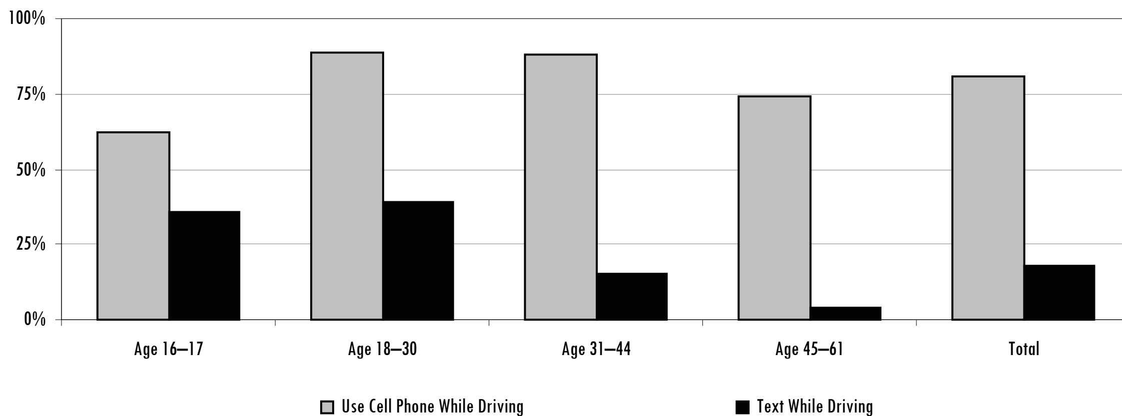
The number of drivers using cell phones at any given time has increased since 2000 as cell phone use has grown more prevalent in the U.S. The NHTSA estimated that 5 percent of drivers were using a hand-held cell phone at any given time in 2006, the most recent year for which data is available. This percentage is down from the 6 percent that NHTSA estimated in 2005, but up from the 3 percent estimated in 2000. NHTSA additionally noted that drivers observed manipulating hand-held devices, which includes text messaging, doubled from 2005 to 2006, the first year in which it was measured.

The Nationwide Mutual Insurance Company (Nationwide) released the results of a survey in May 2008 that polled 1,503 drivers between the ages of 16 and 61. The survey found that 83 percent of respondents own a cell phone, and 36 percent own a hands-free device. Of drivers who own cell phones, 81 percent report that they talk on a cell phone while driving. Additionally, Nationwide found that 18 percent of all cell phone owners use a wireless communication device to text while driving. As **Figure 243** shows, the survey found that 62 percent of cell phone owners in the age 16 to 17 range will talk on a cell phone while driving. This percentage is less than the average, which is possibly due to the prohibitions in many states on teenagers talking on hand-held cell phones while driving. However, 36 percent of cell phone owners in the age 16 to 17 range will text while driving. Cell phone owners in the age 18 to 30 range were most likely to talk on the cell phone (89 percent) and to text while driving (39 percent). Cell phone owners in the lower end of the age 18 to 30 demographic may use wireless communication devices at an even greater rate. A 2007 poll by the polling firm Zogby International found that 66 percent of cell phone owners from the ages of 18 to 24 admit to texting while driving. Additionally, a 2007 study in the *Journal of American College Health* found that college students are as much as 50 percent more likely to use cell phones while driving than in previous estimates, which the researchers argue could increase the possibility of a collision for the college-aged demographic.

Cell phone owners in the age 31 to 44 range were almost as likely as cell phone owners in the age 18 to 30 range to talk on the cell phone (88 percent), but about one-third as likely to text while driving (15 percent). Cell phone owners in the age 45 to 61 range were less likely to talk on a cell phone than the national average, although 74 percent of this group will do so, and rarely text while driving (4 percent).

When asked if they consider themselves to be safe drivers, 98 percent of all drivers between ages 16 and 61 stated that they did, even though 72 percent admitted to multi-tasking while driving. When asked about how to prevent cell phone use while driving, 42 percent of respondents thought that a law making cell phone use illegal would be most effective, while 43 percent preferred a technological advance that would

FIGURE 243
USE OF WIRELESS COMMUNICATION DEVICES WHILE DRIVING AMONG CELL PHONE OWNERS BY AGE GROUP, 2008



SOURCE: Nationwide Mutual Insurance Company.

prevent cell phones from working in a vehicle and 13 percent preferred less pressure for constant availability.

ACTIONS NOW LIMITING WIRELESS COMMUNICATION DEVICES USAGE

Texas law does not prohibit most drivers from using wireless communication devices while driving. Legislation enacted by the Seventy-ninth Legislature, Regular Session, 2005, amended the Texas Transportation Code, Chapter 545, to ban all cell phone usage for bus drivers when a passenger age 17 or younger is present and for novice license holders in the first six months of their licensure.

Figure 244 shows the status of state laws regarding driving while using a wireless communication device in the U.S. No state has instituted a comprehensive ban on driving while using any wireless communication device, whether hand-held or hands-free. However, as of September 2008, five

FIGURE 244
BANS ON WIRELESS COMMUNICATION DEVICES BY STATE, SEPTEMBER 2008

STATE	ALL CELL PHONE BAN	HAND-HELD BAN	TEXTING BAN
Alabama	no	no	no
Alaska	no	no	all drivers
Arizona	school bus drivers	no	no
Arkansas	school bus drivers	no	school bus drivers
California	school and transit bus drivers and drivers younger than 18	all drivers	all drivers, effective January 1, 2009
Colorado	learner’s permit holders	no	no
Connecticut	learner’s permit holders, drivers younger than 18, and school bus drivers	all drivers	school bus drivers
Delaware	school bus drivers and learner’s permit and intermediate license holders	no	learner’s permit and intermediate license holders
District of Columbia	school bus drivers and learner’s permit holders	all drivers	all drivers
Florida	no	no; local governments prohibited	no
Georgia	school bus drivers	no	no
Hawaii	no	no	no
Idaho	no	no	no
Illinois	learner’s permit holders younger than 19, drivers younger than 19, and school bus drivers	local option	no
Indiana	no	no	no
Iowa	no	no	no
Kansas	no	no	no
Kentucky	school bus drivers	no; local governments prohibited	no
Louisiana	school bus drivers	no; local governments prohibited	all drivers
Maine	learner’s permit and intermediate license holders	no	learner’s permit and intermediate license holders
Maryland	learner’s permit and intermediate license holders	no	learner’s permit and intermediate license holders
Massachusetts	school bus drivers	local option	no
Michigan	no	local option	no
Minnesota	school bus drivers and learner’s permit holders and provisional license holders during the first 12 months after licensing	no	all drivers

FIGURE 244 (CONTINUED)
BANS ON WIRELESS COMMUNICATION DEVICES BY STATE, SEPTEMBER 2008

STATE	ALL CELL PHONE BAN	HAND-HELD BAN	TEXTING BAN
Mississippi	no	no; local governments prohibited	no
Missouri	no	no	no
Montana	no	no	no
Nebraska	learner's permit and intermediate license holders younger than age 18	no	learner's permit and intermediate license holders younger than 18
Nevada	no	no; local governments prohibited	no
New Hampshire	no	no	no
New Jersey	school bus drivers and learner's permit and intermediate license holders	all drivers	all drivers
New Mexico	no	local option	no
New York	no	all drivers	no
North Carolina	drivers younger than 18 and school bus drivers	no	drivers younger than 18 and school bus drivers
North Dakota	no	no	no
Ohio	no	local option	no
Oklahoma	no	no; local governments prohibited	no
Oregon	drivers younger than age 18 who hold either a learner's permit or an intermediate license	no; local governments prohibited	drivers younger than 18 who hold either a learner's permit or an intermediate license
Pennsylvania	no	local option	no
Rhode Island	school bus drivers and drivers younger than age 18	no	no
South Carolina	no	no	no
South Dakota	no	no	no
Tennessee	school bus drivers and learner's permit and intermediate license holders	no	no
Texas	bus drivers when a passenger age 17 and younger is present; intermediate license holders for first six months	no	bus drivers when a passenger 17 and younger is present; intermediate license holders for first six months
Utah	no	all drivers as part of careless driving law; local governments prohibited	no
Vermont	no	no	no
Virginia	drivers younger than age 18 and school bus drivers	no	drivers younger than 18 and school bus drivers
Washington	no	all drivers	all drivers
West Virginia	drivers younger than age 18 who hold either a learner's permit or an intermediate license	no	drivers younger than 18 who hold either a learner's permit or an intermediate license
Wisconsin	no	no	no
Wyoming	no	no	no

SOURCE: Insurance Institute for Highway Safety.

states have banned driving while talking on a hand-held cell phone outright: California, Connecticut, New Jersey, New York, and Washington. The District of Columbia and the U.S. Virgin Islands have also banned driving while talking on a hand-held cell phone. These bans are enforced by fines ranging from $20 in California to $250 in New Jersey. These bans, except in Washington, are designated primary enforcement, meaning that an officer may ticket a driver for using a hand-held cell phone without any other traffic offense taking place. Six states and the District of Columbia have banned texting while driving: Alaska, California, Louisiana, Minnesota, New Jersey, and Washington.

Utah and New Hampshire treat cell phone use as a larger distracted driving issue. In New Hampshire, cell phone use is punishable under a larger distracted driving law. In Utah, cell phone use is punishable if the driver is committing another moving violation at the same time. Seventeen states, including Texas, and the District of Columbia restrict all cell phone use by novice drivers. Sixteen states, including Texas, and the District of Columbia prohibit school bus drivers from all cell phone use when passengers are present except in emergencies.

Local governments in another six states have banned driving while talking on a cell phone: Illinois (Chicago), Massachusetts (Brookline), Michigan (Detroit), New Mexico (Santa Fe), Ohio (Brooklyn, North Olmstead, and Walton Hills), and Pennsylvania (Conshohocken, West Conshohocken, and Lebanon). Eight states have prohibited local governments from banning cell phone use while driving: Florida, Kentucky, Louisiana, Mississippi, Nevada, Oklahoma, Oregon, and Utah.

Internationally, as many as 40 countries, including Australia, most European countries, Brazil, Egypt, Japan, South Korea, and Zimbabwe, restrict or prohibit the use of cell phones while driving.

ACCIDENTS INVOLVING WIRELESS COMMUNICATION DEVICES

Texas law enforcement officers have reported 6,473 accidents involving cell phones in fiscal years 2007 and 2008, out of 892,356 total reported accidents, as shown in **Figure 245**. It is important to note that this data has not yet been finalized, as many law enforcement agencies do not finalize reports for the Crash Records Information System until later in the year. This data also includes only reportable motor vehicle traffic crashes, defined as any motor vehicle crash in traffic that results in injury, death, or property damage that appears to be greater than $1,000. Finally, the law enforcement officer filing the report at the scene of the accident must identify and document the use of a cell phone as contributing to the accident.

FIGURE 245
PRELIMINARY DATA FROM THE TEXAS CRASH RECORDS INFORMATION SYSTEM, FISCAL YEARS 2007 AND 2008

FISCAL YEAR	CRASHES INVOLVING CELL PHONES	ALL CRASHES
2007	3,365	456,285
2008	3,108	436,071

SOURCE: Texas Department of Transportation.

Of these 6,473 reported accidents in Texas involving cell phones in fiscal years 2007 and 2008, 2,802 involved injuries or potential injuries, and 55 accidents were fatal. The Public Policy Institute of California estimated that California's 2008 law banning the use of hand-held cell phones while driving will reduce the number traffic deaths by at least 300 annually, although mostly in bad weather and wet road conditions.

PROHIBIT USE OF WIRELESS COMMUNICATION DEVICES WHILE DRIVING

Recommendation 1 would amend Texas Transportation Code, Section 545, to prohibit use of any wireless communication devices while driving, except in cases of emergency use. This ban should be enforced by a misdemeanor fine of no more than $200, which would be similar to the enforcement fines for other traffic offenses, including child passenger safety seat systems, seat belts, and riding in open-bed trucks, as established in Texas Transportation Code, Sections 545.412–545.414. As in those statutes, a municipality or county should send to the Comptroller of Public Accounts an amount equal to 50 percent of fines collected for violations of this provision.

Recommendation 2 would amend Texas Transportation Code, Section 545, to direct DPS to make use of a wireless communication device while driving a surchargeable offense in the points category under the Driver Responsibility Program (DRP). DRP points are added for a large number of driving violations that range from minor to serious, including failure to use a child passenger safety seat system and allowing a child to ride in an open bed of a truck. This recommendation would add two points for a regular moving violation while using a wireless communication device and three for a violation involving an accident. Under current law, when six points or more are reached in a three-year period, violators must pay a surcharge to the State of Texas for the next three

years of $100 per year for the first six points and $25 per year for each point thereafter.

INFORM DRIVERS OF THE WIRELESS COMMUNICATION DEVICE BAN

In 1985, Texas became one of the first states to implement a primary enforcement seat belt law. Through extensive outreach and visible enforcement, Texas reached a seat belt use rate of roughly 75 percent by the mid-1990s, where it remained until 2001. In May 2002, Texas participated in a national Click It or Ticket (CIOT) campaign designed to inform the greater public to use seat belts. In the CIOT campaign, Texas spent approximately $1 million on paid advertising in its 10 largest cities, and law enforcement officers issued 27,260 seat belt violations, a rate of 40 per 10,000 residents. Seat belt use in these cities increased from 80.5 percent before CIOT to 86.4 percent immediately after the campaign. With about 80 percent of the Texas population residing in these cities, statewide belt use increased from 76.1 percent in 2001 to 81.1 percent in 2002. In 2007, the seat belt use rate in Texas reached 91.8 percent.

As with seat belt laws, changing the high-risk driving behavior of wireless communication device use while driving will take publicity, visible enforcement, and institutional coordination. In a 2007 statement before the Oregon Senate Committee on the Judiciary, the Insurance Institute for Highway Safety (IIHS) cited reports stating that the New York and District of Columbia cell phone bans were met with initial compliance followed by a gradual return to previous behavior. To increase compliance, the IIHS recommended enforcement that is well-publicized and vigorous.

Recommendation 3 would include a contingency rider in the 2010–11 General Appropriations Bill that would appropriate collections not to exceed $500,000 in General Revenue Funds per year of the 2010–11 biennium to DPS for informing drivers of the ban on wireless communication devices. With better public awareness, drivers will be better informed about the traffic risks they create when using a wireless communication device while driving.

FISCAL IMPACT OF THE RECOMMENDATIONS

These recommendations would result in an estimated net revenue gain of $1.9 million in General Revenue Funds and General Revenue–Dedicated Funds for the 2010–11 biennium from fines and surcharges paid by individuals using wireless communication devices while driving.

Recommendation 1 would generate $2.3 million in General Revenue Funds and General Revenue–Dedicated Funds for the 2010–11 biennium. The new fine for driving while using a wireless communication device would result in $1.5 million in General Revenue Funds in the 2010–11 biennium, and increased revenues from the $30 State Traffic Fine would result in the other $0.8 million in General Revenue Funds and General Revenue–Dedicated Funds in the 2010–11 biennium. Fines for violations of the statute related to use of child-passenger-safety-seat systems and seat belts are split equally between the local government that issued the tickets and the state, which deposits revenues into Tertiary Care Account (General Revenue Funds). In California, the initial year of primary enforcement of drivers using hand-held cell phones has led to approximately 25 percent as many tickets being issued for violating the ban as tickets issued for seat belt violations. However, as more drivers violate the ban, the number of tickets issued has increased. Based on this trend, it is estimated that state and local revenue gain from the new fine for driving while using a wireless communication device will be 25 percent in the first year of implementation over current fines for drivers who violate the child-passenger-safety-seat system and seat belt laws. This revenue gain is estimated to increase to 50 percent over current fines for drivers who violate the child-passenger-safety-seat system and seat belt laws by the fifth year.

Each ticket issued would also increase revenues from the $30 State Traffic Fine. Local governments keep 5 percent of revenues from this fine. One-third of the remainder is deposited in Trauma Facility and EMS Account (General Revenue–Dedicated Funds) and the other two-thirds are deposited to the General Revenue Fund.

Recommendation 2 adds cell phone violations to the list of surchargeable driving offenses in the points category under the DRP and would generate an estimated total of $0.5 million in General Revenue Funds and General Revenue–Dedicated Funds in the 2010–11 biennium. It is estimated that the number of traffic violations leading to six points or more would increase by 5 percent annually. The collection rate of 67 percent would likely remain static, absent other factors. DRP surcharges are deposited to the General Revenue Fund, which receives 51.5 percent, and the Trauma Facility and EMS Account (General Revenue–Dedicated Funds), which receives 49.5 percent.

Recommendation 3 adds a contingency rider in the 2010–11 General Appropriations Bill that would appropriate collections not to exceed $500,000 in General Revenue

Funds for each year of the 2010–11 biennium to DPS for driver education related to the ban on wireless communication devices. This amount will allow DPS to fund one statewide information campaign and plan for future education efforts and costs.

Therefore, the estimated net revenue gain in General Revenue Funds and General Revenue–Dedicated Funds for the 2010–11 biennium from fines and surcharges paid by individuals using wireless communication devices while driving would be $1.9 million. The probable revenue gain in General Revenue Funds for the 2010–11 biennium, which includes revenue estimates from the new fine, increased DRP points collections, and the $30 State Traffic Fine, would be $2.4 million. The probable revenue gain in General Revenue–Dedicated Funds for the 2010–11 biennium Trauma Facility and EMS Account, which includes revenue from increased DRP points collections and the $30 State Traffic Fine, would be $0.5 million. The probable revenue gain to local governments in the 2010–11 biennium, which includes revenue estimates from the new fine and the $30 State Traffic Fine, would be $1.5 million. The probable cowst in General Revenue Funds in the 2010–11 biennium would be $1 million, and assumes the implementation of the contingency rider in Recommendation 3. **Figure 246** shows the five-year fiscal impact of the recommendations.

The introduced 2010–11 General Appropriations Bill does not include any adjustments as a result of these recommendations.

FIGURE 246
FIVE-YEAR FISCAL IMPACT, FISCAL YEARS 2010 TO 2014

FISCAL YEAR	PROBABLE NET GAIN/(LOSS) IN GENERAL REVENUE FUNDS	PROBABLE NET SAVINGS/(COST) IN GENERAL REVENUE FUNDS	PROBABLE NET GAIN/(LOSS) IN GENERAL REVENUE–DEDICATED TRAUMA/EMS FUND	PROBABLE NET GAIN/(LOSS) TO LOCAL GOVERNMENTS
2010	$1,066,378	($500,000)	$253,095	$697,310
2011	$1,266,571	($500,000)	$291,139	$836,772
2012	$1,393,222	$0	$320,253	$920,449
2013	$1,671,012	$0	$371,125	$1,115,696
2014	$2,062,644	$0	$438,800	$1,394,620

Source: Legislative Budget Board.

EXPAND THE APPLICATION OF AND LOWER THE CHARGE FOR THE DNA TESTING COURT COST

Legislation enacted by the Seventy-seventh Legislature, 2001, established a DNA Testing Court Cost. This fee was established to pay for the cost of collecting DNA samples from persons convicted or arrested on specific sexual assault related charges. The fee is $50 for misdemeanors and $250 for felonies. Although the court cost was originally intended to subsidize the creation of DNA records for sexual assault offenders, the scope and use of DNA testing as a forensic tool has broadened since 2001. Reducing the court cost, applying it to additional offenses in which DNA testing is used, and ensuring counties are informed about this and other fees would make this court cost more equitable and more relevant to Texas.

FACTS AND FINDINGS

- From fiscal years 2002 to 2008, the DNA Testing Court Cost generated a total of $748,431 in General Revenue–Dedicated and Other Funds. Thirty-five percent of this revenue is deposited to the State Highway Fund, from which the Department of Public Safety crime labs are financed. Sixty-five percent of the revenue is deposited to the Criminal Justice Planning General Revenue–Dedicated account, which finances criminal justice grants offered by the Office of the Governor.
- The Department of Public Safety crime labs have performed DNA testing for murder, sexual assault, assault (or aggravated assault), burglary, hit and run, and other crimes. In 2007, 41 percent of DNA sample tests were for rape/sexual assault; 25 percent were for murder; 15 percent were for burglary; and 4 percent were for assault.
- In 2007, the average cost to perform a DNA test at the Department of Public Safety crime labs was $294 per sample.
- The number of offenses that the DNA Testing Court Cost applies to is small. Admissions to the Texas Department of Criminal Justice facilities for sexual assault related crimes totaled 3,584 offenders for fiscal year 2007. Offenders placed on probation for sexual assault related crimes totaled 1,919.

CONCERNS

- Though DNA testing is used mostly for sexual assault cases, it is also used for other violent crimes such as manslaughter and murder as well as non-violent property crimes. As DNA testing becomes more common and better understood, its usefulness is expanding, yet the DNA Testing Court Cost applies only to sexual assault offenses.
- The court cost was estimated to generate $1.8 million in General Revenue–Dedicated Funds and Other Funds in fiscal year 2002 and $2.4 million in subsequent years, yet the total collected for all years is less than $750,000.
- Compared to other state court costs and fees, the court cost for DNA testing is high, so it is less likely to be assessed by judges or collected by the counties.
- The DNA Testing Court Cost has a lower priority for assessment and collection than other fees, such as monthly probation fees and restitution.
- Other than a list of fees that is updated biennially, the state lacks a process to educate counties or courts about new fees or changes to existing fees. While compiling information for this report, Legislative Budget Board staff found at least one county was completely unaware of the court cost for DNA testing. In the seven years since the creation of the fee, this county had never changed its system to begin assessing the fee on applicable offenses.

RECOMMENDATIONS

- **Recommendation 1:** Amend the Code of Criminal Procedure, Section 102.020, to make the DNA Testing Court Cost applicable to any conviction where DNA testing is used during the criminal investigation.
- **Recommendation 2:** Amend the Code of Criminal Procedure, Section 102.020, to lower the DNA Testing Court Cost to $30 for misdemeanors and to $60 for felonies.
- **Recommendation 3:** The Office of Court Administration, with the assistance of the Comptroller

of Public Accounts, should inform and educate local courts about new or revised fees on a biennial basis.

DISCUSSION

The court cost for DNA testing, established by the Seventy-seventh Legislature through Senate Bill 638, 2001, was intended to fund the creation of a DNA record for persons convicted of or arrested for sexual assault crimes. The legislation required persons convicted of specified sexual assault related crimes to pay $50 per misdemeanor count and $250 per felony count as a court cost. **Figure 247** shows the types of criminal offenses to which the court cost applies.

Sex offenses comprise a small portion of criminal offenses in Texas. Less than 1 percent of all offenders placed on community supervision and 8 percent of all offenders incarcerated during fiscal year 2007 had been convicted of sex offenses.

USES OF DNA TESTING IN TEXAS AND ELSEWHERE

"DNA" stands for deoxyribonucleic acid, which is genetic material present in the nucleus of a cell. DNA testing provides an accurate way to determine identity through genetic identifiers. It has proven useful in many areas, particularly in the realm of criminal investigations. DNA testing can be used in criminal cases where biological matter is present, including blood, saliva, semen, and hair.

Law enforcement agencies have been using DNA testing in criminal investigations since the mid-1980s. In Texas, the Department of Public Safety (DPS) has been using DNA testing as part of its Crime Laboratory Service division since 1994; the agency has the resources to perform DNA testing at 8 of its 13 regional crime labs including the Austin headquarters lab.

DNA testing has been most commonly used in sexual assault cases. Over time though, the usefulness of DNA testing has expanded to include other types of crimes, both violent and non-violent. During 2007, DPS examined 13,300 DNA samples. Of these samples, approximately 41 percent were for rape cases; 25 percent were for murder cases; 15 percent were for burglary cases; 4 percent were for assault; and another 15 percent were for miscellaneous crimes. **Figure 248** shows the type of cases in which DPS examined DNA samples. **Figure 249** shows the increasing trend in DNA exams since 2003.

As **Figure 248** and **Figure 249** show, the use of DNA testing has expanded beyond sexual assault cases in Texas. Both internationally and nationally, law enforcement and criminal forensics labs use DNA testing for a variety of criminal cases where biological evidence is present. The United Kingdom is considered to have the most efficient collection and processing of DNA samples in the world; the country has put more emphasis on using DNA testing in property crimes rather than violent crimes. Law enforcement agencies would use DNA testing more than they do, but the funding and forensic resources available to states and counties to perform the testing are not enough to meet the demand. As a result, states and counties make choices to use other types of evidence in a case if available. A National Forensic DNA Study Report completed by Washington State University in 2004 showed that state and local crime labs have 221,000 rape and homicide cases with possible biological evidence that have

FIGURE 247
OFFENSES APPLICABLE TO THE DNA TESTING COURT COST, 2001 LEGISLATION

OFFENSE	CRIME TYPE	PENAL CODE CITATION
Public lewdness	Misdemeanor	Section 21.07
Indecent exposure	Misdemeanor	Section 21.08
Inflict bodily harm/abuse sexually	Felony	Section 20.04 (a) (4)
Indecency with a child	Felony	Section 21.11
Sexual assault	Felony	Section 22.011
Aggravated sexual assault	Felony	Section 22.021
Prohibited sexual conduct	Felony	Section 25.02
Burglary with attempt or intent other than felony theft	Felony	Section 30.02 (d)
Compelling prostitution	Felony	Section 43.05
Sex performance by a child	Felony	Section 43.25
Child pornography	Felony	Section 43.26
Continued sexual abuse of a young child	Felony	Section 21.02

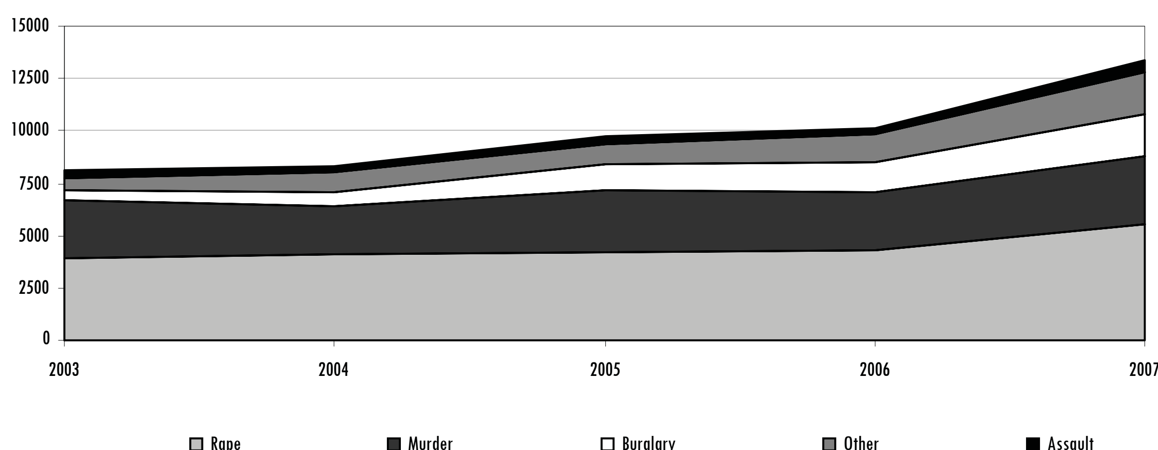
SOURCE: Legislative Budget Board.

FIGURE 248
TYPES OF DNA EXAMS COMPLETED BY DPS, CALENDAR YEARS 2003 TO 2007

CALENDAR YEAR	TOTAL DNA EXAMS COMPLETED	MURDER	RAPE	ASSAULT	BURGLARY	MISCELLANEOUS
2003	8,166	2,787	3,896	396	464	623
2004	8,294	2,373	4,068	296	648	909
2005	9,702	2,961	4,188	306	1,245	1,002
2006	10,141	2,832	4,255	345	1,413	1,296
2007	13,330	3,275	5,501	562	1,996	1,996

Source: Texas Department of Public Safety.

FIGURE 249
NUMBER OF DNA EXAMS BY TYPE OF OFFENSE, 2003 TO 2007



Source: Legislative Budget Board.

not been submitted for DNA testing; the report also noted that there are 264,000 property crimes with biological evidence that have not been submitted for DNA evidence.

When it was established in 2001, the DNA Testing Court Cost was part of several bills enacted that addressed issues related to sex offenders. But DNA testing and its potential uses exceed the realm of sex offenses. Therefore, given the expanding use of DNA testing, it would be appropriate to apply the DNA Testing Court Cost to additional offenses.

Recommendation 1 would amend the Code of Criminal Procedure, Section 102.020, to make the DNA Testing Court Cost applicable to any conviction where DNA testing is used in the criminal investigation.

As law enforcement agencies have expanded their use of DNA testing, the cost associated with this type of forensic analysis has played a crucial role in its accessibility and speed of processing. For the DPS crime labs, in criminal trial cases using DNA testing, the average cost per DNA sample analyzed in 2007 was $294, including salaries, supplies, and other operating costs; the average cost per case was $930. In Texas, the DPS crime labs also process many DNA samples for the Combined DNA Index System (CODIS), which is a DNA database of convicted felons, the cost per sample for 2007 was significantly lower at $36.16 per sample. CODIS samples are collected from incarcerated felons; the collection typically involves a blood sample and is processed in bulk, thus lowering the cost of processing.

ASSESSMENT AND COLLECTION OF THE DNA TESTING COURT COST

The Legislative Budget Board's original fiscal analysis of the 2001 legislation estimated that the fee would provide over $2 million annually in revenue. Like most state court costs and fees, the counties are permitted to retain 10 percent of the total revenue from the DNA Testing Court Cost as a collection fee before remitting to the Comptroller of Public Accounts (CPA).

The revenue received by the CPA is split according to requirements in the Code of Criminal Procedure, Section

102.020. The State Highway Fund receives 35 percent of the revenue and the Criminal Justice Planning Account receives the remaining 65 percent of the revenue. The Legislative Budget Board's fiscal analysis for the 2001 legislation included information from DPS and CPA, which used arrest and disposition data. The analysis projected that 5,750 offenders per year would be subject to the court cost.

The court cost collections have fallen short of the original projection. This shortfall may be due in part to the difficulty of accurately estimating convictions of the applicable offenses or due to the insufficient information available at the time concerning collection rates for the district and county level courts, where the offenses incurring the DNA Testing Court Cost are disposed. The Office of Court Administration (OCA) typically uses a statewide collection rate of 60 percent to 65 percent for all criminal court costs and fees for those courts participating in the Collection Improvement Program, a program designed to help counties more effectively collect court fees. According to OCA, the overall collection rates for different court types is lower than the 60- to 65-percent rate attributed to programs within the Collection Improvement Program. For the different court types, the overall collection rate for all courts for court costs, fees, and fines is: municipal courts, 56.12 percent; justice courts, 74.41 percent; county courts, 36.51 percent; and district courts, 10.38 percent. **Figure 250** shows the total collections from the DNA Testing Court Cost by fund for fiscal years 2002 to 2008.

The number of offenders convicted of sex offenses was approximately 5,500 for fiscal year 2007. **Figure 251** provides information on the placement of offenders convicted of sex offenses for fiscal years 2006 and 2007.

As shown in **Figure 251**, the population to which the DNA Testing Court Cost would apply is small. A higher percentage of sex offenders are incarcerated rather than placed under community supervision, which also lessens the likelihood of fee collection.

Compared to other types of state and local court costs and fees, the DNA Testing Court Cost is high. **Figure 252** shows some of the state courts costs that might apply to an offender. Not all of these fees would be applicable to a sex offender, but this figure does show that the court cost for DNA testing tends to be higher than other state court costs and fees for criminal convictions, particularly for felonies.

In addition to the fees and court costs shown in **Figure 252**, there are other types of financial obligations for a convicted offender. These obligations include monthly probation fees, restitution, and fines that can range from $2,000 to $10,000, depending on the offense.

Judges in county and district courts have to make decisions about an offender's case. If an offender is convicted, a judge or jury will make a decision on fines and fees. These decisions are balanced between providing an appropriate level of punishment for the case in question with realistic expectations about what conditions an offender can reasonably and successfully fulfill as part of a sentence.

With all the potential fees and fines an offender may incur as well as non-financial considerations, judges may use their

FIGURE 250
DNA TESTING COURT COST, PROJECTED AND COLLECTED REVENUE
FISCAL YEARS 2002 TO 2008

	PROJECTED REVENUE			ACTUAL REVENUE COLLECTED			
FISCAL YEAR	STATE HIGHWAY FUND 006	CRIMINAL JUSTICE PLANNING GENERAL REVENUE–DEDICATED ACCOUNT 421	TOTAL	STATE HIGHWAY FUND 006	CRIMINAL JUSTICE PLANNING GENERAL REVENUE–DEDICATED ACCOUNT 421	TOTAL	REVENUE DIFFERENCE
2002	$620,550	$1,152,450	$1,773,000	$3,747	$6,959	$10,706	$1,762,294
2003	$828,450	$1,538,550	2,367,000	$16,022	$29,755	45,777	$2,321,223
2004	$828,450	$1,538,550	2,367,000	$29,261	$54,342	83,604	$2,283,396
2005	$828,450	$1,538,550	2,367,000	$40,847	$75,858	116,705	$2,250,295
2006	$828,450	$1,538,550	2,367,000	$50,563	$93,903	144,465	$2,222,535
2007	NA	NA	NA	$60,389	$112,150	172,539	NA
2008	NA	NA	NA	$61,123	$113,514	174,636	NA
TOTAL			**$11,241,000**			**$748,431**	

Note: Projected revenue based on original estimates used in the fiscal note for Senate Bill 638, Seventy-seventh Legislature, 2001.
Sources: Legislative Budget Board; Texas Comptroller of Public Accounts.

FIGURE 251
PLACEMENT OF SEX OFFENDERS
FISCAL YEARS 2006 TO 2007

PLACEMENT	2006	2007
Community Supervision	1,989	1,919
Incarceration	3,112	3,584
TOTAL	**5,101**	**5,503**

SOURCE: Legislative Budget Board.

FIGURE 252
COMPARISON OF CURRENT DNA TESTING COURT COST TO OTHER CURRENT STATE COURT COSTS AND FEES

APPLICABLE FEE	MISDEMEANOR OFFENSES	FELONY OFFENSES
Jury Reimbursement Fee	$4	$4
Arrest Fee	$5	$5
Judicial Support Fee	$6	$6
Driving Record Fee	$10	$10
Restitution Installment Fee	$12	$12
Time Payment Fee	$25	$25
Failure to Appear	$30	$30
Failure to Pay	$30	$30
State Traffic Fine	$30	$30
Drug Court Program Fee	$50	$50
EMS Trauma Fund	$100	$100
Consolidated Court Cost	$83	$133
DNA Testing Court Cost	$50	$250

SOURCE: Texas Comptroller of Public Accounts.

discretion when assessing certain fees. Though the DNA Testing Court Cost is by statute a mandatory fee for applicable offenses, LBB staff found anecdotal evidence that indicates the fee is not always being assessed. Interviews with court staff suggest that judges may feel the cost is too high and has a lower priority than other obligations.

Recommendation 2 would amend the Code of Criminal Procedure, Section 102.020, to lower the DNA Testing Court Cost to $30 for misdemeanors and to $60 for felonies. By bringing these fees more in line with other court costs and fees, judges will be more likely to assess the fee and offenders would be able to afford to pay the fee. By charging a lowered fee on a broader array of charges, the state could realize more revenue to help pay for the cost of DNA testing. A lowered fee could generate approximately $197,500 per year, or $395,000 per biennium. **Figure 253** shows the applicable offenses, charges, and revenue collection related to the court cost for DNA testing if its applicability is expanded and the charge is lowered.

While the projected revenue would not fully fund DNA testing at the DPS crime labs or any local crime lab, lowering the court cost for DNA testing makes it a more practical fee to assess. Part of the success for offenders completing the terms of community supervision or parole involves their ability to pay court costs, fees, and fines. If court costs, fees, and fines are affordable, offenders are more likely to pay and successfully complete the terms of their sentence.

FIGURE 253
ANNUAL PROJECTED DNA TESTING COURT COST REVENUE IF FEE IS REDUCED

TYPE OF CRIMINAL OFFENSE	CHARGE	TOTAL CONVICTIONS	PERCENTAGE USING DNA TESTING	CASES CHARGED FEE	TOTAL CHARGED	COURT TYPE	COLLECTION RATE	REVENUE COLLECTED
Capital Murder	$60	280	90%	252	$15,120	District	10.38%	$1,569
Murder	$60	768	90%	691	$41,460	District	10.38%	4,304
Assault or Attempted Murder	$60	12,864	90%	11,578	$694,680	District	10.38%	72,108
Sexual Assault - Adult	$60	775	90%	698	$41,880	District	10.38%	4,347
Indecency with a Child	$60	3,753	75%	2,815	$168,900	District	10.38%	17,532
Robbery	$60	5,737	20%	1,147	$68,820	District	10.38%	7,144
Burglary	$60	12,416	50%	6,208	$372,480	District	10.38%	38,663
Theft	$60	14,607	5%	730	$43,800	District	10.38%	4,546
Auto theft	$60	4,065	5%	203	$12,180	District	10.38%	1,264
Theft or Worthless Check	$30	56,716	5%	2,836	$85,080	County	36.51%	31,063
Assault	$30	29,933	5%	1,497	$44,910	County	36.51%	16,397
TOTAL								**$198,937**

NOTE: Total convictions based on average from conviction data covering fiscal years 2003 to 2008.
SOURCES: Legislative Budget Board; Texas Office of Court Administration.

ONGOING EDUCATION ABOUT COURT COSTS AND FEES

The process for educating local courts about changes to court costs and fees is incomplete. Texas Government Code, Section 51.607, requires the Comptroller of Public Accounts (CPA) to publish a list of all court costs, fees, and fines from criminal and civil cases. Currently, the agency publishes this list in two parts—one for the municipal courts and one for the justice, county, and district courts. Beyond the published list of fees, the state does not require additional education or information be provided to counties about court costs and fees on a regular basis.

The Local Government Assistance (LGA) division within the CPA is a major resource for local government offices and courts needing information on various taxes, fees, and related matters. This division publishes the biennial list of court costs and fees. The LGA posts the lists on the agency's website, and it provides printed copies upon request.

In the recent past, the Office of Court Administration (OCA) had published a Court Cost and Fee Handbook for municipal courts, justice of the peace courts, and one for county and district courts. These handbooks were a resource provided by the OCA on a voluntary basis; there was no rule or statute requiring the agency to create them. The handbooks were updated biennially and provided more detailed information than the CPA's published list. The provision of this resource by the OCA was dependent on having a knowledgeable staff with extensive expertise in the area of court costs and fees; the agency no longer has that expertise internally and has discontinued the publication of these handbooks.

Though the state has had published materials available to the courts on court costs and fees, these publications are the extent of education about these fees. Both CPA and OCA answer questions and provide information on these issues when requested; but given the duties these agencies already have, education for local courts about these fees has remained focused on publications and being a question and answer resource.

While compiling information for this report, LBB staff contacted 10 counties for information regarding how often the DNA Testing Court Cost had been assessed over a three-year period from 2005 to 2007. To underscore how this education gap poses a problem for the state, one county admitted it had failed to change its collection system to reflect the DNA Testing Court Cost; and in the seven years since its creation, the county had never assessed or collected the fee. Education about courts costs, fees, and fines goes beyond the DNA Testing Court Cost, but making sure appropriate charges are applied upon conviction is a critical component of the criminal justice system.

Recommendation 3 suggests that the Office of Court Administration (OCA), with assistance from the Comptroller of Public Accounts (CPA), undertake biennial educational efforts to inform the local courts about the new or revised fees beyond the publication of fees. These educational efforts could include but are not limited to a new handbook on court costs or more in-depth discussion by OCA staff with courts participating in the Collection Improvement Program.

FISCAL IMPACT OF THE RECOMMENDATIONS

Implementing these recommendations would result in a revenue gain of $34,317 to the Criminal Justice Planning Fund and a revenue gain of $18,478 to the State Highway Fund in the 2010–11 biennium.

This fiscal impact is a combination of Recommendations 1 and 2. Recommendation 1 expands the DNA Testing Court Cost making it applicable to any conviction where DNA testing is used in the criminal investigation process. Currently, the cost only applies to sexual assault-related crimes.

Recommendation 2 reduces the DNA Testing Court Cost to $30 for misdemeanors and to $60 for felonies. The court cost is currently $50 for misdemeanors and $250 for felonies.

Recommendation 3 would have no significant fiscal impact for the 2010–11 biennium. Since OCA previously provided other education, the agency should be able to absorb these costs.

Figure 254 shows the fiscal impact of these recommendations.

FIGURE 254
FIVE-YEAR FISCAL IMPACT
FISCAL YEARS 2010 TO 2014

FISCAL YEAR	PROBABLE GAIN/(LOSS) TO THE CRIMINAL JUSTICE PLANNING FUND (GENERAL REVENUE–DEDICATED FUNDS)	PROBABLE GAIN/(LOSS) TO THE STATE HIGHWAY FUND (OTHER FUNDS)
2010	$17,158	$9,239
2011	$17,158	$9,239
2012	$17,158	$9,239
2013	$17,158	$9,239
2014	$17,158	$9,239

SOURCE: Legislative Budget Board.

The introduced 2010–11 General Appropriations Bill does not address these recommendations.

IMPROVE STATE COORDINATION OF THE DEVELOPMENT OF A PASSENGER RAIL SYSTEM

Traffic congestion is increasing on Texas roadways. In 2005, the Texas Transportation Institute ranked four Texas metropolitan areas as among the worst in the country for annual hours of delay per traveler. Highways and aviation have historically benefited from federal and state government for both financing and planning, while rail development has largely been left to private enterprise. Expanding transportation planning to a multi-modal approach incorporating passenger rail is an economically and environmentally viable method for addressing current and future congestion in Texas.

Multiple entities in the state are statutorily authorized to plan, develop, and/or operate a passenger rail system, including regional mobility authorities and commuter rail districts. Austin, Dallas, and Houston created passenger rail systems in their metropolitan areas and are working to expand and extend them. To date, however, no passenger rail system has been planned to connect the state's biggest cities which also have the most developed local transit systems. State coordination and planning for the development of passenger rail would help address current transportation challenges facing Texans.

FACTS AND FINDINGS

- Traffic congestion is increasing on Texas roadways. In 2005, the Texas Transportation Institute ranked the Dallas-Fort Worth-Arlington area as the fifth worst in the country for annual hours of delay per traveler. Houston ranked seventh, Austin ranked thirteenth, and San Antonio ranked twenty-ninth. The Texas Transportation Institute expects congestion to worsen as the state's population continues to experience considerable growth.
- In 2005, the Seventy-ninth Legislature enacted legislation that transferred all powers and duties regarding the regulation of railroads to the Texas Department of Transportation. The Legislature's intent was to increase the Texas Department of Transportation's involvement in rail projects and the further development of the state's multimodal transportation system.
- Passenger rail service in Texas is currently provided at the regional/intercity level by the National Railroad Passenger Corporation (Amtrak) and at the commuter level by Dallas Area Rapid Transit (DART) and Fort Worth Transportation Authority (the "T"). A number of additional entities such as Regional Mobility Authorities, Metropolitan Planning Organizations, and various rail entities also have statutory authority to participate in the planning, development, and operation of passenger rail on a local level.

CONCERNS

- Businesses weigh public transportation heavily when considering where to locate. Transportation inefficiencies, such as congestion between major cities, put Texas cities at a disadvantage compared to cities with more developed transportation systems. The Governor's Business Council estimates that solving the congestion problems in the state's largest metropolitan areas would result in $540 billion in economic benefits.
- The Transportation Code does not require the Texas Department of Transportation to take a leading role in passenger rail development. Statute does authorize the agency to plan, design, construct, and maintain a passenger rail system, though little progress towards the development of such a system has been made to date.
- The state lacks a single, lead entity to coordinate passenger rail development. Numerous entities are statutorily authorized to develop and construct rail projects in Texas, yet few legislative provisions require these entities coordinate their work. This patchwork of authority can lead to duplications in effort, higher costs, and lack of interconnectivity, inhibiting the state's ability to realize a multi-modal transportation system.

RECOMMENDATIONS

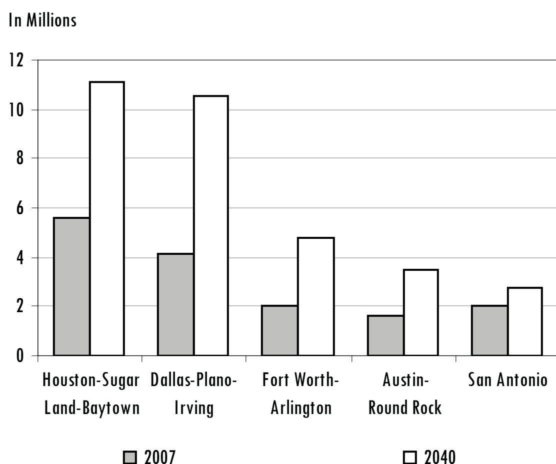
- **Recommendation 1:** Amend Texas Transportation Code, Chapter 91, to require the Texas Department of Transportation to create and annually update a long-term plan for a statewide passenger rail system.

- **Recommendation 2:** Amend Texas Transportation Code, Chapter 91, to require the Texas Department of Transportation to coordinate activities regarding the planning, construction, operation, and maintenance of a statewide passenger rail system.
- **Recommendation 3:** The Texas Department of Transportation should centralize agency employees responsible for freight and passenger rail activities into a single division to provide a focus on such operations and a direct, single line of communication to executive management.

DISCUSSION

In 2007, 23.9 million Texans, or 64 percent, lived in the Houston, Dallas, Fort Worth, Austin, and San Antonio metropolitan areas. The Office of the State Demographer predicts the state's population will increase 82 percent, to 43.6 million, by 2040. The demographer's office also projects that 75 percent of the population, or 32.7 million citizens, will live in the Houston, Dallas, Fort Worth, Austin, and San Antonio metropolitan areas. These five cities, often referred to as the Texas Triangle area, are expected to account for 89 percent of growth in Texas between now and 2040. **Figure 255** shows projected population increases for each of these cities between 2007 and 2040.

FIGURE 255
PROJECTED POPULATION INCREASES FOR SELECTED METROPOLITAN AREAS IN TEXAS, 2007 AND 2040



Sources: State Demographer of Texas; The University of Texas at San Antonio.

These areas are already highly congested and in need of transportation alternatives to crowded highways. In 2005, the Texas Transportation Institute ranked the Dallas-Fort Worth-Arlington area as the fifth worst nationally for annual hours of delay per traveler. Houston ranked seventh, Austin ranked thirteenth, and San Antonio ranked twenty-ninth. The Travel Time Index measures the change in commute times. For instance, if it takes a driver one hour to travel a distance at an off-peak time, a travel time index of 1.25 means that covering the same distance in congestion will take an extra 15 minutes. **Figure 256** shows an increase in the travel time index for the central Texas Metro areas.

The majority of goods exported through Texas are transferred via roadways. During 2002, trucks were used to ship 64 percent of goods from Texas. Exports from Texas exceeded $117 billion in 2005 and increased to over $168 billion by 2007. This represents an increase of 44 percent in export growth. An additional 11 percent of the goods were shipped using a combination of modes including those involving roadways.

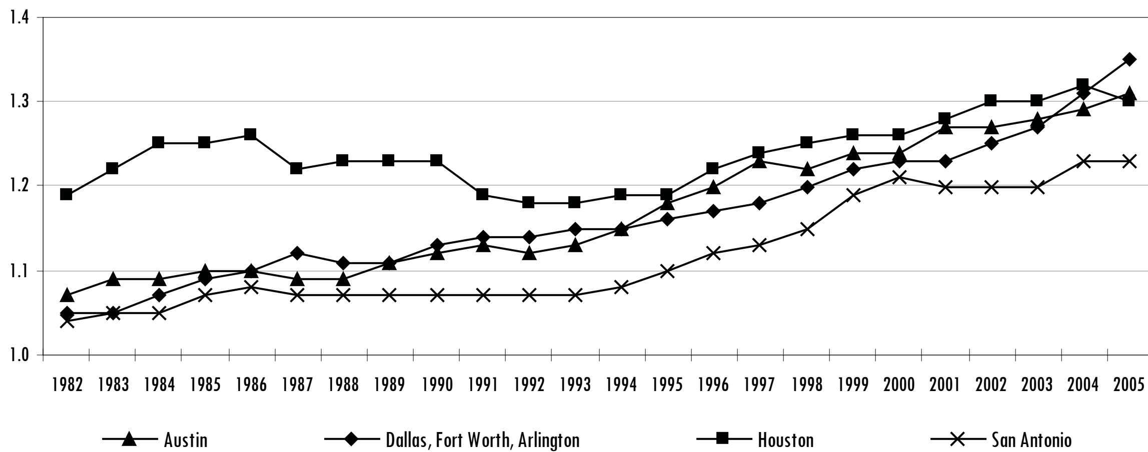
During 2006, Texas citizens and visitors traveled a total of 238.3 billion vehicle miles. The Texas Department of Transportation (TxDOT) predicts vehicle miles traveled (VMT) in Texas could reach 320.8 billion by 2022 and projects that between 2000 and 2025 VMT will increase 21 percent in Harris County and 60 percent in Tarrant County. The Dallas-Fort Worth to San Antonio corridor has experienced the fastest increase in VMT among Texas' major metropolitan regions and is expected to increase another 58 percent through 2025.

The IH-35 corridor between Austin and San Antonio is one of the busiest highways in Texas. This area, according to the Austin-San Antonio Intermunicipal Commuter Rail District, already has the highest number of fatalities, most congestion, slowest average speed per mile, and worst air pollution along the entire 1,700-mile route of IH-35 from Mexico to Canada. Additionally, truck traffic carrying freight in the Austin-San Antonio corridor grows nearly 15 percent each year. The Federal Highway Administration predicts that by 2020 truck tonnage in Texas will increase 95 percent from 1998 levels.

COST OF CONGESTION

Economic development in Texas is partly attributable to low urban congestion in Texas cities compared to other U.S. cities, which indicates that increasing congestion in Texas could negatively affect the state's competitive advantage. **Figure 257** shows some of the costs associated with road congestion in major Texas cities, including costs associated

FIGURE 256
CHANGES IN TRAVEL TIME INDEX FOR MAJOR TEXAS CITIES, 1982 TO 2005



SOURCE: Texas Transportation Institute.

FIGURE 257
CONGESTION COSTS BY METROPOLITAN AREA, 2005

URBAN AREA	ANNUAL TRAVELER-HOURS OF DELAY (IN THOUSANDS)	ANNUAL GALLONS OF FUEL WASTED (IN THOUSANDS)	ANNUAL COST DUE TO CONGESTION (IN MILLIONS)
Austin	22,580	15,505	$422
Dallas-Fort Worth-Arlington	152,129	106,207	2,747
Houston	124,131	92,559	2,225
San Antonio	29,380	20,425	530
TOTAL	**328,220**	**234,696**	**$5,924**

SOURCE: Texas Transportation Institute.

with both travel delays and fuel wasted for passenger and commercial vehicles.

The Governor's Business Council estimates that $540 billion in economic benefits could be gained from addressing congestion in Texas' eight largest cities. These benefits include $37 billion from decreased fuel consumption, $104 billion from saved travel time, and $80 billion from improved business efficiency and operating savings.

Congestion and traffic delays along Texas highways contribute to increased operating costs and economic losses for national shippers and businesses operating in Texas or shipping goods through the state. Improved reliability allows businesses to more accurately predict travel time and reduce operating costs and losses. This in turn reduces storage costs and the amount of inventory that must be maintained in one location. Additionally, a less congested system creates savings for businesses by reducing labor costs associated with the amount of time drivers are on the road and operating costs related to reductions in vehicle repair and fueling.

The Governor's Competitiveness Council acknowledges Texas businesses are highly dependent upon their ability to receive raw materials and ship finished products in a timely manner. Therefore, the state must take steps to improve transit infrastructure and minimize the costs for businesses to operate efficiently. The growth in Texas' population and road use coupled with slow growth in road capacity has the potential to increase factors such as congestion that will make the state less attractive to business as well as increase the cost and lower the quality of living for state residents.

EFFECTS ON AIR QUALITY

Motor vehicles emit pollutants such as particulate matter, nitrogen oxides, carbon monoxide, sulfur dioxide, and hazardous air pollutants. Some of these emissions contribute to the development of ground-level ozone. Increases in both the number of vehicles driven and VMT have counteracted many of technology's gains in lowering emissions output. As increases in travel time continue to occur because of congestion, the number of pollutants emitted by motor vehicles increases as well. Increasing highway capacity to

relieve congestion will not necessarily offset these factors, because the latent travel demand resulting from increased appeal of a less congested route often leads to increases in VMT levels.

Forty-one Texas counties are classified as non-attainment or near nonattainment areas for ozone. These counties include the major urban areas of the state: Houston, Dallas, San Antonio, Austin, Fort Worth, El Paso, and Corpus Christi. The cost of nonattainment potentially includes a loss of federal grant and highway funding, measures and implementations to achieve attainment, requiring certain sectors of the economy to purchase pollution offsets which increases the cost of doing business, and the cost of medical attention for various maladies linked to air pollution.

PASSENGER RAIL AS A SOLUTION TO CONGESTION

The Federal Railroad Administration states that multimodal transportation strategies are necessary to address congestion problems because they do not have the same space, cost, and environmental constraints that additional highway lanes have. The Governor's Competitiveness Council supports converting underused freight rail systems to light-rail passenger transportation services to decrease congestion and attract business. TxDOT acknowledges that increased highway traffic and congestion will negatively affect air quality in Texas cities and may increase demand for rail as a transportation option. The Senate Committee on Transportation and Homeland Security's Interim Report to the Eightieth Legislature, 2007, supported improving passenger and freight rail facilities to address congestion in Texas and stated that the use of public funds is appropriate in this endeavor.

In a 2008 Texas Lyceum Poll, 76 percent of those surveyed supported a regional rail system connecting cities such as Dallas, Fort Worth, Austin, and San Antonio. The poll also found that Texans are more accepting of higher spending on public transportation than toll roads. Additionally, 58 percent of respondents said that state and local government should be spending more on rail projects.

Research into the feasibility of high-speed rail between Texas cities during the 1990s indicated that ridership between Austin, Dallas-Fort Worth, Houston, and San Antonio would generate significant passenger volumes, with an estimated potential ridership of 45.5 million by 2010. Amtrak has also concluded there is a demand for high-speed passenger rail in Texas. Many of the corridors between major Texas cities are considered viable locations for intercity passenger rail. Corridors that maintain dense populations and with less than 500 miles between them are the most feasible location for passenger rail services. The corridors between Dallas, Fort Worth, Waco, Austin, San Antonio, and Houston all meet these criteria.

Expanding capacity for any transportation mode requires significant capital investment. A 1998 feasibility study estimated that a passenger rail system between Austin and San Antonio would cost $500 million. In contrast, $10 billion in highway projects for the Austin-San Antonio corridor are planned for construction over several decades. These highway projects are expected to be at capacity shortly after completion. Once a rail system is in place, additional capacity can be gained from adding rail cars, additional stops, and altering schedules.

Increasing capacity on a highway system requires additional lanes, which has become an increasingly expensive and time-consuming endeavor. According to TxDOT, the cost of highway construction ranges from $1.7 million to $360.0 million per lane mile, depending on factors such as where in the state the lane mile is being built and the type of road being constructed.

The development of a passenger rail system could help relieve congestion by diverting current and future traffic from highway corridors between the Dallas-Fort Worth, Waco, Austin, San Antonio, and Houston metropolitan areas. Passenger rail would provide a multi-modal transportation alternative that contributes less than other transportation options to air pollution and allows for efficient expansion.

Legislation enacted by the Seventy-eighth Legislature, Regular Session, 2003, and the Seventy-ninth Legislature, Regular Session, 2005, expanded TxDOT's purview of rail issues. Bills enacted during these sessions authorized TxDOT to finance, construct, maintain, and operate freight or passenger rail as well as enter into comprehensive development agreements for rail projects. TxDOT also now administers most federal funding for rail infrastructure construction. Finally, TxDOT may now enter into agreements with public or private entities using pass-through fares for reimbursement of facility expenses.

LOCAL RAIL AUTHORITY PROJECTS

The Metropolitan Transit Authority of Harris County, Texas (METRO) opened a seven-and-one-half mile light rail line in January 2004. Ridership grew 30 percent between June 2004 and June 2005, and weekday ridership reached 40,000

well before that benchmark's original 2020 projection. Implementation of METRO's Phase 2 is ahead of its original schedule. Phase 2 includes an Intermodal Terminal, 9 new miles of light rail, 21 miles of Bus Rapid Transit, and 28 miles of commuter rail lines running to Cypress Park and Missouri City.

Capital Metro (CapMetro) will begin operating MetroRail in Austin on March 30, 2009, with the initial route running 32 miles from Leander to downtown Austin. CapMetro has also submitted a proposal to a transit-working group to use 28 miles of existing CapMetro rail lines to establish a second passenger rail line running from downtown Austin to Elgin, east of Austin.

The Trinity Rail Express (TRE) is a joint project of Dallas Area Rapid Transit (DART) and the Fort Worth Transportation Authority (the "T"). The system links Fort Worth, downtown Dallas, and the Dallas/Fort Worth Airport. The TRE opened with 10 miles of track in 1996 and the system now covers 35 miles. The TRE averaged over 2 million riders each year since 2002. Fiscal year 2007, with a ridership of approximately 2.5 million, was its most successful by this measure. DART, the "T," and the Denton County Transportation Authority are planning to expand passenger rail and other transit services to 11 additional corridors throughout the DFW metroplex.

The Seventy-fifth Legislature, Regular Session, 1997, enacted legislation allowing an inter-municipal commuter rail district to study, create, and operate a passenger rail system between Austin and San Antonio. The Austin-San Antonio Intermunicipal Commuter Rail District's board met for the first time in February 2003. Since then, they have hired a team of engineers and rail specialists to update a 1999 feasibility study and develop an implementation plan. Their proposed system is 112 miles, has 36 vehicles, and can carry approximately 11,500 passengers daily by 2030. The district expects to operate their rail system from San Antonio to Georgetown within 10 years. The Capital Area Metropolitan Planning Organization and the San Antonio-Bexar County Metropolitan Transportation Planning Organization include the commuter rail system in their 2025 long-range transportation plans.

TXDOT RAIL ACTIVITIES

TxDOT last updated its rail system plan in 2005. The document is described as a baseline analysis of the state's rail development programs. A baseline analysis is only useful, however, as a starting point from which to launch additional studies, monitor and measure the progress of current activities, and evaluate the success of a program. Since 2005, the rail systems developed in Austin, Dallas-Fort Worth, and Houston have increased ridership capacity, accelerated plans for expansion, and redefined regional transportation goals and measures. The plan also speaks to the possibility of the Rail Relocation and Improvement Fund, which voters approved since the publication of the plan. Having an updated plan for a coordinated statewide rail system would enhance the benefits of local rail development efforts to both the local governments and the statewide population.

In its Legislative Appropriations Request for the 2010–11 biennium, TxDOT includes exceptional item requests of $152 million for rail-related projects. The additional funds would be used to acquire federal matching funds for intercity passenger rail and to complete preliminary engineering for rail projects in Houston and the Austin-San Antonio region. TxDOT also disburses federal funds to the Austin-San Antonio Intermunicipal Commuter Rail District for their planning activities as well as for a feasibility study on high-speed rail between Dallas and Shreveport, Louisiana. Without a comprehensive plan for rail development, it is difficult to determine whether these proposed projects are the best use of funds for rail projects.

RECOMMENDATIONS

Recommendation 1 would amend the Texas Transportation Code to require TxDOT to create a statewide plan for a passenger rail system and to update the plan for the Legislature annually. The Texas Transportation Code, Section 201.601, requires TxDOT to develop a statewide multimodal transportation plan. The result of this requirement is TxDOT's Unified Transportation Program (UTP), a 10-year plan for transportation development. The 2007 UTP includes few intercity rail projects, focusing primarily on the development of the state highway system. Additionally, the Texas Transportation Code, Section 201.616, requires TxDOT to report to the Legislature on certain financial activities annually, including expenditures made in connection with the Unified Transportation Program and rail facilities described in Texas Transportation Code, Chapter 91.

Recommendation 2 would amend the Texas Transportation Code to require TxDOT to coordinate the activities of all entities with statutory authority to participate in the planning, development, and operation of passenger rail systems in the state.

Numerous entities are statutorily authorized to develop and construct rail projects in Texas. These entities are responsible for ensuring that communication and collaboration occur, yet this has not prevented duplications in some areas. For instance, both the Austin-San Antonio Intermunicipal Commuter Rail District and the Texas High Speed Rail and Transportation Corporation are separately developing a rail line that runs between Austin and San Antonio. Ensuring a unified plan for the development of passenger rail in Texas would ensure that all public and private resources are used effectively for the best system possible to serve the citizens of Texas.

One of the obstacles to developing intercity passenger rail in Texas has been the lack of a single, lead entity coordinating passenger rail development. Numerous entities are statutorily authorized to develop and construct rail projects in Texas, yet few legislative provisions require these entities to work together cooperatively to best serve the transportation interests of the state. This recommendation would define TxDOT as the lead entity in addressing intercity passenger rail development and help prevent duplication of efforts, excessive development costs, and inefficient service to Texans.

Recommendation 3 would direct TxDOT to centralize the organizational structure of its freight and passenger rail activities and resources. Although TxDOT is well-positioned to build, maintain, and relocate rail facilities and to contract for and provide funding for rail facility construction, its decentralized structure impedes its ability to meet evolving passenger rail needs. TxDOT has individual divisions that oversee support operations such as public transportation and motor vehicle titles and registration and divisions responsible for engineering operations for aviation and traffic operations, yet no centralized division is responsible for overseeing rail activities. Consolidating responsibilities for passenger rail planning, development, and oversight will ensure that resources are devoted to the advancement of passenger rail, create a tangible and accountable leadership entity for passenger rail, and assist the Legislature in tracking and monitoring budget appropriations for rail activities.

FISCAL IMPACT OF THE RECOMMENDATIONS

There would be no fiscal impact from implementing these recommendations during the 2010–11 beinnium. TxDOT should be able to perform the required tasks and activities given current levels of appropriations and authorized resources.

The introduced 2010–11 General Appropriations Bill does not address the recommendations in this report.

IMPLEMENT A STUDY TO DETERMINE THE FEASIBILITY OF A VEHICLE MILES TRAVELED TAX

The current motor fuels tax is no longer an adequate source of revenue for funding the construction and maintenance of the Texas highway system. Additional transportation capacity is needed, and as Texas' highway system ages and road use increases, maintenance needs increase. However, funding to build this capacity and to continue to maintain roads has grown more slowly than the need for roads. Various entities have reviewed the gap between transportation needs and transportation funding. While the extent of this shortfall is unknown, estimates range between $40 billion and $80 billion depending upon the methodology and assumptions used. Various factors contributed to this shortfall, including the increasing fuel efficiency of motor vehicles and an increase in the use of hybrid vehicles. Both of these factors have decreased the amount of gasoline motor vehicles consume and hence the amount of motor fuels tax paid.

A vehicle miles traveled tax is a user fee that taxes persons based directly on their use of the road system. This tax provides a direct link to road use by taxing persons based on how much they drive rather than how much gasoline they purchase. Therefore, as fuel economy increases and hybrid cars continue to gain popularity, a source of revenue compensating for these factors would exist. Additionally, a vehicle miles traveled tax provides the flexibility to institute other road-pricing mechanisms that can help to mitigate congestion by influencing traffic behavior. Implementing a study of a vehicle miles traveled tax in Texas would allow the state to determine the ability of such a mechanism to address its transportation needs and consider any concerns that would need to be addressed prior to statewide implementation.

CONCERNS

- Motor vehicles have become more fuel efficient and the number of hybrid vehicles purchased has been steadily increasing. This efficiency reduces the amount of fuel purchased, which decreases the amount of motor fuels tax paid per mile driven. Motor vehicle fuel efficiency is expected to continue to increase, as indicated by the recent increase in Corporate Average Fuel Economy standards at the federal level.
- Before an alternative to the motor fuels tax can be implemented, a number of factors such as public acceptance, the effect on businesses, and possible collection methods would need to be examined through a study of the feasibility and full implementation of a vehicle miles traveled tax.

RECOMMENDATIONS

- **Recommendation 1:** Include a rider in the 2010–11 General Appropriations Bill that requires the Texas Transportation Institute to conduct a study testing a vehicle miles traveled tax contingent upon receipt of a federal grant for that purpose.
- **Recommendation 2:** Include a rider in the 2010–11 General Appropriations Bill that requires the Texas Department of Transportation to provide 20 percent in matching funds to the Texas Transportation Institute contingent upon the Texas Transportation Institute's receipt of a federal grant to implement a test of a vehicle miles traveled tax.

DISCUSSION

The current motor fuels tax consists of three separate taxes: a tax on diesel fuel, a tax on gasoline, and a tax on liquefied gas. The gasoline tax was first enacted in Texas during 1923 at the rate of $0.01 per gallon. Eventually a tax was also placed on diesel fuel and liquefied gas and the rate of the gasoline tax has intermittently risen to the current level of $0.20 per gallon for diesel and gasoline fuel (set in 1991) and $0.15 per gallon for liquefied gas (set in 1987). Texas' gasoline tax is lower than the national average of $0.27 per gallon. During fiscal year 2007, the motor fuels tax was the fourth largest source of tax revenue in Texas, generating $3.1 billion in revenue for the state. In addition to the state gasoline tax, a federal gasoline tax of $0.18 per gallon is also charged to the purchase of gasoline. This rate came into effect in October 1993.

Suppliers pay gasoline and diesel fuel taxes to the State Treasury. They are then reimbursed for the tax by distributors and importers. Distributors and importers recover the tax from terminal operators who collect the tax from consumers who pay the motor fuels tax at the point of sale. Suppliers, terminal operators, and licensed distributors are all required to file a monthly return, which includes payment, for the amount of tax reported due. Interstate truckers also pay

gasoline and diesel fuel taxes at the point of sale. However, most interstate truckers belong to the International Fuel Tax Agreement (IFTA) and are required to file a quarterly tax return to a central processing office which calculates how much motor fuels tax each state should have received based on the miles driven in that state by interstate truckers. The states are then either billed for motor fuels taxes overpaid in their jurisdiction (based on miles driven by interstate truckers) or receive a payment for motor fuels taxes not paid in their jurisdiction.

Motor fuels tax revenues in Texas are increasing, but they are doing so at a decreasing rate. According to the Comptroller of Public Accounts, most of the historical growth in motor fuels tax revenues is the result of legislative rate increases. Increases in Texas' population and, therefore, the number of drivers and vehicle miles traveled has also influenced growth rates of motor fuels tax revenues. This, along with inflation factors, changes in vehicle fuel economy, and the development of alternative sources for powering vehicles, has contributed to the inadequacy of the current motor fuels tax to fund road maintenance and construction needs.

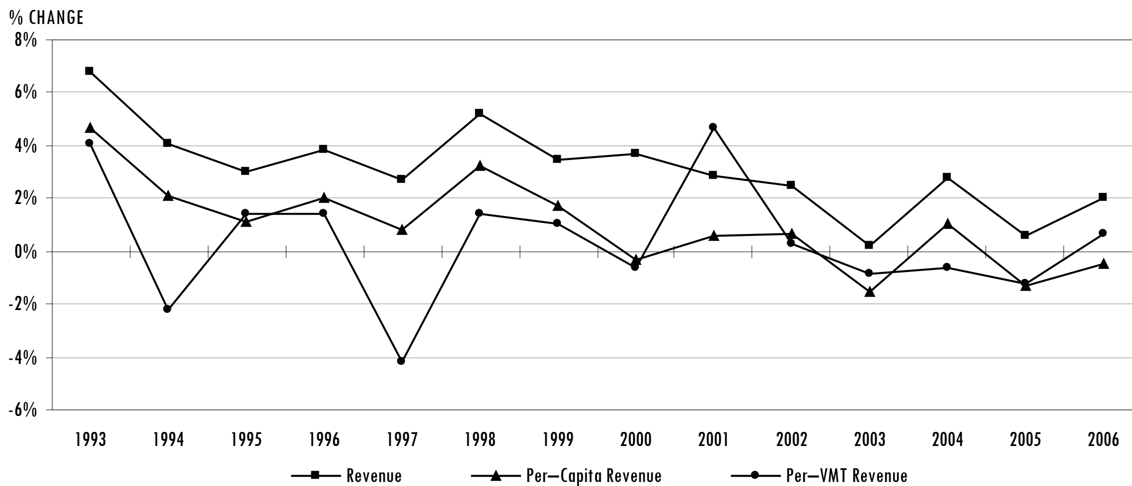
Motor fuels tax revenue is in decline when adjusted for inflation. Additionally, as **Figure 258** shows, the growth rate of the motor fuels tax is much smaller and even negative in some years when adjusted for increases in both population and vehicle miles traveled. The population and number of drivers in Texas are expected to continue to increase. Therefore, nominal growth in motor fuels tax revenues is likely to continue despite considerations for inflation, rising vehicle fuel economies, and greater use of hybrid vehicles.

When adjusted for inflation, the current rate of gasoline and diesel fuel tax that was set at $0.20 in 1993 is worth $0.13 today. Additionally, $0.0124 in state motor fuels tax was paid per mile driven in 1993, which equates to $0.008 today when adjusted for inflation. This depreciation is compounded by large increases in the cost of materials used for highway construction. From 2002 to 2007, the highway construction cost index increased by 62 percent in Texas. During the same period, the Consumer Price Index (CPI) increased by 15.3 percent, meaning that the price of road construction materials outpaced the CPI.

Motor vehicles have become more fuel efficient, requiring less motor fuel to travel. Corporate Average Fuel Economy (CAFÉ) standards were set at 27.5 miles per gallon (mpg) in 1990, and recent federal legislation mandates that all new passenger and non-passenger vehicle fleets average 35 mpg by 2020. As shown in **Figure 259**, the fuel efficiency of the entire U.S. vehicle fleet is increasing.

Additionally, technological advances have led to the manufacturing of a variety of alternatively fueled vehicles, often referred to as hybrid vehicles. The number of hybrid vehicles in use in Texas increased by 26.7 percent from 2003 to 2006. During 2007, hybrid vehicles made up 4.9 percent of all new vehicle registrations in Texas, ranking Texas fourth in new hybrid vehicle registrations. However, because hybrid vehicles are more fuel efficient, their use decreases motor fuels tax revenue. This trend will intensify as the number of

FIGURE 258
MOTOR FUELS TAX ANNUAL REVENUE GROWTH RATE COMPARISON, FISCAL YEARS 1993 TO 2006



Source: Legislative Budget Board.

FIGURE 259
AVERAGE FUEL EFFICIENCY OF U.S. PASSENGER CARS AND LIGHT TRUCKS, 1980 TO 2006

CATEGORY	VEHICLE	1980 (MPG)	1985 (MPG)	1990 (MPG)	1995 (MPG)	2000 (MPG)	2005 (MPG)	2006 (MPG)
Average U.S. passenger car fuel efficiency (calendar years)	Passenger cars	16.0	17.5	20.3	21.1	21.9	22.1	22.4
	Other 2-axle 4-tire vehicle	12.2	14.3	16.1	17.3	17.4	17.7	18.0
New vehicle fuel efficiency (model years)	Passenger car	24.3	27.6	28.0	28.6	28.5	30.3	30.2
	Domestic	22.6	26.3	26.9	27.7	28.7	30.5	30.4
	Imported	29.6	31.5	29.9	30.3	28.3	29.9	29.7
	Light truck (<8,500 lbs GVWR)	18.5	20.7	20.8	20.5	21.3	22.1	22.5

SOURCE: U.S. Department of Transportation.

hybrid vehicles on the road increases and technological advances continue to improve the fuel economy of alternatively powered vehicles.

BENEFITS OF A VEHICLE MILES TRAVELED TAX

In its interim report released during February 2008, the National Surface Transportation Infrastructure Financing Commission (NSTIFC) noted that the current method of funding roads is inadequate and is not the most effective way to promote efficient use of the road network. The NSTIFC stated that fees for vehicle miles traveled should be examined for feasibility and revenue-generating potential. The NSTIFC noted that a fee with a direct nexus to road use, such as a vehicle miles traveled (VMT) tax, encourages efficient use of the system which also reduces the need for new capacity. Moreover, a VMT tax provides a comparatively steady source of tax revenue. The amount of revenue generated would vary, depending on the number of miles traveled; however, the number of miles traveled is positively correlated with road maintenance and construction needs.

As shown in **Figure 260**, if a VMT tax were to be instituted in Texas, the revenue generated would increase compared to the income the state now receives from the motor fuels tax. These calculations are based on a flat-rate tax of $0.0124 per mile traveled (this is equivalent to the state motor fuels tax paid per mile driven in 1993) and do not include various pricing strategies that could be employed to account for factors such as vehicle emissions, efficiency, or weight. This tax would result in an estimated $826 million in additional revenue over anticipated motor fuels tax revenues from fiscal years 2010 to 2014.

A VMT tax can be structured to encompass external costs associated with driving if desired. The tax structure could consider pollution factors by applying various rates based on a vehicle's emission standards, engine specifications, or fuel efficiency. Different rates could apply to vehicles of various weight classes to take into account the amount of road damage a vehicle creates. Vehicle weight is the basis for VMT taxes applied to semi-trucks in Oregon, New Mexico, Kentucky, and New York. Additionally, a VMT tax is capable of accounting for congestion through various pricing mechanisms. Variable pricing, time-of-day pricing, and cordon pricing can all be implemented through a system that taxes based on vehicle miles traveled. Value pricing mechanisms include the following examples:

FIGURE 260
MOTOR FUELS TAX AND VMT TAX COLLECTIONS, FISCAL YEARS 2010 TO 2014

FISCAL YEAR	TOTAL VMT* (IN MILLIONS)	MOTOR FUELS TAX* (IN MILLIONS)	VMT TAX** (IN MILLIONS)	DIFFERENCE (IN MILLIONS)
2010	266,730.9	$3,198.3	$3,307.5	$109.1
2011	274,823.6	3,263.5	3,407.8	144.3
2012	281,203.8	3,320.2	3,486.9	166.7
2013	287,668.2	3,376.0	3,567.1	191.1
2014	294,239.1	3,433.5	3,648.6	215.0
TOTALS	**1,404,665.5**	**$16,591.7**	**$17,417.9**	**$826.2**

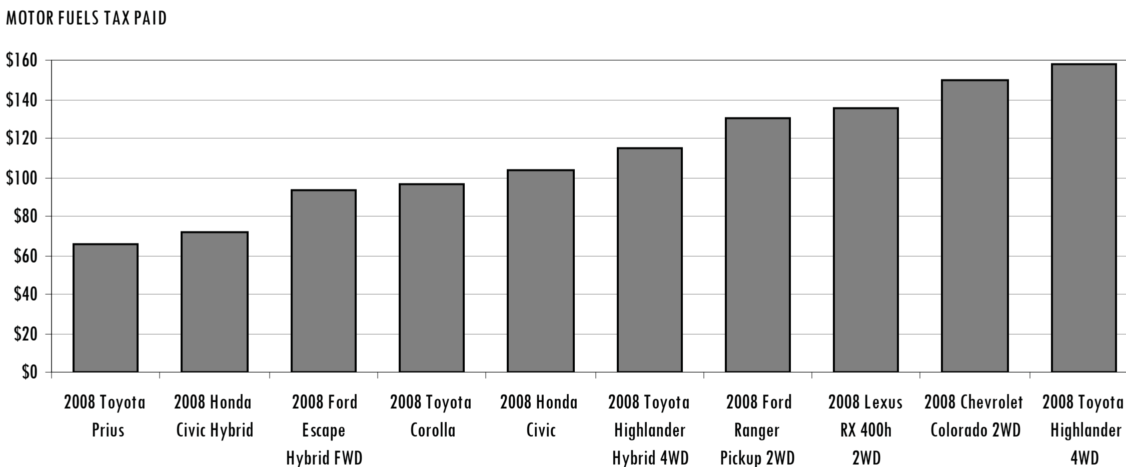
*Vehicle Miles Traveled and Motor Fuels Tax projections based on historical growth rates.
**The VMT tax is a flat-rate tax set at .0124 (which corresponds to the amount of state motor fuels tax paid per mile driven in 1993). The increase in revenue under a VMT tax results from an increase in total VMT.
SOURCE: Legislative Budget Board.

- **Cordon pricing:** A cordon area is defined, and vehicles are charged a fee to enter or exit specified zones, such as a central business district or shopping area. This has been used in Singapore's central business district since 1975 and also in several Italian cities and Stockholm, Sweden.
- **Congestion pricing:** A fee is charged of drivers based on the level of traffic on a congested road. The purpose is to allocate roadway space in an economically efficient manner. This form of pricing has been implemented in several cities in France and England as well as in parts of California, New Jersey, and New York.
- **Mileage-based Fee:** A fee charged to operate a vehicle based on the number of vehicle miles traveled.
- **Time-of-day Pricing:** Charges that are levied for traveling at certain times of day as determined by congestion levels. Time-of-day charges are higher during peak travel periods and are used by other industries, such as airlines.
- **Variable pricing:** Fees for driving that are higher on congested routes and during congested times and lower on roads that are in less demand and during non-congested periods. This form of pricing is used when capacity is fixed but demand oscillates. It has been used in other industries by telephone providers, utility companies, and movie theaters.

The system of motor fuels taxation results in a discrepancy of taxes paid based on the type of vehicle driven. A VMT tax is a more equitable form of taxation since all motor vehicle operators who use roads will pay the same tax per mile driven. Hybrid vehicles and smaller cars generally have better fuel economies than large sport utility vehicles and passenger trucks; therefore, operators of these vehicles purchase less gas and pay less motor fuels tax as **Figure 261** shows.

Despite differences in the amount of motor fuels tax paid, these vehicles all create a relatively equal amount of road damage. This discrepancy could be corrected under a VMT tax because all motor vehicle operators would pay a user fee based on the number of miles traveled, rather than how much fuel was used to travel that distance. Therefore, based on an average of 15,000 miles traveled per year and a VMT tax of $0.0124 per mile driven, each motor vehicle operator would pay $186 annually in state motor fuels tax. By paying a tax based on miles traveled, the operators of more fuel-efficient cars would contribute equally to the cost of maintaining the roads they use. Under a VMT tax, the driver of a 2008 Toyota Prius would pay an additional $121 per year in taxes compared to the current state motor fuels tax, while the driver of a 2008 Toyota Highlander 4WD would pay $28 more per year compared to the current state motor fuels tax. The owner of a more fuel-efficient car would still achieve a cost savings because of the reduction in fuel purchased. The operator of a 2008 Toyota Prius would pay $1,218 per year for fuel. This is $1,734 per year less than the operator of 2008 Toyota Highlander 4WD, which would require $2,952 in fuel per year to operate.

FIGURE 261
ANNUAL MOTOR FUELS TAX PAID FOR SELECT VEHICLES, 2008



NOTE: Based on 15,000 miles driven per year.
SOURCES: Legislative Budget Board; U.S. Department of Energy; U.S. Environmental Protection Agency.

OVERVIEW OF PILOT PROGRAMS TESTING A VEHICLE MILES TRAVELED TAX

To address concerns about the steady decline in Oregon's gas tax, the Oregon Legislative Assembly created the Road User Fee Task Force (Task Force) in 2001. The Task Force was instructed to identify potential alternatives to the motor fuels tax that were based on road use. The Task Force identified 28 potential revenue sources, but singled out a VMT fee as a fair, simple, and affordable way to generate revenue through a user fee. During 2004, the Oregon Department of Transportation (ODOT) and Oregon State University tested on-board equipment that could be used to collect data and calculate a VMT tax in vehicles and at gas stations. A pre-pilot was conducted using this technology during fall 2005. A 12-month pilot program to test this technology and the potential effect of a VMT tax began with 260 vehicles in April 2006.

The pilot program used a global positioning system (GPS) receiver that counted the number of miles traveled but did not obtain trip data. When a motor vehicle operator purchased gasoline, mileage data was instantaneously transmitted through a wireless signal to a computer inside the fuel station. This computer calculated the mileage fee, deducted the gas tax, and applied congestion charges when appropriate. Participants in the pilot program did not actually pay the mileage fee, but rather were provided an endowment fund by ODOT that was debited each time the mileage fee was calculated. The pilot program was conducted in two phases. During the first six months, miles driven by zone were recorded, but participants paid the standard motor fuels tax rather than a VMT tax. During the later six months, the participants were divided into three groups. The first group paid a $0.012 per mile tax based on the number of miles traveled rather than the motor fuels tax. The second group also paid a VMT tax rather than the motor fuels tax, but applying time-of-day pricing to the VMT tax was tested by including an additional charge for each mile driven from 7:00 AM to 9:00 AM and from 4:00 PM to 6:00 PM on weekdays. The last group served as a control group and continued to pay the motor fuels tax. ODOT's final report stated that the pilot proved that the technology, administrative elements, and concept of the VMT tax are viable. As a result of the pilot, ODOT reported the following findings:

- paying at the pump works;
- the mileage fee can be phased in;
- integration with current systems can be achieved;
- congestion and other pricing options are viable;
- privacy is protected;
- the system would place minimal burden on business;
- potential for evasion is minimal; and
- cost of implementation and administration is low.

The Puget Sound Regional Council (PSRC) is a conglomeration of counties, cities, towns, ports, tribes, transit agencies, and the state of Washington in the Puget Sound area. In 1995, PSRC created a Transportation Pricing Task Force charged with developing a course for road pricing policy. The Federal Highway Administration (FHA) provided a grant to PSRC in 2002 to conduct a pilot program entitled the Traffic Choices Study. The study examined how motor vehicle operators would alter their travel in response to variable charges for road use. Variable road pricing is an additional charge to the motor fuels tax paid by vehicle operators based on their use of particular roads. Therefore, unlike the VMT tax pilot program, this study did not examine an alternative to the current motor fuels tax. However, the results of the study apply to a discussion of the feasibility of a VMT tax because the concept is based on user fees, and the technology used for both charges is similar.

The study began in 2005 with more than 275 volunteer households and 450 vehicles. The driving patterns of each household were observed at the start of the study. After a baseline had been established, hypothetical tolls were charged for driving on major freeways and arterial roads in the Seattle metropolitan area. Each participant received an account with money to cover the cost of their tolls as determined by the baseline observations. Participants were allowed to keep any funds left in their account at the end of the study, which provided an incentive for participants to alter their driving patterns. A GPS device was installed in each vehicle in the study that communicated with satellites to determine a vehicle's position. The position was then matched to a toll-road network map implanted in the meter, and the appropriate charge was applied based on the time of day and road traveled. The meter displayed the user charges for passenger observation and transmitted location and toll information to a central computer. An on-line account was also created for each member of the study that enabled him or her to monitor his or her travel, trip choices, and the costs of his or her driving patterns.

The study determined that variable road pricing would result in a reduction of and changes in travel demand. The following changes were observed during the study:

- a 7 percent reduction in vehicle trips per week;

- a 12 percent decline in vehicle miles traveled;
- an 8 percent decline in minutes of driving per week;
- 6 percent fewer trip segments conducted per week; and
- a reduction in vehicle miles traveled on toll roads by 13 percent.

According to the study's authors, these changes in travel behavior among study participants could equate to a significant reduction in congestion if variable pricing were implemented at a network-wide level. The study also determined that the monetary and societal value of net benefits in the Puget Sound region could exceed $28 billion (after consideration for the increased cost of driving to consumers and the costs of implementing and operating the system) over 30 years. The largest savings would be in the form of travel time, which is calculated at $36 billion. Additionally, the study estimated that $87 billion in tolls would be produced. The study also determined that the core technology necessary for satellite-based toll systems exists and is dependable, and that proven systems, viable business models, and public acceptance would be necessary to create a GPS-based road tolling program.

The University of Iowa Public Policy Center (center) undertook a three-year research project to devise a way to utilize intelligent transportation system smart-vehicle technology to implement road user charges. This research concluded in 2002 and was funded by FHA and 15 state departments of transportation, including the Texas Department of Transportation (TxDOT). During this research project, technology was developed that uses GPS signals to determine a vehicle's position. This information is stored on a vehicle-installed computer that is able to calculate the per-mile user fee for different vehicle types based on the vehicle's location. The on-board computer stores only the total amount owed to each jurisdiction and not route or time information. The mileage information is compared to the odometer data to confirm the number of miles traveled. Once a month, the on-board system transmitted the total amount owed in each jurisdiction to a billing and dispersal center, which then billed the vehicle owner and dispersed the revenue to the appropriate jurisdictions.

The federal *Safe, Accountable, Flexible, Efficient, Transportation Equity Act: A Legacy for Users* of 2005 requires the technology developed during the center's research to be field tested. This requirement is intended to ensure that the road-user fee concept allowed for by the development of the center's technology will be field tested and widely understood if the federal government or state governments choose to implement the road-user fee concept. The second phase of the center's project will occur over a four-year evaluation period and $16.5 million in funding has been provided. Six test sites have been selected: (1) Austin, Texas; (2) Baltimore, Maryland; (3) Boise, Idaho; (4) Eastern Iowa; (5) the Research Triangle Region of North Carolina; and (6) San Diego, California. Field testing will occur for two years, with approximately 2,700 participants. Participant vehicles will be equipped with the technology developed by the center, and each month participants will receive a mock bill. Initially, bills will only reflect the total amount due. However, billing statements will eventually include greater detail that documents the basis for the charge levied. This detail will help determine whether participants place a higher value on privacy or documentation justifying the fees charged.

In April 2002, the Motorway Toll Act for Heavy Commercial Trucks became effective in Germany. This legislation authorized the German government to establish a distance-based toll for all vehicles using the German toll-road network that have a minimum permissible total weight of 12 tons and that are solely used for goods transport. The toll rate is based on a truck's emission category, number of axles, and length of the toll route. Three methods of collection exist for paying the tolls: (1) on-board units, (2) manual payment terminals, and (3) the Internet. Ninety percent of trucks paying the toll contain on-board units, which consist of GPS devices and on-board odometers or tachographs used as a backup. These technologies calculate the distance a truck has traveled and authorize a toll payment through a wireless link. More than 3,500 toll payment terminals have been set up along toll ways for drivers to manually pay their toll in advance if the truck does not have an on-board unit installed. Drivers also have the option of paying tolls in advance via the Internet. In 2007, it was reported that the average capture rate of tolls was 99.75 percent.

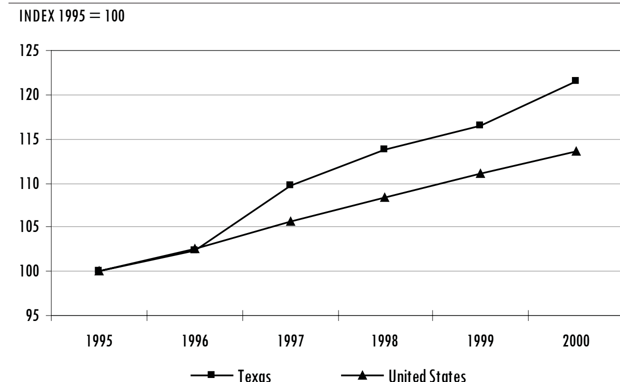
In 2007, the Texas Transportation Institute (TTI) and the Northeast Texas Regional Mobility Authority (NET RMA) investigated potential alternatives to the motor fuels tax. Using an $80,000 grant from the University Transportation Center for Mobility, TTI conducted stakeholder interviews, established focus groups, and created a community advisory committee to determine public perceptions of a mileage-based fee system. TTI's research found that the public primarily has negative feedback regarding alternatives to the

motor fuels tax; although as the public becomes more aware of the limitations of the motor fuels tax, they become more open to alternatives. Additionally, TTI discovered that persons in the NET RMA felt rural areas have not received a proportionate share of transportation funds and that the public feels that it is important for commercial motor vehicles to pay their "fair share." Using information gathered during this study, TTI developed a pilot proposal to test a VMT tax that considers technological issues and user fee criteria, such as the effect on rural areas and businesses.

CONCERNS REGARDING A VEHICLE MILES TRAVELED TAX

A number of considerations and concerns need to be evaluated and addressed before implementing a VMT tax. These issues range from administrative and technological processes to public concerns surrounding equity and privacy. Several other pilot programs have considered many of these concerns. However, none of these pilots were specific to Texas' unique qualities: the state's size and geography, the system of collecting taxes, and population characteristics. **Figure 262** shows that the average number of highway vehicle miles traveled in Texas from 1995 to 2000 is much higher than the national average. None of the previous pilot studies took into account the current system that divides motor fuels taxes paid by interstate truckers across state boundaries.

FIGURE 262
HIGHWAY VEHICLE MILES TRAVELED, UNITED STATES AND TEXAS, 1995 TO 2000



SOURCE: U.S. Department of Transportation, Bureau of Transportation Statistics.

One concern that has been raised in regards to a VMT tax is the potential for an invasion of privacy. Several methods of calculating vehicle miles traveled for the purposes of a VMT tax exist. One common method uses GPS devices which transmit data to a computer where it is stored. These devices have the potential to collect personal data regarding a person's movements and whereabouts. Futhermore, some service stations may be concerned that they would be required to share proprietary information about their customer base. These concerns could be alleviated based on the design of the tracking system used to determine vehicle miles traveled. The type of data required for transmittal could be limited to user identification and total amount owed. If more sensitive information were required, such as the location in which miles were driven, this data could be transmitted through an unnamed connection which allows a central processing unit to divide revenues among jurisdictions.

The current system of taxing motor fuels provides an incentive for people to buy and drive more fuel-efficient vehicles; however, the tax incentives for driving these vehicles are reduced under the VMT tax. Environmentalists have raised concerns that this could inadvertently increase the number of high-polluting vehicles on the road. The VMT tax has the potential to mitigate concerns such as this by linking tax rates to vehicle emission standards, thus continuing a tax incentive for buying lower-polluting vehicles. Additionally, the monetary incentives for purchasing fuel-efficient vehicles would still exist as a cost savings would still be realized from purchasing less fuel.

New technology would likely be required for the implementation of any VMT tax system. Questions surrounding the feasibility of retrofitting vehicles to include the necessary technology and the cost of including appropriate technology into new vehicles could be addressed through a pilot program. Furthermore, depending on the method in which the tax would be collected, service stations may need to acquire technology. This could require these businesses to invest in new capital and equipment.

In addition to the concern of potentially high capital expenses, it could be difficult to ensure that individuals are not evading the VMT tax. Under the current motor fuels tax, it is difficult to evade the tax because it is included in the up-front price of fuel at service stations. An odometer or GPS device placed in a car could potentially be disconnected or tampered with by a motor vehicle operator, allowing a person to avoid paying a VMT tax. However, safeguards can be put into place to prevent access to vehicle odometers and GPS devices. These safeguards could include checks against the odometer, monitoring data transmitted at the pump, or the use of roadside devices verifying that onboard units are functioning properly.

Additionally, it could be expensive to administer a VMT tax system, depending on the system implemented. These costs could be generated from the use of GPS technology installed in vehicles, billing centers, an increased need for audits to check against evasion, and the costs of transmitting data through satellite or cellular technology.

The manner in which a VMT tax would be integrated would need to be determined. While all motor vehicle manufacturers could be required to include appropriate technology in new vehicle models, it would be expensive to retrofit existing cars with the proper technology. It takes an estimated 20 years for the vehicle fleet on the road to turn over. Therefore, it is likely that both the current motor fuels tax and a VMT tax would exist simultaneously or a method of collecting a VMT tax from cars without the necessary technology would need to be established. These factors could make integration of the VMT tax difficult.

TESTING A VEHICLE MILES TRAVELED TAX IN TEXAS

Recommendation 1 would require TTI to implement a pilot program in Texas similar to those in Oregon, Puget Sound, or the one being conducted by Iowa State to determine what steps would be necessary to switch from the current form of motor fuels taxation to a VMT tax in Texas. TTI is a state agency affiliated with Texas A&M University that conducts policy and planning research relating to all transportation modes. TTI has previously studied transportation user-fees, including a VMT tax, and has already submitted a grant proposal to the Federal Highway Administration's Value Pricing Pilot Program for funding to carry out a pilot demonstration of a VMT tax.

Testing of the VMT tax in Texas should take into consideration both passenger vehicles and commercial trucks. Texas leads the nation in total highway vehicle miles traveled and truck volume in proportion to total vehicle miles traveled, so it is important that the effect of a VMT tax on trucking be carefully considered. If possible, the pilot should incorporate interstate trucks. Interstate truckers and passenger vehicles are taxed differently, and the effect of a VMT tax on this group should be examined. Additionally, interstate trucks regularly travel through all parts of the state which makes it easier to identify difficulties based on the varied geography of the state and could also be used to discern any potential issues arising by vehicles crossing state boundaries or the simultaneous use of a VMT tax system with the current motor fuels tax. The Comptroller of Public Accounts (CPA), which oversees collection of the state's motor fuels tax collections, should also be consulted during this study to ensure that issues with the state's tax collection system will be appropriately considered and addressed.

Recommendation 1 could be implemented by including a rider in Article III of the 2010–11 General Appropriations Bill. The rider would require TTI to implement a pilot program and would be contingent upon receipt of a grant from the Federal Highway Administration. The pilot would consider the impact of a VMT tax on commercial trucks traveling in Texas and include input from CPA regarding the way in which the state's tax collection system would be affected by a transition to and implementation of a VMT tax.

Recommendation 2 requires the Texas Department of Transportation (TxDOT) to provide funds to TTI contingent upon TTI's receipt of a federal grant to conduct a pilot program testing a VMT tax. Upon receipt of a grant from FHA, the state would be required to contribute a 20 percent match. This match would cost approximately $500,000 to $600,000. TTI received more than $22 million in interagency contracts during both fiscal years 2008 and 2009, the majority of which were interagency contracts with TxDOT. Therefore, it is assumed that TxDOT could provide matching funds by using presently available resources.

FISCAL IMPACT OF THE RECOMMENDATIONS

There would be administrative and operational costs associated with implementing the pilot. TTI has already absorbed the cost of designing the pilot study and applying to FHA for a grant to carry out the proposed pilot. The pilot proposal developed by TTI estimates that the total cost of executing the pilot will be approximately $2.5 million to $3.0 million, with $500,000 to $600,000 in matching state funds.

The introduced 2010–11 General Appropriations Bill includes a rider implementing Recommendation 1. No changes to the introduced 2010–11 General Appropriations Bill have been made as a result of Recommendation 2.

RESTRUCTURE THE HIGHWAY MAINTENANCE FEE TO BETTER ALIGN IT WITH THE COST OF ROAD MAINTENANCE AND REPAIRS

Overweight vehicles cause more damage to Texas highways than passenger vehicles, but pay for a smaller share of the damage. According to the Comptroller of Public Accounts the cost of damage to the state highway system caused by overweight vehicles was $62.8 million in 1988. Adjusted for inflation, that is equivalent to $110 million in damage in 2007 to the Texas highway system.

The current highway maintenance fee that the state charges overweight vehicles was implemented in 1991 to offset the costs of additional damage that these vehicles create on roadways. Revenue from the highway maintenance fee is deposited into the State Highway Fund. The fee accounts only for the vehicle's weight and does not reflect the variability in each vehicle's highway use or distance it traveled. Vehicle weight and distance traveled are the two factors most closely associated with roadway damage caused by vehicles.

Restructuring the highway maintenance fee to account for weight and distance, and reevaluating the fee and adjusting it as necessary, would help make it more equitable and proportional to the damage created by overweight vehicles.

CONCERNS

- Texas lacks a process to ensure that permit fees for oversized/overweight vehicles are adjusted to reflect changes in the variables that influence road maintenance costs.
- The highway maintenance fee for overweight vehicles does not reflect the variability of each vehicle's actual highway use (distance traveled).

RECOMMENDATIONS

- **Recommendation 1:** Amend Section 623.007 of the Texas Transportation Code to require the Texas Department of Transportation to evaluate oversized/overweight permit fees including the highway maintenance fee and report to the Legislative Budget Board by October 1 of each even year of the biennium on recommended oversized/overweight permit fee adjustments.
- **Recommendation 2:** Amend Section 623.077 of the Texas Transportation Code to require the Texas Department of Transportation to restructure the highway maintenance fee assessed to overweight vehicles so that it reflects weight and distance traveled.

DISCUSSION

In Texas, an oversized and overweight (OS/OW) vehicle is defined as a vehicle with a gross load that exceeds the statutorily defined maximum legal width, height, length, or weight. Maximum legal limits are shown in **Figure 263**.

FIGURE 263
DEFINING OVERSIZED AND OVERWEIGHT VEHICLES
FISCAL YEAR 2008

MEASUREMENT	MAXIMUM LEGAL LIMIT
Width	8.5 feet
Height	14 feet
Length	65 feet
Weight	80,000 pounds

SOURCE: Texas Department of Transportation.

According to the Arizona Department of Transportation, highway infrastructure protection has been the primary consideration in determining truck size and weight limits.

Legal axle weight is also considered when defining OS/OW vehicle status. The maximum legal axle weight cannot exceed 20,000 pounds for a single axle, 34,000 pounds for a tandem axle, and 42,000 pounds for a triple axle.

There has been an increase in OS/OW vehicle travel on Texas roads and highways as reflected in the increased demand for OS/OW vehicle permits. According to the Texas Department of Transportation (TxDOT), the demand for OS/OW vehicle permits has grown by 25 percent in the last three fiscal years. By value, OS/OW vehicles transport 75 percent of manufactured goods and raw materials that move through Texas. A 2006 report by the Texas Senate Committee on Transportation and Homeland Security (SCTHS) found that Texas leads the nation in interstate highway miles traveled and also has the highest truck volume in the nation in proportion to total vehicles miles traveled. The increased operation of OS/OW vehicles on Texas roads results in increased road damage.

As cited in the SCTHS report to the Eightieth Legislature, 2007, a single 80,000-pound truck is equivalent to 9,200 passenger cars relative to pavement stress and road damage. Pavement damage is dependent on a number of factors including but not limited to:

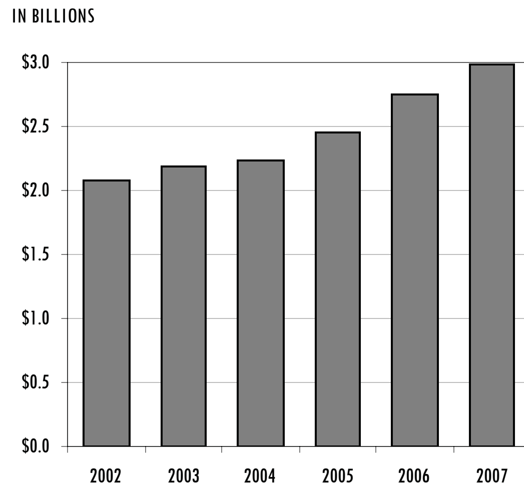
- vehicle weight;
- axle weight, the number of axle loadings, and the spacing within axle groups;
- traffic volume/ distance traveled;
- pavement condition, performance and structural capacity; and
- climate and environmental conditions.

According to the Comptroller of Public Accounts (CPA), vehicle weight and distance traveled are the two factors most closely associated with roadway damage caused by vehicles. A SCTHS report cited a 1988 study by the U.S. Department of Transportation's Federal Highway Administration that found that heavy trucks cause greater damage to roads compared to other vehicles, but pay for a smaller share of the costs required for repairing and maintaining U.S. roads.

Few studies quantify the relationship between vehicle weight and the cost of road damage or maintenance. Results from existing studies vary due to factors such as different environmental conditions and pavement structures. According to CPA, the Texas Transportation Institute estimated the amount of damage to the state highway system caused by overweight vehicles to be $62.8 million per year in 1988. Adjusted for inflation, that is the equivalent of $110 million in damage in 2007 without considering the increased number of OS/OW vehicles since 1988. A 2005 report completed by the Arizona Department of Transportation indicated that heavy vehicles account for about $170 million per year in planned state highway expenditures for Arizona.

The cost to maintain Texas roads has steadily increased due to inflation and rising material costs. **Figure 264** shows TxDOT expenditures for road maintenance from fiscal years 2002 to 2007.

FIGURE 264
TEXAS STATE HIGHWAY MAINTENANCE AND PRESERVATION EXPENDITURES, FISCAL YEARS 2002 TO 2007



Source: Texas Department of Transportation.

TEXAS' OVERSIZED AND OVERWEIGHT VEHICLE PERMITS

Prior to 1989, OS/OW vehicle travel on Texas state highways was regulated by both local and state government. Vehicles with a load that exceeded the maximum legal weight limit were prohibited from using certain roads and bridges.

In 1989, legislation enacted by the Seventy-first Legislature established a state permit that allowed vehicles carrying an overweight divisible load to operate at a percentage over the legal gross weight by obtaining a state permit. Permit fees were initially intended to offset the disproportionate amount of damage caused by OS/OW loads. There are now 25 different permits issued for the operation of OS/OW vehicles in Texas.

In fiscal year 2007, TxDOT issued over 554,000 OS/OW permits, which is a 6 percent increase from fiscal year 2006, and a 33 percent increase from fiscal year 2003. In 2007, $51 million was collected in OS/OW permit fees. Of the revenue generated from OS/OW permits, 61 percent was deposited to the General Revenue Fund and the remainder was deposited to the State Highway Fund.

Permit fees in Texas for OS/OW vehicles were increased by the Eightieth Legislature, 2007, with the enactment of House Bill 2093. The increase in permit fees was not intended to cover maintenance and repair costs but rather to support enforcement efforts against violators of motor vehicle size and weight laws and address administrative issues of untimely issuance of permits. This legislation changed the structure or increased the fees for various OS/OW permits and fees. **Figure 265** shows the changes that were made to various OS/OW permits as a result of House Bill 2093.

The 2007 legislation also specified the amount of revenue that should be deposited into the General Revenue Fund and the State Highway Fund for certain permits. An increase in staff was funded by House Bill 1 to improve OS/OW permitting. Prior to 2007, the permit fees for OS/OW vehicles had not been increased since 1991. This demonstrates that Texas lacks a process to ensure that OS/OW vehicle permit fees are adjusted to reflect changes in the variables

FIGURE 265
CHANGES MADE TO OVERSIZED/OVERWEIGHT PERMITS AND FEES PER HOUSE BILL 2093 EFFECTIVE SEPTEMBER 2008

PERMIT/FEE TYPE	CHANGES MADE TO PERMIT/FEE AS A RESULT OF HB 2093
Weight Tolerance Permit	The structure and variable fees (dependent on the number of counties a vehicle operates in) were changed. The range of variable fees changed to $175–$2000 from $125–$2000.
General Single-Trip Permit	The base fee was doubled to $60 from $30.
Highway Maintenance Fee	The range of fees was tripled to $150–$375 from $50–$125.
Multiple-day Permit	The range of fees was doubled to $120–240 from $60–$120.
Annual Permit–implement of husbandry	The fee increased to $270 from $135.
Annual permit–super-heavy or oversize equipment	The statutory cap on the fee increased to $7,000 from $3,500.
Manufactured and industrialized housing	The fee was doubled to $40 from $20.
Annual permit–manufactured homes	The maximum cap on the fee was increased to $3,000 from $1,500.
Portable building	The fee was doubled to $15 from $7.50.
Annual permit–to move unladen lift equipment	The fee was doubled to $100 from $50.

Source: Legislative Budget Board.

that influence road maintenance costs. To account for changes in the variables that affect highway maintenance costs, such as inflation and rising material costs, the highway maintenance fee and other permit fees for OS/OW vehicles should be evaluated on a regular basis. Recommendation 1 would amend Section 623 of the Texas Transportation Code to require TxDOT to evaluate oversized/overweight permit fees, including the highway maintenance fee, and make recommendations to the Legislative Budget Board by October 1 of each even year of the biennium regarding necessary permit fee adjustments.

TEXAS' GENERAL SINGLE-TRIP PERMIT AND THE HIGHWAY MAINTENANCE FEE

The most commonly issued permit for an OS/OW vehicle is the general single-trip permit. General single-trip permits are valid for one trip, from a specific point of origin to a specific destination. This permit is issued to interstate and intrastate traveling vehicles carrying loads that exceed either legal width, height, or length limits. Carriers must be registered by the TxDOT Motor Carrier Division or by the International Registration Plan (IRP) before obtaining a permit. According to the IRP website, the IRP is a registration reciprocity agreement among states of the United States, the District of Columbia and provinces of Canada providing for payment of apportioned fees on the basis of total distance operated in all jurisdictions. Certain types of vehicles, such as farm vehicles, are exempt from having to pay a permit fee since they do not have to register as a motor carrier. The general single-trip permit application can be submitted online, by telephone, by fax, or in person. Applicants must specify their origin and destination for travel on the application and the vehicle's number of axles, axle spacing, and axle weight. Weight and size measurements are typically verified when a vehicle is stopped and inspected by law enforcement, except in the case of vehicles with super-heavy loads. Vehicles with super-heavy loads have a gross weight over 254,301 pounds, or over 200,000 pounds with less than 95 feet of axle spacing. Either the Texas Department of Public Safety or an appropriate law enforcement agency verifies the weights of these vehicles before a permit is issued. Once an application is submitted, permit officers at the TxDOT Motor Carrier Division review the application for completeness and provide the safest, optimum route using the specified origin and destination of travel. The agency completes the routing process manually by using various tools including but not limited to map books, map software, and a database that contains an updated list of new roadways and structures. The Texas Permit Routing Optimization System (TxPROS) is an automated web-based tool that is now being developed and will capture the detailed route and mileage of every load routed. TxPROS is expected to be implemented by late 2009.

For the general single-trip permit, a base permit fee of $60 is administered and fees collected are deposited into the General Revenue Fund and the State Highway Fund. In fiscal year 2007, there were 351,559 general single-trip permits issued ($30 each), generating revenue of $10.5 million.

In addition to the $60 base fee, loads with a gross weight of 80,000 pounds or more must pay a highway maintenance fee. This fee was established in 1991 to assess an additional

charge in relationship to vehicle weight to offset the costs of additional damage to roadways. **Figure 266** shows the structure of the current highway maintenance fee for overweight vehicles.

FIGURE 266
HIGHWAY MAINTENANCE FEE FOR OVERWEIGHT VEHICLES, FISCAL YEAR 2008

GROSS WEIGHT IN POUNDS	HIGHWAY MAINTENANCE FEE	PERMIT FEE	TOTAL FEE
80,001 to 120,000	$150	$60	$210
120,001 to 160,000	$225	$60	$285
160,001 to 200,000	$300	$60	$360
200,001 and above*	$375	$60	$435

*In addition to the permit fee and highway maintenance fee, vehicles with super heavy loads must pay a vehicle supervision fee.
Source: Texas Department of Transportation.

In fiscal year 2007, TxDOT assessed 154,088 highway maintenance fees and collected $10.8 million in revenue. Revenue from the fee is deposited in the State Highway Fund.

OVERSIZED AND OVERWEIGHT HIGHWAY-USE FEES IN OTHER STATES

Other states also require vehicle owners or operators of OS/OW vehicles to purchase a permit to travel on state roads. Kentucky, New Mexico, New York, and Oregon assess a weight-distance tax for heavy vehicles. The weight at which a vehicle must pay the weight-distance tax varies in each state, but the tax is applied to heavier vehicles because they cause more damage to roads. In each state certain types of vehicles, such as farm vehicles, are exempt from having to pay a weight-distance tax.

The weight-distance tax is a type of highway user fee that increases with the weight of the vehicle and distance traveled. It is paid per mile of truck operation in each state and is used to pay for additional road maintenance. The amount assessed under the weight-mile tax is calculated by multiplying a weight-graduated tax rate by the number of miles a truck is driven in the state. Compared to a flat fee or a fee based solely on weight, the weight-distance tax more accurately reflects the cost of road wear. Oregon's weight-distance tax includes an axle incentive that offers tax reductions for vehicles with a gross weight of 80,000 pounds or greater that operate with more than the required number of axles for the weight they carry. According to the Oregon Department of Transportation, engineers nationwide agree that any effects on road wear and damage are mitigated by the number of axles employed by heavy trucks. **Figure 267** shows the details of the weight-distance tax in Kentucky, New Mexico, New York, and Oregon.

The states use revenue derived from the tax to pay for road construction, repairs, and maintenance. Motor carriers are required to report the distance traveled and pay the tax on either a monthly, quarterly, or annual basis in each state. Oregon offers motor carriers the option to report their miles-traveled electronically, and New Mexico is looking into electronic submission in the future.

FIGURE 267
SUMMARY OF THE WEIGHT-DISTANCE TAX IN OTHER STATES, FISCAL YEAR 2008

STATE	VEHICLES	ADMINISTRATION	VERIFICATION OF WEIGHT AND DISTANCE	OTHER ROAD USE FEES
Kentucky	Vehicles over 60,000 pounds	Mileage is reported quarterly electronically and by mail	NA	Registration fees, state fuel tax
New Mexico	Vehicles over 26,000 pounds	Mileage is reported quarterly on a tax return and is sent by mail	Occurs through law enforcement at port of entry and audits	Registration fees, state fuel tax
New York	Vehicles over 18,000 pounds	Mileage is reported quarterly on a tax return and is sent by mail	Occurs through law enforcement during roadside check points, and through audits	Registration fees, state fuel tax
Oregon	Vehicles over 26,000 pounds	Mileage is reported online, monthly, quarterly, or annually.	Occurs through motor carrier enforcement officers at weight stations and weigh-in motion systems, and through audits	Registration fee, vehicles that pay the weight-distance tax do not have to pay the state fuel tax.

Source: Legislative Budget Board.

RESTUCTURING THE TEXAS HIGHWAY MAINTENANCE FEE

The current structure of the highway maintenance fee for overweight vehicles in Texas does not reflect the variability of each vehicle's actual highway use (distance traveled). Recommendation 2 would amend Section 623.077 of the Texas Transportation Code to require TxDOT to restructure the highway maintenance fee assessed to overweight vehicles so that it reflects weight and distance traveled. The new rate structure would be established such that the revenue generated would be similar to projected revenue collections under the current fee structure.

The highway maintenance fee would be restructured so that the fee would increase with the weight of the vehicle and distance traveled. Under the current structure of the highway maintenance fee, a vehicle with a gross weight of 120,000 pounds traveling a distance of five miles pays the same amount that a vehicle of the same weight traveling a distance of 500 miles would pay. Restructuring the highway maintenance fee to include both weight and distance traveled would make the fee more equitable and proportional to road damage. **Figure 268** shows an example of the restructured highway maintenance fee for vehicles with a gross weight from 80,000 pounds to 120,000 pounds.

The rates in **Figure 268** are calculated to generate the same revenue realized from the fiscal year 2008 highway maintenance fee and are based on a random sample of vehicles that paid the fee in fiscal year 2007. The highway maintenance fee for each vehicle would be calculated by multiplying the rate based on the vehicle's weight category by the miles traveled. TxDOT would need to develop a methodology to establish rates per mile for all weight categories.

Vehicle owners or operators of vehicles with a gross weight of 80,000 pounds or greater that apply for the general single-trip permit would still pay the $60 base fee for the general single-trip permit and the highway maintenance fee in the same way that it is paid now. The general single-trip permit application could still be submitted online, by telephone, by fax, or in person, and applicants could still have to specify their origin and destination for travel. Permit officers at the TxDOT Motor Carrier Division would continue to review applications for completeness and provide the safest, optimum route, in addition to the estimated miles to be traveled based on the information provided in the application. As opposed to assessing a fee based solely on weight, the highway maintenance fee would be calculated based on the vehicle's gross weight and distance traveled. The implementation of TxPROS and existing tools would allow permit officers to track the number of miles traveled by vehicles that have to pay the highway maintenance fee, and there would be no change in enforcement.

FIGURE 268
RESTRUCTURED HIGHWAY MAINTENANCE FEE
FISCAL YEAR 2009

WEIGHT CATEGORY (POUNDS)	RATE PER MILE
80,000 to 82,000	0.3636
82,001 to 84,000	0.3727
84,001 to 86,000	0.3818
86,001 to 88,000	0.3909
88,001 to 90,000	0.4000
90,001 to 92,000	0.4091
92,001 to 94,000	0.4182
94,001 to 96,000	0.4273
96,001 to 98,000	0.4364
98,001 to 100,000	0.4455
100,001 to 102,000	0.4546
102,001 to 104,000	0.4637
104,001 to 106,000	0.4728
106,001 to 108,000	0.4819
108,001 to 110,000	0.4910
110,001 to 112,000	0.5001
112,001 to 114,000	0.5092
114,001 to 116,000	0.5183
116,001 to 118,000	0.5274
118,001 to 120,000	0.5365

SOURCE: Legislative Budget Board.

FISCAL IMPACT OF THE RECOMMENDATIONS

Implementing these recommendations would not result in a revenue gain for the 2010–11 biennium. Recommendation 2 would revise the rate structure for the highway maintenance fee so that it accounts for both weight and distance traveled. The per mile rates would be established such that the revenue generated would be similar to projected revenue collections under the current fee structure. The introduced 2010–11 General Appropriations Bill does not include any adjustments as a result of these recommendations.

STREAMLINING AND EVALUATING TUITION AND FEE EXEMPTION AND WAIVER PROGRAMS

For 80 years, the state of Texas has entitled numerous groups of students to pay reduced or, in some cases, no tuition and fees to attend its public institutions of higher education. In recent fiscal years, the state has foregone more than $250 million annually in tuition and fee revenue by discounting or eliminating charges to select categories of recipients—more than 150,000 a year on average (since 2005) across 57 different exemption and waiver programs. The $319 million discounted in fiscal year 2007 is significant when compared to the $435 million disbursed that same year in conventional state student financial aid, exceeding the amount awarded in Toward EXcellence And Success (TEXAS) Grants.

The lack of a consolidated statutory structure for these programs encourages proliferation, redundancy, under-utilization, and inefficient delivery of this type of student financial support, impeding the optimal achievement of their inherent purposes. Divergent statutory provisions for these programs are not adaptive to changes in educational trends and state and federal policy initiatives, leading to disparities and unintended consequences. Unlike conventional state student financial aid, these programs are unevaluated for access or financial need, unaccountable for performance, and unmonitored for growth, creating uncertainty as to whether legislative intent is fulfilled efficiently and effectively. Streamlining the exemption and waiver statutes by grouping programs into categories and adding uniform provisions and common general requirements would enhance the programs' efficiency. Program evaluation and performance measurement, student-level data collection and periodic reporting, and uniform administrative oversight would enable the Legislature to better gauge how well these discounts are functioning and determine whether any changes are necessary.

FACTS AND FINDINGS

- From fiscal year 2003 to fiscal year 2007, the value of exemptions and waivers increased at an average annual rate of 13 percent while state financial aid grew at an average annual rate of 9 percent. If these growth rates continue, the value of exemptions and waivers will equal the value of state financial aid by fiscal year 2015.
- The pertinent statutes for the state's 57 unreimbursed exemption and waiver programs are located in four different chapters of the Texas Education Code and the Texas Government Code. Most exemptions are listed individually in a single subchapter of the Education Code, and most waivers are spread throughout the residency statutes (one is a budgetary rider). In fiscal year 2007, seven programs were unused, 10 had fewer than 10 recipients, and one had been superseded. Twenty programs further academic purposes; two directly promote economic development; four recognize public service or promote public safety; 13 serve military personnel or veterans and their families; 10 foster interstate cooperation and international relations; and eight address special individual or familial circumstances.
- The statutes governing exemptions and waivers contain divergent provisions regarding eligibility, maintenance requirements, cumulative benefit values, and time frames and duration. Eighteen exemptions and/or waivers are optional at institutions' discretion; the rest are mandatory. The state directly reimburses institutions for four programs; thus, they are not administered as exemptions.
- The Texas Higher Education Coordinating Board has calculated performance measures for recipients of military waivers and the Hazlewood (veterans) exemptions. The lack of student-level data precludes comparable information for all other exemption and waiver programs benefiting more than 166,000 recipients and worth more than $283 million in fiscal year 2007. Although there is some overlap with conventional financial aid, most recipients' actual levels of financial need are unknown.
- At the institution level, one or more campus offices, but usually not student financial aid, administer and interpret exemption and waiver programs, statutes, and rules and develop their own forms and procedures. The Texas Higher Education Coordinating Board's website embeds consumer-oriented exemption and waiver information in the student financial aid pages

of its Internet website. The amount of information about exemptions and waivers, and the degree of accessibility to them, vary across institutions.

CONCERNS

- The lack of a statutory framework for tuition and fee exemption and waiver programs that has coherent organization or logical groupings perpetuates program proliferation and impedes the efficient and effective delivery of this type of student financial support.
- The statutes for tuition and fee exemption and waiver programs are not uniform, often do not use common terminology or definitions, and set few compliance standards. As a whole, they are not adaptable to changes in educational trends and state policy initiatives that may affect the benefits derived by recipients of exemptions and waivers, leading to disparities and unintended consequences.
- The performance of tuition and fee exemption and waiver programs is seldom measured, and no rigorous program evaluation or outcome analysis has been undertaken. The present level of scrutiny does not allow Texas legislators to identify, enhance, or emulate successful programs, nor will it support oversight of projected growth in the monetary value and utilization of exemptions and waivers.
- Data reporting/collection of tuition and fee exemption and waiver programs is inconsistent and not well defined. The lack of student-level data limits the state's ability to measure the performance of exemption and waiver programs or track recipient outcomes.
- The lack of student-level data in tuition and fee exemption and waiver programs regarding financial need hinders evaluation of the efficiency of state financial support to students.
- Tuition and fee exemption and waiver programs may be underutilized by eligible students due to the lack of access to consistent and comprehensive information or to ineffective decentralized administration on campuses. Program administration may be overly complicated by the lack of uniformity in the application, documentation, and awarding processes.

RECOMMENDATIONS

- **Recommendation 1:** Amend the statutes governing tuition and fee exemptions and waivers by repealing unused or superseded programs and consolidating related programs into several broad categories reflecting their purposes and/or target populations: academics, economic development, interstate cooperation and international relations, military, public service and safety, and special circumstances (physical disabilities, personal hardships, etc.).
- **Recommendation 2:** Amend statutory provisions of tuition and fee exemptions and waivers by adding uniform definitions and common general provisions on benefits and cumulative values, duration, qualifications for initial and ongoing eligibility, maintenance requirements, and desired outcomes, and by clarifying whether each program is optional or mandatory and directly reimbursed or unreimbursed.
- **Recommendation 3:** Amend Texas Education Code, Chapter 61, Subchapter C, to require the Texas Higher Education Coordinating Board to: (1) conduct annual program evaluations for tuition and fee exemption and waiver programs whose annual foregone revenue equals or exceeds $1 million; (2) measure performance (identifying proficiencies as well as deficiencies); (3) determine the impact on cost of attendance; and (4) report its findings to the appropriate entities by November 1 of even-numbered years. Amend Texas Education Code, Section 61.066, to require the agency to include exemptions and waivers among the student resources used to cover cost of attendance and reported in the biennial cost of attendance study.
- **Recommendation 4:** Include a contingency appropriation rider in the 2010–11 General Appropriations Bill authorizing 1.5 full-time-equivalent positions at the Texas Higher Education Coordinating Board to implement Recommendation 3. The rider would appropriate $225,000 in General Revenue Funds.
- **Recommendation 5:** Amend Texas Education Code, Chapter 61, Subchapter C, to require the Texas Higher Education Coordinating Board to collect student-level data for all tuition and fee exemption and waiver

recipients, as is currently done for recipients of state and federal student financial aid.

- **Recommendation 6:** Include a contingency appropriation rider in the 2010–11 General Appropriations Bill authorizing a 0.5 full-time-equivalent position at the Texas Higher Education Coordinating Board to implement Recommendation 5. The rider would appropriate $75,000 in General Revenue Funds.
- **Recommendation 7:** Amend Texas Education Code, Chapter 61, Subchapter C, to require the Texas Higher Education Coordinating Board to develop rules that require all exemption and/or waiver recipients to complete either the Free Application for Federal Student Aid or the ApplyTexas Application, as determined most appropriate by the agency, to enable evaluation of the efficiency of state financial support to students.
- **Recommendation 8:** Amend Texas Education Code, Chapter 61, Subchapter C, to grant the Texas Higher Education Coordinating Board rule-making authority over all tuition and fee exemption and waiver programs and require the agency to develop rules to streamline application and documentation for the awarding of exemptions and waivers and to maintain a central repository online of all tuition and fee exemption and waiver program information. Amend Texas Education Code, Chapter 54, Subchapter A, to require public institutions of higher education to designate ombudsmen or responsible campus offices to administer all tuition and fee exemption and waiver programs.

DISCUSSION

The Texas Legislature creates tuition and fee exemptions and waivers in statute. This authorized subsidization reduces recipients' bills through exemptions from tuition and most fees charged to Texas residents or through waivers of nonresident tuition and some fees charged to out-of-state students. It is up to students to learn whether they may be eligible for a program and seek an exemption or waiver when they apply for admission or subsequently register for classes.

Most exemption and waiver programs are implemented by Texas public colleges and universities. They process applications, determine eligibility, verify documentation, and adjust billing, often through more than one office (and not always the same office across campuses). Institutions also report data on usage levels and dollar values to the Texas Higher Education Coordinating Board (THECB), which administers a few programs.

These discounts have grown incrementally into 57 separate and uncoordinated programs. Most of the programs are mandated by the state, but some are discretionary. The discounts are not directly reimbursed to colleges and universities, which replace the lost revenue from various sources (including a higher "sticker price" for tuition). Exemptions represent primarily institutional (non-state) funds, whereas waivers represent appropriations because they affect statutory tuition exclusively. These subsidies constitute an important form of student financial support, providing more than $319 million worth of assistance to more than 182,600 recipients in fiscal year 2007. Both of those totals exceeded those of Toward EXcellence And Success (TEXAS) Grants; exemptions and waivers' monetary value was more than 82 percent greater, and the number of recipients was almost three-and-one-half times larger.

Since the THECB's adoption in 2000 of *Closing the Gaps by 2015*—the statewide strategic plan for higher education—and the onset of tuition deregulation, few attempts have been made to reexamine tuition and fee exemptions and waivers holistically. In 2006, as mandated by legislation enacted by the Seventy-ninth Legislature, 2005, THECB issued *An Evaluation of Exemption and Waiver Programs in Texas*. This report made many valuable findings and viable recommendations, but none were implemented. However, the issues raised in the report remain valid, especially as they relate to the state's priorities of broader student access and greater success in the context of institutional accountability and educational affordability.

MONETARY VALUE OF EXEMPTIONS AND WAIVERS

As shown in **Figure 269**, the overall monetary value of waivers was more than double that of exemptions, although almost three times as many exemptions were granted as waivers.

In fiscal year 2007, exemptions and waivers represented a discount of approximately 8 percent of total tuition and fee charges billed to students before any adjustments were made. Exemption and waiver recipients comprised about 17 percent of all students enrolled at public colleges and universities.

When the $319 million in exemption/waiver discounts are included with the $435 million in conventional state student financial aid, they represent 42 percent of the resultant $754

FIGURE 269
TUITION/FEE CHARGES, COLLECTIONS, AND DISCOUNTS, AND EXEMPTION/WAIVER RECIPIENTS, FISCAL YEAR 2007

TUITION/FEES (IN MILLIONS)		STUDENTS/RECIPIENTS	
Charges (unadjusted gross)	$4,044.2	Total enrollment	1,101,174
		Non-exemption and waiver enrollment	918,526
Discounts (exemptions and waivers)	$319.1	Exemption and waiver recipients	182,648
Exemption discounts	$98.1	Exemption recipients	133,628
Waiver discounts	$221.0	Waiver recipients	49,020
Discounts (exemptions and waivers) as share of charges	8%	Exemption and waiver recipients as share of enrollment	17%

Source: Texas Higher Education Coordinating Board.

million in combined total assistance. From fiscal year 2003 to fiscal year 2007, the value of exemptions and waivers increased at an average annual rate of 13 percent while state financial aid grew at an average annual rate of 9 percent. If these growth rates continue, the value of exemptions and waivers will equal the value of state financial aid by fiscal year 2015.

NEED TO REFORM EXEMPTIONS AND WAIVERS

There are basic deficiencies in this virtually unevaluated yet burgeoning facet of Texas' student financial assistance system. Legislative Budget Board staff formulated six proposals to simplify and clarify the law, evaluate programs, measure performance, track outcomes, collect data, and improve accessibility and administration.

The statutory structure for exemption and waiver programs is unwieldy and lacks coherent organization or logical groupings. The relevant statutes are located in Texas Education Code, Chapters 54, 65, and 130 and Texas Government Code, Chapter 615. Most exemptions are listed individually in a single subchapter of the Education Code, but they are not arranged logically or organized coherently. Most waivers are embedded within the tuition rate statutes dealing with residency. One waiver is a rider in the Eightieth Legislature, General Appropriations Act, 2008–09 Biennium. In their current formats, the relevant portions of the codes are not easily accessible or conducive to amendment or enhancement. The statutes should clearly delineate exemptions and waivers in separate subchapters, use consistent terminology, and denote which ones are optional and reimbursed.

The current statutory structure perpetuates the proliferation of programs and furthers redundancy, inhibiting the determination of duplication across programs. In fiscal year 2007, seven programs were unused, three programs had fewer than 10 recipients, and one had been superseded. Twenty of them further academic purposes; 2 directly promote economic development; 10 foster interstate cooperation and international relations; 13 serve military personnel or veterans and their families; 4 recognize public service or promote public safety; and 8 address special individual circumstances (physical disabilities, personal hardships, etc.).

Clarifying the existing statutes would make them easier to revise or reform, interpret, and implement. Streamlining and consolidating would allow more discrete quantification and enable the Legislature to better monitor, regulate, and/or modify usage of exemptions and waivers, especially within broad categories. The current structure perpetuates a disorderly, inefficient, and ineffective delivery of this type of student financial support, impeding the achievement of legislative purposes.

Recommendation 1 would amend Texas Education Code, Chapter 54, Subchapters D and B, to streamline exemption and waiver programs by repealing unused or superseded programs, consolidating related programs, and reordering the statutes to reorganize programs into several broad categories reflecting their purposes and/or target populations: academics, economic development, interstate cooperation and international relations, military, public service and safety, and special circumstances (physical disabilities, personal hardships, etc.).

The statutes governing exemptions and waivers should include uniform provisions and be adaptable to changes in educational trends and state and federal policy initiatives, while avoiding disparities and unintended consequences. However, the statutes are not uniform, do not use common terminology or definitions, and set few compliance standards. They contain divergent provisions regarding eligibility, maintenance requirements, benefit values, and time frames and duration. Exemption and waiver programs often differ in how students qualify, when they may (and may no longer) enter programs, how they remain in programs, how much

they receive in discounts, and how long they may continue to benefit. **Figure 270** shows the largest and smallest exemption and waiver programs.

Of the exemptions granted during fiscal year 2007, about 75 percent of the monetary value and almost 84 percent of recipients were concentrated in only six programs. Three programs—high school/community college dual enrollment, Hazlewood (veterans), and the Texas Tomorrow Fund—accounted for more than half the monetary value. High school students dually enrolled in community college courses represented 41 percent of the recipients, while veterans and the Texas Tomorrow Fund each accounted for 7 percent of recipients.

Of the waivers granted during fiscal year 2007, approximately 82 percent of the monetary value and almost 79 percent of recipients were concentrated in only five programs. Almost one-third of the monetary value benefited teaching and research assistants, who also comprised the largest single category of recipients (almost double the next largest group, military).

Benefit values range from as low as one fee per term to as high as all tuition and fees for life, as long as the recipient is enrolled. Most are of unlimited duration. The cumulative value of the benefit to individual recipients within each program is unknown. As shown in **Figure 271**, the average annual value of an exemption was $734 per recipient, whereas the average annual value of a waiver was $4,509 per recipient.

The benefit values for individual exemption and waiver recipients vary considerably by type and institution. The higher average value of waivers compared to exemptions is most likely due to nonresident tuition rates being much higher than resident tuition rates. Similarly, four-year universities typically are more expensive than two-year community colleges. The cost of foregoing tuition/fee revenue may be expressed in terms of those students who do not receive exemption and waiver discounts. Based on 2007 enrollment, their share of this subsidization was $347 per capita in fiscal year 2007 (see **Figure 272**).

There is a high degree of variation in definitions and terminology across programs. The 38 target populations encompass valedictorians and competitive scholarship recipients, veterans and peace officer dependents, border state residents, and Mexican nationals. Initial eligibility requirements reflect narrowly focused efforts aimed at assisting specific groups, rather than a concerted effort to

FIGURE 270
TUITION/FEE EXEMPTION AND WAIVER PROGRAM USAGE, FISCAL YEAR 2007

EXEMPTIONS	VALUE (IN MILLIONS)	RECIPIENTS	WAIVERS	VALUE (IN MILLIONS)	RECIPIENTS
LARGEST					
High school/community college dual enrollment	$22.4	54,180	Teaching/research assistants	$72.9	14,886
Hazlewood (veterans)	19.6	9,096	Competitive scholarships (undergraduate academic)	40	6,961
Texas Tomorrow Fund contracts	12.9	9,537	Competitive scholarships (graduate academic)	37.3	6,690
Irrelevant fees	9.8	12,574	Military in Texas	16	7,385
Deaf/blind students	7.1	3,530	Mexican citizens	15.1	2,625
Concurrent enrollment/ Minimum tuition	5.4	10,849	Competitive scholarships (undergraduate non-academic)	9.4	1,767
SMALLEST					
National Guard (fees)	0.005	7	Nursing graduates	0.01	5
Prisoners of war	0.001	1	Radiology at MSU	0	0
Children of POWs/MIAs	0	0	Foreign Service officers	0	0
Tuition reduction	0	0	Public health	0	0
Prorated fees	0	0	Continuously enrolled military personnel	0	0
TOTAL	**$98**	**133,628**	**TOTAL**	**$221**	**49,020**

SOURCE: Texas Higher Education Coordinating Board.

FIGURE 271
AVERAGE ANNUAL EXEMPTION AND WAIVER BENEFIT PER RECIPIENT, FISCAL YEAR 2007

BENEFIT CATEGORY	VALUE
Combined overall	$1,747
Exemptions	$734
Universities	$1,237
Community colleges	$466
Waivers	$4,509
Universities	$5,461
Community colleges	$1,032

Source: Texas Higher Education Coordinating Board.

FIGURE 272
AVERAGE ANNUAL DISCOUNT VALUE PER NON-RECIPIENT, FISCAL YEAR 2007

Exemption and Waiver Tuition/Fee Discounts	$319.1 million
Non-recipient Enrollment	918,526
Per Capita Share	$347

Source: Texas Higher Education Coordinating Board.

help similarly situated individuals. Nine programs tie eligibility to enrollment either in a degree plan (five specify which ones) or for a certain number of semester credit hours. About a dozen have residency criteria, and five take financial need into account. Only four specifically require proof of eligibility, but colleges and universities typically require some type of documentation, according to THECB's 2006 evaluation report.

Compliance standards and maintenance requirements for ongoing eligibility also vary for exemption and waiver programs. Only two programs mandate continuous enrollment, satisfactory academic progress, or other standards. This lack of uniformity obscures whether recipients are making progress toward desired outcomes. To enhance student success, some programs could limit time to degrees and/or require degree awards. Student access and method of finance vary as well for programs. Eighteen exemptions and/or waivers are optional at institutions' discretion, while 39 are mandatory. Four programs are directly reimbursed by the state, while 57 are not. Campus administration is complicated by these differences.

Educational trends along with recent state policy initiatives such as *Closing the Gaps*, tuition deregulation, and residency reform may be affecting the relative value of benefits derived by exemption and waiver recipients. The lack of uniform provisions allows disparities and unintended consequences, which, if unaddressed, create inequities in relative benefit values. Survivors of various deceased public servants are entitled to room, board, and textbooks, for example, whereas dependents of disabled fire fighters and peace officers are not.

Few, if any, significant across-the-board policy changes or program enhancements to exemptions and waivers have been considered formally by the state in recent years, and the state lacks sufficient pertinent information to do so. Exemption and waiver programs generally are not adaptive to changes in educational trends and state policy initiatives and do not conform to *Closing the Gaps*. Moreover, some programs may be incongruent with other current state goals, policies, and priorities, or changes at the federal level. Moving tuition/fee exemption and waiver statutory provisions toward more uniformity would improve program efficiency and alignment with state higher education goals and policies while supporting the state's emphasis on accountability and outcome-based assistance.

Recommendation 2 would amend Texas Education Code, Chapters 54, 65, and 130, and Texas Government Code, Chapter 615, by adding uniform definitions and common general provisions on benefits and cumulative values, duration, qualifications for initial and ongoing eligibility, degree program enrollment, satisfactory academic progress, and desired outcomes. It also would clarify whether each program is optional or mandatory and directly reimbursed or not reimbursed.

PROGRAM EVALUATION AND REPORTING

In fiscal year 2007, 17 percent of all students enrolled in Texas public colleges and universities received at least one unreimbursed exemption or waiver. The number of recipients increased 92 percent from fiscal years 2001 to 2007, with exemptions growing more rapidly than waivers (166 percent to 9 percent, respectively). The most widely used programs could be categorized as serving academic purposes. Growth this decade in the number of exemption and waiver recipients and the value of tuition/fee discounts is outpacing growth in public college and university enrollment. Yet, the state is unable to fully monitor or adequately explain changes in exemption and waiver programs in terms of dollars discounted, students served, or benefit values per recipient. Evaluating and reporting on these entitlements using student-level data would provide essential insights into program dynamics and the factors influencing them, better gauge exemption and waiver impact, and alert lawmakers to the potential need for changes.

Individual benefit values also vary greatly by program, both for exemptions and waivers. Because of their relationships to tuition and fee amounts, exemptions and waivers are the only form of student financial assistance that mirror inflation. However, those providing the greatest values to individuals, on average, may not be those with the highest overall values or the most recipients, as shown in **Figure 273**.

The value and usage of exemption and waiver programs is growing, in some cases exponentially, especially exemptions (see **Figure 274**). Since fiscal year 2001, all but one of the 18 programs with the highest overall dollar values in fiscal year 2007 increased those values by at least double-digit percentages (12 by triple digits). While the number of recipients has not increased as dramatically (three programs declined, one was virtually unchanged), average individual values all rose. Nine programs more than doubled in overall value, and three more than doubled in recipients. Academic programs, particularly dual credit and the Texas Tomorrow Fund, and those addressing special circumstances increased both their dollar values and number of recipients.

On average, 41 percent of exemption programs and 75 percent of waiver programs provided recipients with at least $1,000 worth of annual benefits (discounts) in fiscal year 2007. The exemptions and waivers most beneficial monetarily to individual recipients, on average, are not necessarily those programs having the most recipients or the highest overall dollar values. Only two of the eight most individually beneficial exemptions and none of the five most individually beneficial waivers were among the most costly or widely used in fiscal year 2007. The average annual benefit value per exemption recipient ranged from $4,282 to $179 (calculated median value: $800). For waiver recipients, the range was $10,095 to $388 (calculated median value: $4,952). Teaching/research assistants were the largest single waiver program in terms of both overall value (almost $73 million) and number of recipients (almost 15,000). But TAs/RAs were in the mid-range of average benefit value per recipient at slightly less than $5,000. The top four programs were the biomedical M.D./Ph.D. scholars, Western Hemisphere nations ("Good Neighbor"), economic development, and The University of Texas System science and technology employees, each of which exceeded $8,700 per recipient.

Although some of these disparities may be explained by variations in tuition rates and fee amounts across degree programs and institutions or by student characteristics such as course loads and persistence rates, questions arise as to the role of internal factors, namely, the lack of uniformity in benefits and the parameters affecting them, or the way programs are administered. If the latter were the case, it could raise issues regarding unintended consequences, fairness, and legislative intent. The answers will not be forthcoming, however, without rigorous program evaluation.

THECB has calculated a few performance and outcome measures, such as enrollment and graduates, for the recipients of military waivers (7,385 granted in fiscal year 2007 worth more than $16 million) and the Hazlewood exemptions (more than 9,000 granted in fiscal year 2007 worth more than $19.6 million). However, comparable information is not available for more than 166,000 other exemptions and waivers granted in fiscal year 2007 and valued at approximately $283 million. THECB lacks student-level data to track inputs or explanatory and outcome variables, such as affordability, access, part-time enrollment, critical-shortage areas, transfers, grade-point average, persistence and graduation rates, *Closing the Gaps* targets, or their relationships to program costs. While the 2006 THECB report produced at the Legislature's direction provided a focused overview, no rigorous exemption and waiver program evaluation or trend analyses were mandated or undertaken. Although THECB occasionally conducts internal audits of the four reimbursed programs it oversees, it seldom evaluates their performance. Currently, the extent to which exemptions and waivers are producing desired results largely is unknown; consequently, the state is unable to ascertain the return on its investment.

Unlike financial aid paid directly or credited to students in sums certain applicable toward their college education, exemptions and waivers are discounts applied to students' charges that reduce certain portions of their bills. Financial

FIGURE 273
MOST INDIVIDUALLY BENEFICIAL PROGRAMS, FISCAL YEAR 2007

			OVERALL VALUE		RECIPIENTS	
TYPE	PROGRAM	AVERAGE VALUE PER RECIPIENT	DOLLARS	RANK	NUMBER	RANK
Exemption	Highest-ranking high school graduates	$4,282	$4.6 million	7	1,077	13
Waiver	Biomedical M.D./Ph.D. scholars	$10,095	$0.9 million	15	87	19

SOURCE: Texas Higher Education Coordinating Board.

FIGURE 274
CHANGES IN SELECTED EXEMPTION AND WAIVER PROGRAMS, FISCAL YEARS 2001 TO 2007

PROGRAM (MOST OVERALL $ DISCOUNTED, 2007)	VALUE (IN MILLIONS)			RECIPIENTS			AVERAGE VALUE PER RECIPIENT		
	2001	2007	PERCENTAGE CHANGE	2001	2007	PERCENTAGE CHANGE	2001	2007	PERCENTAGE CHANGE
EXEMPTIONS									
Dual High School/Junior College Enrollment	$4.2	$22.4	430	17,073	54,180	217	$248	$414	67
Hazlewood (veterans)	7.5	19.6	161	7,589	9,096	20	991	2,159	118
Texas Tomorrow Fund/Public University (program began 2004)	3.4	13.0	284	3,692	9,537	158	917	1,362	49
Deaf and Blind Students	2.6	7.1	175	2,365	3,530	49	1,096	2,016	84
Highest-ranking High School Scholars	1.8	4.6	158	967	1,077	11	1,850	4,282	131
Foster Care Students	0.5	3.4	523	478	1,689	253	1,133	1,996	76
Dual High School/College Enrollment (program began 2004)	0.4	3.3	676	2,541	4,615	82	169	722	327
TOTAL	**$16.7**	**$73.5**	**341**	**28,472**	**83,724**	**194**	**$6,404**	**$12,951**	**102**
WAIVERS									
TAs/RAs	$51.0	$72.9	43	14,809	14,886	1	$3,444	$4,895	42
Competitive Scholars (4 combined total)	47.7	86.9	82	10,517	15,466	47	4,533	5,620	24
Military in Texas	12.1	16.0	32	10,545	7,385	(30)	1,150	2,170	89
Mexican Citizens	9.1	15.1	67	1,746	2,625	50	5,199	5,767	11
Border Counties/Parishes	6.9	8.6	24	2,133	1,886	(12)	3,258	4,577	40
Border States	1.8	4.8	170	2,092	2,865	37	855	1,684	97
College Teachers/Professors, et al.	1.5	4.0	169	673	818	22	2,194	4,848	121
"100-mile" Schools	3.8	3.3	(14)	907	627	(31)	4,193	5,204	24
TOTAL	**$133.9**	**$211.7**	**58**	**43,422**	**46,558**	**7**	**$24,826**	**$34,765**	**40**

Source: Texas Higher Education Coordinating Board.

aid is based on need or merit, whereas exemptions and waivers benefit only select groups based on specific criteria. Furthermore, these criteria often are linked to conditions or trends unrelated to academics or, due to program variation, each other. Evaluating the major exemption and waiver programs would enable the state to connect the factors affecting usage of this assistance to what it is producing and determine its acceptability.

Inconsistent reporting, dissemination, and analysis of exemption and waiver usage and value data hinder the state's ability to periodically review and oversee these subsidies for any trends affecting their impact or utilization. Educational trends, such as more non-traditional students, along with tuition deregulation, continue to alter the higher education landscape. The state lacks sufficient information to gauge the impact of such trends, make causal determinations, or act decisively upon them. Currently, little if any critical trend analysis is performed. Most programs are of unlimited duration with no attendant progress measures or expected outcomes. The oldest program dates back to 1929; the most recent, 2005; and, not unlike many legislative sessions, changes were made to a few programs in 2007. Rigorous program evaluation using student-level data would better position the state to explain results in terms of educational trends and state and federal policy initiatives.

Legislators have a dearth of pertinent, updated reviews at their disposal if and when they wish to exercise oversight, make changes or improvements to existing programs, or

create new ones. Critical-needs fields, such as education (i.e., teaching), science, technology, engineering, and mathematics could be targeted, which could help boost national recognition and increase federal science and engineering research contracting (two *Closing the Gaps* goals). Program evaluation would enable THECB—or colleges and universities—to recommend ways to improve existing program parameters or to devise new ones, such as limits on benefits or tenure, disclosure of subsidy costs, other states' initiatives, and statutory updating.

Recommendation 3 would amend Texas Education Code, Chapter 61, Subchapter C, to require the Texas Higher Education Coordinating Board to: (1) conduct annual program evaluations for tuition and fee exemption and waiver programs whose annual foregone revenue equals or exceeds $1 million; (2) measure performance (identifying proficiencies as well as deficiencies); (3) determine the impact on cost of attendance; and (4) and report its findings to the appropriate entities by November 1 of even-numbered years. Program evaluation would allow growth comparisons to be made among the most costly and widely used programs as well as with such external factors as gross (unadjusted) tuition/fee charges, all conventional state student financial aid, and enrollment. **Figure 275** shows how such comparisons could be drawn at a high level using gross and combined total amounts. Doing so would bring exemptions and waivers into the calculus of the key components of meeting college costs and indicate to what extent the more significant trends in exemptions and waivers are attributable to them, and vice versa.

Also, Recommendation 3 would amend Texas Education Code, Section 61.066, to include exemptions and waivers in the resources used by students to cover college costs and reported in the biennial cost of attendance study. The military/veterans programs also should be re-examined in light of the enhanced educational benefits contained in the recently enacted GI bill.

Currently, no distribution mechanisms exist for exemption and waiver data. Some of these data are available in multiple THECB databases and reports, but no definitive documentation or dissemination is required upon collection, making monitoring and oversight problematic. Having THECB make such findings readily available in similar or greater detail (i.e., at the student level) in its annual student financial aid report should improve both the quality of data submitted by colleges and universities and its usefulness to legislators, stakeholders, and the general public.

The state is not in a position to identify patterns, monitor trends, or explain variations in benefit values or program

FIGURE 275
COMPARISONS OF TUITION/FEE DISCOUNTS; EXEMPTION AND WAIVER RECIPIENTS; ENROLLMENT; AND CONVENTIONAL STATE STUDENT FINANCIAL AID, FISCAL YEARS 2001 TO 2007 (IN MILLIONS)

	2001	2002	2003	2004	2005	2006	2007	PERCENTAGE CHANGE 2001–2007
TUITION/FEE DISCOUNTS (foregone revenue from exemptions and waivers)	$162.2	$174.2	$194.6	$221.3	$260.2	$298.6	$319.1	97
Exemptions	27.3	29.6	34.3	41.4	57.1	71.5	98.1	259
Waivers	134.9	144.7	160.3	179.9	203.1	227.0	221.0	64
Conventional State Student Financial Aid Disbursements	$186.4	$256.5	$309.6	$303.8	$325.8	$400.6	$435.3	134
STUDENTS								
Enrollment (public colleges and universities)	922,183	985,285	1,023,066	1,054,586	1,066,606	1,082,955	1,101,174	19
Exemption and Waiver Recipients	95,349	125,728	126,457	130,326	149,608	158,816	182,648	92
Exemptions	50,176	73,898	76,880	81,660	98,877	108,090	133,628	166
Waivers	45,173	51,830	49,577	48,666	50,731	50,726	49,020	9
Conventional State Financial Aid Recipients	76,538	119,967	135,984	132,004	124,254	133,087	128,056	67

Sources: Legislative Budget Board; Texas Higher Education Coordinating Board.

activity from year to year because it does not centrally administer the vast majority of exemption and waiver programs, nor are the data collected from the colleges and universities analyzed or interpreted. Currently, program data collection is inconsistent and not well defined. Data are submitted by the institutions to THECB annually (by the end of each December; three times a year for veterans programs) but from different offices on each campus and with varying degrees of accuracy. (There is no verification or cross-checking with the Financial Aid Database System, or FADS.). Some programs are not included—specifically, the four that are directly reimbursed by the state and function more like scholarships—so that they are not treated by THECB as exemptions. Some programs have been mis-categorized in colleges and universities' reports to THECB as "other."

This arrangement precludes identification of factors contributing to programs' productivity, or the lack thereof. Moreover, the state should be able to identify program cost drivers including, but not limited to, duplication of benefits, fees not required for enrollment, repeated/dropped courses, high-cost courses, time to degree, multiple degrees, and graduate semester credit hours. External factors, such as economic conditions and educational trends and policies, also should be examined for their possible effects on exemptions and waivers' relative benefit value to recipients. These determinations require more accurate, timely, and robust data than are being gathered at present.

The colleges and universities' missions, priorities, and constituencies vary such that they do not all emphasize or utilize the same programs equally. The lack of uniformity across programs obscures how well recipients are being served. Consequently, the extent to which these discounts benefit their target groups, and the state as a whole, largely is unknown. For example, THECB administers the exemption and waiver programs serving military personnel and veterans but is unsure how many are eligible and/or unserved. More than one-third of the state's highest ranking high school graduates do not receive the optional valedictorian exemption, which applies only to the first two semesters' tuition (and must be used within two years of graduation).

Recommendation 5 would amend Texas Education Code, Chapter 61, Subchapter C, to require the Texas Higher Education Coordinating Board to collect student-level data, including usage levels and benefit values, for all exemption and waiver recipients, as is currently done for recipients of state and federal student financial aid. Doing so would facilitate evaluation and measurement. Analyzing student-level data would enable the state to better evaluate whether the original legislative intent is being fulfilled and whether the incentives provided are sufficient to accomplish that intent. Student-level data would allow estimates of the percentage of eligible populations being served, including regional differences for optional programs. The state also could ascertain which academic programs or cohorts of students are taking advantage of these benefits over any given time period (see **Figure 276**).

The average values per recipient of the exemptions and waivers categorized as economic development and interstate cooperation/international relations are noticeably higher than most others and well above both the overall average and the waiver programs average. This is attributable to these two categories having relatively small numbers of recipients and no exemption programs. The programs in these two categories are aimed almost exclusively at nonresident students and their families. Waivers provide much greater individual benefits primarily because nonresident tuition is much more expensive than resident tuition.

It is important from an efficiency standpoint to quantify any duplication across programs as well as with conventional state student financial aid. In fiscal year 2007, almost 22,400 exemption and waiver recipients (12 percent) received some amount of conventional student financial aid (state or federal) in addition to $79.5 million in tuition/fee discounts. Only six unreimbursed programs are need-based, though recipients of some exemptions and waivers by design may be perceived as needy (several could be considered merit-based). Identifying the level of financial need across programs would provide a useful measurement of the programs' impact.

Recommendation 7 would amend Texas Education Code, Chapter 61, Subchapter C, to require the Texas Higher Education Coordinating Board to develop rules that require all exemption and/or waiver recipients to complete either the Free Application for Federal Student Aid (FAFSA) or the online ApplyTexas Application for the purpose of measuring the efficiency of state financial support to students. Specifically, all exemption and waiver recipients should be included in the FADS, with their respective benefit dollar values reported as discounts to the gross cost of attendance. It follows that a better understanding of exemption and waivers' fiscal functions would facilitate estimates of the impact upon tuition charged/collected from non-exemption and waiver students, which currently is not considered.

FIGURE 276
EXEMPTION AND WAIVER PROFILE BY PROPOSED CATEGORY, FISCAL YEAR 2007

PROPOSED CATEGORY	VALUE	PERCENTAGE OF TOTAL	RECIPIENTS	PERCENTAGE OF TOTAL	AVERAGE VALUE PER RECIPIENT
Academics	$231,136,781	72.4	146,594	80.3	$1,577
15 exemptions	65,577,655	20.6	114,455	62.7	573
11 waivers	165,559,126	51.8	32,139	17.6	5,151
Economic development	$1,681,586	0.5	189	0.1	$8,897
0 exemptions	0	0	0	0	0
2 waivers	1,681,586	0.5	189	0.1	8,897
Interstate cooperation/international relations	$37,504,147	11.8	8,848	4.8	$4,239
0 exemptions	0	0	0	0	0
10 waivers	37,504,147	11.8	8,848	4.8	4,239
Military	$35,686,540	11.2	16,506	9.0	$2,162
5 exemptions	19,658,134	6.2	9,121	4.9	2,155
3 waivers	16,028,406	5.0	7,385	4.0	2,170
Public service/safety	$746,237	0.2	355	0.2	$2,102
3 exemptions	746,237	0.2	355	0.2	2,102
0 waivers	0	0	0	0	0
Special circumstances	$12,352,036	3.9	10,156	5.6	$1,216
6 exemptions	12,088,324	3.8	9,697	5.3	1,247
2 waivers	263,712	0.1	459	0.25	575
TOTAL EXEMPTIONS AND WAIVERS (57)	**$319,107,326**		**182,648**		**$1,747**
29 exemptions	$98,070,350		133,628		$734
28 waivers	$221,036,976		49,020		$4,509

SOURCES: Legislative Budget Board; Texas Higher Education Coordinating Board.

PROGRAM ADMINISTRATION

THECB monitoring of exemption and waiver programs is dependent on the information it gathers from the colleges and universities, which administer the vast majority of programs, including 18 optional ones, with little if any scrutiny. Almost all of them are handled at the campus level (chiefly as a billing adjustment), but the responsible offices may vary across institutions or overlap within each school.

While exemptions and waivers reflect state policy, THECB is not tasked with their implementation, for the most part. The wide variety of exemptions and waivers produces a range of administrative tasks for colleges and universities that vary by institution and program. Enhancing data collection and requiring program evaluation should, in turn, yield recommendations for ways to improve the administrative process, including rule-making authority, awareness, outreach, effective decentralization, reporting, uniform application forms, proof of eligibility, deadlines, itemization of discounts on tuition/fee bills, and costs of administration compared to the benefits provided. Giving THECB rule-making authority would allow for much-needed administrative uniformity while retaining decentralization.

THECB maintains information about exemption and waiver programs on its Internet website, but the agency indicates that publicity by colleges and universities varies widely and is not likely to be consistent. THECB's website contains program-specific information about exemptions and waivers embedded within listings of other types of financial aid, but it is not comprehensive. Requiring all program information to be contained in a central repository online, to which all institutions would link to via the Internet, would make information available to potential recipients at their primary point of contact—the college or university campus. Including the repository's Internet link in IHEs' relevant admissions and registration materials would enhance the usefulness of this connection. It also would make the programs more "user friendly" to students, especially those who transfer or whose

circumstances, and, conceivably, program eligibility change during the course of their college careers.

Designating ombudsmen and/or consolidating offices into, or delegating responsibility to, a single campus office for administration of all exemption and waiver programs would facilitate recipients' usage of these varied and decentralized programs. It also might improve the reporting of usage and value data to THECB, which would enhance the state's ability to measure program performance.

Recommendation 8 would amend Texas Education Code, Chapter 61, Subchapter C, to grant THECB rule-making authority to simplify decentralized administration and enhance accountability. The agency also would be required to maintain a central repository online of all exemption and waiver program information and require colleges and universities to link to it via the Internet. Amendment of Texas Education Code, Chapter 54, Subchapter A, would require public institutions of higher education to designate ombudsmen or responsible campus offices to administer all tuition and fee exemption and waiver programs. THECB's 2006 evaluation report made similar recommendations.

FISCAL IMPACT OF THE RECOMMENDATIONS

Implementation of Recommendation 1 would be feasible within existing budgetary resources.

Implementation of Recommendation 2 would have no net fiscal impact over five years. Institutions of higher education initially would incur costs of adapting to new rules and transitioning to savings from efficiencies in the middle years, resulting in increased access to programs and attendant costs in the latter years.

Implementation of Recommendation 3 would cost $225,000 in General Revenue Funds for the 2010–11 biennium and would support 1.5 full-time-equivalent (FTE) positions above THECB's current staffing levels. Program evaluation on a regular basis would require additional THECB staff, contracting, or outsourcing.

To fund implementation of this recommendation, Recommendation 4 would include a contingency appropriation rider in the 2010–11 General Appropriations Bill that appropriates $225,000 in General Revenue Funds for the biennium and authorizes 1.5 FTE positions at THECB.

Implementation of Recommendation 5 would cost $75,000 in General Revenue Funds for the 2010–11 biennium and would support a 0.5 FTE position above THECB's current staffing levels. Data management would require additional THECB staff.

To fund implementation of this recommendation, Recommendation 6 would include a contingency appropriation rider in the 2010–11 General Appropriations Bill that appropriates $75,000 in General Revenue Funds for the biennium and authorizes a 0.5 FTE position at THECB.

Implementation of Recommendations 7 and 8 would be feasible within existing budgetary resources.

Figure 277 details these costs.

FIGURE 277
FIVE-YEAR FISCAL IMPACT OF RECOMMENDATIONS, FISCAL YEARS 2010 TO 2014

FISCAL YEAR	PROBABLE SAVINGS/ (COSTS) IN GENERAL REVENUE FUNDS	CHANGE IN FULL-TIME-EQUIVALENT POSITIONS COMPARED TO 2008–09 BIENNIUM
2010	($150,000)	2
2011	($150,000)	2
2012	($150,000)	2
2013	($150,000)	2
2014	($150,000)	2

SOURCE: Legislative Budget Board.

The introduced 2010–11 General Appropriations Bill does not address any of these recommendations.

IMPROVE FINANCIAL AID AWARD NOTIFICATION AT TEXAS PUBLIC INSTITUTIONS OF HIGHER EDUCATION

Students who apply for financial aid at an institution of higher education are issued an award notification detailing the aid that the institution proposes to offer them. Some elements of this aid are determined by set formula (e.g., Pell Grants) while others are awarded using institutional discretion (e.g., TEXAS Grant). The format and information conveyed in these notifications are under institutional control (with certain elements specified by federal regulations). There are no current state guidelines on how the notifications should be designed or delivered. A survey of financial aid officers of public institutions of higher education found disparate notifications that do not communicate all needed information to aid recipients. A clear and consistent presentation of financial aid awards would reduce confusion about the obligations parents and students agree to by accepting an aid package, improve their ability to plan for the expenses they may incur by attending an institution of higher education, and enable them to compare the value of one institution's package to another.

CONCERNS

- No Texas public institution of higher education reports all important financial aid data on financial aid notifications. The most frequently omitted information includes a differentiation between loans and grants, an estimate of tuition and fee charges, and a calculation of net need as determined by the institution. Without this information students and families cannot fully understand the scope of aid offered and have difficulties comparing aid packages offered by different institutions.
- Some institutions do not clearly communicate the next step to take after receiving a financial aid award—23 percent of financial aid notifications do not specify whether the institution is "opt-in" or "opt-out." By not clearly communicating the next step in the process, institutions may raise barriers to students in accepting time-sensitive aid.
- Institutions vary in the types of aid that are included in the financial aid award notification—40 percent of institutions exclude exemptions and waivers, 24 percent exclude work-study, and 18 percent exclude at least some scholarships. Students who attend a college or university that does not include all of these sources of aid will receive financial aid notifications that show a higher cost of attending the institution than the true cost they will face.
- Many financial aid officers express a desire to move to electronic financial aid notification. However, it is unclear that these changes will result in notifications that include all information needed by students and parents.

RECOMMENDATIONS

- **Recommendation 1:** Amend the Texas Education Code to require the Texas Higher Education Coordinating Board to develop a common financial aid notification and to require that all Texas public institutions of higher education use it for financial aid notification beginning with the 2011–12 academic year.
- **Recommendation 2:** Amend the Texas Education Code to require all public institutions to include all sources of financial aid in their financial aid notifications beginning with the 2011–12 academic year.
- **Recommendation 3:** Amend the Texas Education Code to require public institutions to provide an electronic version of the common financial aid notification to all students if they do not use a traditional letter for notification beginning with the 2011–12 academic year.

DISCUSSION

Students who attend institutions of higher education often apply for financial aid. This financial aid is delivered to students as either direct grants (which do not need to be repaid), tuition and fee waivers (which reduce the cost of attending an institution but are not a grant of money), or loans (which do need to be repaid). Financial aid is provided by the federal government (e.g., Pell Grants), the State of

Texas (e.g., TEXAS Grants), and the institution (e.g., academic scholarships).

Students who apply for financial aid at an institution of higher education are issued an award notification detailing the aid that the institution proposes to offer them. Some elements of this aid are determined by set formula (e.g., Pell Grants) while others are awarded using institutional discretion (e.g., TEXAS Grant). The information conveyed in these notifications, as well as the format used, is under institutional control (with certain elements specified by federal regulations). There are no state guidelines on how the notifications should be conducted.

The mixture of different categories of aid and sources of funds leads to a challenging communication problem between institutions and students. There is a maze of complex rules and regulations concerning how funds are awarded, what must be done to retain them, and what the terms of a specific award entail. Highlighting this regulatory information can result in notifications that are difficult to compare to notifications from other institutions, obscure award details that parents and students need for financial planning, and can confuse award recipients about the financial burden they will incur.

Legislative Budget Board staff examined financial aid award notification practices at Texas' public institutions of higher education in spring 2008. Financial aid directors were also asked to participate in a survey of attitudes on financial aid administration topics. Of the institutions surveyed, 90 percent provided a response. **Figure 278** shows this response by education sector (note that some community college districts report by campus).

ATTITUDES OF FINANCIAL AID ADMINISTRATORS

There is an inherent tension between the information that financial aid officers must transmit (by federal regulation) and the information parents want to know. **Figure 279** shows the attributes of award letters most frequently cited by financial aid officers.

The survey of financial aid officers shows that 46 percent (the highest number of responses) stated that understanding program requirements, conditions, and other regulatory details were important information for the letter to convey while 39 percent stated that the amount of the award was important. When asked about the information parents and students want to receive, 77 percent (also the highest number of responses) of the respondents stated that the amount of award was needed while 59 percent said the type of award was important. A fourth factor, simplicity of the award document, was also frequently cited as an important characteristic of award notifications, both from the financial aid officer and student perspectives.

FIGURE 278
SURVEY RESPONSE RATE AND STUDENT HEADCOUNT REPRESENTED, 2007 FALL HEADCOUNT

INSTITUTION	SURVEYED INSTITUTIONS	RESPONDING INSTITUTIONS	SURVEYED INSTITUTION HEADCOUNT (FALL 2007)	RESPONDING INSTITUTION HEADCOUNT (FALL 2007)
Four-year institutions	32	28 (88%)	497,195	460,619 (93%)
Two-year institutions	59	54 (92%)	587,244	526,531 (90%)
STATE TOTAL	**91**	**82 (90%)**	**1,084,439**	**987,150 (91%)**

NOTE: Response rate is for institutions that provided sample financial aid notifications.
SOURCES: Legislative Budget Board; Texas Higher Education Coordinating Board.

FIGURE 279
MOST FREQUENT ATTRIBUTES OF AWARD LETTERS CITED BY FINANCIAL AID OFFICERS, 2008

INSTITUTION N=SURVEY RESPONDENTS	FINANCIAL AID OFFICERS PRIORITIES		PARENT/STUDENT PRIORITIES, AS SEEN BY FINANCIAL AID OFFICERS	
Four-year institutions	Regulatory information	16 (55%)	Amount of award	23 (79%)
n=29	Amount of award	14 (48%)	Type of award	22 (76%)
	Simplicity of notification	11 (38%)	Cost to attend an institution of higher education	13 (45%)
Two-year institutions	Regulatory information	22 (42%)	Amount of award	40 (75%)
n=53	Amount of award	18 (34%)	Type of award	26 (49%)
	Type of award	16 (30%)	Simplicity of notification	10 (19%)
All institutions	Regulatory information	38 (46%)	Amount of award	63 (77%)
n=82	Amount of award	32 (39%)	Type of award	48 (59%)

NOTE: One community college did not include financial aid officer survey. One four-year institution provided a survey but no financial aid notifications.
SOURCE: Legislative Budget Board.

IMPROVE FINANCIAL AID NOTIFICATION CONTENT

The disparity between the information financial aid officers feel they have to provide and the information parents and students need (at least from the financial aid officer perspective) is reflected in the information that is contained in financial aid awards. While all the award letters examined contained federally mandated compliance information, few award letters included key data on several important affordability measures. This finding is particularly striking, given that the attitude survey indicated awareness of the overriding desire of parents and students to receive such information.

In addition to the survey on attitudes detailed above, financial aid officers were asked to supply a sample of actual financial aid notifications from the 2006–07 academic year. These notifications were examined to determine whether they contained five important pieces of information needed by students to judge the value and comprehensiveness of a given financial aid package:

- estimated tuition;
- Cost of Attendance;
- Expected Family Contribution;
- net need; and
- proportion of award composed of loans.

Figure 280 shows the percentage of financial aid notifications reviewed that did not provide each of these key pieces of information.

ESTIMATED TUITION

The parent or student needs information about the direct, out-of-pocket cost to attend class. Eighty-four percent of financial aid notifications did not include this information. Without estimated tuition, the student or parent lacks a clear picture of how much the direct cost to attend an institution of higher education will be and how well their proposed award addresses this cost. While estimated tuition may be available from other institutional sources, not including it on the financial aid letter obscures the link between aid and tuition.

COST OF ATTENDANCE, EXPECTED FAMILY CONTRIBUTION, AND NET NEED

A federal financial aid formula determines two important variables needed to calculate an award. Cost of Attendance (COA) considers many costs beyond simply tuition and fees involved in attending college (e.g., room and board). Expected Family Contribution (EFC) calculates how much a family must pay based on factors such as income, financial resources, and number of children attending an institution of higher education. Net need is the difference between COA and EFC and shows how much aid a family is eligible (but not guaranteed) to receive. Without these data, parents and students are unable to determine the value of an institution's proposed financial aid award. They are also unable to compare EFC and COA on the institution's financial aid notification to their Free Application for Federal Aid (FAFSA) response to ensure that the institution has correctly applied these data to their award package. Fifty-seven percent of financial aid notifications examined did not include COA, 66 percent did not include EFC, and 76 percent did not include net need.

PROPORTION OF AWARD FROM LOANS

Finally, students and parents need to know what proportion of an award is composed of loans (which need to be repaid) and what proportion is composed of grants, exemptions, or waivers (which function as gifts). Ninety-five percent of financial aid notifications did not clearly make this distinction. Many financial aid notifications mix in loan and grant amounts in a seemingly random fashion, while others truncate award names making identifying the type of award

FIGURE 280
KEY FINANCIAL AID INFORMATION NOT PROVIDED ON FINANCIAL AID NOTIFICATIONS, 2007 ACADEMIC YEAR

INSTITUTION (N=SURVEY RESPONDENTS)	ESTIMATED TUITION AND FEES	COST OF ATTENDANCE (COA)	EXPECTED FAMILY CONTRIBUTION (EFC)	NET NEED	PROPORTION COMPOSED OF LOANS
Four-year institutions n=28	20 (71%)	12 (43%)	15 (54%)	19 (68%)	27 (96%)
Two-year institutions n=54	49 (91%)	35 (65%)	39 (72%)	43 (80%)	51 (94%)
All institutions n=82	69 (84%)	47 (57%)	54 (66%)	62 (76%)	78 (95%)

Note: Not all public institutions of higher education award loans.
Source: Legislative Budget Board.

difficult. These practices obscure the actual cost to attend an institution of higher education.

IMPROVE STUDENT RESPONSES TO FINANCIAL AID NOTIFICATIONS

The analysis of financial aid notifications found that there is significant disparity in how institutions of higher education communicate to students the "next step to take" to accept an aid package. Federal law allows institutions to use either an "opt-in" (action is required on the part of the student to accept an award) or "opt-out" (awards are assumed to be accepted unless the student indicates otherwise) approach. Most institutions of higher education are explicit in directing students about the next action to take; however, some provide only limited instructions, and some have no instructions at all. By not clearly communicating the next step in the process, institutions may raise barriers to students in accepting time-sensitive aid. **Figure 281** shows the distribution of these practices.

Opt-in award acceptance is clearly the preferred practice among Texas' institutions of higher education, particularly four-year institutions. More troubling is that 23 percent of financial aid notifications examined do not include clear instructions. A financial aid notification should include an explicit and clear description of the requirements that an institution has set in place for a student to claim the awards detailed in the notification.

Recommendation 1 would amend the Texas Education Code by requiring the Texas Higher Education Coordinating Board to develop a common financial aid notification and to require that all Texas public institutions of higher education use it for financial aid notification beginning with the 2011–12 academic year. (Private institutions of higher education would be permitted but not required to use this common notification.) This notification should, at a minimum, include the following information in a clear, concise, and uniform manner, either by paper copy or online, on a single form suitable for printing:

- the student's Cost of Attendance, Expected Family Contribution, and net financial need;
- estimated tuition and fees and a comparison of this amount to all grants, exemptions, waivers, and scholarships awarded by the institution;
- a clear division of aid by gift aid (grants, exemptions, waivers, scholarships), work study, and loans; and
- an explicit statement of the institution's policy and timelines to claim or decline awards.

REPORT ALL TYPES OF FINANCIAL AID

Financial aid notifications in Texas are often limited in the types of financial aid that are reported. The most common types of aid that are not reported on financial aid award notifications are exemptions/waivers, work study, external scholarships, and institutional scholarships. **Figure 282** shows a summary of these reporting practices.

FIGURE 281
FINANCIAL AID ACCEPTANCE PROVISIONS, 2007 ACADEMIC YEAR

INSTITUTION (N=SURVEY RESPONDENTS)	OPT-IN	OPT-OUT	UNSPECIFIED
Four-year institutions n=28	22 (79%)	2 (7%)	4 (14%)
Two-year institutions n=54	28 (52%)	11 (20%)	15 (28%)
All institutions n=82	50 (61%)	13 (16%)	19 (23%)

Source: Legislative Budget Board.

FIGURE 282
SELECTED FINANCIAL AID CATEGORIES NOT REPORTED ON FINANCIAL AID NOTIFICATIONS, 2007 ACADEMIC YEAR

INSTITUTION (N=SURVEY RESPONDENTS)	EXEMPTIONS/ WAIVERS	WORK STUDY (TEXAS OR FEDERAL)	EXTERNAL SCHOLARSHIPS	INSTITUTIONAL SCHOLARSHIPS
Four-year institutions n=28	11 (39%)	4 (14%)	6 (21%)	3 (11%)
Two-year institutions n=54	22 (41%)	16 (30%)	9 (17%)	9 (17%)
All institutions n=82	33 (40%)	20 (24%)	15 (18%)	12 (15%)

Source: Legislative Budget Board.

The most common type of financial aid that is not reported on financial aid notifications is exemptions and waivers, which were not included on 40 percent of financial aid notifications surveyed. The reason for not including this information is related to an institutional division of responsibility between the financial aid office and the business office. Several institutions stated that not only is this information not included on the financial aid notification but also that it is the responsibility of the student to tell the financial aid office if an exemption or waiver is applied to their fee bill. Even institutions that do include exemptions or waivers on the financial aid notification do not refer to it in a consistent fashion. Sometimes it is a line item along with other aid types, sometimes it appears as an additional resource on a student budget calculation, and some institutions simply display it as a tuition reduction without explanation.

Work-study programs are also unreported on 24 percent of financial aid notifications. The most common reason cited for not including work-study is that limited funds for the programs make issuing these awards prior to matriculation difficult. In addition, some institutions of higher education distribute work-study funds through a job application process after students attend the institution.

Finally, a number of institutions do not report external scholarships they administer for the scholarship grantor (18 percent) or institutional scholarships offered by the institution of higher education (15 percent). As with exemptions and waivers, the reason is related to an institutional division of responsibilities between the scholarship office and the financial aid office.

Students who attend an institution of higher education that does not include all of these sources of aid will receive financial aid notifications that show a higher cost of attending the institution than the true cost they will face. Financial aid notifications should compile, in a single and concise manner, all of the aid that reduces the cost of attending an institution.

Recommendation 2 would amend the Texas Education Code requiring institutions to include all sources of aid (including grants, exemptions, waivers, scholarships, work-study, and loans awarded by the institution) in financial aid notifications, beginning with the 2011–12 academic year.

ELECTRONIC NOTIFICATION OF FINANCIAL AID

One developing theme discovered in the review of financial notification procedures is that institutions are moving to electronic methods of dissemination. **Figure 283** shows electronic notification efforts as of the 2006–07 academic year.

FIGURE 283
ELECTRONIC FINANCIAL AID AWARD NOTIFICATION, 2007 ACADEMIC YEAR

INSTITUTION (N=SURVEY RESPONDENTS)	ONLY ONLINE NOTIFICATION OF AWARDS
Four-year institutions n=28	8 (29%)
Two-year institutions n=54	10 (19%)
All institutions n=82	18 (22%)

Source: Legislative Budget Board.

Texas' institutions of higher education are in a period of transition concerning financial aid notifications. Twenty-two percent have shifted to an entirely electronic means of financial aid notification. A greater proportion of four-year institutions (29 percent) use entirely online award notifications than do two-year institutions (19 percent).

Many financial aid officers surveyed claimed that online notification of financial aid awards has the potential to reduce costs and improve the student experience through interactivity. Many also expressed a desire to shift to all-electronic systems in the future. A review of existing electronic notification systems shows that these systems vary more significantly than traditional paper notifications in the format and amount of information provided to students. As a result, electronic financial aid notification systems are likely to make comparison of awards from different institutions even more difficult in the future than it is today.

Recommendation 3 would amend the Texas Education Code requiring institutions to provide an electronic version of the common financial aid notification to all students if they do not use a traditional letter for notification, beginning with the 2011–12 academic year.

FISCAL IMPACT OF THE RECOMMENDATIONS

Institutions will bear some costs implementing Recommendation 1 because they will have to translate their institutional data systems to a format that can be transmitted using a common financial aid notification. These costs can be met through existing appropriations.

Institutions may also bear some costs in implementing Recommendation 2 since the communication procedures between offices at the institution of higher education may need to be modified. These costs can be met through existing appropriations.

Finally, institutions will bear little to no cost in implementing Recommendation 3 since any existing system designed to print letters to paper can be used to print electronic versions of the same letters.

The introduced 2010–11 General Appropriations Bill does not address the recommendations of this report.

UPDATE ON FEDERAL REIMBURSEMENTS TO STATE-OWNED TEACHING HOSPITALS

The state-owned teaching hospitals (The University of Texas Medical Branch at Galveston, The University of Texas M.D. Anderson Cancer Center, and The University of Texas Health Science Center at Tyler) have requested additional state funding to address the rising number of uninsured individuals, Medicaid and Medicare shortfalls, and increasing costs of medical services. The federal government allows each state to develop its own hospital reimbursement methodology and rates, subject to federal approval. This report examines the current federal reimbursement of hospital services to the three state-owned teaching hospitals.

FACTS AND FINDINGS

- Total uncompensated care, which combines charity care and bad debt, reported by the three state-owned teaching hospitals in fiscal year 2007 was $437.2 million ($266.5 million when adjusted for the ratio of cost-to-charges).
- In fiscal year 2007, charity charges at The University of Texas Medical Branch at Galveston decreased by 42 percent from fiscal year 2006, and charity charges at The University of Texas Health Science Center at Tyler have decreased by 57 percent from fiscal year 2006.
- Charity charges at The University of Texas M.D. Anderson Cancer Center have decreased every year since fiscal year 2004.
- Total contractual allowances (i.e., difference between the hospital's charges and the hospital's payments) for patients eligible for the Medicaid program and for the Children with Special Health Care Needs program, services provided under county indigent care contracts, and services provided under other state or local government programs reported by the three state-owned hospitals in fiscal year 2007 was $279.8 million ($168.5 million when adjusted for the ratio of cost-to-charges).
- The University of Texas Medical Branch at Galveston and The University of Texas M.D. Anderson Cancer Center's contractual allowances have increased between fiscal year 2006 and fiscal year 2007.
- The total Medicaid hospital payments to the three teaching hospitals increased from $85.8 million in fiscal year 2000 to $147.1 million in fiscal year 2006.
- In fiscal years 2008 and 2009, the three teaching hospitals will receive an increase of $31.3 million in Medicaid payments due to reimbursement changes.
- The Texas Health and Human Services Commission submitted an amendment to the state Medicaid plan to draw federal Medicaid Graduate Medical Education funds using intergovernmental transfers from the three state-owned hospitals. The Texas Health and Human Services Commission reported that a total of $67.6 million in estimated Graduate Medical Education reimbursements for the three state-owned teaching hospitals would become available retroactively for fiscal years 2008 and 2009.

DISCUSSION

A teaching hospital is characterized by its services, clinical education, and research. Services provided by a teaching hospital are more complex, specialized, and technologically progressive than services provided by a non-teaching hospital. Teaching hospitals serve as clinical education sites for undergraduate medical students and graduate medical students, as well as other health professional students. Most teaching hospitals have a mission to support clinical and health services research that will improve patient care. These are some of the features associated with major teaching hospitals:

- They have a large number of beds and admissions.
- They have a significant number of employees.
- They are usually owned by a non-profit organization or government entity.
- They are primarily located in urban areas.
- They provide complex patient care, education, and research operations.

There are 65 teaching hospitals in Texas. The state of Texas provides support to three of these teaching hospitals, which are components of The University of Texas System (UT

System). The teaching hospitals that receive General Revenue Funds are The University of Texas Medical Branch at Galveston (UTMB), The University of Texas M.D. Anderson Cancer Center (M.D. Anderson), and The University of Texas Health Science Center at Tyler (UTHSC-Tyler). **Figure 284** shows an overview of each of the three state-owned teaching hospitals. During fiscal year 2006, these teaching hospitals had more than 57,000 inpatient admissions and 1.8 million outpatient visits.

UTMB provides inpatient services to patients at six facilities (John Sealy Hospital, John Sealy Annex, R. Waverly Smith Pavilion, Children's Hospital, Rebecca Sealy Hospital, and the UTMB-Texas Department of Criminal Justice Hospital). There are 24 outpatient clinics in Galveston and surrounding communities where patients can also access healthcare and mental healthcare services. UTHSC-Tyler consists of 28 outpatient clinics, one emergency care center, and one acute care hospital. M.D. Anderson has two inpatient hospitals (the Albert B. and Margaret M. Alkek Hospital and the Lutheran Hospital Pavilion), four outpatient care clinics, five cancer treatment centers in surrounding communities, and one in Albuquerque, New Mexico.

STATE FUNDING TO TEXAS TEACHING HOSPITALS

There are several state funding streams supporting the three state-owned teaching hospitals: (1) Higher Education funding, (2) Correctional Care, (3) Tobacco funds, (4) Special Items, (5) Trauma and Emergency Services Funding, and (6) Multi-categorical Teaching Account funds.

HIGHER EDUCATION FUNDING

The three state-owned teaching hospitals are considered health-related institutions under the Texas system of public higher education. Appropriations to health-related institutions are similar to the appropriations for general academic institutions. There are funding formula and non-formula appropriations made directly to the institutions, as well as appropriations that benefit the institutions but are not included in the General Appropriations Act (GAA), such as the Available University Fund, certain staff benefits, funds trusteed at the Texas Higher Education Coordinating Board (THECB), and tobacco settlement funds.

Like other higher education institutions, the appropriations for health-related institutions are a lump sum, and funding strategies are presented for informational purposes in the GAA. The funding strategies in a health-related institution's bill pattern (within the GAA) represent how state funds are "allocated" but not how they must be spent. Also, a portion of the appropriation is estimated. This means that if, for example, patient income for an institution is above the amount included in the GAA, the institution can spend more than the amount listed in the GAA.

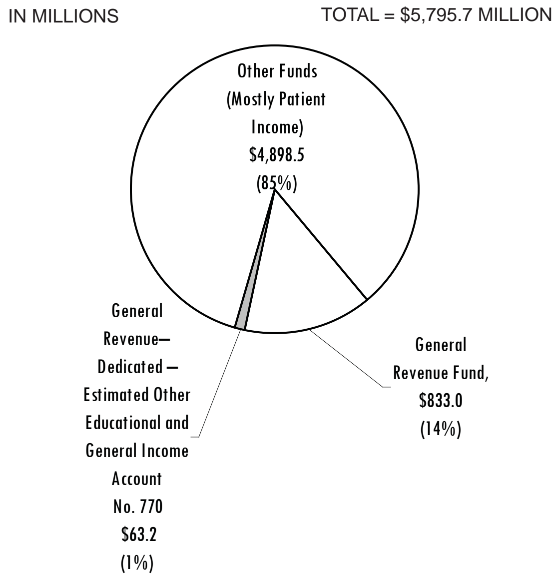
Figure 285 shows the 2008–09 biennium method of finance for $5.8 billion in appropriations for three teaching hospitals, but it does not include appropriations for retirement benefits. Of this amount, $896.2 million, or 15 percent, is in General Revenue Funds and General Revenue–Dedicated Funds. General Revenue–Dedicated Funds include income from tuition and student fees. The appropriations also include $4.9 billion in Other Funds, of which 99 percent is from patient income. Patient income is revenue that an institution generates through the operation of a hospital or a dental clinic (inpatient and outpatient charges). **Figure 286** shows the percentage change in state funding for each of the three teaching hospitals. General Revenue–Dedicated Funds decreased for each teaching hospital during the 2006–07 biennium mainly because of the exclusion of indirect cost recovery associated with research grants from the GAA. The

FIGURE 284
OVERVIEW OF STATE-OWNED TEACHING HOSPITALS
FISCAL YEAR 2007

TEACHING HOSPITAL	THE UNIVERSITY OF TEXAS HEALTH SCIENCE CENTER AT TYLER	THE UNIVERSITY OF TEXAS M.D. ANDERSON CANCER CENTER	THE UNIVERSITY OF TEXAS MEDICAL BRANCH AT GALVESTON
Type of Service	General medical and surgical	Cancer	General medical and surgical
Number of Staffed Beds	114	507	679
Number of Admissions	2,521	22,257	29,472
Inpatient Days	12,941	163,007	162,187
Average Length of Stay (Days)	5.1	7.3	5.5
Outpatient Visits	154,397	930,319	752,560

Source: Texas Department of State Health Services.

FIGURE 285
METHOD OF FINANCE FOR THREE STATE-OWNED TEACHING HOSPITALS, 2008–09 BIENNIUM



Source: Legislative Budget Board

teaching hospitals still receive these funds. Health-related institutions have access to funds outside the appropriations process. Examples of this include certain tuition revenue, grants, and gifts.

CORRECTIONAL CARE

UTMB provides a significant amount of healthcare to the Texas Department of Criminal Justice (TDCJ) state-managed offenders. In 1993, the Seventy-third Legislature established a Correctional Managed Health Care Advisory Committee and charged it with developing a managed healthcare delivery system to provide healthcare to TDCJ offender patients. This committee established a contract with UTMB and Texas Tech University Health Sciences Center to provide a full range of healthcare services, including psychiatry support, pharmacy services, AIDS care, and hospice care. These institutions provide the healthcare services for inmates at the TDCJ facilities and at the TDCJ hospital, which is located on the campus of UTMB. In fiscal year 2008, UTMB was allocated $322.6 million to provide healthcare and mental-health services to offender patients. The cost per inmate is estimated to be $6.65 and $6.82 per day for fiscal years 2008 and 2009, respectively. The Texas Youth Commission (TYC) contracts with UTMB to provide medical care for youths in its care. The medical cost per youth is estimated to be $17.30 and $17.82 per day for fiscal years 2008 and 2009, respectively.

TOBACCO FUNDS

The three teaching hospitals receive appropriations from interest earnings from endowments established in legislation

FIGURE 286
STATE APPROPRIATIONS CHANGES BETWEEN BIENNIA FOR THREE TEACHING HOSPITALS, 2000–01 TO 2008–09 BIENNIA

	PERCENTAGE CHANGE			
HOSPITAL	**2000–01 TO 2002–03**	**2002–03 TO 2004–05**	**2004–05 TO 2006–07**	**2006–07 TO 2008–09**
The University of Texas Health Center at Tyler				
General Revenue Fund	10.6%	(0.5%)	1.9%	5.6%
General Revenue–Dedicated	51.8%	35.1%	(488.7%)	3.9%
Health-Related Institutions Patient Income	33.2%	(6.4%)	(16.6%)	(1.8%)
The University of Texas Medical Branch at Galveston				
General Revenue Fund	0.7%	(2.4%)	5.1%	1.4%
General Revenue–Dedicated	25.6%	26.7%	(151.6%)	(21.4%)
Health-Related Institutions Patient Income	18.9%	15.2%	(2.3%)	10.3%
The University of Texas M.D. Anderson Cancer Center				
General Revenue Fund	(3.2%)	(0.9%)	7.0%	5.5%
General Revenue–Dedicated	25.8%	25.7%	(248.7%)	36.4%
Health-Related Institutions Patient Income	18.3%	24.5%	24.3%	19.7%

Source: Legislative Budget Board.

enacted by the Seventy-sixth Legislature, 1999. This legislation established the Permanent Health Fund for Higher Education and permanent endowments for each of the individual health-related institutions.

The Permanent Health Fund for Higher Education is a $350 million endowment from which distributions are appropriated for programs that benefit medical research, health education, or treatment programs at the nine public health-related institutions and at the Baylor College of Medicine. Appropriations from this fund are distributed to the nine public health-related institutions and at the Baylor College of Medicine—70 percent in equal amounts to each institution and 30 percent based on each institution's proportional expenditures on instruction, research, and charity care in the 2006–07 biennium.

The nine individual health-related institution endowments total $500 million, from which the estimated distributions are appropriated to the institutions based on the original endowment amount. Funds from the individual endowments may be used only for research and other programs that benefit public health. **Figure 287** shows the tobacco settlement endowments and related appropriations for the three teaching hospitals.

SPECIAL ITEMS

Special items are intended to represent a hospital's area of expertise or special need. These areas include public service, research, residency programs, instruction and operations, and healthcare. The following are examples of special items at the three teaching hospitals:

- support for indigent care at UTMB ($7 million) and UTHSC-Tyler ($2.6 million);
- research support for scientists at M.D. Anderson ($6 million);
- support for a Breast Cancer Research program at M.D. Anderson ($4 million); and
- funding for the Regional Emergency Medical Dispatch Resource Center Pilot Program at UTMB ($150,000).

Also included in special items is institutional enhancement funding, which allows each institution to address its unique needs and to ease diseconomies of scale at smaller institutions. Each health-related institution receives a minimum of $875,000 per fiscal year, except Texas A&M University System Health Science Center and Texas Tech University Health Sciences Center, which receive additional funding because these institutions operate multiple campuses.

TRAUMA AND EMERGENCY MEDICAL SERVICES

In 2003, legislation was enacted that established the Designated Trauma Facility and Emergency Medical Services Account (DTF/EMS). General Revenue–Dedicated Funds collected under this account support a portion of the uncompensated trauma care provided by eligible trauma facilities. Funds deposited to the designated trauma account come from two revenue sources: (1) the Driver Responsibility Program, which accesses surcharges for certain traffic violation convictions, and (2) a $30 state traffic fine relating to traffic offense convictions. Designated trauma facilities, county and regional emergency medical services (EMS), and trauma-care systems are eligible to receive DTF/EMS funds. After an initial $0.5 million is set aside for an extraordinary emergency reserve, the remaining funds in the DTF/EMS Account are distributed as follows: 96 percent to fund a portion of the uncompensated trauma care provided by designated trauma facilities and those facilities actively pursuing trauma designation; 2 percent to EMS providers; 1 percent to Regional Advisory Councils in the trauma

FIGURE 287
TOBACCO SETTLEMENT ENDOWMENTS AND PERMANENT FUNDS FOR STATE-OWNED TEACHING HOSPITALS, 2008–09 BIENNIUM

HOSPITAL	INSTITUTION/ PERMANENT FUND ENDOWMENT AMOUNT (IN MILLIONS)	2008–09 APPROPRIATION (IN MILLIONS)	PERMANENT HEALTH FUND AMOUNT 2008–09 APPROPRIATION (IN MILLIONS)
The University of Texas Medical Branch at Galveston	$25.0	$2.4	$3.4
The University of Texas M. D. Anderson Cancer Center	100.0	12.2	4.9
The University of Texas Health Center at Tyler	25.0	2.6	2.7
TOTAL	**$150.0**	**$17.2**	**$11.0**

SOURCE: Legislative Budget Board.

system; and 1 percent for administrative costs at the Texas Department of State Health Services (DSHS).

With stakeholder input, DSHS developed the following formula to distribute the DTF/EMS Account funds:

- 15 percent shared equally among all eligible applicants up to $50,000 each, and
- 85 percent based on a pro-rata share of total uncompensated trauma care reported by eligible hospitals.

According to DSHS, the total cost of the uncompensated trauma care provided in fiscal year 2008 by UTMB (the only eligible state-owned teaching hospital) was approximately $5.7 million. This amount of uncompensated trauma care was the basis for the distribution of $2 million in funding from the designated trauma account (see **Figure 288**) in fiscal year 2008. A total of $239.1 million has been distributed to eligible hospitals since the establishment of the DTF/EMS Account.

FIGURE 288
UNCOMPENSATED TRAUMA CARE DISTRIBUTIONS, FISCAL YEARS 2005 TO 2008

FISCAL YEAR	DTF/EMS FUNDS (IN MILLIONS)
2005	$1.8
2006	1.7
2007	1.0
2008	2.0
TOTAL	**$6.5**

SOURCE: Texas Department of State Health Services.

MULTI-CATEGORICAL TEACHING HOSPITAL ACCOUNT

The Seventy-sixth Legislature, 1999, first made unclaimed lottery prize money available for teaching hospitals and tertiary care facilities. The first $40 million in each biennium was appropriated to DSHS for reimbursement to UTMB through the Multi-categorical Teaching Hospital Account. The Seventy-eighth Legislature, 2003, reduced this amount to $20 million for the biennium. These funds assist UTMB in providing healthcare services to indigent patients. Reimbursements must not exceed 90 percent of the Medicaid fee-for-service rate at the time of service and may not cover patient co-payments. According to DSHS, the average monthly number of indigent clients served at UTMB in fiscal year 2008 was 6,254. **Figure 289** shows that the average monthly number of indigents served has been decreasing each year since fiscal year 2004.

FIGURE 289
INDIGENT HEALTHCARE REIMBURSEMENTS AT THE UNIVERSITY OF TEXAS MEDICAL BRANCH, FISCAL YEARS 2004 TO 2008

MEASURE	2004	2005	2006	2007	2008
Average Monthly Number of Indigents	8,438	8,101	7,209	6,530	6,254

SOURCE: Texas Department of State Health Services.

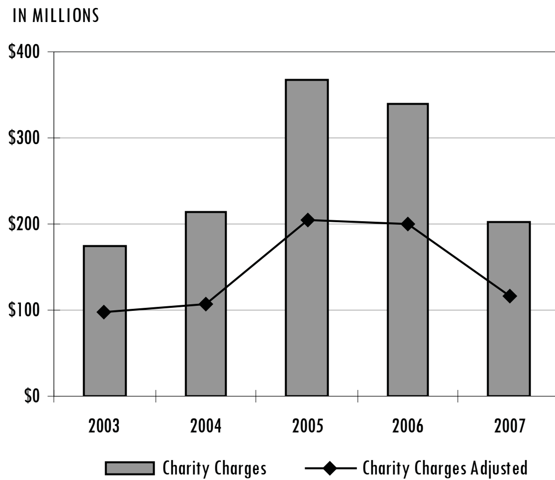
Beginning in the 2006–07 biennium, the Legislature restricted the use of Multi-categorical Teaching Hospital funds. These funds that are provided to UTMB may be used for indigent patients from Galveston, Brazoria, Harris, Montgomery, Fort Bend, and Jefferson counties only if those counties' County Indigent Health Care income eligibility levels or those counties' hospital district income eligibility levels exceed the statutory minimum set for the County Indigent Health Care Program.

AMOUNT OF CHARITY CARE

Texas state law requires DSHS to collect aggregate financial, utilization, and other data from all licensed hospitals. Through the 2007 Annual Survey of Hospitals, 508 acute care hospitals reported providing about $6.4 billion in charity care. Charity care refers to health services that are never expected to result in cash payments. The three state-owned teaching hospitals reported providing about $312.2 billion in charity care in 2007. A hospital's policy to provide healthcare services free of charge to individuals who meet certain financial criteria determines the extent of its charity care. Charity-care charges are usually adjusted to reflect the difference between what hospitals commonly charge and what they receive in negotiated or discounted payments. When adjusted for the ratio of cost-to-charges, the amount of uncompensated care reported by three state-owned hospitals is reduced to about $188.4 million. **Figures 290, 291, and** 292 compare the amounts of charity care charges reported and the charity care charges adjusted by the ratio of cost-to-charges for each of the three state-owned teaching hospitals from fiscal year 2003 to fiscal year 2007. UTMB and UTHSC-Tyler charity charges increased from fiscal years 2003 to 2005, and decreased in fiscal year 2006 and fiscal year 2007. M.D. Anderson's charity charges decreased each year since fiscal year 2004.

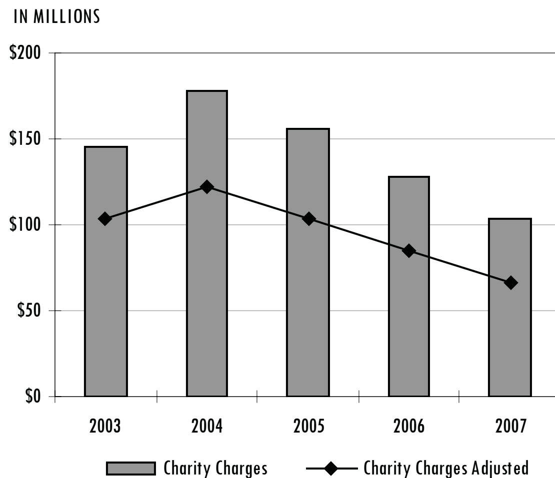
In addition to charity care, the three state-owned teaching hospitals reported $125 million in bad debt. When this amount is adjusted for the ratio of cost-to-charges, the figure is about $78.1 million. Bad debt charges are uncollectible hospital charges that result from the extension of credit.

FIGURE 290
THE UNIVERSITY OF TEXAS MEDICAL BRANCH AT GALVESTON CHARITY CARE CHARGES, FISCAL YEARS 2003 TO 2007



SOURCES: Legislative Budget Board; Texas Department of State Health Services.

FIGURE 291
THE UNIVERSITY OF TEXAS M.D. ANDERSON CANCER CENTER CHARITY CARE CHARGES, FISCAL YEARS 2003 TO 2007

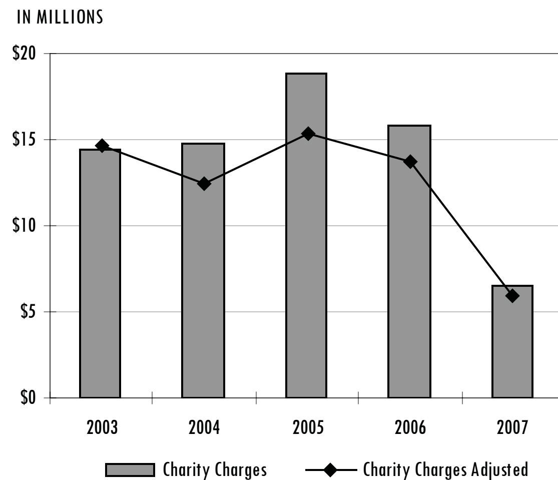


SOURCES: Legislative Budget Board; Texas Department of State Health Services.

Therefore, total uncompensated care, which combines charity care and bad debt, for the three state-owned teaching hospitals was reported to be about $266.5 million when adjusted for the ratio of cost-to-charges.

The three state-owned teaching hospitals, along with other health-related institutions, are required by the GAA to report the amount of unsponsored charity care provided through each institution's respective physician practice plan and

FIGURE 292
THE UNIVERSITY OF TEXAS HEALTH SCIENCE CENTER AT TYLER CHARITY CARE CHARGES, FISCAL YEARS 2003 TO 2007

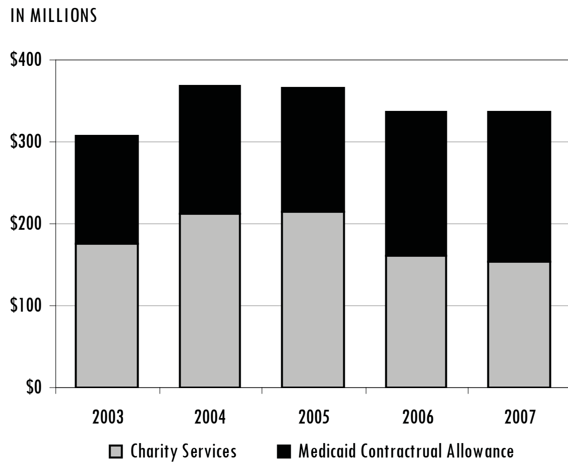


SOURCES: Legislative Budget Board; Texas Department of State Health Services.

hospital or clinic. Unsponsored charity care is defined by the GAA as services provided to financially indigent and medically indigent patients. Financially indigent includes the uninsured or underinsured patients accepted for care with no obligation or a discounted obligation to pay for services rendered based on a teaching hospital's eligibility system. Financially indigent services include both noncovered services and contractual allowances (i.e., the difference between the hospital's charges and the hospital's payments) for patients eligible for the Texas Medicaid Program and for the Children with Special Health Care Needs program, services provided under county indigent care contracts, and services provided under other state or local government programs tied to the federal poverty level. The GAA defines medically indigent as patients who are responsible for their living expenses, but whose healthcare bills, after payment of any applicable third-party payers, exceed (a) a specified percentage of the patient's annual gross income in accordance with a teaching hospital eligibility system, or (b) the financially indigent criteria as established by teaching hospitals.

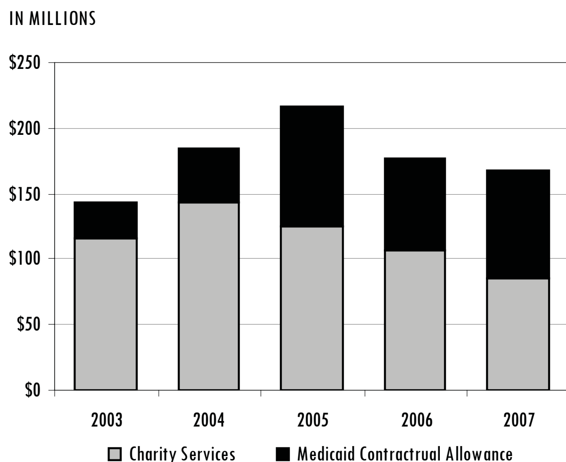
The amount of charity charges and contractual allowance reported by the three state-owned teaching hospitals for the fiscal years 2003 to 2007 are shown in **Figures 293, 294, and 295**. Each teaching hospital shows a decrease in unsponsored charity care over the last few years. UTMB's Medicaid contractual allowance increased during this period.

FIGURE 293
THE UNIVERSITY OF TEXAS MEDICAL BRANCH AT GALVESTON UNSPONSORED CHARITY CARE, FISCAL YEARS 2003 TO 2007



Sources: Legislative Budget Board; The University of Texas Medical Branch at Galveston.

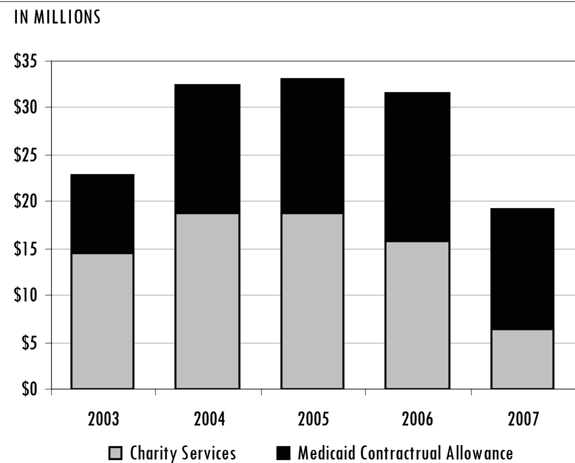
FIGURE 294
THE UNIVERSITY OF TEXAS M.D. ANDERSON CANCER CENTER UNSPONSORED CHARITY CARE, FISCAL YEARS 2003 TO 2007



Sources: Legislative Budget Board; The University of Texas M.D. Anderson Cancer Center.

According to The University of Texas System Strategic Plan 2006–2015, teaching hospitals were to limit the rate of growth of uncompensated care to no more than 3 percent per year by 2010. Health-related institutions were to address the growth of uncompensated care through the combination of (1) increasing core product lines to attract those who are insured, (2) mechanisms to decrease emergency room use and hospitalization for those who could be managed on an ambulatory basis, and (3) improving funding for the uninsured.

FIGURE 295
THE UNIVERSITY OF TEXAS HEALTH SCIENCE CENTER AT TYLER UNSPONSORED CHARITY CARE, FISCAL YEARS 2003 TO 2007



Sources: Legislative Budget Board; The University of Texas Health Science Center at Tyler.

FEDERAL REIMBURSEMENT

State-owned teaching hospitals receive federal reimbursement primarily from two programs: (1) Medicaid (inpatient, outpatient, Disproportionate Share Hospital, Upper Payment Limit, and Graduate Medical Education), and (2) Medicare (inpatient and outpatient). These hospitals also receive reimbursement for providing health benefits to active duty and retired uniformed services personnel and their families (TRICARE) and emergency services to undocumented persons (Section 1011).

TEXAS MEDICAID PROGRAM

The Texas Medicaid Program is a joint federal-state partnership for providing medical care to cash assistance recipients: Temporary Assistance for Needy Families, children, pregnant women, the elderly, and disabled persons. Inpatient hospital services are mandated Medicaid benefits (i.e., must be provided to all Medicaid-eligible clients). The three teaching hospitals, along with 448 general, acute care, and rehabilitation hospitals, 9 children's hospitals, 29 non-state-owned psychiatric hospitals, and 10 state-owned hospitals, participate in the Texas Medicaid Program. On average, every year there are about 500,000 admissions of Medicaid patients to these hospitals in Texas. Medicaid reimbursement for inpatient services is limited to $200,000 per client, per year (except for children).

The Texas Health and Human Services Commission (HHSC) is the designated state agency responsible for the Texas Medicaid Program and the final executive authority for its

oversight. HHSC contracts with Texas Medicaid & Healthcare Partnership (TMHP) to process claims submitted by hospitals and physicians participating in the Texas Medicaid Program.

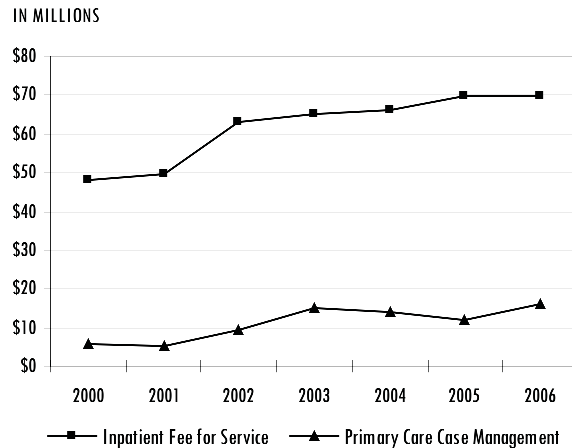
Federal law requires that a committee be established to advise the state Medicaid director about the program. The Medical Care Advisory Committee (MCAC) consists of consumer representatives, provider members, and three members that are designees of HHSC. The MCAC considers, observes, studies, and makes suggestions and recommendations concerning health and medical assistance issues and policies, the scope and utilization of services, payment methodology, quality of services, program changes, and cost containment initiatives.

The MCAC comments on any changes to hospital Medicaid payments that the Hospital Payment Advisory Committee (HPAC) suggests to HHSC. This committee is composed of hospital industry representatives, consumer representatives, and HHSC staff, and includes an MCAC representative to facilitate the exchange of information between both advisory committees. HPAC advises the state Medicaid director in developing and maintaining the inpatient hospital rate-setting methodology. In addition, HPAC comments and advises on necessary changes in payment methodologies for inpatient hospital prospective payments and on adjustments of the Disproportionate Share Hospital (DSH) program.

Since 1987, Texas has reimbursed most general, acute care hospitals for inpatient hospital services provided to clients not served through managed care (fee-for-services) through a prospective payment system. A prospective payment system bases payments for inpatient services on a patient's diagnosis before the provision of services. Calculating a hospital payment involves three elements: (1) the Diagnosis Related Group (DRG), (2) the DRG relative weight, and (3) the standard dollar amount. DRG relative weights are calculated by dividing the average of all paid claims for a given DRG in a base year by the average of payments for all DRGs in that same period.

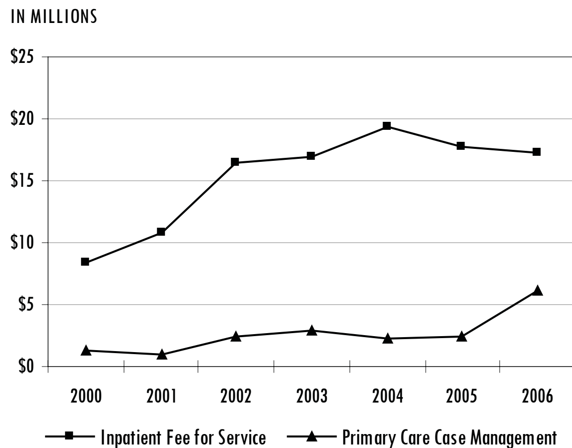
Hospitals receive payments based on services provided to clients enrolled in the Primary Care Case Management (PCCM) model. PCCM is a service delivery model under the Texas Medicaid Managed Care Program and is administered by TMHP. The PCCM Program operates under a state plan amendment for clients who reside in the 202 rural Texas counties. TMHP negotiates discounted rates for hospital services for all hospitals participating in PCCM provider networks. **Figures 296, 297, and 298** show the Medicaid payments made to each of the three state-owned hospitals for clients served through Medicaid fee-for-service inpatient and PCCM service delivery models.

FIGURE 296
THE UNIVERSITY OF TEXAS MEDICAL BRANCH AT GALVESTON MEDICAID PAYMENTS, FISCAL YEARS 2000 TO 2006



SOURCES: Legislative Budget Board; Texas Health and Human Services Commission.

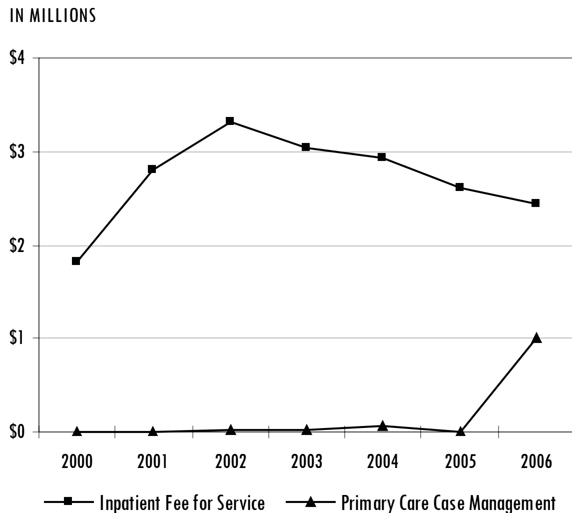
FIGURE 297
THE UNIVERSITY OF TEXAS M.D. ANDERSON CANCER CENTER MEDICAID PAYMENTS, FISCAL YEARS 2000 TO 2006



SOURCES: Legislative Budget Board; Texas Health and Human Services Commission.

Another form of payments hospitals receive from the Texas Medicaid Program is for services provided to clients in managed care. HHSC contracts with different Health Maintenance Organizations (HMOs) in the various regions of Texas; a client's county of residence determines which

FIGURE 298
THE UNIVERSITY OF TEXAS HEALTH SCIENCE CENTER AT TYLER, MEDICAID PAYMENTS, FISCAL YEARS 2000 TO 2006



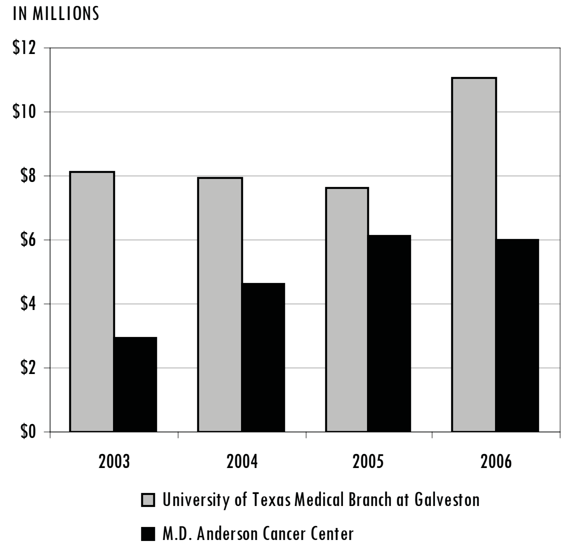
SOURCES: Legislative Budget Board; Texas Health and Human Services Commission.

HMOs are available for client participation. HMOs negotiate discounted rates for hospital services for all hospitals participating in the HMO provider network. **Figure 299** shows the Medicaid payments to UTMB and M.D. Anderson for inpatient and outpatient services provided to managed-care clients. UTHSC-Tyler has not served managed-care clients at the same rate as the two other state-owned teaching hospitals. For fiscal year 2006, Medicaid managed-care payments to UTHSC-Tyler totaled $4,253.

Another type of Medicaid payment hospitals receive is for clients that are eligible for both Medicare and Medicaid. The Texas Medicaid Program will pay for premiums, deductibles, and coinsurance for low-income Medicare beneficiaries who are called "dual eligibles." In fiscal year 2006, these crossover inpatient and outpatient claims made up less than 0.5 percent of UTMB's Medicaid total reimbursement. For the same period, M. D. Anderson's crossover claims were 2.2 percent of all the facility's Medicaid reimbursement. Crossover claims for UTHSC-Tyler were 5.2 percent of its total Medicaid reimbursements.

During the 2008–09 biennium, the three state-owned hospitals received an increase to their Medicaid fee-for-service inpatient payments. In fiscal year 2008, HHSC updated the base year used to calculate DRG relative weights for the three teaching hospitals. In fiscal year 2009, the three state-owned teaching hospitals will be reimbursed based on a retrospective cost-based reimbursement system (authorized

FIGURE 299
MEDICAID MANAGED-CARE PAYMENTS TO THE UNIVERSITY OF TEXAS MEDICAL BRANCH AT GALVESTON AND THE UNIVERSITY OF TEXAS M.D. ANDERSON CANCER CENTER, FISCAL YEARS 2003 TO 2006



SOURCES: Legislative Budget Board; Texas Health and Human Services Commission.

by the federal Tax Equity and Fiscal Responsibility Act). A retrospective system allows the three teaching hospitals to bill Medicaid for all the services provided to a particular patient. HHSC reimburses these hospitals with an interim rate payment for Medicaid inpatient services based on the historical relationship of costs compared to charges. At the end of the reporting cycle, HHSC completes an audit of costs and determines if additional reimbursements or recoupments will occur. **Figure 300** shows the estimated increase in funding for each of the three teaching hospitals

FIGURE 300
ESTIMATED FISCAL IMPACT OF REBASING AND COST-BASED REIMBURSEMENT TO STATE-OWNED TEACHING HOSPITALS, FISCAL YEARS 2008 TO 2009 (IN MILLIONS)

	2008	2009	INCREASED BIENNIAL FUNDING CHANGE
The University of Texas Health Science Center at Tyler	$0.5	$1.1	$1.6
The University of Texas M.D. Anderson Cancer Center	$1.7	$4.3	$6.0
The University of Texas Medical Branch at Galveston	$13.1	$10.6	$23.7

SOURCE: Texas Health and Human Services Commission.

for both reimbursement changes that occurred in the 2008–09 biennium.

OUTPATIENT HOSPITAL REIMBURSEMENT

Outpatient hospital services covered for Medicaid recipients (about 4 million encounters per year) consist of diagnostic, therapeutic, or rehabilitative services delivered in a licensed hospital setting. **Figure 301** shows the percentage of outpatient visits paid by Medicaid to M.D. Anderson and UTHSC-Tyler. Outpatient hospital reimbursement rates for non-managed-care areas are determined retrospectively using a cost-based system. An interim payment rate is used, subject to cost settlement at year-end. A discount factor is applied to each outpatient payment, and then the final rate is determined. High-volume Medicaid hospitals are paid at 84.5 percent of cost. All three teaching hospitals meet the definition of a high-volume Medicaid hospital (paid at least $200,000).

FIGURE 301
OUTPATIENT VISITS PAID BY MEDICAID, FISCAL YEARS 2005 TO 2007

	2005 PERCENTAGE OF ALL VISITS	2006 PERCENTAGE OF ALL VISITS	2007 PERCENTAGE OF ALL VISITS
The University of Texas M.D. Anderson Cancer Center	4%	3%	3%
The University of Texas Health Science Center-Tyler	14%	14%	15%
The University of Texas Medical Branch at Galveston	Not reported.		

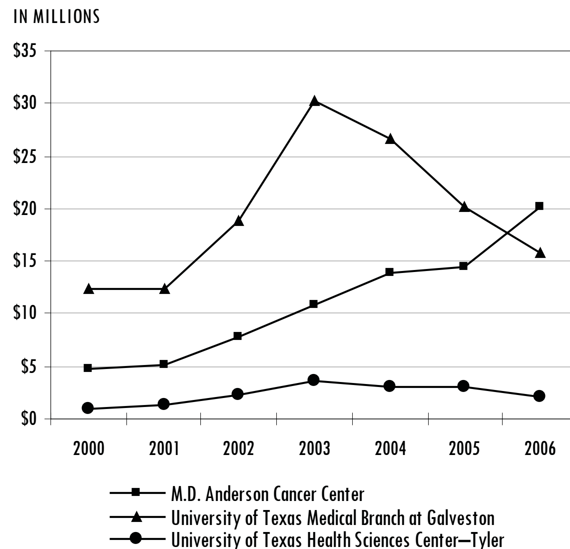
SOURCES: Legislative Budget Board; Texas Department of State Health Services.

Figure 302 shows the payments for outpatient services provided to Medicaid clients for fiscal years 2000 to 2006 for each of the three state-owned teaching hospitals. M.D. Anderson is the only teaching hospital that has seen an increase in payments for outpatient services provided to Medicaid clients.

DISPROPORTIONATE SHARE HOSPITAL PROGRAM

The Omnibus Budget Reconciliation Act of 1981 created the Disproportionate Share Hospital Program (DSH) to provide special Medicaid payments for hospitals that serve large numbers of Medicaid patients and uninsured patients.

FIGURE 302
MEDICAID PAYMENTS FOR OUTPATIENT SERVICES FOR THREE STATE-OWNED TEACHING HOSPITALS, FISCAL YEARS 2000 TO 2006



SOURCES: Legislative Budget Board; Texas Department of State Health Services.

Hospitals receive DSH payments to offset the costs not covered by payments from Medicaid, third-party reimbursement, and patient revenue collections. DSH payments are funded using the same matching rate as medical services (59.53 percent Federal Funds, 40.47 percent state funds in federal fiscal year 2009). Both the state-owned and non-state-owned DSH hospitals use intergovernmental transfers (IGTs) to supply the non-federal share of Medicaid funding. IGTs involve fund exchanges between different levels of government institutions. Appropriations made to state-owned hospitals are counted as match for the DSH Program. The hospitals include UTMB, M.D. Anderson, and UTHSC-Tyler, as well as 11 state-owned or state-funded mental health facilities.

States must also follow federal payment limits for DSH hospitals. Specifically, no DSH hospital can receive a DSH payment that exceeds its individual DSH payment limit. The DSH hospital payment limit is calculated by adding the sum of a hospital's Medicaid shortfall (the difference between the cost of Medicaid inpatient and outpatient services and the hospital's non-DSH Medicaid payments) to its costs of services to uninsured patients (adjusted for inflation). In Texas, a hospital's Medicaid shortfall is determined each year by its two-year prior cost report. For example, DSH payments for fiscal year 2008 were based on cost reports from fiscal year 2006.

State-owned facilities participating in the DSH program receive 100 percent of their adjusted hospital-specific limit. However, HHSC modified the DSH program to implement higher hospital-specific limits for the three state-owned teaching hospitals during the 2004–05 biennium. Federal legislation passed in 2000 extended to all states a special DSH provision that raised the hospital-specific cap for public hospitals to compensate them for Medicaid shortfalls and uncompensated care. For state fiscal years 2004 and 2005, the hospital-specific DSH cap for all state-owned hospitals was up to 175 percent of each state hospital's cost of uncompensated care. This provision was previously available only to California hospitals. The modification in Texas provided $127.8 million in additional federal DSH funds for state hospitals for the 2004–05 biennium. The federal provision that allowed states to increase the hospital-specific limit for public hospitals up to 175 percent of each hospital's cost of uncompensated care was authorized for only two years.

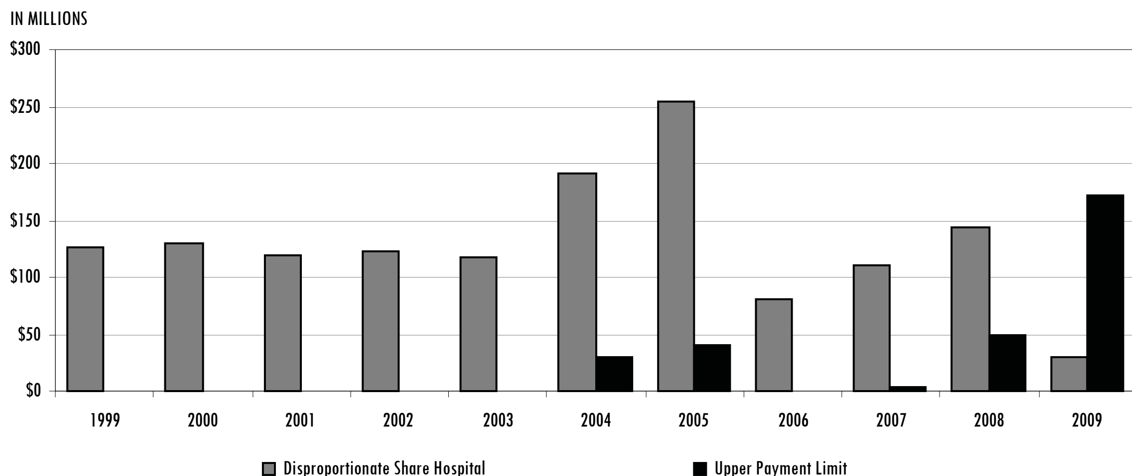
The state-owned hospitals participating in the DSH program transfer non-federal appropriated funds to HHSC in the amount of their DSH allocation. HHSC returns to the state-owned hospitals the same amount of funds in state and federal dollars. The remaining balance of transferred funds, which is equal to the amount of federal matching funds obtained, remains in the State Treasury as unappropriated General Revenue Funds. This amount is counted in the revenue estimate as a net increase. **Figure 303** shows deposits to General Revenue Funds generated by DSH transfers from the teaching hospitals from fiscal years 1999 to 2009.

As a result of the Medicare Modernization Act of 2003, the Centers for Medicare and Medicaid Services (CMS) issued proposed regulations in fiscal year 2005 that specify new reporting and auditing requirements for hospital-reported information that states use to make DSHP payments to hospitals. These regulations have not been finalized, but have significant implications for hospitals and states. For example, when the regulations are finalized and if there are no changes to the CMS proposal, states will have to verify the reduction of uncompensated care costs that reduce the total amount of claimed DSHP expenditures. In addition, the states must document and retain a record of all costs and claimed expenditures under the their Medicaid Program, as well as uninsured costs and payments used in determining the DSH payment adjustments.

UPPER PAYMENT LIMITS FOR MEDICAID

Federal Medicaid law offers states flexibility regarding payments to healthcare providers. However, Medicaid payments can be no higher than the amount Medicare would pay for the same service (referred to as the Upper Payment Limit (UPL) for Medicaid). Beginning in 2004, HHSC implemented supplemental payments to certain state-owned hospitals. The three state-owned teaching hospitals provide IGTs to draw down Federal Funds. For fiscal years 2004 and 2005, these state-owned hospitals provided $43.2 million in IGTs to match $69.1 million in Federal Funds. The Federal Funds allowed the state to save $69.1 million in General Revenue Funds. Supplemental payments to these hospitals will not save additional General Revenue Funds in the current biennium due to their effect on DSH payments. In

FIGURE 303
TEACHING HOSPITALS' DISPROPORTIONATE SHARE HOSPITAL PROGRAM AND UPPER PAYMENT LIMIT TRANSFERS TO GENERAL REVENUE FUNDS, FISCAL YEARS 1999 TO 2009



Sources: Legislative Budget Board; Texas Comptroller of Public Accounts.

the future, these supplemental payments will offset the loss of General Revenue Funds generated by DSH payments. A hospital's Medicaid shortfall must be reduced by any non-DSH Medicaid payments. UPL payments, like DSH payments, allow General Revenue Funds to be generated for the state. Figure 20 shows the General Revenue Funds generated by UPL transfers from the teaching hospitals.

MEDICAID GRADUATE MEDICAL EDUCATION

The Texas Medicaid Program allows states to receive matching Federal Funds for Graduate Medical Education (GME). GME payments provide additional Medicaid reimbursement to teaching hospitals for treating patients who have more complex conditions and to cover some of the costs of training residents. Until fiscal year 2004, appropriations of General Revenue Funds have been provided for the state share of GME funding. For the 2004–05 biennium, GME funding would be available to teaching hospitals only if additional unclaimed state lottery proceeds were generated in excess of what was estimated by the Texas Comptroller of Public Accounts in the 2004–05 Biennial Revenue Estimate. **Figure 304** shows that GME funds for the three state-owned teaching hospitals decreased from fiscal year 2003 to fiscal year 2005 (a loss of $4.9 million). UTMB's loss in GME payments accounted for a significant portion ($4.6 million) of this change from fiscal year 2003.

FIGURE 304
MEDICAID GRADUATE MEDICAL EDUCATION FUNDING FOR STATE-OWNED TEACHING HOSPITALS, FISCAL YEARS 2002 TO 2005 (IN MILLIONS)

	2002	2003	2004	2005
The University of Texas Medical Branch at Galveston	$10.6	$10.8	$0.0	$6.2
The University of Texas M.D. Anderson Cancer Center	0.5	0.7	0.0	0.4
The University of Texas Health Science Center at Tyler	0.3	0.2	0.0	0.2
TOTAL	**$11.4**	**$11.7**	**$0.0**	**$6.8**

NOTE: There were no Graduate Medical Education payments in fiscal year 2004.
SOURCE: Texas Health and Human Services Commission.

The Texas Legislature did not make unclaimed state lottery proceeds available for GME payments for the 2006–07 biennium, instead a rider in the General Appropriations Act was included to authorize HHSC to expend up to $80.9 million for the state portion of GME payments to teaching hospitals. However, this authority was contingent upon receipt of IGTs from public teaching hospitals to serve as the state share for Medicaid GME. HHSC reported that public teaching hospitals did not show interest in providing IGTs.

The Texas Legislature modified the rider in the 2008–09 biennium to authorize HHSC to use allowable funds from only state-owned teaching hospitals as the non-federal share for Medicaid GME. HHSC was directed to develop a payment methodology for Medicaid GME payments to ensure that state-owned teaching hospitals would receive GME payments. In September 2008, HHSC submitted an amendment to the state Medicaid plan to draw federal Medicaid GME payments retroactively for fiscal years 2008 and 2009. HHSC estimates that a total of $67.6 million in GME reimbursements to state-owned teaching hospital would become available based on fiscal year 2007 Medicaid cost report data. **Figure 305** shows the GME payments for each of the state-owned hospitals for fiscal years 2008 to 2009 if CMS approves the state plan amendment.

FIGURE 305
PROPOSED MEDICAID GRADUATE MEDICAL EDUCATION PAYMENTS TO STATE-OWNED TEACHING HOSPITALS, FISCAL YEARS 2008 TO 2009 (IN MILLIONS)

	2008	2009	INCREASED BIENNIAL FUNDING CHANGE
The University of Texas Health Science Center at Tyler	$0.6	$0.7	$1.3
The University of Texas M.D. Anderson Cancer Center	4.1	4.2	8.3
The University of Texas Medical Branch at Galveston	28.5	29.5	58.0
TOTAL	**$33.2**	**$33.4**	**$67.6**

SOURCE: Texas Health and Human Services Commission.

MEDICARE

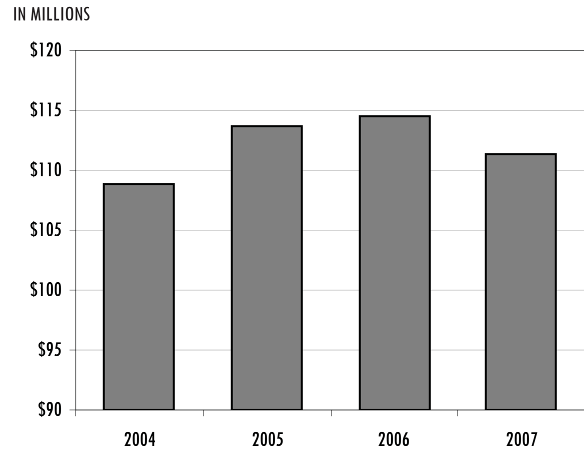
Teaching hospitals treat clients that are served by the federal Medicare program. Medicare is a health insurance program for people age 65 or older, people under age 65 with certain disabilities, and people of all ages with permanent kidney failure requiring dialysis or a kidney transplant. Medicare Part A helps cover inpatient care in hospitals, including critical access hospitals, and skilled nursing facilities (not custodial or long-term care). Medicare Part B helps cover doctors' services and outpatient care.

Inpatient hospital services are paid based on the Medicare prospective payment system (PPS). Under this reimbursement methodology, claims are paid a predetermined amount based on a patient's placement into a specific DRG and an additional amount, known as an outlier, for stays that have extraordinarily high costs. Patients that have similar clinical characteristics and similar costs are assigned to a DRG based on diagnosis, surgical procedures, age, and other information. The DRG is associated with a fixed payment amount based on the average cost for patients in the group. Medicare uses information provided in hospital bills to determine payment amounts. A hospital can receive a higher payment for any or all of the following reasons: (1) it is classified as a teaching hospital; (2) it treats a high percentage of low-income patients (disproportionate share); (3) it treats unusually expensive cases (outlier payments); and (4) it pays its employees more compared to the national average because the hospital is in a high-cost area (wage index).

M.D. Anderson is one of only 12 hospitals in the nation that requested and received a special exemption from the Medicare PPS system. This exemption allows M.D. Anderson to be paid by Medicare for inpatient treatment on a reasonable cost basis, subject to certain limitations, rather than under the PPS system. Medicare also reimburses for allowable capital costs at M.D. Anderson on a reasonable cost basis. **Figures 306, 307, and 308** show the payments for hospital services provided to Medicare clients for fiscal years 2004 to 2007 for each of the three state-owned teaching hospitals. M.D. Anderson is the only teaching hospital that has seen an increase in payments for inpatient services provided to Medicare clients.

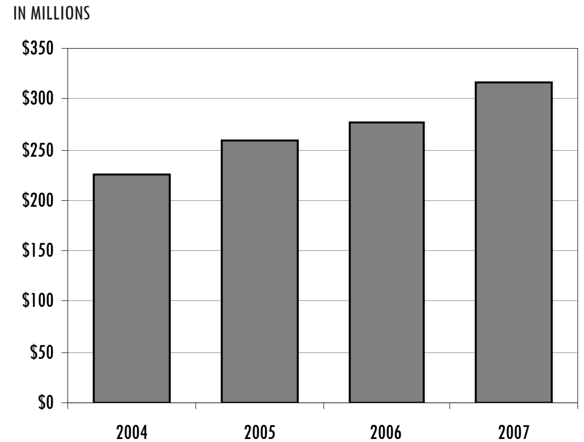
According to CMS, while many hospitals collect information on patient satisfaction, there is no national standard for collecting or publicly reporting this information that would enable valid comparisons to be made across all hospitals. The Consumer Assessment of Healthcare Providers and Systems (CAHPS) Hospital Survey is a standardized survey instrument and data collection methodology for measuring patients' perspectives of hospital care. CAHPS is a core set of questions hospitals currently collect to support internal customer service and quality-related activities. Voluntary collection of CAHPS data for public reporting began in October of 2006. The first public reporting of CAHPS results was in March 2008, which encompasses eligible discharges from October 2006 to June 2007. Beginning in July 2007, hospitals subject to PPS payment provisions collected and submitted CAHPS data to receive their full PPS annual payment update for

FIGURE 306
MEDICARE NET REVENUE FOR THE UNIVERSITY OF TEXAS MEDICAL BRANCH AT GALVESTON, FISCAL YEARS 2004 TO 2007



SOURCES: Legislative Budget Board; The University of Texas Medical Branch at Galveston.

FIGURE 307
MEDICARE NET REVENUE FOR THE UNIVERSITY OF TEXAS M.D. ANDERSON CANCER CENTER, FISCAL YEARS 2004 TO 2007

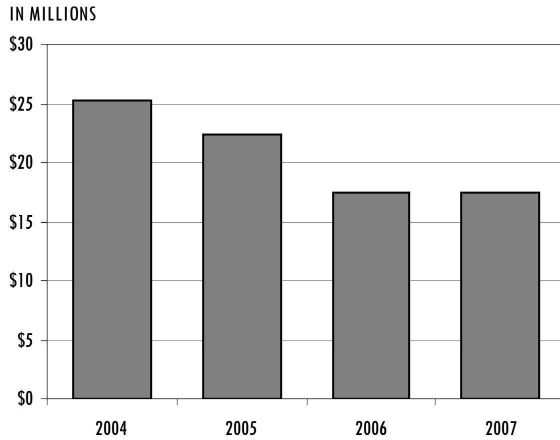


SOURCES: Legislative Budget Board; The University of Texas M.D. Anderson Cancer Center.

fiscal year 2008. Inpatient PPS hospitals that failed to report the required quality measures, which include the CAHPS survey, may receive an annual payment update that is reduced by two percentage points.

Outpatient hospital services are paid based on the number of times that the service or procedure being reported was performed. Hospitals are required to report claims for outpatient services using coding from the Healthcare Common Procedure Coding System. **Figure 309** shows UTHSC-Tyler and M.D. Anderson's percentage of outpatient visits paid by Medicare compared to the revenue paid by the

FIGURE 308
MEDICARE NET REVENUE FOR THE UNIVERSITY OF TEXAS HEALTH SCIENCE CENTER AT TYLER, FISCAL YEARS 2004 TO 2007



SOURCES: Legislative Budget Board; Texas Department of State Health Services.

FIGURE 309
OUTPATIENT VISITS PAID BY MEDICARE, FISCAL YEARS 2005 TO 2007

	2005 PERCENTAGE OF ALL VISITS	2006 PERCENTAGE OF ALL VISITS	2007 PERCENTAGE OF ALL VISITS
The University of Texas M.D. Anderson Cancer Center	29%	28%	29%
The University of Texas Health Science Center at Tyler	44%	45%	48%
The University of Texas Medical Branch at Gavelston		Not reported.	

SOURCES: Legislative Budget Board; Texas Department of State Health Services.

Medicare program. UTHSC-Tyler's Medicare revenue increased significantly from fiscal year 2004 to fiscal year 2005 (a gain of $12.7 million).

TRICARE PROGRAM

The three teaching hospitals also receive payments for clients served through the U.S. Department of Defense (DOD) TRICARE program. TRICARE provides health benefits to active duty and retired uniformed services personnel and their families. Several health plan options are offered to beneficiaries. **Figure 310** shows the gross patient revenue received by the three state-owned teaching hospitals for serving TRICARE clients in the fiscal years 2004 to 2006.

FIGURE 310
DEPARTMENT OF DEFENSE TRICARE GROSS PATIENT REVENUE FOR STATE-OWNED TEACHING HOSPITALS, FISCAL YEARS 2004 TO 2006 (IN MILLIONS)

	2004	2005	2006
The University of Texas Medical Branch at Galveston	$2.7	$2.3	$2.3
The University of Texas M.D. Anderson Cancer Center	$16.8	$17.4	$20.6
The University of Texas Health Science Center at Tyler	$0.8	$0.5	$1.3

SOURCES: Legislative Budget Board; Texas Department of State Health Services.

EMERGENCY HEALTH SERVICES TO UNDOCUMENTED PERSONS

The Social Security Act includes provisions that require Medicare-participating hospitals that offer emergency services to provide medical screening examinations, as well as necessary stabilizing treatment or appropriate transfer, to all individuals. These provisions (along with provisions that prohibit hospitals from delaying required medical screening or stabilizing treatment to determine patient's payment method or insurance status) were established in the Emergency Medical Treatment and Labor Act (EMTALA) passed in 1986 as part of the Consolidated Omnibus Budget Reconciliation Act of 1985. Congress enacted EMTALA because of the increasing number of reports that hospital emergency rooms were refusing to accept or treat individuals with emergency conditions if the individuals did not have insurance.

With the enactment of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA), Congress appropriated Federal Funds to reimburse health care providers that provide emergency services to undocumented immigrants and other specified immigrants. Under Section 1011 of the MMA, the federal government will distribute $250 million annually for fiscal years 2005 to 2008 directly to enrolled providers. Two-thirds of the total ($167 million) will be distributed to eligible providers in all states based on each state's share of undocumented immigrants. One-third of the total ($83 million) will be distributed in the six states with the highest number of undocumented immigrant apprehensions.

Section 1011 of the MMA, defines an eligible provider as a hospital, physician, or provider of ambulance services (including an Indian Health Service facility). Enrolled providers are required to seek reimbursement from all available funding sources before requesting Section 1011

funds. For fiscal year 2007, Texas' allocation was an estimated $47.3 million. Only UTMB applied to become an enrolled provider. **Figure 311** shows that from fiscal year 2005 to fiscal year 2007 UTMB received a total of $1.8 million in Section 1011 funding. Submitted claims, however, totaled 3,031 and were valued at $11 million. M.D. Anderson and UTHSC-Tyler reported that there was little benefit to applying for Section 1011 federal funds due to the small number of undocumented immigrants that receive emergency services at their facilities.

FIGURE 311
SECTION 1011 FEDERAL FUNDING PAYMENTS TO THE UNIVERSITY OF TEXAS MEDICAL BRANCH AT GALVESTON, FISCAL YEARS 2005 TO 2007

FISCAL YEAR	NUMBER OF CLAIMS SUBMITTED	VALUE OF APPROVED CLAIMS (IN MILLIONS)	NET SECTION 1011 PAYMENT
2005	478	$1.6	$0.4
2006	1,039	4.6	1.4
2007	1,465	5.6	1.1
TOTAL	**2,982**	**$11.8**	**$2.8**

NOTE: Fiscal year 2005 only includes two quarters.
SOURCES: Center for Medicare and Medicaid Services; Trailblazer, Health Enterprises Inc.

The 2007 Texas legislative session included various discussions regarding hospital reimbursement. HHSC submitted a Medicaid waiver proposal to CMS in April 2008. The waiver request includes the state's plan to expand health coverage options in the state, reduce reliance on expensive emergency room visits for basic care, and make it easier for the low-income individuals to buy into employer-sponsored coverage. The financing of the waiver includes the following:

- combining UPL and DSH funds into a low-income pool (Health Opportunity Pool) to be used to fund uncompensated care;
- stabilizing UPL funding to address the CMS proposals that would restrict the use of IGTs; and
- using Certified Public Expenditures as the basis for drawing Federal Funds for healthcare provided by public hospitals to the non-Medicaid medically indigent population.

It is not clear if the Texas waiver will be approved before the end of this federal current administration.

CENTRALIZE COLLEGE TEXTBOOK SELECTION TO REDUCE STUDENT COSTS

College textbook prices rose at twice the rate of inflation during the last two decades, averaging 6 percent per year. Nationally, yearly textbook costs for students at two-year public institutions represent up to 72 percent of total academic expenses, 26 percent at four-year public institutions, and 8 percent at private institutions. Average text expenses for a student attending college in Texas can exceed $1,000 per year. Texas students have limited opportunity to individually control their textbook expenses given the current structure of the college textbook market, and recent studies in California determined that rising textbook costs increase the probability students will forgo or delay attending college. Therefore, the Texas Higher Education Coordinating Board, with the assistance of public colleges and universities, should take steps to help minimize the cost of texts while maintaining the academic integrity of institutions of higher education.

CONCERNS

- Rising college textbook costs create a financial barrier for students already burdened by increases in tuition, fees, and campus housing. The additional costs are especially difficult for lower income students attending community college, where textbook costs represent up to 72 percent of academic expenses.
- Some professors and faculty selecting texts for use in their courses are unaware of the retail pricing and marketing practices of textbook publishers.

RECOMMENDATIONS

- **Recommendation 1:** Amend the Texas Education Code to implement an adoption process for higher education texts used in core curriculum courses, by establishing a textbook advisory council within the Texas Higher Education Coordinating Board. The council would be composed of representative tenured faculty members of both two-year and four-year public colleges and universities, supported by staffing resources from the Texas Higher Education Coordinating Board.
- **Recommendation 2:** Include a contingency rider in the 2010–11 General Appropriations Bill to fund a textbook advisory council and related administrative functions. The rider would appropriate $509,000 in General Revenue Funds to the Texas Higher Education Coordinating Board and increase the agency's full-time-equivalent position cap by four employees.
- **Recommendation 3:** Include a rider in the 2010–11 General Appropriations Bill that directs the Texas Higher Education Coordinating Board to prepare a report detailing the cost of college textbooks to Texas students and noting any material discrepancies between the reported price of texts at the time of selection and the final retail price.

DISCUSSION

From 1985 to 2005 national college textbook prices increased at twice the rate of inflation. Showing an average 6 percent increase during that period, textbook price increases followed a general trend in the rising cost of most components of higher education, including tuition, fees, and campus housing. In 2005, national textbooks costs, as a percentage of tuition and fees, represented 72 percent of total collegiate expenses at two-year public institutions, 26 percent at four-year public institutions, and 8 percent at four-year private institutions. This data from the U.S. Government Accountability Office (GAO) indicates community college students are bearing the greatest burden related to textbook costs, disproportionately affecting lower income populations.

The college textbook market is significant, with sales of more than $6.5 billion nationally during the 2005–06 academic year. While other college costs, such as tuition, have increased at a greater rate, textbooks can strain or exceed the remaining financial resources of students and their families because the expense comes last, often making it the final barrier to college. This is especially true for students attending community college who can see the low cost of tuition and fees doubled by textbook expenses. According to GAO, textbook purchases per student averaged $898 at four-year public colleges, and $886 at two-year public colleges, during the 2003–04 academic year. Given current market growth and price increases, today's yearly cost to students can easily approach $1,000.

Students attending Texas public colleges and universities can expect textbook expenses higher than these national averages. A 2008 case study performed by Legislative Budget Board staff suggests mid-level students entering pre-professional degree plans at Texas public colleges and universities can expect to spend between $545 and $604 on introductory texts per semester, when used book pricing is available. When used books are not available and only new books can be purchased, those prices rise to between $732 and $814. A larger survey sampling, conducted by the Texas Higher Education Coordinating Board (THECB) for the 2007–08 academic year, resulted in average statewide yearly textbook expenses per student of $1,052, or $526 per semester.

The price of a new college textbook reflects the expenses and profits of three primary contributors: the author, the publisher, and the retailer. On average, the author receives approximately $0.12 cents per dollar of a textbook's price to cover research and writing expenses. Publishers receive $0.59 cents per dollar to cover production expenses, such as paper, printing, editorial costs, marketing expenses, and taxes, and another $0.07 cents per dollar in after-tax profit. Retailers, college bookstores often owned by, or under the control of, the university, receive $0.18 cents per dollar for expenses, split between personnel expenses and storage overhead, and another $0.04 cents in pre-tax profit. For the average new textbook, priced at $53 during fall 2006, publishers received $3.71 profit, while retailers realized $2.33 in profit. With total U.S. market sales of $6.5 billion during the 2005 academic year, publishers realized $455.0 million in profit.

As reported by the U.S. Department of Education in 2004, textbook expenses for low-income students, those in the twenty-fifth percentile of family income, attending four-year public colleges consume 2.2 percent of total family income. Adding to the high cost of textbooks is a gap in grant aid provisions to low- and moderate-income students. In 2004, average grant aid for a low-income student attending community college fell short of educational expenses by $1,693, even before room, board, books, and supplies were included. For four-year public colleges, the gap in the same year was $1,513.

In the textbook market, students, as the ultimate consumer, have no direct influence on price, quality, or availability. In combination with rapid price increases and lack of affordability, lack of consumer influence illuminates a flawed market system. Publishers market materials to professors, who in turn select the texts students will be required to purchase, leaving the consumer out of the process. Even minor decisions, such as whether to purchase a new or a used textbook, are taken out of the consumers' hands through the strict control of academic supply chains by publishing companies and book sellers. This control results in price inelasticity, where rising prices result in limited market response.

Students can attempt to reduce the total cost of course text materials by purchasing used books when available. Used books cost an average of 25 percent less than new books, but comprise less than 30 percent of all market materials with demand regularly outstripping supply. A 2004 study in California found that 59 percent of students wishing to purchase used books during the fall 2003 semester were unable to locate a used book for their class. Book publishers control the supply of used textbooks in the market by printing new versions of existing texts and packaging texts with additional study aids and supplemental materials, an industry process referred to as bundling.

The longer a textbook goes unchanged between edits or revisions the greater the availability of used books in the market. However, once a new version is announced the buyback value of the existing version drops to zero as wholesalers attempt to deplete their inventories, leaving only the newer, more expensive book for students to purchase. New text editions average a 12 percent price increase over the previous edition's new book price, which itself was 33 percent more expensive than a similar used book. Therefore, the release of a new textbook edition can increase student costs by 49 percent. A $75 used book would cost $100 new in the previous version and $112 new in the updated version.

Although revision cycles for textbooks vary by subject, publishers have decreased the average time a text goes unchanged over the last two decades to every three to four years. The publishing industry criticizes professors for the speed of version changes, citing an academic desire for the most current research or adaptations for evolving teaching practices. However, many professors in more stable and established disciplines, such as mathematics and physics, see the constant revision as unnecessary and have petitioned publishers to delay revisions. One survey by the Student Public Interest Research Groups (PIRGs) found that 71 percent of instructors believe textbook revisions are justified only sometimes or rarely. The publishing industry typically links textbook revision cycles to sales revenue projections that decline the longer a text is on the market due to increases in the supply of used books available.

"Bundling," the process of packing and selling supplemental course materials with a text, also causes non-production driven price increases to the student. Bundled texts sell for an average of 10 percent more than their non-packaged equivalents. While most supplemental materials are of the same, or better, quality as the primary text and can be useful to a student's mastery of the subject matter, the combination of materials limits a student's ability to purchase less expensive used books or to make decisions to purchase only those materials that will aid them in their individual studies. The ultimate use of supplemental materials has also been called into question by surveys citing up to 65 percent of faculty reporting they either rarely or never reference bundled supplemental material.

On August 14, 2008, the federal Higher Education Opportunity Act of 2008 became law. While primarily defining federal higher education grants and financial assistance programs, the legislation does take certain steps to address the rising cost of college textbooks. Specifically, the law seeks to enhance the transparency and disclosure of the textbook selection process by requiring publishers to provide faculty members the retail prices of considered course materials, the copyright dates of the three previous editions, and a description of any substantial content revisions since the last text edition was released. It also requires publishers to make selected texts and supplemental materials available separately if a "bundled" package is marketed to students. Finally, the legislation puts requirements in place for institutions of higher education to publish certain textbook information, such as the International Standard Book Number and retail pricing, in course catalogs, schedules, and on the institution's website. The release of this information is intended to increase students' ability to shop for the best textbook prices available.

TEXTBOOK SELECTION OVERSIGHT AND CONSOLIDATION OF PURCHASING POWER

Textbook selection at Texas institutions of higher education is currently a decentralized process. Not only does each campus within a university system have the ability to select individualized texts, at most universities and colleges each course section can be assigned a different text from the other sections of the same course. For example, a university that offers six classes of introductory biology for the fall semester could be using a different primary text in each of those courses.

Academic freedom plays a large role in the selection of multiple primary texts for use in the same course. Professors selecting textbooks are principally concerned with the academic integrity and quality of their courses' texts and can often disagree as to which book offers students the best understanding of the subject. While the academic integrity of textbook selection must be explicitly defended to maintain a rigorous educational environment, the associated costs borne by the student cannot be completely removed from the decision.

In creating a centralized statewide textbook review and approval program, Texas would simultaneously support both the academic integrity of core and fundamental college classes and improve affordability of the higher education process. Centralizing textbook review and selection for core curriculum courses would enable the state to leverage the combined purchasing power of more than 1 million Texas students and potentially negotiate lower retail rates with select publishers. With appropriate involvement and control by representative faculty and professors from around the state, Texas could improve academic quality statewide and encourage the consistency of educational standards from campus to campus.

Implementation of Recommendation 1 would require a statutory change to the Texas Education Code, adding a requirement that THECB administer a program to standardize the review and selection of college textbooks for those courses comprising the core curriculum, including state required courses. These courses, such as Algebra I, American History, and English Composition, are suitably standardized to allow for the selection of texts to be used uniformly across campuses without infringing on the academic freedom of individual professors. THECB would only be responsible for the coordination and administration of the program, not activities related to the review process or final approval of materials. Texts would be reviewed and approved on a rotating schedule set by THECB, beginning with statutorily required classes and progressing through the core curriculum. To select texts for identified courses, THECB would solicit representative tenured faculty from institutions across the state to participate in a review panel. The panel would be provided with sample text materials and related retail pricing schedules to study and review over the course of a set period and then assemble to discuss the available texts and select those approved for use at state institutions. Selections would be made based on a best value calculation considering academic merit and costs to students.

Once the review council selects a text, or texts, THECB would be responsible for negotiating the final retail price with the publisher, establishing a statewide procurement contract for the purchase of the texts by public universities, and notifying all state public universities and colleges of the text's selection, identifying information, and negotiated retail price.

Using conservative savings estimates for procurement consolidation projects in Texas, the state could potentially negotiate up to a 7 percent reduction in textbook prices by leveraging the combined buying power of Texas college students in core curriculum courses. Such an outcome would have translated into direct student savings of $34.7 million during fiscal year 2007.

Recommendation 2 would fund the implementation of a textbook advisory council and related administrative functions by including a contingency rider in the 2010–11 General Appropriations Bill appropriating funds to THECB and increasing their full-time-equivalent (FTE) position cap by four employees.

Recommendation 3 requires THECB to prepare a report submitted to the Legislature by January 1, 2011 detailing the cost of college textbooks to Texas students and noting any material discrepancies between the reported price of texts at the time of selection and the final retail price available in the university bookstore. The report would contain current trends in college textbook pricing, average college textbook prices in Texas as well as detailed information from each campus, and descriptions of activities by the Higher Education Coordinating Board and institutions of higher education to reduce the costs of textbooks. THECB would also be required to report actions to further reduce the price of textbooks used in Texas public colleges and universities undertaken by the agency or individual institutions.

FISCAL IMPACT OF THE RECOMMENDATIONS

The recommendations would cost $510,000 in General Revenue Funds during the 2010–11 biennium. The cost to the state arises from the creation of an administrative operation to coordinate centralized textbook review and approval processes established in Recommendation 1 and manage the reporting requirements and database established in Recommendation 3.

Recommendations 1 and 2 would cost $510,000 in General Revenue Funds during the 2010–11 biennium. This cost would support 4 FTE positions above THECB's current staffing levels. The staff of the review and approval program would be responsible for (1) notifying publishers of the review of texts and materials for a specific course category, (2) distributing text and material samples to review panel participants, (3) organizing review panel meetings, (4) negotiating textbook and material procurement contracts with publishers for use by public institutions, and (5) notifying institutions of approved text selections, pricing, and packaging. Review program staff would also be responsible for managing the requirements of Recommendation 3 if both recommendations are implemented.

Recommendation 3 would have no fiscal impact. The report could be completed with existing agency resources.

For all recommendations, costs in the first year of implementation are reduced to allow for program development, which could delay some staffing costs until the second half of the fiscal year. Beginning with the second year of implementation, fiscal year 2011, full program costs are reflected. **Figure 312** shows the five-year impact of centralizing the review and selection of college textbooks at public colleges and universities.

FIGURE 312
FIVE-YEAR FISCAL IMPACT OF CENTRALIZING COLLEGE TEXTBOOK REVIEW

FISCAL YEAR	PROBABLE SAVINGS/ (COST) IN GENERAL REVENUE FUNDS	PROBABLE ADDITION/ (REDUCTION) OF FULL-TIME-EQUIVALENT POSITIONS
2010	($221,412)	3
2011	($288,113)	4
2012	($283,312)	4
2013	($283,312)	4
2014	($283,312)	4

SOURCE: Legislative Budget Board.

The introduced 2010–11 General Appropriations Bill does not address these recommendations.

OVERVIEW OF BOND FINANCING OPTIONS FOR HIGHER EDUCATION

In recent years, higher education institutions in Texas have sought increased state funding for capital projects to meet institution needs. Financing capital projects for public higher education institutions in Texas presents a challenge. Three state-funded bond programs are available to higher education institutions for capital projects: Permanent University Fund bonds, Higher Education Fund bonds, and tuition revenue bonds. The largest program is tuition revenue bonds, which has advantages and disadvantages for the state and public institutions.

FACTS AND FINDINGS

- Tuition revenue bonds, the most commonly used state-supported bond financing program for higher education, provide flexibility to the state, but are less transparent than other types of bond programs because they are grouped together with other types of university revenue bonds when issued.
- As of the end of fiscal year 2008, tuition revenue bond debt authorizations total $3.3 billion. This amount includes $2.1 billion in issued debt and $1.2 billion in unissued debt.
- General Obligation bonds, a possible option for higher education projects, would provide more funding transparency but have disadvantages, such as affecting the state's constitutional debt limit. The Texas Higher Education Coordinating Board's Capital Funding Work Group recommends a General Obligation bond program for higher education in lieu of tuition revenue bonds.
- Texas' constitutional debt limit restricts the debt service paid by unrestricted General Revenue Funds to no more than 5 percent of the average of the last three fiscal years' unrestricted General Revenue Funds. As of the end of fiscal year 2008, the Bond Review Board estimates that the state's official constitutional debt limit is 4.09 percent, which includes authorized but unissued debt.
- The current process of authorizing tuition revenue bonds isolates higher education projects from other types of state bond financed projects. If the state were to use a General Obligation bond program for higher education, institutions would be competing directly with other state agencies for bond funding.
- There are other alternatives to tuition revenue bonds and General Obligation bonds, such as a bond program with state security or a type of lease revenue program.

DISCUSSION

Texas has used a variety of methods to finance ongoing capital needs, including pay-as-you-go and debt financing. Within debt financing, there are three types of bond programs used for higher education needs: Permanent University Fund (PUF) bonds, Higher Education Fund (HEF) bonds, and tuition revenue bonds (TRB), the latter being the most prominent of capital financing sources. **Figure 313** shows the outstanding debt for these three programs.

TRBs are a major source of capital financing for universities in Texas partially because of the limitations of the other two bond programs. PUF bonds are supported by the PUF corpus, a state endowment with land grants; annual allocations of PUF proceeds are distributed through the Available University Fund (AUF). Only specific schools in the Texas A&M and The University of Texas (UT) systems

FIGURE 313
OUTSTANDING DEBT FOR HIGHER EDUCATION BOND PROGRAMS, FISCAL YEAR 2008

BOND PROGRAM	DEBT OUTSTANDING
Tuition Revenue Bonds (TRB)	$2,062,714,000
Permanent University Fund (PUF) Bonds	1,753,610,000
Higher Education Fund (HEF) Bonds	51,605,000
TOTAL DEBT OUTSTANDING FOR CAPITAL PROJECTS	**$3,867,929,000**

SOURCES: Legislative Budget Board; Texas Bond Review Board.

(24 institutions or entities) are eligible for PUF bonds. One-third of the annual AUF allocation goes to the Texas A&M system, the other two-thirds goes to The University of Texas system. At the end of fiscal year 2008, there was approximately $1.8 billion in outstanding PUF bond debt. This amount is slightly lower than the current outstanding TRB debt. Like TRBs, PUF bonds are self-supporting revenue bonds and do not count against the constitutional debt limit.

Higher Education Fund (HEF) bonds are available to the institutions that do not qualify for PUF bonds, which includes 26 institutions. Like the PUF bonds, HEF bonds and allocations are eventually intended to be supported by a corpus fund. Created in 1996, the corpus fund, the Permanent Higher Education Fund (PHEF), has a constitutionally set target of $2 billion. Appropriations of $50 million per year were deposited to the corpus fund from fiscal years 1996 to 2001. In fiscal years 2002 and 2003, the $50 million appropriated to the HEF endowment was reduced by the amount of interest earned by the fund. No appropriations were made to the corpus fund for the 2004–05 biennium, and at the end of fiscal year 2007 the corpus fund had a market value of $617 million.

The current HEF allocation appropriated to HEF-eligible institutions per year totals $262.5 million; this allocation is revised every 10 years, with the option for adjustments every 5 years. Fiscal year 2008 was the first year of the $262.5 million allocation. Up to 50 percent of the allocation can be used by HEF-eligible institutions for debt service on bonds. However, HEF bonds are rarely issued because of the shorter amortization schedule permitted for these bonds. The Texas Constitution, Article 7, Section 17 (e), limits the bond term for HEF bonds to 10 years, whereas the typical term for PUF bonds is 30 years and for TRBs is 20 years. A shorter bond term requires larger debt service payments, payments that an individual institution may not be able to make based on its yearly allocation.

As of the end of fiscal year 2008, there was $51.6 million in outstanding HEF bonds. HEF bonds are classified as not self-supporting general obligation debt and count against the constitutional debt limit. In 2008, the Texas Higher Education Coordinating Board's (THECB) Capital Funding Work Group proposed changes to the HEF and HEF bonds to increase their use by universities. The changes the THECB is considering, all but one of which would require constitutional amendments, are:

- Increase the corpus target of the PHEF from $2.0 billion to $4.5 billion.
- Request accelerated funding of the PHEF to achieve the $4.5 billion corpus (does not require constitutional amendment).
- Restrict PHEF distributions to capital renovation and repair projects (phased-in restriction) instead of its current permissive use of land acquisition and new construction.
- Change the maturity of HEF bonds from 10 years to a number determined by the institutions.
- Allow institutions to pledge up to 75 percent of HEF allocations for bond debt service (currently limited to 50 percent).

In fiscal year 2008, only one institution, Texas Southern University, issued HEF bonds. Stephen F. Austin University plans to issue HEF bonds in fiscal year 2009.

The state of Texas currently uses TRBs as the largest source of financing capital projects at institutions of higher education, and it is the only state-supported bond program available to all universities. As of the end of fiscal year 2008, there was $2.1 billion in outstanding authorized and issued TRB debt. Another $1.2 billion in existing authority was unissued at the end of fiscal year 2008.

The tuition revenue bond program began in 1971 as a way to fund capital projects and comply with an existing constitutional provision that prohibited UT and Texas A&M from receiving General Revenue Funds for capital projects under the Texas Constitution, Article VII, Section 18-i; this restriction was extended to all higher education institutions in 1993. There were two bond authorizations in the 1970s: one in 1971 for $185.0 million and one in 1973 for $57.5 million. There was not another TRB authorization until 1991, when $60.0 million was authorized. Almost every two years since 1991 new TRBs have been approved by the Legislature. **Figure 314** shows all legislative authorizations for TRBs since 1971.

The use of TRBs as a method of finance for capital needs has increased substantially since 1991. This could be due in part to the growth in higher education enrollment, which drives the need for increased campus building capacity, a trend experienced at both the state and national levels; enrollment at Texas universities increased 23 percent from 2000 to 2007. In addition, in November 1993, voters approved an

FIGURE 314
LEGISLATIVE AUTHORIZATIONS FOR TUITION REVENUE BONDS, 1971–2007

LEGISLATURE	SESSION	YEAR	AMOUNT (IN MILLIONS)	BILL
62nd	Regular	1971	$185.0	HB 1657
63rd	Regular	1973	57.5	SB 2, SB 129
72nd	Regular	1991	30.0	HB 2102
72nd	1st Called	1991	30.0	SB 3
73rd	Regular	1993	352.4	HB 2058
74th	Regular	1995	9.0	HB 2747
75th	Regular	1997	638.5	HB 1235
77th	Regular	2001	1,081.8	HB 658
78th	Regular	2003	178.4	HB 1941
78th	Regular	2003	15.0	SB 800
78th	Regular	2003	27.0	HB 2522
78th	3rd Called	2003	48.5	HB 28
79th	3rd Called	2006	1,858.8	HB 153
80th	Regular	2007	13.0	HB 1775
TOTAL AUTHORIZED			**$4,524.8**	

Sources: Legislative Budget Board; Texas Higher Education Coordinating Board.

amendment to the Texas Constitution, adding Article VII, Section 17-j, which prevents state universities from receiving General Revenue Funds directly for capital projects. The change to the constitution coincided with the first large TRB authorization. The constitutional debt limit that put restrictions on the amount of General Revenue Funds permitted for debt service was added to the constitution in November 1997 (Article 3, Section 49-j), the same year of another major TRB authorization.

There are advantages and disadvantages to the use of tuition revenue bonds over other types of bond funding. One advantage is that because TRBs are classified as self-supporting revenue debt, unlike not self-supporting General Obligation (GO) bonds, TRBs are not subject to the constitutional debt limit. Another advantage to TRBs is the flexibility provided to the Legislature in tight economic times, because the Legislature does not have to reimburse all of the TRB debt service in a given biennium. During the Seventy-eighth Legislature, Regular Session, 2003, the Legislature chose to reimburse only interest costs for TRBs issued after March 31, 2003 (there was no effect on TRBs that had already been issued). The next session, the Legislature reversed this policy and approved $1.8 billion in new authorizations. Other than in 2003, the Texas Legislature has fully reimbursed higher education institutions for the total cost of TRB debt service.

Another advantage to TRBs is universities' ability to leverage revenues for bond issuance. Most Texas public university systems use a Revenue Financing System (RFS) to issue revenue bonds. An RFS allows a system to leverage revenues from multiple institutions within the system. When RFS bonds are issued by a system, they typically will contain more than one type of bond program authorization within the issuance. By leveraging revenue streams from multiple institutions, the system can often qualify for a higher bond rating than would be possible for the individual institutions within the system.

A disadvantage to the use of TRBs is the lack of transparency. The details of TRB issuances are often indistinguishable from other types of university-issued revenue bonds because they may be consolidated into larger bond issuances that include multiple programs. Some have expressed the opinion that the use of TRBs is misleading to Texas taxpayers because, although legally secured by tuition revenue, TRBs are paid as if they are GO bonds. While the Legislature has the option not to reimburse TRB debt service, as discussed previously, it has rarely done so.

A second disadvantage to TRBs is that there is no limit on how much TRB debt can be authorized. While this feature provides the Legislature and institutions flexibility, it hinders the state's ability to budget for capital finance needs for higher education. Because of the limitations of HEF and PUF bonds and the lack of limitation on TRBs, institutions often aggressively pursue TRB authorization and debt service reimbursement during legislative sessions.

A third disadvantage to TRBs is the disparity in bond ratings between the universities, which leads to different interest rates and different bond issuance costs. Bond issuers typically seek a bond rating from one of the three rating agencies. Based on that rating, issuers will qualify for various interest rates. For university systems that qualify for high ratings, such as The University of Texas which has a AAA rating, the cost of issuance is less expensive than it would be for a smaller system or independent school that has a lower rating, even though institutions issue bonds for similar types of projects. In addition, smaller systems must restrict the amount of TRBs for which they receive approval to ensure their revenues can support the bond authorizations and issuance without lowering their bond rating. Once debt has been authorized, even if it is not yet issued, it affects a school's balance sheet.

During fiscal year 2008, based on its analysis, the Texas Public Financing Authority (TPFA) cautioned Stephen F. Austin State University (SFASU) not to request more TRB authority because the university's financial audits and bond rating could be adversely affected if more debt was authorized.

One alternative to the TRB program is a GO bond program. THECB recommends replacing the current TRB program with a GO bond program for higher education. Under the agency's proposal, the institutions would receive funds as a state match at a specified ratio, either 1:1 or 2:1. THECB includes $11.8 billion in its proposal; this amount is three times the current total of $3.6 billion for all authorized TRB debt and more than double the amount of TRBs that have been authorized since 1971.

Establishing a GO bond program would create a different set of advantages and disadvantages from TRBs. The first advantage would be offering schools with lower bond ratings access to the state's higher bond rating, which could provide savings in interest costs. A second related advantage would be cost savings resulting from eliminating the need for bond insurance, which is not required for GO bonds. According to the Bond Review Board (BRB), market trends in 2008 pushed bond insurance costs up to four times their normal amount. In addition to savings from lower interest rates and omitting bond insurance, other savings may be possible by a partial or full consolidation of higher education bond issuance by having an agency such as TPFA issue GO bonds for institutions and systems, rather than having institutions and systems issue bonds independently. TPFA currently issues TRBs for three institutions.

The third advantage to offering a higher education GO bond program for capital projects is the flexibility created for smaller schools whose financial status and revenue income may not otherwise be able to support an increased revenue-based bonding program, despite need. As mentioned previously, SFASU may not be able to carry additional TRB debt without endangering its bond rating. Having access to a GO bond program would give a school such as SFASU an opportunity to meet capital needs without jeopardizing its financial position.

The fourth advantage to a GO bond program is transparency of bond issuances and the method by which the debt service is paid. Since GO bond programs would not be lumped together with multiple projects from various revenue bonds, it would be easier to identify the total expenditures for these bonds and the ways in which the bond issuances are structured. Transparency from GO bonds may be magnified if issued by an agency such as TPFA.

A fifth advantage to funding capital projects through a GO bond program is added certainty of continued support. Institutions of higher education are concerned about the uncertainty of continued support for a project when it uses a TRB as a funding source. A GO bond program would provide the reassurance of continuing debt service support. Another advantage is that a GO bond program, which is subject to the constitutional debt limit, would provide bond authorizations caps for higher education.

Despite the advantages a GO bond program would provide for institutions and the state, there are also disadvantages or constraints that would come with such a program for both groups:

- New GO bond authority would require a 2/3 vote of the Legislature and voter approval of constitutional amendments.
- Issuance of GO bonds could cause the state to reach the constitutional debt limit. For fiscal year 2008, the state's official constitutional debt limit is 4.09 percent, which includes authorized but unissued debt.
- Universities would be in competition with other GO-based bond programs for the Legislature's support, which does not occur under existing statute.
- Universities would possibly seek to use TRBs as a backup if they cannot get GO bond approval. If the intent is to streamline bond programs and provide limits on higher education bond authorizations by using a GO bond program, this benefit would be negated by universities continuing to seek TRB authority if GO bonds are not an option for a given biennium.
- Some of the flexibility would be lost in issuance procedures that TRBs offer, such as the ability to delay or suspend debt service reimbursements in times of economic downturn.

One consideration in determining the practicality of creating a GO bond program for higher education is the bond rating. Bond ratings play a major role in the interest rates an issuer qualifies for when issuing bonds. Interest rates are part of the overall issuance costs. For institutions or systems that have lower bond ratings than the state, using a GO bond program with access to the state's rating could save money on interest costs. Nine systems and institutions have lower bond ratings

than the state. **Figure 315** shows the bond ratings for the university institutions and systems and for the state.

FIGURE 315
BOND RATINGS FOR UNIVERSITIES AND THE STATE, 2008

	LONG-TERM RATING BY RATING ENTITY		
INSTITUTION	MOODY'S	S&P	FITCH
The University of Texas	Aaa	AAA	AAA
Texas A&M University	Aa1	AA+	AA+
State of Texas (GO bond rating)	**Aa1**	**AA**	**AA+**
Texas Tech University	Aa3	AA	AA
University of Houston	Aa3	AA-	
Texas State University System	Aa3	A+	
University of North Texas	A1	A+	AA-
Texas Woman's University	A1	A	
Midwestern State University	A2		A+
Stephen F. Austin State University	A2		A+
Texas State Technical College	A2	A	
Texas Southern University	Ba3		

Sources: Legislative Budget Board; Texas Public Finance Authority; Texas Bond Review Board.

TPFA issues tuition revenue bonds for three universities: Midwestern State, Stephen F. Austin State, and Texas Southern. Though issued by TPFA, the TRBs for these three schools are not part of the state's debt burden; they count as the universities' debt. All other institutions or systems issue their own TRBs.

Creating a GO bond program for higher education could affect the state's GO bond rating, though in practice the credit rating agencies are aware of the TRB program and consider it both on the university side and when determining the state's credit rating.

The credit market at the time the GO bonds are being considered may also influence the decision whether to pursue the GO bond strategy. Bond insurance is typically used whenever a non-AAA rated entity seeks to qualify for a lower interest rate. Generally, the bond insurance, which gives an issuer an "artificial" AAA-rating and therefore access to better interest rates, is less expensive than the interest rate for which a non-AAA issuer would otherwise qualify. With the fallout from the subprime mortgage industry and the fall 2008 credit crisis, bond insurance is more expensive with fewer insurance companies available. The potential savings related to bond issuance consolidation in a GO bond program may be greater in today's market. However, changes to the credit market in 2008 and the current discussions of how bond ratings may change in the future need to be considered.

Various issues must be considered before deciding whether the state maintains the TRB bond program or implements a GO bond program for higher education capital projects, including deciding which program features or advantages are most important. Because each option has notable advantages and disadvantages, this report does not contain recommendations.

There are also alternatives to either a GO bond program or the current TRB program that could provide a different set of advantages and disadvantages. These options include:

- Option 1: Creating a bond program with state security similar to that of the Permanent School Fund bonds—bonds issued by a local entity, but guaranteed by the state. To craft this type of state-secured bond program may require a significant investment in a corpus fund.
- Option 2: Revising the Permanent University Fund (PUF) and Higher Education Fund (HEF) to make them open to all public four-year institutions. At the time that PUF was created, it was intended for all public universities. Merging the two funds and building the corpus would possibly give significant annual allocations that could be used to pay debt service on PUF bonds.
- Option 3: Creating a lease revenue program similar to the two programs currently issued by TPFA.

Any of these options could provide an effective alternative to TRBs, but they are not without challenges.

If pursued, a GO bond program or other type of financing alternative would require careful crafting to ensure all the benefits of such a program are maximized while minimizing some of the potential downsides. When considering a new GO bond program, or other alternative, various questions should be answered:

- Would the opportunity for new TRBs be eliminated? If TRBs and GO bonds (or other programs) exist simultaneously, would institutions be required to choose one program over the other?
- Should all institutions participate in the new program or should some be excluded? For example, UT has a higher bond rating than the state. Would it make sense to include it in a new GO program?

- What mechanism would be used to limit the size of the GO bond program, or other alternative, besides the constitutional debt limit?
- Should higher education projects be considered along with other, non-higher education projects since they would impact the debt limit?
- Should there be a consolidation of debt issuance by an entity such as the Texas Public Finance Authority?

Tuition revenue bonds use a legal pledge of tuition revenue, which classifies them as self-supporting revenue bonds. GO bonds, the main alternative discussed, are backed by the full faith and credit of the state with no specified revenue source, which classifies them as not self-supporting bonds. One method for limiting a bond program that is not self-supporting would be the Debt Affordability Study (DAS) and its state debt burden ratios. The DAS debt capacity model calculates five key debt ratios to provide a big picture perspective of Texas' debt burden. Within the DAS, Ratio 1, Debt Service as a Percentage of Unrestricted Revenues, mimics the constitutional debt limit, with some minor differences. Ratio 1 includes a target of 2 percent and a cap of 3 percent to help the state determine appropriate debt loads. The DAS, or a similar tool, could be used to limit the size of TRBs or an alternative. This study was first published by the Legislative Budget Board in February 2007. The responsibility for ongoing annual updates to the DAS was assigned to the Bond Review Board (BRB) by enactment of Senate Bill 1332, Eightieth Legislature, 2007. The updated DAS by BRB should be available to the Legislature in February 2009.

POTENTIAL SAVINGS FROM AN ALTERNATIVE BOND PROGRAM

Creating a debt financing program to replace TRBs could produce a modest cost savings for the state. Legislative Appropriations Requests for the 2010–11 biennium include a debt service request of $657.3 million.

If bond issuance for a new higher education bond program were consolidated, one option would be to have TPFA issue these bonds for multiple institutions. If consolidation was used, TPFA would need up to one additional full-time-equivalent position to perform this function (at a cost of less than $100,000 per year). Having TPFA issue the bonds would not eliminate the need for knowledgeable financing staff at the individual institutions or systems.

Potential savings from a GO bond program would be the result of giving institutions with lower bond rating access to the state's GO bond rating, which should lead to lower interest rates and bond insurance costs. Long-term cost avoidance may come in the form of designing an appropriate cap for higher education capital funding. Potential cost savings would vary considerably based on the way in which a new GO bond program or another alternative bond program is structured.

In January 2008, TPFA calculated the financing differences for a bond issue for Stephen F. Austin State University. One option considered interest rates for a TRB issuance, the other option for a GO bond. **Figure 316** shows the cost differences. This calculation is based on a bond issuance amount of $20.2 million, a 20-year bond term, and level debt service payments.

FIGURE 316
EXAMPLE COST SAVINGS
STEPHEN F. AUSTIN STATE UNIVERSITY
GENERAL OBLIGATION BONDS COMPARED TO TUITION REVENUE BONDS, FEBRUARY 2008

	TUITION REVENUE BOND	GENERAL OBLIGATION BOND	COST DIFFERENCE
Interest Rate	4.165871%	3.916503%	0.249368%
TOTAL DEBT SERVICE PAID	**$28,492,225**	**$28,019,515**	**$472,710**

Source: Texas Public Finance Authority.

In addition to costs savings from lower interest rates, cost savings would also come from eliminating the need for issuers to purchase bond insurance, which is typically not needed for GO bonds. For the non-AAA rated institutions and systems that issued TRBs from fiscal years 2006 to 2008, a total of $4 million was expended for bond insurance. This amount would have been saved if these issuances had been GO bonds.

DEFINE AND TRACK CLINICAL PRACTICE HOURS FOR PROFESSIONAL NURSE EDUCATION PROGRAMS

Education programs for training registered nurses require students to complete a defined number of clinical practice hours to be eligible to sit for a licensure examination administered by the Texas Board of Nursing. These clinical practice hours are taught at external, independent medical care facilities. Texas institutions of higher education that provide training for potential registered nurses do not have direct control over the provision of these clinical practice hours.

The Eightieth Legislature, 2007, enacted legislation to increase the number of registered nurses by increasing the number of graduates of professional nursing programs. The efforts were largely focused on elements within the direct control of these institutions. There has not been an assessment of the ability of Texas health service provider facilities to provide the clinical practice hours required to meet these state goals. The effort to increase the number of nursing graduates could be stymied by limitations on available clinical practice hours that institutions are able to access. Establishing a method for tracking available clinical practice hours and specifying a standard range of hours required for certification would increase the possibility that state funds devoted to increase the number of registered nurses would be used efficiently.

FACT AND FINDING

- Locating sufficient clinical practice hours for students of professional nursing programs is a growing concern among directors of registered nurse education programs in Texas.

CONCERNS

- Many professional nurse education programs in Texas cannot provide an estimate of available clinical practice hours in their area. Without this information, these programs may not possess sufficiently precise information about the capacity constraints they face to guide their decision making.
- Professional nurse education programs do not have sufficient information to link clinical practice hour availability to faculty hiring decisions. State efforts to increase the number of registered nurses may direct funds to expand capacity at institutions of higher education that cannot access sufficient clinical practice hours.
- Texas Board of Nursing rules on required clinical practice hours for licensure as a registered nurse allow institutions wide latitude in the amount of clinical practice hours they require for a degree. This allows a wide disparity by institution in the number of clinical practice hours required for a nursing degree. This disparity may contribute to an inefficient allocation of clinical practice hours.

RECOMMENDATIONS

- **Recommendation 1:** Amend the Texas Health and Safety Code to establish a database of available clinical practice hours at the Center for Nursing Workforce Studies in the Department of State Health Services. The center would be required to report unused clinical practice hours to institutions of higher education yearly and to report biennially to the Legislature on the systemic distribution of unused clinical practice hours.
- **Recommendation 2:** Amend the Texas Occupations Code to direct the Texas Board of Nursing to amend its rules to establish a range for the number of clinical practice hours required to be licensed as a registered nurse in Texas.

DISCUSSION

Institutions of higher education produce graduates by using capital (in the form of building and facilities) and labor (in the form of instructors and staff) on students. For the majority of degrees awarded by these institutions, the labor and capital required are completely self-contained in the institution and, along with the institution's productivity, determine a production function. Institutional policies, state statutes, and other directives can be used to modify the production function and influence the quantity of degrees awarded.

For a select group of disciplines, however, the "degree production function" is not self-contained within the institution. Many of these disciplines are in allied health fields. For a student to graduate with a qualification in these disciplines, the degree requirements include clinical practice hours under supervision by a health service provider. Thus, the production function for these degrees also includes health service provider facilities not under the control of the institution or the state. As a result, the number of graduates in some allied health fields is potentially constrained by elements of the production function that are external to the institution.

Registered nursing was one specific allied health field that was the subject of significant attention by the Eightieth Legislature, 2007. This activity occurred after a series of reports showed a growing shortfall in the number of registered nurses (RNs) in Texas over the next two decades. **Figure 317** shows a list of legislative acts from 2007 relating to nursing education. Senate Bills 138 and 139 represent systemic efforts to improve nursing education and to increase productivity within the confines of institutions of higher education. Senate Bills 201 and 289, conversely, are more narrowly tailored approaches to the issue of ensuring the supply of sufficient clinical practice hours.

FIGURE 317
LEGISLATIVE ACTIONS TO IMPROVE PROFESSIONAL NURSE EDUCATION, EIGHTIETH LEGISLATURE, 2007

LEGISLATION	DESCRIPTION
Senate Bill 138	Incentives to promote retention and graduation
Senate Bill 139	Improve nursing program curricula
Senate Bill 201	Tuition exemption for clinical preceptors
Senate Bill 289	Allows part-time faculty for clinical instruction

SOURCE: Legislative Budget Board.

Efforts by the Texas Legislature to increase the productivity of the institution's portion of nursing education could be stymied by limitations on clinical practice hours that institutions are able to access. To examine the extent of this potential constraint, Legislative Budget Board staff conducted a survey of professional nursing education programs at public institutions of higher education in Texas. The survey requested information on a variety of questions related to clinical practice hours. As of September 2008, 49 percent (36 of 74) of nursing programs provided a response to this survey.

CONCERN FOR CLINICAL PRACTICE HOUR AVAILABILITY

Figure 318 shows the response to two survey questions that asked whether clinical practice hours pose a constraint to nursing education programs.

The survey responses to the first query in **Figure 318** show that institutions are concerned about the issue of clinical practice hour availability. Seventy-seven percent of programs surveyed either slightly or strongly agreed with the statement that "finding sufficient clinical hours for our students has been a challenge." Only 20 percent of programs disagreed either slightly or strongly with this statement.

Survey respondents also see clinical practice hour availability as a challenge that will grow in the future. Ninety-one percent of respondents agree with the statement, "I am worried about finding sufficient clinical space in the future." Only 6 percent of respondents disagreed with the statement. Taken together, the responses to two questions in **Figure 318** indicate that clinical practice hours are a current and growing constraint to nursing education programs.

UNCERTAINTY OF INSTITUTIONS' CAPACITY CONSTRAINTS

Institutions that attempt to expand the number of professional nursing graduates produced by their program face a complex production decision. They have to balance the interest of potential students in the area, the constraints imposed by their faculty staffing and physical plant, and the availability of clinical practice hours that are within a reasonable distance of their students.

Institutions were asked how many unused clinical practice hours were available at local facilities. Few of the programs surveyed could estimate these resources. Seventy-four percent of institutions did not provide an estimate of clinical practice hours available to them in their local area. This result suggests that while professional nursing education programs are generally aware of the issue of clinical practice hour availability, they may not possess sufficiently precise information about the capacity constraints to guide their decision making.

RELATIONSHIP OF ADDING FACULTY MEMBERS TO PRODUCING ADDITIONAL PROFESSIONAL NURSE GRADUATES

Professional nursing education programs were asked the number of additional graduates their program could produce if they were able to use all clinical practice hours available to them. The percentage increase by program is shown in **Figure 319**.

FIGURE 318
OPINION OF PROFESSIONAL NURSING PROGRAMS ON CHALLENGE OF PROVIDING CLINICAL PRACTICE HOURS, SEPTEMBER 2008

OPINION	"FINDING SUFFICIENT CLINICAL HOURS FOR OUR STUDENTS HAS BEEN A CHALLENGE."	"I AM WORRIED ABOUT FINDING SUFFICIENT CLINICAL SPACE IN THE FUTURE."
Strongly agree	18	22
Slightly agree	9	10
Neither agree nor disagree	1	1
Slightly disagree	5	2
Strongly disagree	2	0
TOTAL	**35**	**35**

Note: One respondent did not answer these questions.
Source: Legislative Budget Board.

FIGURE 319
PERCENTAGE INCREASE IN PROFESSIONAL NURSE GRADUATES POSSIBLE WITH EXISTING CLINICAL PRACTICE HOUR CONSTRAINTS, SEPTEMBER 2008

PERCENTAGE INCREASE IN NUMBER OF GRADUATES	NUMBER OF PROGRAMS
Do not know	13
0% to 25%	3
26% to 50%	10
51% to 75%	0
76% to 100%	1
More than 100%	6
TOTAL	**33**

Note: Three respondents did not answer this question.
Source: Legislative Budget Board.

FIGURE 320
NUMBER OF FACULTY MEMBERS NEEDED TO REACH CLINICAL PRACTICE HOUR CONSTRAINT, SEPTEMBER 2008

ADDITIONAL FACULTY MEMBERS NEEDED TO REACH CLINICAL PRACTICE HOUR CONSTRAINT	NUMBER OF PROGRAMS
Do not know	14
0	2
1	2
2	3
3	4
4	4
5 or greater	5
TOTAL	**34**

Note: Two respondents did not answer this question.
Source: Legislative Budget Board.

Thirty-nine percent of programs were unable to estimate how many more graduates they could produce using existing clinical practice hours. Thirty-nine percent of programs projected modest increases in graduates (50 percent or less), while 18 percent of programs projected potential increases of over 100 percent. In general, programs that projected larger percentage increases in professional nurse graduates were of smaller scale than those that projected smaller percentage increases.

Figure 320 shows the number of additional faculty members programs estimated they could use given existing clinical practice hours. Forty-one percent of programs were unable to provide this estimate.

Many programs do not have clear information linking the availability of clinical practice hours to their potential to produce additional professional nursing graduates. Thus, state efforts intended to increase the number of RNs may direct state funds to expand capacity at institutions of higher education that do not have sufficient clinical practice hours available in their area. Conversely, the state may not be providing sufficient funds to institutions in areas that have this capacity.

Recommendation 1 would amend Section 105 of the Texas Health and Safety Code to establish a database of available clinical practice hours at the Center for Nursing Workforce Studies. Under Health and Safety Code 222.005, the Commissioner of the Department of State Health Services (DSHS) has the authority to require reports of hospitals. The amended Section 105 would require these facilities to report annually overall clinical practice hour capacity and the usage of these hours by institution of higher education to the center. The center would be authorized to exempt hospitals from this requirement if they are not able to provide clinical practice hours to professional nursing students. The center would be required to report unused clinical practice hours to

institutions of higher education yearly, enabling currently constrained programs to identify and pursue underutilized resources. In addition, the center would be directed to report biennially to the Legislature on the systemic distribution of unused clinical practice hours available for professional nursing education. This report would identify specific programs that could be targeted for capacity increases based on their access to additional clinical practice hours.

VARIANCE OF REQUIRED CLINICAL PRACTICE HOURS

The number of clinical practice hours for an RN qualification is not designated by the Texas Board of Nursing (BON). Board of Nursing Rule 215.9 simply states that:

"[t]here shall be a rationale for the ratio of contact hours assigned to classroom and clinical learning experiences. The recommended ratio is three contact hours of clinical learning experiences for each contact hour of classroom instruction."

Professional nursing education programs were asked how many clinical practice hours were required by degree path at their institution. **Figure 321** shows the distribution of clinical practice hours required for the three most common paths to a professional nursing degree offered by these programs.

On average, 1,162 clinical practice hours were required for the four-year Bachelor of Science in Nursing (BSN) degree offered by universities and health-related institutions. These programs required between 855 and 1,350 clinical practice hours, a variance of 58 percent.

Two-year Associate of Science in Nursing (ASN) degrees offered by community colleges required fewer clinical practice hours than degrees at four-year institutions—on average 1,012 hours. These programs required between 576 and 1,280 clinical practice hours, a variance of 122 percent.

Finally, an Associate of Science degree that allows a licensed vocational nurse (LVN) to meet the licensure requirements of an RN required an average of 675 clinical practice hours. These programs required between 448 and 1,170 clinical practice hours, a variance of 161 percent. Note that these 675 average hours were in addition to the minimum 840 clinical practice hours required for LVN certification under BON Rule 214.

The lack of specificity in BON's regulation of RNs has allowed institutions wide latitude in the amount of clinical practice hours they require for a degree and this may contribute to an inefficient allocation of clinical practice hours. Each of the degree paths shows a pattern of variation that raises concerns. Some BSN programs may be varying to the high side, imposing additional constraints on clinical practice hours in their areas. Some ASN programs may be requiring too few clinical practice hours for the RN qualification—four programs surveyed were below the 840 clinical practice hours required of licensed vocational nurses. Finally, the very wide distribution of LVN-to-RN requirements suggests that this path may pose a significantly higher burden on clinical practice hour resources than traditional education pathways.

Recommendation 2 would amend Section 301.157 of the Texas Occupations Code to direct BON to establish a range on the number of clinical practice hours that would be required to be licensed as a RN in Texas. The range is to be established by BON in consultation with institutions of higher education that provide professional nursing education programs to provide reasonable flexibility for difference in a program's mission. The range may vary by degree path used to attain the professional nursing qualification and reasonable provisions to grandfather existing students are to be allowed.

FIGURE 321
CLINICAL PRACTICE HOURS REQUIRED BY THREE PROFESSIONAL NURSING DEGREE PATHS, SEPTEMBER 2008

DEGREE PATH	LESS THAN 700	701 TO 800	801 TO 900	901 TO 1000	1001 TO 1100	1101 TO 1200	MORE THAN 1200	AVERAGE
4-Year Registered Nurse (BSN)	0	0	1	4	0	1	2	1162
2-Year Registered Nurse (ASN)	3	1	1	5	3	7	1	1012
Licensed Vocational Nurse to Registered Nurse (ASN)	11	4	2	0	0	1	0	675

SOURCE: Legislative Budget Board.

FISCAL IMPACT OF THE RECOMMENDATIONS

Recommendation 1 can be met through existing appropriations to DSHS.

Recommendation 2 can be met through existing appropriations to BON.

The introduced 2010–11 General Appropriations Bill does not address the recommendations of this report.

FUNDING OPTIONS FOR THE PHYSICIAN EDUCATION LOAN REPAYMENT PROGRAM

More than 23 percent of Texans live in a primary care health professional shortage area, a region of the state having a doctor-to-population ratio below 1:3,500. Texas also faces a decline in the number of primary care physicians. Medical school debt makes physicians less likely to pursue primary care and more likely to choose specialties with higher incomes or more leisure time. Areas of the state with a physician shortage also lack important rural economic development opportunities.

Texas' Physician Education Loan Repayment Program, like similar programs in other states, helps physicians repay their student loan debt in exchange for a term of service practicing in a health professional shortage area. Loan repayment programs are common strategies among states to attract physicians to shortage areas. These incentives help supplement the lower salaries physicians receive in rural and other underserved areas. At $9,000 per year, though, the Physician Education Loan Repayment Program's benefits are not competitive with programs in other states. As a result, Texas is losing interested physicians to other states with more lucrative benefits. Increasing funding for the program would allow Texas to offer more competitive benefits and thereby increase the number of physicians in the state' underserved areas.

CONCERNS

- Texas has more primary care health professional shortage areas than any state other than California, and more of its population lives in those areas than any other state. These areas not only fall behind other parts of the state in health outcomes as the population ages but also lack an important driver of rural economic development.
- Texas' Physician Education Loan Repayment Program has an immediate effect by bringing physicians to shortage areas in exchange for student loan debt repayment. However, the program is not funded at a level that makes Texas competitive with similar state and federal programs. As a result, Texas is losing physicians who want to practice in rural and underserved areas.
- The Texas Higher Education Coordinating Board issues co-payable paper checks to physicians in the Physician Education Loan Repayment Program. This method of payment is inefficient, vulnerable to fraud, and costlier than electronic payments.
- The Texas Higher Education Coordinating Board, which administers the Physician Education Loan Repayment Program, does not routinely track the length of time physicians remain in underserved areas beyond their practice obligation. Without this data, Texas cannot measure retention rates for physicians in underserved and rural areas.

RECOMMENDATIONS

- **Recommendation 1:** Increase funding for the Physician Education Loan Repayment Program to allow both increased award amounts and more participants via one of three following methods of finance:
  (1) Amend Texas Occupations Code, Section 153, to add a $25 surcharge to medical licenses;
  (2) Amend Texas Government Code, Subchapter E. Section 481, to allow the Legislature to appropriate from the Texas Enterprise Fund an amount that matches what the program receives each year from a medical school tuition set-aside; or
  (3) Increase the appropriation of General Revenue Funds by an amount that matches the 2 percent set-aside from medical school tuition.

  Options 1 and 2 would require a contingency rider to appropriate funds to the Texas Higher Education Coordinating Board for the Physician Education Loan Repayment Program.
- **Recommendation 2:** The Texas Higher Education Coordinating Board should increase the financial incentives for participation in the Physician Education Loan Repayment Program.
- **Recommendation 3:** Amend Texas Education Code, Subchapter J, to allow the Texas Higher Education Coordinating Board to make electronic payments

to lending agencies on behalf of the physicians participating in the Physician Education Loan Repayment Program.

- **Recommendation 4:** Include a rider in the introduced 2010–11 General Appropriations Bill that requires the Texas Higher Education Coordinating Board to establish an ongoing procedure to track rates and length of provider retention in rural and health professional shortage areas.

DISCUSSION

In 2000, the *Journal of the American Medical Association* (JAMA) looked at state-level programs intended to encourage providers to practice in shortage areas. JAMA found that in 1996 there were 82 programs in 41 states.

The popularity of these programs may derive from their effectiveness. In a 2004 study, the *American Journal of Public Health* found that the rural Health Professional Shortage Area (HPSA) physicians had an average retention duration that was identical or slightly shorter than non-HPSA physicians. The study suggests that public policy makers address recruitment issues, saying that an inadequate inflow of physicians alone can lead to practitioner shortages. Health professional shortage areas are federally designated regions where the physician to population ratio is less than one physician for every 3,500 residents (1:3,500).

The average amount of student debt that physicians accrue in medical school has been rising for 20 years. The American Medical Association (AMA) estimates that 75 percent of all medical students carry at least $100,000 in student loan debt. The average debt for 2007's medical school graduates was $139,517, 6.4 percent more than in 2006.

In 2007, the AMA has found that medical students are less likely to choose primary care and more likely to pursue more lucrative specialties because of medical school debt. The result is that each year there are fewer primary care physicians entering the workforce. This decline, combined with population growth and aging, contributes to a nationwide deficit of primary care practitioners that could be between 35,000 and 44,000 by 2025. Cities and regions with higher salaries have an advantage in attracting physicians that do choose primary care. Doctors interested in rural primary care look for loan repayment incentives to help supplement the lower salaries they will likely draw in these areas.

The Texas Department of State Health Services' Primary Care Office maintains and updates the state's shortage designations. The U.S. Department of Health and Human Services recommends a provider-to-patient ratio of one primary care physician to every 2,000 individuals. The threshold for health professional shortage area (HPSA) designation is a physician to population ratio of 1:3,500. In areas with exceptionally high rates of poverty or infant mortality, the threshold is 1:3,000. Counties can be designated HPSAs in whole or in part. **Figure 322** shows the five states with the most Primary Care HPSAs. Texas has 406 whole and partial county designations, second to California and ahead of Illinois.

FIGURE 322
STATES WITH LARGEST NUMBER OF PRIMARY CARE HEALTH PROFESSIONAL SHORTAGE AREAS, 2008

STATE	SHORTAGE AREAS
California	521
Texas	406
Illinois	275
Florida	240
Michigan	200

Source: Texas Department of State Health Services.

Texas has approximately 5.6 million people, over 23 percent of its population, a proportion greater than any other state, living in some sort of HPSA. **Figure 323** shows the five states with the largest HPSA populations.

FIGURE 323
LARGEST POPULATIONS IN HEALTH PROFESSIONAL SHORTAGE AREAS, 2008

STATE	HPSA POPULATION (IN MILLIONS)
Texas	5.6
California	5.1
New York	4.5
Florida	4.3
Illinois	3.6

Source: Texas Department of State Health Services.

There are two ways for an area to receive an HPSA designation. Every three years the Primary Care Office surveys the providers within existing shortage areas. This survey helps it track measures such as the retirement of physicians, the arrival of new physicians, and changes in the health needs of

the population. A community may also request an off-year survey if the population or supply of providers changes suddenly.

HPSAS AND HEALTH STATUS

A 2003 study by Georgetown University found that adults in rural areas are less healthy than adults in urban areas. Routine chronic disease testing and dental care are also less common among rural adults. The University of Kentucky found that elderly adults living in HPSAs had significantly poorer health than elderly adults in non-HPSAs. The study also found that higher primary care physician to population ratios had a positive correlation with health status and life expectancy.

ECONOMIC CONTRIBUTIONS OF PHYSICIANS IN RURAL AREAS

In addition to having populations with poorer health and reduced life expectancies, communities without a primary health care infrastructure lack an important driver of rural economic development. According to Oklahoma State University, healthcare services can represent from 10 percent to 15 percent of a rural community's employment. Moreover, adding a physician to a rural community will also create other jobs, for instance administrative support, nursing and medical assistance. The U.S. Bureau of Labor Statistics estimates that the combined average salaries of a physician, registered nurse, and medical assistant in Texas are approximately $245,680.

According to a 2000 National Conference of State Legislatures report, each job created at a rural physician's practice generates an additional 1.78 local jobs, and each dollar of direct income to the practice results in another $1.52 throughout the local economy. Primary care physicians also generate hundreds of thousands of dollars in local hospital inpatient and outpatient revenues. These salaries and revenues from healthcare services when spent locally support other sectors of the rural economy and generate tax revenue that fund important community services. In addition to the local economic benefits, a primary healthcare infrastructure is also a factor in attracting businesses, workers, and retirees to a community.

THE PHYSICIAN EDUCATION LOAN REPAYMENT PROGRAM (PELRP)

Texas' Physician Education Loan Repayment Program (PELRP) was established by legislation enacted by the Sixty-ninth Legislature, Regular Session, 1985, and is administered by the Texas Higher Education Coordinating Board (THECB). The program's current method of finance includes General Revenue Funds and a 2 percent set-aside from the tuition payments made to the state medical schools. For each fiscal year of the 2008–09 biennium, PELRP received $197,047 in General Revenue Funds. The medical school tuition set-aside contributed approximately $725,000 for each fiscal year of the 2008–09 biennium.

PELRP entices primary care physicians to practice in health professional shortage areas by paying part of their student loans. The program also reimburses physicians who work for the Texas Department of State Health Services, the Texas Department of Criminal Justice, the Texas Health and Human Services Commission, or the Texas Youth Commission. Participating physicians must accept Medicaid patients and may not deny services based on a patient's inability to pay. The program does not require specific targets or quotas for Medicaid patients or visits. After the physician practices for a year at an approved site, THECB issues a co-payable check to the physician and the lending agency. The physician is then responsible for making the payment to the lender.

There are 65 physicians under contract to PELRP, a participation rate below what the authorized funds for the 2008–09 can afford. THECB staff attributes the low participation rate in PELRP to the program's relatively low repayment rate. THECB is requesting approximately $1.1 million per year for the 2010–11 biennium as an exceptional item in its Legislative Appropriation Request for PELRP.

Doctors serving in an HPSA can earn up to $9,000 per year from PELRP to pay their student loans and can apply to renew their contract annually for a maximum of five years as long as they have qualifying debt. Many states leverage federal grants from the Health Resource and Services Agency (HRSA) to increase their loan repayment program benefits. Texas' application for HRSA funds to supplement PELRP awards has been "approved but not funded" for the last two years, according to the Texas Department of State Health Services. As a result, Texas' loan repayment benefits for physicians are among the lowest in the country.

PELRP has an immediate effect by bringing physicians to shortage areas in exchange for student loan debt repayment. Since other states have similar loan repayment incentives, Texas competes with them for the declining supply of primary care physicians. Texas' $9,000 annual award to PELRP physicians is below what most states offer.

The Michigan State Loan Repayment Program (M-SLRP) offers physicians $25,000 per year. The federal HRSA match increases this to $50,000. Providers may renew their contracts for three more years. The Michigan legislature funds the program with an appropriation of General Revenue Funds in addition to HRSA's federal contribution. In the last few years, there has been more demand from physicians than the program can meet. For equity, the program administrators assign each incoming M-SLRP application a lottery number. Michigan recently started paying closer attention to retention rates. A survey from 2001 found that 58 percent of providers continued to practice at their locations after completing their contract. The average length of retention was approximately 2.5 years.

The state of Washington requires a minimum three-year commitment from providers participating in the state's Health Professional Loan Repayment/Scholarship Program. This program is appropriated $8.7 million in General Revenue Funds and is open to physicians, dentists, pharmacists, advance practice nurses, midwives, and all levels of licensed nursing. Physicians can make up to $75,000 for three years, or $25,000 per year. Washington's program gets more applicants than they can place each year. A retention study they did showed that their loan repayment program gets two years of service for each year paid for.

California's Steven M. Thompson Physician Corps Loan Repayment Program originated in 2002 under the state medical board. In 2006, the loan repayment program came under the purview of the California Health and Human Services Agency. The program pays physicians up to $105,000 in graduated amounts over three years.

The state that offers incentives most similar to Texas' is Arizona, whose loan repayment program pays physicians $16,000 to $20,000 per year for the first two years they serve in an HPSA and $18,000 to $22,000 per year for the third and fourth years.

Recommendation 1 contains three options for expanding the capacity of PELRP. The first option is a statutory change creating a $25 medical license surcharge. The first time they apply for a medical license, Texas physicians pay a total of $885 in application fees plus a prorated registration fee. The registration fee then costs a total of $752 biannually thereafter. **Figure 324** shows the component costs of each total.

There are over 60,000 licensed physicians in Texas. The Texas Medical Board expects to issue at least 29,000 initial and renewal licenses each year through 2011. The first option would generate an estimated additional $1.56 million for the 2010–11 biennium and would provide a stable source of funding for PELRP. If the annual PELRP award were increased to $20,000 per year, surcharge revenues alone would support another 78 physicians per biennium.

FIGURE 324
MEDICAL LICENSE COMPONENT COSTS, FISCAL YEAR 2008

COMPONENT	INITIAL APPLICATION	BIANNUAL REGISTRATION
Application Fee	$680	NA
Registration Fee	NA	$260
Professional Fee	200	400
Texas Online Fee	5	10
License Enforcement	NA	80
Office of Patient Protection Fee	NA	2
TOTAL	**$885**	**$752**

SOURCE: Texas Medical Board.

The first option would include a contingency rider in the 2010–11 General Appropriations Bill to appropriate money from the $25 medical license surcharge to THECB and PELRP.

The second option for increasing PELRP funds is to amend statute to allow the Legislature to appropriate funds that match the medical school tuition contribution to PELRP from the Texas Enterprise Fund. The Enterprise Fund was established by the Seventy-eighth Legislature, Regular Session, 2003. It is a trusteed program within the Governor's Office used for economic and community development projects. It has paid $360 million to 40 entities since the beginning of fiscal year 2004.

Healthcare employment, and the resulting wages, is an important part of the rural economy, accounting for 10 percent to 15 percent of the local jobs. In addition to the direct employment physicians create (such as nurses, medical technologists, and receptionists), they also generate hundreds of thousands of dollars in hospital inpatient and outpatient revenues. Thus, the economic contributions of physicians to underserved areas are at least as important as their medical ones. Appropriating an amount from the Enterprise Fund to match the medical school tuition contribution to PELRP would be consistent with the Enterprise Fund's mission and not significantly decrease its balance. The second option would transfer approximately $1.45 million from the

Enterprise Fund to PELRP for the 2010–11 biennium. If the annual PELRP award were increased to $20,000 per year, this appropriation from the Texas Enterprise Fund would support another 72 physicians each biennium.

The second option would include a contingency rider in the 2010–11 General Appropriations Bill to direct the Governor's Office to transfer an amount authorized by the Legislature to THECB for PELRP.

The third option for funding Recommendation 1 is increasing PELRP's appropriation of General Revenue Funds. An amount that matches the medical school tuition contribution to PELRP would add approximately $1.45 million in General Revenue Funds to PELRP for the 2010–11 biennium. If the annual PELRP award were increased to $20,000 per year, this additional appropriation of General Revenue Funds would support another 72 physicians per biennium.

The second option would redirect a small portion of the appropriation to the Texas Enterprise Fund to the PELRP, which would not result in a cost. The third option would cost $1.45 million in General Revenue Funds during the 2010–11 biennium.

Recommendation 2 would increase PELRP's annual award amount to make the program more attractive to physicians seeking loan repayment programs. Agency rules allow THECB to set the maximum award amount for PELRP. The current maximum, $9,000 per year, is the lowest in the nation. This recommendation would direct THECB to increase their maximum awards to make Texas more competitive with other states.

The current statutory language requires THECB to issue a co-payable check made out to the PELRP physician and the physician's lending institution. The physician is responsible for forwarding the check to the lender. This method of payment is less efficient and more vulnerable to fraud than electronic payments. Recommendation 3 would allow THECB to make electronic payments directly to lending agencies while retaining the option of issuing paper checks when necessary. THECB is already capable of making electronic payments. This change would be more efficient and reduce the risk of fraud.

Recommendation 4 would direct THECB to track the retention rates of PELRP physicians in HPSAs regularly. Academic studies and surveys in other states suggest that participants in loan repayment programs continue to practice in their shortage areas after their contract ends. THECB surveyed former PELRP physicians in June 2008. The survey found that approximately 49 percent of them were still practicing in the same city. Approximately 55 percent were practicing in the same county. Fifty-nine percent of them were still practicing in an HPSA. A regularly occurring survey would help THECB evaluate the success of PELRP as well as provide feedback from physicians and information about specific areas of the state that might strengthen the program.

FISCAL IMPACT OF THE RECOMMENDATIONS

Recommendation 1 has three options for increasing funding for PELRP, allowing for both more awards and larger financial incentives. The first option, a $25 medical license surcharge, would result in a revenue gain of $1.56 million for the 2010–11 biennium and a cost of $1.56 million in General Revenue Funds, as shown in **Figure 325**.

FIGURE 325
FIVE-YEAR FISCAL IMPACT OF OPTION 1, A $25 MEDICAL LICENSE SURCHARGE

FISCAL YEAR	PROBABLE GAIN/ (LOSS) IN GENERAL REVENUE FUNDS	PROBABLE SAVINGS/ (COST) IN GENERAL REVENUE FUNDS
2010	$772,400	($772,400)
2011	$787,850	($787,850)
2012	$725,000	($725,000)
2013	$725,000	($725,000)
2014	$725,000	($725,000)

Source: Legislative Budget Board.

This license surcharge is small enough that it would not deter physicians from seeking a medical license in Texas, nor would it increase the number of people paying fees. The Texas Medical Board would collect this fee by using existing processes and resources.

The second option for Recommendation 1 is an appropriation from the Texas Enterprise Fund that matches PELRP's 2 percent medical school tuition set-aside. This transfer of funds would not represent any additional cost.

The third option for financing Recommendation 1 is an increased appropriation of General Revenue Funds that match PELRP's 2 percent medical school tuition set-aside. This option would result in a cost of $1.45 million in General Revenue Funds for the 2010–11 biennium, as shown in **Figure 326**.

FIGURE 326
FIVE-YEAR FISCAL IMPACT OF OPTION 3, USING AN INCREASED GENERAL REVENUE APPROPRIATION TO FINANCE THE PHYSICIAN EDUCATION LOAN REPAYMENT PROGRAM

FISCAL YEAR	SAVINGS/(COST) IN GENERAL REVENUE FUNDS
2010	($725,000)
2011	($725,000)
2012	($725,000)
2013	($725,000)
2014	($725,000)

Source: Legislative Budget Board.

Recommendation 3 would allow THECB to make payments electronically as well as with paper checks. Recommendation 4 would direct THECB to increase the amount of money paid to physicians in the PELRP. Recommendation 5 would direct THECB to survey PELRP physicians to track retention rates in state HPSAs. THECB could implement Recommendations 3, 4, and 5 with existing resources.

The introduced 2010–11 General Appropriations Bill does not include any adjustments as a result of these recommendations.

FEDERAL REVENUES AT TEXAS PUBLIC TWO-YEAR INSTITUTIONS OF HIGHER EDUCATION COMPARED TO NATIONAL BENCHMARKS

Federal revenue allows public two-year institutions of higher education to expand program offerings, increase affordability for students, or reduce the burden imposed on state and local resources. Legislative Budget Board staff used a federal education database to determine total federal revenue at public two-year institutions across the United States. Student financial aid grants, which are generally allocated by formula and which function as tuition offsets that supplant rather than supplement other sources of revenue, were removed from this total. The remaining amount was adjusted per full-time-equivalent student. This measure provides an estimate of federal institutional support per full-time-equivalent student and allows comparisons of public two-year institutions in Texas and other large states.

FACTS AND FINDINGS

- Texas two-year institutions received $627 in federal institutional support per full-time-equivalent student—13 percent more than the national average ($553) and 39 percent more than the average of the 10 most populous states ($453).
- From fiscal years 2004 to 2006, federal institutional support per full-time-equivalent student increased 11 percent for Texas two-year institutions compared to 10 percent for the national average and 6 percent for the 10 most populous states.
- Texas ranked second among the 10 most populous states in federal institutional support per full-time-equivalent student at two-year institutions in fiscal year 2006. Texas advanced two places in this ranking from fiscal years 2004 to 2006.

DISCUSSION

Federal revenue represents a portion of the funding stream for most Texas public two-year institutions of higher education (community colleges, Texas State Technical Colleges, and the Lamar State Colleges). If federal revenue could be increased at these institutions, the resulting funds could be used to expand program offerings, increase affordability for students, or reduce the burden on state and local resources.

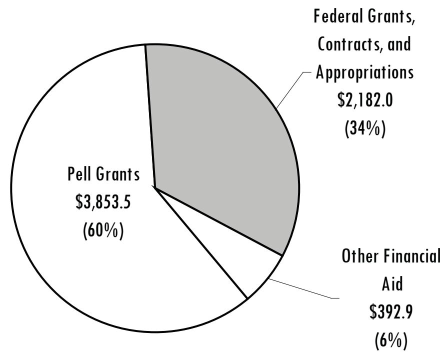
One approach to determining the potential for Texas two-year institutions to expand federal revenues is to examine federal appropriations at the program level and evaluate whether Texas institutions are taking full advantage of these opportunities. This approach would identify specific potential federal revenue sources, determine the scope of revenues that could be accessed in a particular program, assess the rules for allocating funds from that program, evaluate whether the program rules influence the allocation, and decide if the marginal increase in federal revenues is worth the cost of the action required.

An alternative approach would provide a broader picture of the potential to increase federal revenues by comparing federal revenue at Texas public two-year institutions to similar institutions in other states. Texas sources of data cannot be used for this purpose. Access to the internal databases of other states is uncertain and those states may measure key variables in a manner that precludes direct comparisons to Texas data.

In October 2008, Legislative Budget Board staff conducted an analysis of federal revenue at public two-year institutions using the U.S. Department of Education's Integrated Postsecondary Education Data System (IPEDS). This database collects several different annual surveys covering virtually all higher education institutions in the U.S. **Figure 327** shows the distribution of the major types of federal revenue in fiscal year 2006.

Pell Grants and other direct sources of student financial aid (e.g., Supplemental Opportunity Education Grants) represent 66 percent of total federal support to the public two-year institution sector reported in the IPEDS database. Pell Grants are the largest federal student aid program and are calculated for students based on financial need by federal formula. These grants function essentially as entitlements and thus are not amenable to institutional efforts to increase federal revenues. Other federal financial aid programs are also allocated according to formula. In addition, these federal financial aid funds are disbursed to students directly by the institution and largely function as tuition offsets because they supplant rather than supplement that source of revenue. Including federal financial aid funds in an analysis designed

FIGURE 327
TYPES OF FEDERAL REVENUE TO PUBLIC TWO-YEAR INSTITUTIONS OF HIGHER EDUCATION, FISCAL YEAR 2006



SOURCE: U.S. Department of Education.

to detail possibilities for increasing federal revenue will overstate the amount that institutions could realistically strive to access.

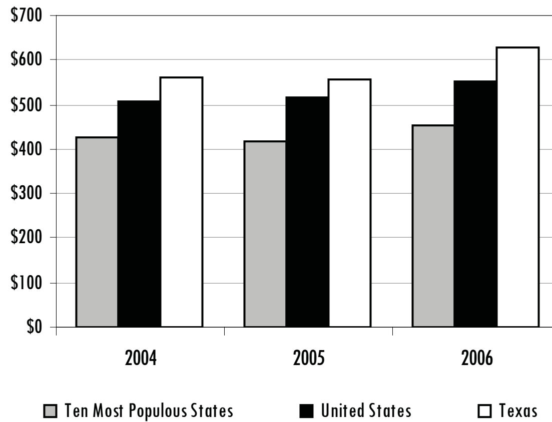
To derive a measure of federal support to the two-year institution sector, this report analyzes federal revenues other than Pell Grants and other financial aid programs. This measure provides an estimate of the amount of federal support for public two-year institutions beyond tuition and fees that would otherwise be collected directly from students. Federal revenue data from IPEDS was modified to remove Pell Grants, resulting in a measure of "federal institutional support." This measure was then divided by 12-month full-time-equivalent (FTE) student enrollment to establish federal institutional support per FTE student.

TRENDS IN FEDERAL REVENUES

Figure 328 shows federal institutional support per FTE student at two-year institutions in fiscal years 2004 to 2006 for Texas, the U.S., and Texas' closest peers—the 10 most populous states.

In fiscal year 2006, Texas two-year institutions received $627 in federal institutional support per FTE student—13 percent more than the United States average ($553) and 39 percent more than the average of the 10 most populous states ($453). This gap increased from fiscal year 2004 to fiscal year 2006. Federal institutional support per FTE student for Texas two-year institutions increased 11 percent between fiscal years 2004 and 2006 compared to 10 percent for both the U.S. average and 6 percent for the 10 most populous states.

FIGURE 328
FEDERAL INSTITUTIONAL SUPPORT PER FULL-TIME-EQUIVALENT STUDENT AT PUBLIC TWO-YEAR INSTITUTIONS OF HIGHER EDUCATION, FISCAL YEARS 2004 TO 2006



NOTE: Ten most populous states are California, Florida, Georgia, Illinois, Michigan, New York, North Carolina, Ohio, Pennsylvania, and Texas. Texas Southmost College is not included in this analysis.
SOURCE: U.S. Department of Education.

TEXAS COMPARED TO THE 10 MOST POPULOUS STATES

On the aggregated measure shown previously, Texas public two-year institutions are clearly generating more federal institutional support per FTE student than the basic benchmarks of the national average and the average of the 10 most populous states. **Figure 329** shows how Texas compared to each of the 10 most populous states in fiscal years 2004 to 2006.

FIGURE 329
FEDERAL INSTITUTIONAL SUPPORT PER FULL-TIME-EQUIVALENT STUDENT TO THE 10 MOST POPULOUS STATES AT PUBLIC TWO-YEAR INSTITUTIONS OF HIGHER EDUCATION, FISCAL YEARS 2004 TO 2006

STATE	2004	2005	2006
Pennsylvania	$531	$551	$628
Texas	**$563**	**$555**	**$627**
Georgia	$602	$565	$554
Michigan	$614	$642	$524
Illinois	$485	$507	$523
New York	$547	$410	$426
Florida	$773	$185	$383
California	$235	$353	$377
Ohio	$268	$231	$330
North Carolina	$249	$328	$308
Ten Most Populous	$427	$416	$453

NOTE: Texas Southmost College is not included in this analysis.
SOURCE: U.S. Department of Education.

On this more discrete benchmark comparing Texas to its closest peer states, Texas public two-year institutions also performed well. In fiscal year 2006, Texas ranked second among the 10 most populous states in federal institutional support per FTE student at two-year institutions. Texas institutions have also improved in recent years on this benchmark, advancing two places in this ranking from fiscal years 2004 to 2006.

On the benchmarks analyzed here, Texas public two-year institutions appear to be receiving more federal institutional support per FTE student than their peer institutions in other states. While this broad analysis does not preclude examining specific federal programs to determine if there are opportunities to increase federal revenue, it does suggest that there are fewer likely federal dollars to target for these efforts than might be expected.

STRENGTHEN FINANCIAL MONITORING AND ASSESSMENT FOR COMMUNITY COLLEGES

In fiscal year 2007, Texas public community college districts reported total funding of approximately $3.9 billion from federal, state, and local sources. Since fiscal year 2002, tax-supported debt increased $1.1 billion, or 157 percent. Numerous funding and cost factors can affect the financial condition of a district, impacting the ability to maintain, improve, or expand facilities and provide for the educational and training needs of the community. Operating budget and financial reports are required to be submitted annually, but rapid changes in economic conditions may impair the internal dynamics of a district's financial structure in some circumstances.

Texas lacks a fiscal monitoring or risk assessment process to determine if the public community college districts are using funds efficiently. A state-level early warning system would consistently and continuously ensure that financial risks at the local level are identified. By establishing criteria and standards for the periodic assessment of the fiscal condition of districts, Texas and the districts could resolve financial conditions before a crisis occurs. The implementation of a financial monitoring and risk assessment system should be accompanied by automation of district annual financial reports.

CONCERNS

- The Texas Higher Education Coordinating Board lacks a formal mechanism to assist 18 public community college districts that may have financial difficulties. Without this mechanism, the state's assistance to resolve the financial condition of identified districts may be too late.
- Unlike state agencies, public community college districts do not submit annual financial reports in an electronic format. This practice necessitates transcription from printed reports and hampers the ability of the Texas Higher Education Coordinating Board to monitor the financial condition of districts.

RECOMMENDATIONS

- **Recommendation 1:** Amend Texas Education Code, Section 61.065, to require the Texas Higher Education Coordinating Board to use standard financial ratios to detect early concerns at Texas public community college districts and to work with the districts to improve financial conditions and decrease financial risks.
- **Recommendation 2:** The Texas Higher Education Coordinating Board should create an electronic format for the required submission of annual financial reports from Texas public community college districts to permit efficient and effective monitoring of financial conditions.
- **Recommendation 3:** Include a contingency appropriation rider in the 2010–11 General Appropriations Bill that appropriates $200,000 in General Revenue Funds for the biennium and authorizes one full-time-equivalent position at the Texas Higher Education Coordinating Board.

DISCUSSION

Each Texas public community college district has its own governance structure to manage the fiscal resources affecting all aspects of the district. As stewards of the resources entrusted to the district, board members have the responsibility to ensure that the financial condition and results of operations are presented in the district financial statements in as transparent a manner as possible. Numerous revenue and cost factors can affect the financial condition of a district, impacting the ability to maintain, improve, or expand facilities and provide for the educational and training needs of the community.

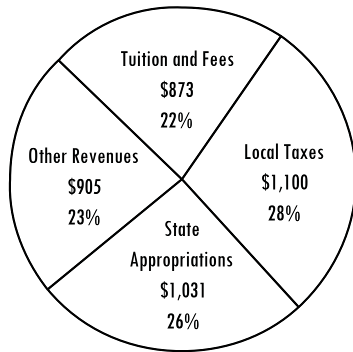
Open access to the results of financial operations fosters trust and confidence in a district's financial management and viability. Annual financial reports provide extensive detail about a district's financial strategy for internal and external stakeholders. To improve the interpretation of such detail, a statewide process is needed to determine financial condition and strengthen the financial viability of districts.

FUNDING LIMITATIONS OF THE DISTRICTS

Each district must balance a combination of revenue sources while generating sufficient revenues to fund capital and operational expenses. In fiscal year 2007, districts statewide reported total revenues of approximately $3.9 billion from federal, state, and local sources. As shown in **Figure 330**, the major sources of funding are state appropriations of General Revenue Funds, local taxes, student tuition and fees, federal grants, and other income.

FIGURE 330
FUNDING SOURCES AS A PERCENTAGE OF TOTAL COMMUNITY COLLEGE DISTRICT REVENUES, FISCAL YEAR 2007

IN MILLIONS TOTAL = $3, 908 MILLION



Source: Legislative Budget Board.

The Texas Legislature appropriates General Revenue Funds to districts. The majority of these funds are based on a community and technical college funding formula. The Legislature limits the use of these funds to cover instructional and administrative costs. A rider in the General Appropriations Act of the Eightieth Texas Legislature, 2007, restricts the use of formula-generated funds to "the payment of the following elements of cost: instruction, academic support, student services, institutional support, organized activities, and staff benefits associated with salaries paid from general revenue."

Local revenue for many districts, especially those in rural areas of the state, is limited by their tax bases. In fiscal year 2007, 14 districts did not meet the $2.5 billion minimum assessed property valuation requirement established by the Texas Legislature in 1985 for the creation of new districts. All of those districts are rural or in smaller cities, and several have a taxable area significantly smaller than the county in which they are located. The poorest district has a gross assessed valuation of $74 million and collected taxes of $186,000.

In addition, several community college districts have reached, or are near, their maximum local tax levy, according to the *Strategic Plan for Texas Public Community Colleges 2009–2013*. Increasing local tax revenue is a complex process.

Districts use revenues generated from local taxes to fund costs related to physical plant and facilities. At the end of fiscal year 2007, the Texas Bond Review Board reported that districts had $2.8 billion in principal debt outstanding ($1.8 billion in tax-supported debt, $869 million in revenue debt, and $139 million in lease-purchase obligations). Sixty-four percent of outstanding debt is tax-supported (bonds that are payable from ad valorem taxes levied upon all taxable property within the districts). Total principal outstanding for districts increased 96 percent over the last five years. Since fiscal year 2002, tax-supported debt increased $1.1 billion, or 157 percent. Of the 50 districts, 25 have tax-supported debt, 45 have revenue debt, and one has lease-purchase contracts for facilities. Twenty-two districts have both tax and revenue debt. Two districts, Ranger College District and Texarkana Community College District, are debt free.

Tuition rates vary by community college, although the minimum tuition charge is determined by state law. Other student fees can provide additional resources, but the institution must consider the negative impact such increases could have on enrollment. With enrollment-driven state appropriations, a decrease in enrollment could cause other fiscal concerns for an institution. Attempts to improve efficiency through an increase in tuition and elimination of staff and programs do not always lead to greater organizational performance within districts.

Districts need skilled administrators to compete for federal, additional state, and external funds. There are a number of federal funding sources available to all districts. These sources range from student financial assistance to various federal grants for the operation of specific educational programs. These sources of funding generally require commitment of institutional resources, as well, and can be labor-intensive to manage as a result of federal regulations. Administrative skill and capacity also come into play in generating entrepreneurial revenues through corporate contract training, auxiliary sales in food courts and bookstores, and in fundraising.

HISTORY AND USE OF RATIOS

The accounting firm, KPMG LLP, published *Ratio Analysis in Higher Education* in the 1970s. Its purpose was to help trustees, senior managers, credit agencies, and policy makers better understand financial statements through the use of financial ratio analysis. This publication evolved into *Ratio Analysis in Higher Education: Measuring Past Performance to Chart Future Direction, 4th Edition for Independent Institutions (1999)* and *Strategic Financial Analysis for Higher Education–Sixth Edition* published by KPMG in 2005. Today, some of the ratios developed are used not only by trustees, senior managers, and chief financial officers but also by the U.S. Department of Education to determine if an institution is viable to receive federal financial aid, by rating agencies, by investors, and by education accrediting bodies. Financial ratio analysis is considered an accurate means of measuring viability, not only by institutional constituencies but also by the federal government, creditors, and accreditors. The fiscal ratio analysis presented in this report was derived directly from the work of KPMG.

KPMG, et al., created an overall measure of an institution's financial health, called the Composite Financial Index (CFI), which was based on four core financial ratios: Primary Reserve Ratio, Operating Margin Ratio, Return on Net Assets Ratio, and Viability Ratio (**Figure 331**). The CFI index compares an institution's operating commitments, Primary Reserve Ratio, and its long-term obligations, Viability Ratio, expendable wealth, Operating Margin Ratio, and the Return on Net Assets Ratio.

Two basic concepts were emphasized in this analysis. First, a few measures would effectively provide insight to financial health. Second, the ratios were useful if the information was readily obtainable and the calculations repeatable. All ratios were calculated using data from each of the district annual financial reports. The core financial ratios properly weighted and scored on a common scale can create a single score of institutional financial condition. The use of a single score is superior to individual measurement of each core financial ratio because a single score allows a weakness in a particular ratio to be offset by strength in another ratio.

In the KPMG methodology for calculating CFI, after the values of the core financial ratios are computed, they are converted to strength factors along a common scale of 1 to 10, multiplied by weighting factors, and totaled to produce the CFI. Standard weighting factors used in this report include: Primary Reserve Ratio – 0.35, Operating Margin Ratio – 0.10, Return on Net Assets Ratio – 0.20, and Viability Ratio – 0.35.

As shown in **Figure 332**, a CFI substantially higher than 3 suggests that a district can consider how to deploy its resources effectively to strengthen services and market position. A CFI of 3 is the minimum necessary for an institution to meet financial targets. A CFI less than 3 indicates that the financial condition should be watched, suggesting that a district is vulnerable to unexpected changes in the economy and the market place. The district should construct a financial strategy that targets the weakest components of the core financial ratios within the CFI. A lower CFI for a number of years,

FIGURE 331
CORE FINANCIAL RATIOS, 2005

RATIO DESCRIPTION	CALCULATION
Primary Reserve Ratio – measures financial strength by providing an indication of how long an institution could operate on its expendable reserves without additional assets generated by operations.	[expendable net assets]/[total expenses]
Operating Margin Ratio – shows whether total unrestricted operations have resulted in a deficit or surplus; shows whether the institution is living within its means. Depreciation expense is included to reflect a more complete picture of operating performance as it reflects use of physical assets.	[operating income (loss) plus net nonoperating revenues (expenses)]/[operating revenues plus nonoperating revenues]
Return on Net Assets Ratio – shows whether an institution is financially better off than prior years by measuring total economic return.	[change in unrestricted net assets]/[total unrestricted income]
Viability Ratio – shows the availability of expendable net assets to cover debt as of balance sheet date; a very basic measure of an institution's financial condition.	[expendable net assets]/[long-term debt]

Source: KPMG.

FIGURE 332
COMPOSITE FINANCIAL INDEX CONDITION, 2008

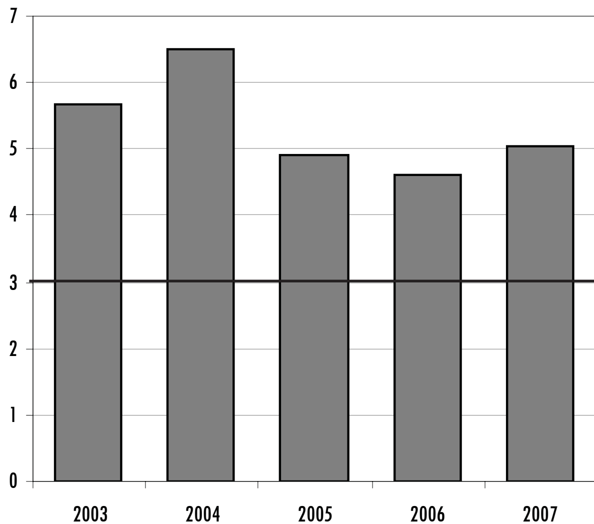
COMPOSITE FINANCIAL INDEX	CONDITION
3 and above	Satisfactory
<3 and>= 1	Watch
Below 1	Unsatisfactory

SOURCE: Legislative Budget Board.

especially below 1, indicates that immediate action is required.

According to LBB analysis, the statewide average CFI for districts was consistently above 3 from fiscal years 2003 to 2007 as shown in **Figure 333**. However, there has been a slight decline in the statewide average since 2004. A decline in a single year is not cause for concern if the districts were financially strong and the reasons for the deficit are known. A decline over a period of years signals the need for a more in-depth look at district revenues and expenditures.

FIGURE 333
TEXAS PUBLIC COMMUNITY COLLEGE DISTRICTS STATEWIDE AVERAGE COMPOSITE FINANCIAL INDEX, FISCAL YEARS 2003 TO 2007



SOURCE: Legislative Budget Board.

As shown in **Figure 334**, the districts were grouped into three financial conditions (satisfactory, watch, and unsatisfactory as described in **Figure 332**) based on the fiscal year 2007 CFI. The financial condition of a district is best understood if the CFI is calculated over an established time period, for example, the past three to five years. The magnitude and direction of the CFI yield further insights into a district's ability to adapt to crisis and new opportunities.

FIGURE 334
TEXAS PUBLIC COMMUNITY COLLEGE DISTRICTS COMPOSITE FINANCIAL INDEX CONDITION, FISCAL YEAR 2007

COMPOSITE FINANCIAL INDEX CONDITION	NUMBER OF DISTRICTS*	AVERAGE CFI
Satisfactory	28	7.08
Watch	16	2.08
Unsatisfactory	2	0.14

*Incomplete data available for four districts.
SOURCE: Legislative Budget Board.

Examining the trend of the core financial ratios included in the CFI can identify factors that must be changed to improve financial condition. In some cases, isolated financial difficulties in particular areas are material enough to threaten the overall financial results. Twenty-eight institutions were in satisfactory financial condition. As shown in **Figure 335**, these institutions exhibit a general history of relatively stable or increasing core financial ratios.

FIGURE 335
CORE FINANCIAL RATIOS FOR DISTRICTS IN SATISFACTORY FINANCIAL CONDITION, FISCAL YEARS 2005 TO 2007

CORE FINANCIAL RATIO	STANDARD BENCHMARKS*	2005	2006	2007
Primary Reserve Ratio	0.15	Above	Above	Above
Operating Margin	2	Above	Above	Above
Return on Net Assets	3	Above	Above	Above
Viability Ratio	1.25	Above	Above	Above

*KPMG.
SOURCE: Legislative Budget Board.

Sixteen institutions in watch financial condition should be monitored for declining trends. These institutions exhibit a history of relatively unstable or declining core financial ratios. As shown in **Figure 336**, the viability ratio was below the standard benchmark from fiscal years 2005 to 2007.

Two institutions had an unsatisfactory financial condition and additional investigation into the possible cause is recommended. These institutions exhibit a history of relatively unstable core financial ratios. As shown in **Figure 337**, the primary reserve ratio was above the standard benchmark from fiscal years 2005 to 2007. The operating margin ratio is below the benchmark in two of three years, possibly due to material operating difficulties or uncertainties caused by either internal management decisions or external factors. Moody's Investor Services suggests that districts with

FIGURE 336
CORE FINANCIAL RATIOS FOR DISTRICTS IN WATCH FINANCIAL CONDITION, FISCAL YEARS 2005 TO 2007

CORE FINANCIAL RATIO	STANDARD BENCHMARKS*	2005	2006	2007
Primary Reserve Ratio	0.15	Above	Above	Above
Operating Margin	2	Above	Above	Above
Return on Net Assets	3	Above	Above	Above
Viability Ratio	1.25	Below	Below	Below

*KPMG.
SOURCE: Legislative Budget Board.

FIGURE 337
CORE FINANCIAL RATIOS FOR DISTRICTS IN UNSATISFACTORY FINANCIAL CONDITION, FISCAL YEARS 2005 TO 2007

CORE FINANCIAL RATIO	STANDARD BENCHMARKS*	2005	2006	2007
Primary Reserve Ratio	0.15	Above	Above	Above
Operating Margin	2	Below	Above	Below
Return on Net Assets	3	Below	Above	Below
Viability Ratio	1.25	Below	Below	Below

*KPMG.
SOURCE: Legislative Budget Board.

operating margin ratio deficits for more than two years need immediate attention. The return on net assets ratio is below the benchmark in two of the years analyzed and could be considered a threat to the overall financial stability of the institution. The viability ratio is below the standard benchmark from fiscal years 2005 to 2007.

CFI values are not precise; rather, they are indicators of ranges of financial condition that can be indicators of overall district well-being when combined with non-financial indicators. **Figure 336** and **Figure 337** identify declining viability ratios and other potential financial risks for districts in the watch and unsatisfactory financial conditions. The viability ratio is a district's safety net in the event of extraordinarily adverse conditions. Corrective actions may be necessary. At a basic level, the viability ratio can be improved by working to increase the numerator or decrease the denominator. The numerator of the viability ratio includes all unrestricted and expendable restricted net assets. Multiple institutional strategies can be used to increase revenues and decrease costs that will result in net asset increases. The viability ratio denominator includes all amounts borrowed by the institution for long-term purposes from third parties. One corrective action could include the adoption or revision of a formal debt policy to ensure that debt is used most effectively to advance the district's mission and objectives. However, there is no absolute threshold that will indicate whether the institution is no longer financially viable and the level that is "right" is institution specific.

The volatility of core financial ratios may also be due to material operating difficulties or uncertainties caused by either internal management decisions or external factors, but it is unknown at this time. Texas relies primarily on the governing board of a district to monitor financial structure and internal processes. District operating budget and financial reports are required to be submitted annually to the state, but rapid changes in economic conditions may impair the internal dynamics of a district's financial structure in some circumstances. A state-level early warning system would consistently and continuously ensure that financial risks at the local level are identified.

Improvements in financial condition may be needed for districts in both the watch and unsatisfactory conditions. Without additional follow-up of those districts, the cause and materiality of the financial issues cannot be resolved. A monitoring and mitigation process should be implemented to improve the financial condition and decrease the financial risk of districts.

DEVELOP FINANCIAL MONITORING AND ASSESSMENT SYSTEM

Shifts in federal, state, and local fiscal funding introduce financial challenges for districts. The Texas Higher Education Coordinating Board (THECB) established the Higher Education Accountability System for community colleges in 2004, but no fiscal monitoring or risk assessment process has been established to determine if resources are being used efficiently. By establishing criteria and standards for the periodic assessment of the fiscal condition of Texas public community colleges, Texas and the districts could resolve financial conditions before a crisis occurs. Early detection would allow the district and Texas the opportunity to take proactive and preventative steps to stabilize and resolve the financial condition of identified districts and reduce the cost of formal state intervention.

Multiple state agencies are charged with varying tasks for district reporting, statutory compliance, and institutional effectiveness, but no formal coordination of these agencies for financial oversight occurs until a fiscal crisis has taken place. The district annual financial report is the primary tool for fiscal accountability at the state level. Texas Education Code, Section 61.065, requires community colleges to submit their annual financial reports to THECB, Legislative

Budget Board (LBB), and State Auditor's Office (SAO). THECB and the Comptroller of Public Accounts (CPA) provide guidance as to what information is included in the district annual financial reports. THECB staff then review all completed annual financial reports for requirements and completeness.

These annual financial reports include an analysis of the college's overall financial position and results of operations in the Management Discussion and Analysis and comprehensive annual financial report statistical section (required by the Governmental Accounting Standards Board (GASB) and the THECB). GASB does not require management to determine and report whether the college's financial position improved or deteriorated during the period. At best, this is a subjective assessment and must include "significant" factors that caused the variations. If the reader does not have a basic understanding of the annual financial report, these assessments may go unquestioned at the state level.

At the local level, community colleges contract with certified public accountants for annual financial audits. Despite this safeguard, financial problems still persist at some districts. A May 2008 report by the SAO identified 92 percent of districts that were in full or substantial compliance with the Texas Public Funds Investment Act. One community college district was in minimal compliance with the act. Three community college districts did not comply with the act because they did not provide acceptable compliance audits. Eighty-six percent of districts were in full or substantial compliance with the higher education investment reporting requirements. Two community college districts did not post their investment reports, current investment policies, and other required disclosures on their websites and, therefore, were non-compliant. Five community college districts were minimally compliant with the higher education investment reporting requirements.

THECB serves several state roles including the approval of academic, technical, and vocational post-secondary degree and certification programs and the evaluation of public community and technical colleges for institutional effectiveness, but there is little emphasis on fiscal accountability. THECB reviews community colleges for institutional effectiveness once every three years using Accountability System and Annual Data Profile data according to *Texas Higher Education Coordinating Board Institutional Effectiveness Guidelines* (September 2007). THECB reviews are generally desk reviews and on-site review occurs in certain instances (community college president request or immediate need). Financial indicators are not included as factors for determining whether either on-site or desk review attention might be necessary.

Two states, California and Ohio, have implemented financial monitoring systems to ensure fiscal accountability at community colleges. Each state routinely monitors key conditions affecting the fundamental elements of financial viability and answers to certain questions concerning a community college's overall financial condition. By using annual financial information to set benchmarks based on multiyear trends of specific financial measures that determine whether districts are beginning to experience financial difficulty, each state determines which actions can be taken to correct the situation.

Both states have developed early detection systems. The California Community College System has developed standards to identify districts that may benefit from preventative management assistance and those that may require state intervention. The California monitoring plan utilizes various information sources, including local and state audits, to assess the financial condition of all community college districts. The Ohio Board of Regents relies on the quarterly submission of financial statement data and three KPMG core financial ratios: viability, primary reserve, and net income. A CFI of or below 1.75 for two consecutive years for Ohio community colleges results in an institution being placed on fiscal watch.

Texas Government Code, Section 2104.031, authorizes THECB to adopt policies, enact regulations, and establish rules for action concerning the conservatorship of a public community college when requested by the Governor and upon the advice and assistance of the State Auditor. Texas could identify and resolve problems before state intervention is required if a monitoring and mitigation process were implemented. Specific financial measures from annual financial reports would provide multiyear trends. Comparison to established benchmarks would permit early detection of districts experiencing financial difficulties. An ongoing monitoring system would evaluate the progress of strategic financial management in corrective action plans of districts. Management assistance would determine which internal or external policy actions could correct the situation.

Recommendation 1 would amend Texas Education Code, Section 61.065, to strengthen fiscal accountability and encourage sound fiscal management practices that would require:

- THECB to establish criteria and standards for the periodic assessment of the fiscal condition of Texas public community college districts;
- THECB to notify the governing board of a district when certain financial conditions exist;
- THECB, with assistance from CPA, to establish guidelines for developing and evaluating corrective action plans and providing direct management assistance to districts;
- the district to submit a corrective action plan to THECB and resolve the certain financial conditions within a required time frame;
- the district to report the implementation status of any corrective action plans in periodic updates to THECB, the Annual Financial Report, and the Legislative Appropriations Request; and
- THECB to coordinate a state response to continued deficiencies as required in Texas Government Code, Section 2104.

A full-time-equivalent position would be integral to the creation and implementation of the monitoring and mitigation process at the agency.

AUTOMATE TEXAS PUBLIC COMMUNITY COLLEGE DISTRICT ANNUAL FINANCIAL REPORT SUBMISSION

The implementation of a financial monitoring and risk assessment system at THECB should be accompanied by automation of district annual financial reports. THECB and other state agency staff largely depend on printed annual financial reports as a primary mechanism for financial monitoring and oversight of districts. As a result, agency staffs expend time and effort searching for, maintaining, and processing these reports. A high level of effort is required by the district and agencies to prepare, track, and consolidate these documents. By automating the annual financial reports, periodic assessment of any district's financial condition can be created more efficiently and used more effectively by agency management and staff. Districts may realize a cost savings.

All state agencies, except public community colleges, have the opportunity to submit their annual financial reports in an electronic format. Texas Government Code, Section 2101.011, requires all state agencies, including institutions of higher education, to submit an annual financial report to the Governor, LBB, State Auditor, and CPA each year. Texas Education Code, Section 61.065, requires CPA and THECB jointly "to prescribe and periodically update a uniform system of financial accounting and reporting for institutions of higher education… ." CPA identified agencies that are eligible to participate in a simplified submission process, which requires annual financial reports to be submitted electronically. To accelerate the submission process, CPA encourages these "simplified reporting agencies" to take advantage of incentives for submitting their reports early. The deadline for early submission is October 1 each year.

Districts are required to submit their annual financial reports by January 1 each year. In odd-numbered years, this minimizes the usability during the legislative session. According to THECB staff, once the agency receives the 50 reports, each report is manually reviewed for completeness and accuracy, which sometimes takes several weeks. THECB staff manually enters AFR data and some elements may be requested again from the college for other THECB programs. As a result, districts may be required to submit financial data to the agency multiple times in multiple formats including the *Report of Fundable Operating Expenses*. The printed annual financial reports can cost the college $700 or more in printing, binding, and postage costs.

Recommendation 2 would direct THECB to create an electronic format for the required submission of annual financial reports from Texas public community college districts to permit efficient and effective monitoring of financial conditions.

Recommendation 3 would include a contingency appropriation rider in the 2010–11 General Appropriations Bill and authorize one full-time-equivalent position at THECB.

FISCAL IMPACT OF THE RECOMMENDATIONS

Implementation of Recommendation 1 would cost $150,000 for the 2010–11 biennium to support one full-time-equivalent position above THECB's current staffing levels. The position would be integral to the creation and implementation of the monitoring and mitigation process at the agency.

Implementation of Recommendation 2 would cost $50,000 in fiscal year 2009. THECB would incur one-time start-up costs for an electronic system, which would produce savings from efficiencies in later years for the districts.

To fund implementation of these recommendations, Recommendation 3 would include a contingency appropriation rider in the 2010–11 General Appropriations Bill that appropriates $200,000 in General Revenue Funds for the biennium and authorizes one full-time-equivalent position at the Texas Higher Education Coordinating Board. **Figure 338** details these costs.

FIGURE 338
FIVE-YEAR FISCAL IMPACT OF RECOMMENDATIONS, FISCAL YEARS 2010 TO 2014

FISCAL YEAR	PROBABLE SAVINGS/ (COST) IN GENERAL REVENUE FUNDS	CHANGE IN FULL-TIME EQUIVALENTS COMPARED TO 2008–09 BIENNIUM
2010	($125,000)	1
2011	($75,000)	1
2012	($75,000)	1
2013	($75,000)	1
2014	($75,000)	1

Source: Legislative Budget Board.

The introduced 2010–11 General Appropriations Bill does not address these recommendations.

INCREASE THE STUDENT TRANSFER RATE FROM TWO-YEAR TO FOUR-YEAR INSTITUTIONS OF HIGHER EDUCATION

Texas public two-year institutions have generally grown more rapidly than four-year institutions and are expected to continue to outpace four-year institution growth. Each year, tens of thousands of students begin academic studies at a two-year institution, but most do not make the transition to a four-year institution. The transfer rate for first-time undergraduates has remained flat at 20 percent from fiscal years 2004 to 2007.

Attrition along the transfer pathways may stem from inconsistent alignment of courses and financial aid needed for transfer. Texas needs seamless pathways with transparent requirements to link courses at two-year institutions to baccalaureate degrees related to state goals. But, minimal state guidance is currently available for the development of institutional agreements to align curricula and guarantee acceptance of transfer coursework at both the program and course levels. Also, an inconsistency exists between students' aspirations to transfer and the financial support needed to achieve this goal. Many transfer students have financial need, face higher costs, but do not fare well in the competition for available financial aid. Other states have developed financial aid programs to support state goals and address the financial barriers faced by transfer students.

Transfer pathways could be improved in several other ways. Full and timely communication between colleges and universities and full utilization of the existing information tools would enhance existing transfer practices and simplify the transfer process. A comprehensive and systematic planning and monitoring program would assess the effectiveness of transfer policies. Research on emerging issues would recommend policies and practices targeted to reduce identified barriers to transfer.

The existing structure to address these transfer issues in Texas does not provide the appropriate oversight and accountability for the transfer process at all higher education institutions. By establishing a transfer council at the Texas Higher Education Coordinating Board, the state could provide a stronger organizational structure to strengthen pathways between these institutions and ensure progress toward improved statewide goals for transfer. The seamless movement of students from institution to institution is important in reducing a student's total time to earn a degree, the total cost of that degree to students and families, and the cost to the state.

CONCERNS

- Sixty-one percent of lower division academic semester credit hours occurred at two-year institutions, while transfer students were awarded 34 percent of baccalaureate degrees, indicating that transfer remains inefficient. A Texas resident transfer student could save an estimated average 35 percent of the cost of tuition and fees over four years, but an inefficient system may decrease the probability of graduation.
- In fiscal year 2007, it is estimated that almost 17,000 students with an academic associate degree and over 18,000 core curriculum completers did not apply for transfer to a Texas public four-year institution. More institutional support and consistency would reduce the ongoing mismatch between students' academic aspirations and attainment.
- The major student financial aid programs in Texas are not designed to support financial need for students who intend to transfer without an associate degree. At least one-third of students with the intent to transfer to four-year institutions have financial need while transfer students are awarded less than 8 percent ($16 million) of the state financial aid dollars and comprise 6 percent of recipients.
- Challenges, such as inadequate transfer policies or enforcement, uneven institutional support, inconsistency in course alignment, and lack of guaranteed course acceptance, may suppress completion of academic associate degrees, hinder transfer, allow repetition of comparable courses, extend time to degree completion, and increase costs.

RECOMMENDATIONS

- **Recommendation 1:** Amend Texas Education Code, Chapter 61.821, to establish a transfer council to

improve transfer of two-year courses into four-year degrees, recommend financial support for transfer students with need, improve student access to transfer information, measure and evaluate transfer performance, research policies to reduce other barriers to transfer, and submit an annual report of its progress.

- **Recommendation 2:** Include a contingency appropriation rider in the 2010–11 General Appropriations Bill that authorizes one full-time-equivalent position at the Texas Higher Education Coordinating Board. The agency would reimburse transfer council members for travel expenses.

DISCUSSION

According to the National Articulation and Transfer Network, "transfer" is the process of a student moving from one college to the next. Historically, transfer was treated as a "planned event." A student started a course of study at a community college, completed an associate degree, and then transferred to a university academic degree program with recognition of all credits previously earned, because the student took the correct pre-determined courses to assure transferability. When two-year and four-year institutions worked together to ensure former credits counted toward the baccalaureate degree, a student's chances of successful transfer were greatly enhanced. However, transfer today is not necessarily sequential, and students face many barriers to transfer.

"Articulation" is the method or manner of joining two separate parts. In higher education, articulation agreements describe how credits from one college (usually a community college or two-year college) are recognized toward a baccalaureate degree at a four-year college or university. Articulation agreements are formal written agreements that identify courses that are acceptable toward specific course requirements at a "receiving" institution. Successful articulation occurs when courses are in vertical alignment between the institutions.

"Vertical alignment" is the degree to which the elements of an education system are aligned with other forces, such as national standards, public opinion, work force needs, textbook content, classroom instruction, and student outcomes. An education system relies on alignment to articulate and maintain its desired course and intensity. An aligned system is better able to focus its resources and thereby strengthen its capacity for making deep, meaningful changes in instructional decision-making and practice. Alignment also serves to keep local policy efforts in synch with larger scale initiatives.

CONTEXT OF STUDENT TRANSFER

In Texas, students can choose multiple paths to a baccalaureate degree. A student can start at a bachelor's degree granting institution or the student can start at a two-year institution and plan to transfer. For thousands of students, transfer is an effective and efficient way to complete their studies. A Texas resident transfer student could save an estimated average 35 percent of the cost of tuition and fees over four years. Many students, especially those from low-income and disadvantaged backgrounds, are attracted to the lower cost of tuition, regional locations, and flexible admissions standards at two-year institutions. Transfer has long been emphasized as one of the missions of Texas community colleges, although the emphasis on transfer relative to other functions differs among the colleges, depending on local needs and economic conditions.

Texas public two-year institutions have generally grown more rapidly than four-year institutions and are expected to continue to outpace four-year institution growth. Successful coordination between two-year institutions and four-year institutions is increasingly necessary to achieve the state's goals for baccalaureate attainment. However, the transfer rate for first-time undergraduates has remained flat at 20 percent from fiscal years 2004 to 2007. Strengthening pathways between these institutions would enable progress toward these goals.

The U.S. Department of Education found a positive correlation between completing an associate degree before transfer and the likelihood of eventually completing a baccalaureate degree. In 2001, the Texas Higher Education Coordinating Board (THECB) Transfer Issues Advisory Committee found no significant difference in the quality of student performance at the receiving institutions (as measured by grade-point averages) between native students (those who began at the receiving institutions) and those who transferred after completing at least 30 semester credit hours (SCH) at their prior institutions.

A transfer system should efficiently convert lower division academic SCH from two-year institutions into baccalaureate degrees at four-year institutions. One measure of transfer efficiency would be to determine the relationship of SCH to degrees and compare that performance to a benchmark or to sub-groups. As an example that is not overly complex, what are the proportions of SCH and degrees that can be attributed

to two-year institutions and students? How does that compare to the proportions for four-year institutions and students?

The majority of lower division academic SCH occurred at two-year institutions as shown in **Figure 339**. From fiscal years 2000 to 2007, two-year institutions' share of lower division academic SCH increased from 56 percent to 61 percent.

In **Figure 340**, the minority of baccalaureate degrees were awarded to students who transferred from two-year institutions. From fiscal years 2000 to 2007, the share of baccalaureate degrees awarded to transfers from two-year institutions increased from 30 percent to 34 percent.

Thus in 2007, 61 percent of lower division academic SCH occurred at two-year institutions, while transfer students were awarded 34 percent of baccalaureate degrees. Conversely, 39 percent of lower division academic SCH occurred at four-year institutions, while non-transfer students were awarded 66 percent of baccalaureate degrees. Comparison of these proportions indicates that transfer remains inefficient. Overall, conversion of lower division academic SCH into baccalaureate degrees is becoming more efficient for transfers from two-year institutions but remains inefficient compared to all other students.

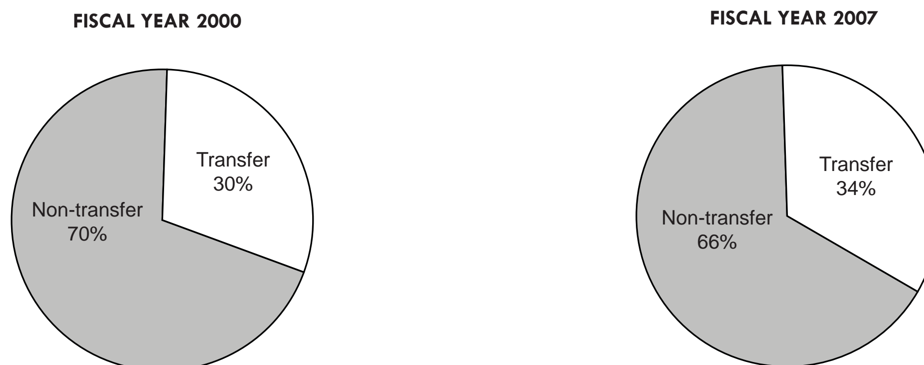
STUDENT ASPIRATIONS AND ATTAINMENT

Applications for transfer do not fully reflect student aspirations. Each year, tens of thousands of students begin academic studies at a two-year institution, but most do not make the transition to a four-year institution. Of 72,870 first-time-in-college academic students at two-year institutions in fall 2002, 78 percent expressed intent to graduate with an associate degree and/or transfer. Of those 57,098 students, 25 percent (14,275) transferred to a four-year institution by fall 2005. The inconsistency between students'

FIGURE 339
TOTAL LOWER DIVISION ACADEMIC SEMESTER CREDIT HOURS, FISCAL YEARS 2000 AND 2007

SOURCE: Texas Higher Education Coordinating Board.

FIGURE 340
BACCALAUREATE DEGREES AWARDED, FISCAL YEARS 2000 AND 2007



SOURCE: Texas Higher Education Coordinating Board.

academic aspirations and attainment may be related to the level and type of support offered by institutions.

According to the July 2006 THECB report, *A Study Regarding the Feasibility of Implementing an Automatic Admission Policy for Transferring Undergraduate Students Who Meet Certain Qualifications*, students who applied to Texas public universities with an academic associate degree had more than a 100 percent acceptance rate (indicating multiple acceptances), and 78 percent of those accepted were enrolled. As shown in **Figure 341**, about 25 percent of students who received an academic associate degree—whose primary purpose is to prepare a student to transfer to a university— applied for transfer upon receiving the degree. In fiscal year 2007, it is estimated that almost 17,000 students with an academic associate degree did not apply for transfer to a Texas public four-year institution.

Although state policy ensures acceptance of the general education core curriculum for those who pursue transfer, only 7 percent of students who completed the core curriculum applied for transfer. In fiscal year 2007, it is estimated that over 18,000 core curriculum completers did not apply for transfer. Eight community colleges reported no core curriculum transfers. Forty-four percent of core curriculum completers who transferred statewide were enrolled at the University of North Texas.

There are many possible reasons for inefficient conversion of two-year lower division academic SCH into baccalaureate degrees. Transfer rates are influenced by numerous challenges faced by students. Attrition along the transfer pathways may stem from lack of purpose, economic capacity, academic capacity, or organizational barriers.

Transfer rates are affected by the proportion of students attending two-year institutions for various purposes other than obtaining an associate degree for transfer to a four-year institution. Some students attend a two-year institution to obtain job skills, enrichment, or workforce certifications with no intent to pursue a baccalaureate degree.

Student characteristics related to economic capacity create challenges for potential transfer students. Working full- or part-time to address financial need, maintaining independent status from parents, or supporting dependents (perhaps as a single parent) may make transfer difficult.

Student characteristics related to academic capacity also create challenges. Academic preparation is likely to be insufficient for high school dropouts or GED recipients, leading to delayed enrollment, part-time enrollment, and/or developmental education coursework not accepted in degree programs. Low grades, repeated courses, and changes of major also lead to coursework not accepted in degree programs.

Localities, institutions, and the state may create barriers to transfer. Local employment, economic conditions, demographics, and program offerings may work against the probability of transfer. Geographic proximity to a four-year institution and higher admission standards can also serve as hurdles for transfer students. Inconsistent advising and rules create confusion. In a Council of Public University Presidents and Chancellors 2008 survey, the most frequently cited barriers for transfer students were: (1) the lack of financial aid and scholarships (with one respondent adding that scholarships are limited to full-time students and many transfer students enroll part-time); and (2) advisement from community colleges that differs from the university.

The challenges previously cited often create barriers to transfer, but the determining causes are largely unknown. However, **Figure 341** portends an ongoing mismatch between students' aspirations to transfer and the level of institutional support and consistency needed for students to achieve that goal. At least two of the organizational barriers

FIGURE 341
TWO-YEAR COMPLETERS, FOUR-YEAR APPLICATIONS, AND TRANSFER ENROLLMENT BY DEGREE OR COMPLETION (ESTIMATED), FISCAL YEAR 2007

	COMPLETERS	DID NOT APPLY (LOST)	APPLICATIONS	DID NOT ENROLL (LOST)	TRANSFER ENROLLMENT
Academic Associate Degree	22,301	16,726 (75%)	5,575 (25%)	1,227 (6%)	4,348 (19%)
Common Core Curricululm	19,692	18,314 (93%)	1,378 (7%)	289 (1%)	1,089 (6%)
TOTAL	**41,993**	**35,040 (83%)**	**6,953 (17%)**	**1,516 (4%)**	**5,437 (13%)**

Source: Texas Higher Education Coordinating Board.

appear to require state action—course alignment and financial aid.

DISCONNECT BETWEEN TWO-YEAR COURSES AND FOUR-YEAR DEGREES

Existing community college pathways for transfer to a possible baccalaureate degree are often disconnected for students pursuing an associate degree, core curriculum, or field of study. Generally, courses taken in the liberal arts as part of an academic program will be accepted at four-year institutions. Low transfer rates can be attributed to numerous challenges, such as inadequate transfer policies or enforcement, lack of guaranteed course acceptance, and lack of curricular alignment.

An academic associate degree is a program leading to the Associate of Arts (AA), Associate of Science (AS), or Associate of Fine Arts (AFA) degree. Although an academic associate degree is designed and intended specifically for transfer to a four-year institution, no policy provision specifically guides the transfer of students who complete that degree. Academic associate degree programs typically include the entire core curriculum offered by the college and may also contain coursework in an appropriate field of study curriculum approved by the THECB.

For transfers with academic associate degrees, each four-year institution may determine degree applicability of up to 24 semester credit hours of coursework beyond the core curriculum. Students transferring lower level major specific coursework have little guarantee that the courses will apply to their major because acceptance of these courses may vary at four-year institutions. The Texas Common Course Numbering System does not guarantee all receiving institutions will make the same assessments of course transferability.

As stated earlier, only 25 percent of academic associate degree holders apply for transfer to a four-year institution. Course alignment with baccalaureate degree programs may be a barrier. These obstacles may deter students from completing academic associate degrees or force students to take comparable courses more than once, thereby extending time to degree completion and increasing costs.

In 1997, the Seventy-fifth Texas Legislature enacted Senate Bill 148, requiring the THECB to develop a statewide core curriculum to strengthen articulation and transfer. Texas Education Code, Section 61.821, defines core curriculum as "the curriculum in liberal arts, humanities, sciences, political, social, and cultural history that all undergraduate students of an institution of higher education are required to complete before receiving an academic undergraduate degree." By law, a core curriculum at a public college, university, or health science center in Texas must consist of a minimum of 42 semester credit hours (SCH), and be fully transferable. A completed core curriculum must be substituted for the receiving institution's core curriculum even if the two are not entirely equivalent.

The statewide core curriculum was intended to provide, for students unsure about their educational goals, a mechanism that guarantees acceptance of a core of courses that apply toward meeting general education requirements at four-year institutions. According to a recent 2008 survey by the Council of Public University Presidents and Chancellors, the core curriculum has not worked effectively to accomplish that goal for several reasons. Courses listed in the module are required to be updated every 10 years and may not quickly reflect changes in general education programs at four-year institutions. Institutions acknowledge that the state policy has improved communications between two-year and four-year institutions, but incentives for compliance or consequences of non-compliance have not been tied to policy implementation, and the issue of resources to monitor and enforce policy has not been addressed at the state level.

Only 7 percent of students who completed the core curriculum applied to transfer. Texas could expand and improve acceptability of the core curriculum by ensuring oversight and revision, relevance to global conditions, rigor for transfer preparation, and consistency between and among both two-year and four-year institutions.

Under statutory directive, THECB developed "field of study" (FOS) curricula to facilitate transfer of courses within high-demand disciplines. Such agreements are now in place for 38 disciplines and majors. Four-year institutions are not required to accept all credits from FOS completers, but some institutions have elected to do so. Courses in the major have historically been the hardest to transfer.

Less than 1,600 students completed the FOS curriculum in fiscal year 2007. Twenty-six (74 percent) of universities reported no FOS transfers. Again, state action may be required to ensure institutional support and consistency in course alignment needed for students to transfer.

In Texas, there is a pressing need for more college graduates with associate and baccalaureate degrees to achieve the goals of Closing the Gaps, the state's higher education plan adopted

by the THECB in 2000. Attention and effort is needed to improve seamless transfer and articulation for students, especially for academic majors. One strategy is to continue to develop and implement institutional articulation agreements, but it also seems appropriate to work on state initiatives.

Articulation is one way to increase credit transfer from one institution to another. The Texas Education Code and the Texas Administrative Code contain only limited provisions to govern articulation efforts in Texas. Consequently, minimal state guidance is currently available for the development of articulation agreements between institutions. Individual institutions must work out the details of articulation among themselves. Policies have been developed to guide the articulation efforts of individual institutions for core and field of study curriculum, but institutions are not provided a statewide articulation plan.

The THECB found that the top five successful recruitment and enrollment strategies that appear to be working and are used by institutions across the state include: (1) scholarships, (2) articulation agreements, (3) academic advising, (4) partnerships with local schools, and (5) transfer and field-of-study courses. Scholarships and other forms of financial aid are helpful in recruiting and enrolling students into teacher education programs. Additional financial aid is needed, and special scholarships for students pursuing preparation in high-needs areas such as mathematics, science, foreign language, and special education should be provided. Careful academic advising, articulation agreements, and the transfer of courses among and between institutions have been found to be helpful in recruitment and enrollment efforts. It is critical that students receive accurate information regarding their degree plans from their academic advisors.

In 2004, THECB established the Associate of Arts in Teaching degree (AAT) and three Associate of Arts in Teaching curricula intended for transfer to baccalaureate programs; to date the largest transfer initiative focused on the major. The AAT degree as defined by the THECB is fully transferable to all Texas public universities. Because the AAT fulfills the requirements of the field of study curriculum statutes and Coordinating Board rules, all Texas public universities must accept the three AAT curricula if they offer the applicable baccalaureate degrees leading to initial teacher certification. Thirty-nine Texas public community colleges, Lamar State College-Orange, and Lamar State College-Port Arthur offer the AAT, and it has been accepted by several educator preparation programs at four-year institutions. **Figure 342** shows the growth of AAT degrees. This project could serve as a conceptual model for other statewide articulation programs focused on other academic majors.

FIGURE 342
ASSOCIATE OF ARTS IN TEACHING DEGREES AWARDED, FISCAL YEARS 2005 TO 2007

	2005	2006	2007	PERCENTAGE CHANGE
Statewide	385	370	692	80%

SOURCE: Texas Higher Education Coordinating Board.

Students who seek to transfer often find that the lack of curricular alignment between institutions requires course repetition, creating layers of complexity for institutions and students alike. The student experience and extra time required can be a hindrance to transfer and successful completion of a bachelor's degree. Furthermore, a lack of course coordination can discourage students from transferring at all. Several community colleges have responded to this problem by developing articulation agreements with four-year public and private colleges to ensure that various community college courses will be accepted at a higher rate. Some states are also currently working to align courses among institutional levels in higher education to ensure ease of transfer.

A transfer council as proposed by Recommendation 1 would facilitate development and implementation of statewide articulation to meet state goals, leverage institutional agreements, enhance program offerings at two-year institutions, and recommend supporting policies and practices. This should be accomplished by vertical teams of university and community college faculty to establish statewide articulated pathways between lower division courses at two-year institutions and four-year baccalaureate degrees, including critical need areas identified in Closing the Gaps and similar to the Associate of Arts in Teaching degree. Streamlining the individual components would increase efficiency of the transfer system.

DISCONNECT BETWEEN FINANCIAL NEED AND AID

The increased costs of a four-year college can be a significant impediment to transfer. In 2007, the College Board determined the average cost of tuition and fees for a full-time-equivalent student in Texas. The annual cost at a community college ($1,610) was about one-fourth the cost at a university ($5,985). Students who transfer may also face costs, such as room and board, transportation, and other expenses, which can total up to an additional $10,000 on average per year.

Moreover, students who seek to transfer from a two-year to four-year institution often find that less institutional aid is available to them because such funds are often targeted at recruiting first-time, full-time students. Adequate financial resources are an important factor when a student is deciding whether or not to enroll in or continue in higher education. If students already have unmet need at the community college level, they may become overwhelmed by these higher costs.

According to the National Center for Education Statistics, most community college students are "nontraditional," one who is financially independent, attends part time, works full time, delays enrollment after high school, has dependents, is a single parent, or does not have a high school diploma. Most community college students are either full-time or part-time employees.

Many students at two-year institutions attempt to balance academics with work. According to the Texas Guaranteed Student Loan Corporation, full-time/full-year attendance is higher at Texas four-year institutions compared to two-year institutions: over 50 percent of undergraduates at four-year institutions attended full-time/full-year whereas at two-year institutions, less than 25 percent of students attended full-time/full-year. Full-time/full-year attendance is lower in Texas than in the U.S. Reasons for less than full-time attendance vary but may be related to students' need to work to meet college costs. Working can also affect determination of need for transfer students who apply for financial aid because income from the previous year affects expected family contribution for the following year.

In a 2007 study by "Achieving the Dream," a multiyear national initiative with more than 80 two-year institutions in 15 states, at least one-third of students with the intent to transfer to four-year institutions have financial need. The number is likely higher, but the financial need of part-time students was not determined. Of the 32,221 fiscal year 2002 first-time-in-college academic students with the intent to transfer, it is estimated that at least 10,633 had financial need.

Some institutions and states offer financial aid targeted directly toward transfer students. For example, Morgan State University in Maryland offers a Bridge Grant to students who earn at least 24 credits before transfer. The grant provides $1,000 each semester along with extra tuition scholarships if an associate degree is earned. Kentucky has directed efforts toward alleviating financial barriers for transfer students. The state now provides financial incentives to four-year institutions to produce graduates and offers similar rewards to two-year colleges to produce more associate degrees and encourage transfer. Such incentives provide institutions with additional resources that, in turn, provide additional financial aid for transfer. In addition, matching scholarships for transfer students and loan-forgiveness programs for students in high-demand fields have been developed to address the financial barriers that these students face.

For students at two-year institutions, transfer students at four-year institutions, and all other students at four-year institutions, **Figure 343** details the dollars disbursed and number of recipients for the major Texas financial aid programs. In fiscal year 2007, less than $16 million was

FIGURE 343
FINANCIAL AID DOLLARS DISBURSED AND RECIPIENTS BY STUDENT TYPE, TEXAS PUBLIC INSTITUTIONS OF HIGHER EDUCATION, FISCAL YEAR 2007

	DOLLARS DISBURSED				RECIPIENTS			
			UNIVERSITY STUDENT				UNIVERSITY STUDENT	
PROGRAM	TOTAL	TWO-YEAR STUDENT[1]	TRANSFER[2]	NON-TRANSFER[3]	TOTAL	TWO-YEAR STUDENT[1]	TRANSFER[2]	NON-TRANSFER[3]
TEXAS Grant	$167,697,867	$20,364,843	$13,851,777	$133,481,247	50,287	15,713	3,411	31,163
Texas B-On-Time	29,366,765	416,647	1,848,754	27,101,364	6,927	280	431	6,216
Texas Educational Opportunity Grant	4,744,824	4,744,824	0	0	3,707	3,707	0	0
TOTAL (Duplicated Recipients)	**$201,809,456**	**$25,526,314**	**$15,700,531**	**$160,582,611**	**60,921**	**19,700**	**3,842**	**37,379**

[1]Students enrolled in a community, technical, or state college.
[2]Students that transferred to a university from a community, technical, or state college (attempted 30 or more semester credit hours at public two-year institutions in six previous years before enrolling at the university in fall 2006).
[3]Students enrolled in a university that did not transfer from a community, technical, or state college.
Source: Texas Higher Education Coordinating Board.

disbursed to transfer students. Overall, transfer students were awarded 8 percent of the dollars and comprise 6 percent of recipients.

TEXAS Grant is the largest state financial aid program available to students with financial need, awarding $168 million in fiscal year 2007. Eight percent of that amount went to transfer students at four-year institutions. Of the 50,287 recipients statewide, 7 percent were transfer students at four-year institutions. A transfer student must have financial need, an Associate degree, and be enrolled three-quarter-time to be eligible for a TEXAS Grant at a four-year institution. The TEXAS Grant focuses on dependent students. At current funding levels, only 51 percent of eligible students receive a TEXAS Grant, and most of the awards are renewals.

Texas B-On-Time is a loan forgiveness program for timely graduation, awarding $29 million in fiscal year 2007. Six percent of that amount went to transfer students at four-year institutions. Of the 6,927 recipients statewide, 6 percent were transfer students at four-year institutions. To be eligible for a B-On-Time Loan at a four-year institution, a transfer student must graduate within four years and have a minimum of a "B" average. Community college students are more likely to be part time and thus not eligible for this program.

Texas Educational Opportunity Grant (TEOG) assists low-income and non-traditional students at two-year institutions, awarding $5 million in fiscal year 2007. Of those funds, 70 percent were awarded to freshman students. A student must have financial need and be enrolled half-time in a certificate or associate degree program to be eligible for a TEOG at a two-year institution. TEOG grants do not follow two-year students who transfer. At current funding levels, only 4 percent of eligible students receive a TEOG.

An inconsistency exists between students' aspirations to transfer and the financial support needed to achieve this goal. Many transfer students have financial need, face higher costs, but do not fare well in the competition for available financial aid. Working to meet those higher costs may exacerbate the challenge by reducing the probability of qualifying for financial aid.

Other states have developed financial aid programs to support state goals and address the financial barriers faced by transfer students. However, the major student financial aid programs in Texas are not designed to support financial need for students who intend to transfer without an associate degree.

A transfer council as proposed by Recommendation 1 would develop policies to address the financial needs of transfer students related to state goals. This should include recommendations to target state financial aid to students with need transferring within Texas from public two-year institutions to public four-year institutions to support success beyond a two-year degree. Should funds become available, modifications to the TEOG program should be considered.

NEED FOR A TRANSFER COUNCIL TO ADDRESS BARRIERS

The Transfer Issues Advisory Committee (appointed by the Commissioner of Higher Education in 2001) was charged to assess the transfer of academic credit among institutions in Texas and to recommend any steps that should be taken to ensure that Texas has a responsive, efficient, and academically sound transfer system. The committee recommended in 2001, "…that the Transfer Issues Advisory Committee continue to meet as needed to help carry out the recommendations it has made and contribute to the greater success of Texas' higher education students." The committee used a complaint and issue resolution process to monitor policy effectiveness and propose changes. The committee disbanded in 2006 because all of the Commissioner's initial charges had been addressed.

Recommendation 1 would amend Texas Education Code, Chapter 61.821, to establish a transfer council at THECB, equally representing both two-year and four-year institutions that would:

- assess statewide and inter-institutional articulated pathways between academic lower division courses at two-year institutions and four-year baccalaureate degrees;
- expand and improve the existing common core curriculum and its acceptability;
- recommend a state financial aid program for students with need transferring within Texas from public two-year institutions to public four-year institutions, based upon GPA, program completion, university acceptance, and satisfactory academic progress;
- collaborate with related efforts to establish and maintain a centralized electronic portal to provide comprehensive information to facilitate transfer;
- develop a statewide system to collect data and track the patterns of transfer student mobility, progress, and completion;

- develop, implement, and monitor performance measures related to the efficiency and effectiveness of student transfer including transfer rates and baccalaureate graduation rates for all groups of two-year program completers, comparison of transfer to native students by degree program, and shared recognition between institutions;
- research emerging issues and recommend policies and practices targeted to reduce identified barriers to transfer; and
- submit an annual report of its progress to the Legislature, Legislative Budget Board, Governor's Office, and THECB on or before December 15.

A full-time-equivalent position would be integral to the transfer council's accomplishment of its responsibilities and functions.

Recommendation 2 would include a contingency appropriation rider in the 2010–11 General Appropriations Bill that authorizes one full-time equivalent position at the Texas Higher Education Coordinating Board. The agency would reimburse transfer council members for travel expenses.

A transfer council would create a stronger organizational structure to respond to statewide issues regarding transfer and to provide oversight and accountability for all higher education institutions. Because of the large number of state, local, and higher education entities involved in Texas, a full-time-equivalent position should be devoted to the effort. Two statewide issues were discussed above: conversion of two-year courses to four-year degrees, and financial support of transfer students with need. Several other issues merit further response.

House Bill 3851, Eightieth Legislature, 2007, requires that "each general academic teaching institution shall adopt a written admission policy to promote the admission of undergraduate transfer students to the institution. The policy must provide for outreach and recruiting efforts directed at junior colleges and other lower division institutions of higher education and may include incentives to encourage transfer applications and to retain and promote transfer students." However, much of the record keeping and tracking function remains with students, and self-reported information may be inaccurate or misleading. Texas has a critical need for better technology to share all in one place the map of transfer paths available to all students and their outcomes.

A transfer council would foster collaboration with related efforts to establish and maintain a centralized electronic portal to provide comprehensive information to facilitate transfer. The establishment of a centralized electronic portal would allow students to investigate their postsecondary options in a clear and organized manner. Full and timely communication between colleges and universities and full utilization of the existing information tools would enhance existing transfer practices and simplify the transfer process.

The 2007 Southern Regional Education Board report, *Clearing Paths to College Degrees*, notes that other states use a variety of methods to check the effectiveness of their transfer policies, including calculating and monitoring the state's rate of students transferring from two-year to four-year colleges, tracking the academic performance of transfer students, and determining how long it takes students to earn degrees (time to degree). Some states also are interested in excess credit hours or the average number of credit hours it takes transfer students to earn degrees beyond the average for other students.

Figure 344 shows the THECB Accountability System measures for transfer students at universities and community colleges.

Currently, these measures do not indicate the effectiveness of policies, such as core curriculum, field of study, Associate of Arts in Teaching, critical need fields in Closing the Gaps, and shared recognition between institutions in relation to transfer

FIGURE 344
TEXAS HIGHER EDUCATION COORDINATING BOARD ACCOUNTABILITY SYSTEM MEASURES FOR TRANSFER, FISCAL YEAR 2008

UNIVERSITY
Percentage of enrollment that are transfers from Texas public two-year colleges with at least 30 semester credit hours attempted.
Graduation rate for two-year college students who completed at least 30 SCH before transferring to a university.
Percentage of baccalaureate graduates completing at least 30 SCH at a Texas two-year college.
COMMUNITY COLLEGE
Percentage of students who transfer to a senior institution.

Source: Texas Higher Education Coordinating Board.

student mobility, progress, and completion. Performance measures should be developed for transfer rates and baccalaureate graduation rates for all groups of two-year program completers, with comparison of transfer to native students by baccalaureate degree program.

A transfer council would establish performance measurement and evaluation of transfer students, transfer programs, and transfer institutions for efficiency and effectiveness. Texas does not have comprehensive and systematic planning and monitoring programs in place to assess the effectiveness of transfer policies. These systems are necessary for continuous improvement and evaluating the effectiveness of transfer programs.

All capable students who enter a transfer degree program at a two-year college should expect to have reasonable access to a baccalaureate degree program. To that end, evidence-based policy research should explore emerging options that are consistent with institutional missions and projected enrollment growth. Such research options include:

- organizational barriers related to why two-year students intend to transfer but do not apply;
- declaration of a field of interest and a transfer institution for two-year students with 30 semester credit hours completed;
- access to distance education for courses not offered locally;
- role of Texas private universities in enrolling transfers from public two-year institutions; and
- relationship of dual credit and acceptance for transfer, applicability to baccalaureate degree, and time-to-degree.

A transfer council would research emerging issues and recommended policies and practices targeted to reduce identified barriers to transfer. Efforts should be directed toward an increase in the conversion of lower division academic semester credit hours from two-year institutions into degree programs at four-year-institutions.

FISCAL IMPACT OF THE RECOMMENDATIONS

Implementation of Recommendation 1 would cost $200,000 for the 2010–11 biennium. Of this cost, $150,000 would support one full-time-equivalent position above THECB's current staffing levels. The position would be integral to the transfer council's accomplishment of its responsibilities and functions. Reimbursement for travel expenses of the transfer council members is estimated at $50,000 for the biennium. Rather than cost savings, improved transfer of two-year courses into four-year degrees would likely result in more degrees.

To fund implementation of this recommendation, Recommendation 2 would include a contingency appropriation rider in the 2010–11 General Appropriations Bill that appropriates $200,000 in General Revenue Funds for the biennium and authorizes one full-time-equivalent position at THECB. **Figure 345** details these costs.

FIGURE 345
FIVE-YEAR FISCAL IMPACT OF RECOMMENDATIONS, FISCAL YEARS 2010 TO 2014

FISCAL YEAR	PROBABLE SAVINGS/ (COST) IN GENERAL REVENUE FUNDS	CHANGE IN FULL-TIME EQUIVALENTS COMPARED TO 2008–09 BIENNIUM
2010	($100,000)	1
2011	($100,000)	1
2012	($100,000)	1
2013	($100,000)	1
2014	($100,000)	1

SOURCE: Legislative Budget Board.

The introduced 2010–11 General Appropriations Bill does not address these recommendations.

REPLACE THE "SMALL INSTITUTION SUPPLEMENT" WITH A STANDARDIZED FORMULA SUPPLEMENT BASED ON CONTACT HOURS AND LOCAL TAX EFFORT

In the 1980s, the Texas Legislature began providing supplemental funding outside the formula to community college districts for various reasons. This funding is referred to as "Floor Funding" or the "Small Institution Supplement." Only three public community colleges have received Small Institution Supplement funding since 1982. For the 2008–09 biennium, only two of those three are appropriated a supplement.

During the 1990s and into the current decade, these supplements continue to be appropriated at consistent and historic levels without regard to local revenue sources. As a result, the need for the Small Institution Supplement may not be the same as in the past. The current method of providing the Small Institution Supplement does not include provisions for changes in local tax revenue resources or other funding efforts made by a community college district. Instituting a formula for the Small Institution Supplement to include local tax revenue resources would ensure each district receives appropriate supplemental funding amounts.

FACTS AND FINDINGS

- ♦ The Maintenance and Operations tax revenue collected per contact hour among the 50 community college districts ranges from $0.18 per contact hour to $11.67 per contact hour.
- ♦ The Maintenance and Operations tax rates among the 50 community college districts ranges from $0.0548 per $100 of property valuation to $0.24 per $100 of property valuation.
- ♦ Overall Maintenance and Operations tax revenue among the 50 community college districts increased by 166 percent between 1998 and 2007, ranging among the districts from 16 percent to 582 percent.
- ♦ The funding for the Small Institution Supplement to community college districts does not account for a district's financial need when determining eligibility for supplemental funding or allocation amounts.

CONCERN

- ♦ Public community colleges are statutorily created as local government entities and have taxing authority within their district. Community college districts are also appropriated state General Revenue Funds through a contact-hour based formula to supplement maintenance and operation costs. However, some districts still may not receive sufficient state funds to meet the district's needs. Although the Legislature has consistently added Small Institution Supplemental funding to several districts, there is no standard methodology to determine the amount.

RECOMMENDATIONS

- ♦ **Recommendation 1:** Establish eligibility criteria community college districts must meet to qualify for Small Institution Supplemental funding. Criteria should include a standardized indicator of relative local effort.
- ♦ **Recommendation 2:** Establish an allocation formula using a standardized indicator of a community college district's need for Small Institution Supplemental funding.
- ♦ **Recommendation 3:** Establish a new method for funding the Small Institution Supplement. Possible methods for funding the supplement are (1) redirecting to the supplement a certain share of existing formula appropriations, (2) providing a new and separate appropriation, or (3) a combination of the two methods.

DISCUSSION

During the 1980s, the Texas Legislature, recognizing certain state institutions of higher education may require assistance to pay basic operation costs, provided to them supplemental funding outside the formula. Texas Education Code, Section 130.003, establishes a formula funding allocation intended to "supplement" local funding efforts by public community colleges. The allocation is based on contact hours within categories developed by the Texas Higher Education

Coordinating Board. The Small Institution Supplement is in addition to these formula allocations.

These supplementary funds, known as "Floor Funding" or the "Small Institution Supplement," have been appropriated to all types of institutions of higher education receiving state formula appropriations. For example, in the 2008–09 biennium, eight general academic institutions were appropriated $750,000 per year in Small Institution Supplement funding in addition to standard state formula appropriations. Also, in the same biennium, all four of the Texas State Technical colleges and all three of the two-year Lamar institutions received annual Small Institution Supplement appropriations in the amount of $375,000 each.

Since 1982, only three public community colleges receive Small Institution Supplement funding. **Figure 346** shows which districts received this funding.

Since the 1990s, the state has not used a formula to apportion supplementary dollars among eligible community college districts. For districts, the Small Institution Supplement is generally based on maintaining state formula funding at a certain historical level. The amount appropriated to community college districts by the Eightieth Legislature, 2007, for the 2008–09 biennium is roughly the same as the appropriation made by the Seventy-eighth Legislature, 2003, for the 2004–05 biennium.

In addition, the current method of determining eligibility to receive supplementary dollars does not account for districts' local tax circumstances or other objective criteria defining a threshold for the funding.

A common method of determining the relative depth of a given revenue stream for community colleges is to divide the total revenue from a given revenue source by the district's number of contact hours. This "dollars per contact hour" value gives a rough estimate of the relative contribution the revenue source makes toward funding the district's educational efforts.

Looking at all significant revenue sources in light of total contact hours, it becomes clear state funding is the most standardized revenue source for public community colleges. The summary at the bottom of the "State Dollars per CH" column in **Figure 347** shows the minimum to maximum state funds per contact hour and ranges from $3.27 to $6.58 per contact hour, for a variation of about 200 percent. This range is a product of several factors, including the different weighting of various formula elements involved in generating the state's formula allocation and the provision of formula add-ons (such as formula hold harmless) for certain districts. However, in relation to tuition and tax revenue sources, this range is relatively minor. The "Tuition Dollars per CH" and "Tax Dollars per CH" columns in the same figure show this

FIGURE 346
COMMUNITY COLLEGE DISTRICTS RECEIVING SMALL INSTITUTION SUPPLEMENTS, 1982–2009

BIENNIUM	BIENNIAL SMALL INSTITUTION SUPPLEMENT LEVEL (IN MILLIONS)	COMMUNITY COLLEGE DISTRICTS
1982–83	$2.4	Clarendon
1984–85	$2.4	None
1986–87	$2.4	None
1988–89	$3.0	Clarendon
1990–91	$3.0	None
1992–93	$3.3	Clarendon, Ranger
1994–95	$4.0	Clarendon, Ranger, Frank Phillips
1996–97	$4.0	Clarendon, Ranger, Frank Phillips
1998–99	$4.1	Clarendon, Ranger, Frank Phillips
2000–01	$4.3	Clarendon, Ranger
2002–03	$4.6	Clarendon, Ranger
2004–05	$4.2	Clarendon, Ranger
2006–07	$4.2	Clarendon, Ranger
2008–09	$4.2	Clarendon, Ranger

SOURCE: Legislative Budget Board.

FIGURE 347
DOLLARS PER CONTACT HOUR (BY REVENUE SOURCE)

DISTRICT	CONTACT HOURS[1]	STATE DOLLARS PER CH[2]	TUITION DOLLARS PER CH[3]	TAX DOLLARS PER CH[4]	TAX RATE PER $100[5]	TOTAL DOLLARS PER CH
Alamo Community College	16,122,747	$5.1790	$3.0515	$4.3466	$0.0898	$12.5771
Alvin Community College	2,318,219	$4.466	$2.184	$3.794	$0.1867	$10.4435
Amarillo College	4,512,977	$4.8755	$2.1935	$2.5172	$0.1365	$9.5862
Angelina College	2,085,634	$4.9578	$2.2302	$1.4359	$0.0970	$8.6239
Austin Community College	12,530,544	$3.8740	$3.6510	$5.3082	$0.0900	$12.8332
Blinn College	6,355,014	$3.7830	$4.1605	$0.1791	$0.0548	$8.1226
Brazosport College	1,472,609	$5.4196	$4.1008	$5.3431	$0.1210	$14.8636
Central Texas College	5,262,232	$4.4277	$5.2807	$1.6181	$0.1420	$11.3266
Cisco Junior College	1,504,748	$4.1824	$1.6335	$0.2152	$0.1021	$6.0311
Clarendon College	541,563	$4.8967	$1.6587	$0.6308	$0.2193	$7.1863
Coastal Bend College	1,503,647	$5.6360	$2.4387	$1.0316	$0.1630	$9.1063
College of the Mainland	1,697,208	$5.5290	$2.1745	$11.6659	$0.2274	$19.3693
Collin County CC	8,675,490	$3.4982	$2.1068	$5.6823	$0.0800	$11.2873
Dallas County CC District	25,708,290	$4.3076	$2.0165	$4.7152	$0.0759	$11.0393
Del Mar College	4,914,983	$5.0287	$2.8291	$5.4119	$0.1871	$13.2698
El Paso Community College	9,352,815	$4.4064	$1.8002	$3.5508	$0.1120	$9.7574
Frank Phillips College	691,649	$5.3229	$1.9927	$1.6864	$0.2200	$9.0019
Galveston College	923,276	$6.5834	$1.4219	$8.2691	$0.1700	$16.2743
Grayson County College	1,899,809	$4.4578	$2.0172	$4.4484	$0.1397	$10.9233
Hill(Incl. branch campus tax)	1,735,735	$4.1402	$1.5720	$1.6840	$0.0668	$7.3961
Houston Community College	18,292,783	$4.2258	$2.9733	$4.1635	$0.0813	$11.3626
Howard College	2,265,927	$5.7101	$1.1735	$1.6129	$0.2096	$8.4964
Kilgore College	3,128,784	$4.1416	$1.9864	$1.5877	$0.1640	$7.7157
Laredo Junior College	3,163,435	$5.5499	$1.8382	$5.2155	$0.1831	$12.6037
Lee College	2,810,175	$4.6598	$1.9071	$5.5456	$0.1873	$12.1125
Lone Star College	16,999,910	$3.6912	$2.1656	$4.3386	$0.0809	$10.1954
McLennan Community College	3,756,476	$4.7570	$2.5278	$2.6191	$0.1005	$9.9039
Midland College	2,609,009	$5.1737	$2.9142	$4.8476	$0.1572	$12.9355
Navarro College	3,716,486	$3.7069	$1.8516	$0.7264	$0.1200	$6.2850
North Central Texas College	2,721,893	$3.6589	$3.3535	$0.6863	$0.0772	$7.6987
Northeast Texas CC	1,103,850	$4.6322	$2.5440	$2.4312	$0.0666	$9.6075
Odessa College	2,016,282	$5.5871	$1.9394	$6.3461	$0.1817	$13.8727
Panola College	974,631	$4.6736	$2.1189	$4.2362	$0.1048	$11.0286
Paris Junior College	2,296,817	$4.0223	$2.1314	$1.1493	$0.1980	$7.3030
Ranger Junior College	432,362	$5.8780	$1.3704	$0.4322	$0.2400	$7.6806
San Jacinto College	10,418,793	$4.2529	$2.7221	$3.6152	$0.1159	$10.5902
South Plains College	4,253,803	$4.4046	$2.8746	$1.7317	$0.2162	$9.0109
South Texas CC	7,618,566	$3.9787	$2.1018	$5.0906	$0.1100	$11.1711
Southwest Texas Junior College	2,026,556	$4.7292	$2.7301	$0.9094	$0.1100	$8.3688

FIGURE 347 (CONTINUED)
DOLLARS PER CONTACT HOUR (BY REVENUE SOURCE)

DISTRICT	CONTACT HOURS[1]	STATE DOLLARS PER CH[2]	TUITION DOLLARS PER CH[3]	TAX DOLLARS PER CH[4]	TAX RATE PER $100[5]	TOTAL DOLLARS PER CH
Tarrant County	13,834,460	$4.1205	$2.9610	$9.8344	$0.1313	$16.9160
Temple Junior College	2,089,831	$3.8001	$2.9442	$0.4912	$0.1647	$7.2355
Texarkana College	2,399,669	$4.6472	$1.6018	$0.4155	$0.0870	$6.6645
Texas Southmost College	3,858,066	$3.2732	$6.9849	$2.4056	$0.1114	$12.6637
Trinity Valley CC	3,204,286	$4.1988	$1.0962	$1.7221	$0.0680	$7.0171
Tyler Junior College	4,422,826	$4.6370	$2.6522	$2.6093	$0.1272	$9.8985
Vernon College	1,385,408	$5.0151	$1.5868	$1.0170	$0.2187	$7.6189
Victoria College	1,724,658	$5.1702	$2.4386	$2.7452	$0.1167	$10.3539
Weatherford College	2,160,969	$4.4729	$2.4665	$3.1601	$0.0970	$10.0996
Western Texas College	906,529	$4.0341	$2.3029	$3.4363	$0.1282	$9.7733
Wharton County Junior College	2,354,350	$4.4978	$4.6562	$1.7585	$0.1349	$10.9125
MINIMUM	**432,362**	**$3.27**	**$1.10**	**$0.18**	**$0.0548**	**$6.03**
MAXIMUM	**25,708,290**	**$6.58**	**$6.98**	**$11.67**	**$0.2400**	**$19.37**
MEDIAN	**2,504,339**	**$4.49**	**$2.19**	**$2.61**	**$0.1241**	**$10.00**
MEAN	**4,755,136**	**$4.61**	**$2.51**	**$3.21**	**$0.1354**	**$10.32**

[1]Contact hour data is from the Summer 2007, Fall 2007, and Spring 2008 semesters, as reported by THECB.
[2]State contributions include formula appropriations and state appropriations for health and retirement benefits, but exclude state grants and contracts.
[3]Tuition income is net of certain discounts.
[4]Tax income excludes taxes for General Obligation Bonds and other debt service.
[5]Includes only Maintenance and Operation tax rates. Rates taken from Texas Association of Community Colleges survey.
SOURCES: Texas Comptroller of Public Accounts; Texas Higher Education Coordinating Board.

range increases to more than 530 percent for tuition income and up to 6,480 percent for tax income.

This variation in tax income is partially attributable to differences in tax effort, as defined by property value tax rates: The "Tax per $100" column in **Figure 347** shows the lowest ad valorem tax rate is $0.0548 per $100 valuation and the highest is $0.24 per $100 valuation, which calculates to a range of local tax effort of about 340 percent. While the statewide tax rate is capped at $1 per $100 of property valuation, all community college districts have set their respective caps below the maximum allowed by state law.

Figure 348 shows the range of tax revenue per contact hour among the 50 districts.

Another factor in determining a formula for allocating Small Institution Supplemental funding to districts is the wide range in property values in Texas. Some districts are located in areas where the underlying property values are relatively low. As such, even when a district sets relatively high tax rates, if the district's property values are low, the district is not likely to generate significant tax revenue. For example, Ranger College has the highest tax rate of all the 50 districts, but generates only $0.43 per contact hour, well below the statewide average of $4.02 per contact hour. A similar circumstance applies to other districts with relatively high tax rates and relatively low per contact hour tax revenues, such as Clarendon College, Frank Phillips College, Howard College, Paris Junior College, South Plains College, and Vernon College.

Finally, certain districts have relatively high tax revenues per contact hour for reasons unique to their districts: College of the Mainland, Tarrant County Junior College, Galveston College, and Odessa College. If these four districts are removed from the calculation of the range of tax dollars per contact hour, the range falls from 6,480 percent to 3,375 percent, which is still a wide range.

While the standardization of state formula funding benefits districts, those districts with higher tax rates and lower revenue yields may still experience some difficulty meeting their basic operating expenses.

FIGURE 348
DOLLARS PER CONTACT HOUR (TAX REVENUE ONLY)

DISTRICT	TAX DOLLARS PER CH
College of the Mainland	$11.6659
Tarrant County	$9.8344
Galveston College	$8.2691
Odessa College	$6.3461
Collin County CC	$5.6823
Lee College	$5.5456
Del Mar College	$5.4119
Brazosport College	$5.3431
Austin Community College	$5.3082
Laredo Junior College	$5.2155
South Texas CC	$5.0906
Midland College	$4.8476
Dallas County CC District	$4.7152
Grayson County College	$4.448
Alamo Community College	$4.3466
Lone Star College	$4.3386
Panola College	$4.2362
Houston Community College	$4.1635
Alvin Community College	$3.7940
San Jacinto College	$3.6152
El Paso Community College	$3.5508
Western Texas College	$3.4363
Weatherford College	$3.1601
Victoria College	$2.7452
McLennan Community College	$2.6191
Tyler Junior College	$2.6093
Amarillo College	$2.5172
Northeast Texas CC	$2.4312
Texas Southmost College	$2.4056
Wharton County Junior College	$1.7585
South Plains College	$1.7317
Trinity Valley CC	$1.7221
Frank Phillips College	$1.6864
Hill (Incl. branch campus tax)	$1.6840
Central Texas College	$1.6181
Howard College	$1.6129
Kilgore College	$1.5877
Angelina College	$1.4359
Paris Junior College	$1.1493
Coastal Bend College	$1.0316
Vernon College	$1.0170
Southwest Texas Junior College	$0.9094
Navarro College	$0.7264
North Central Texas College	$0.6863
Clarendon College	$0.6308
Temple Junior College	$0.4912
Ranger Junior College	$0.4322
Texarkana College	$0.4155
Cisco Junior College	$0.2152
Blinn College	$0.1791

SOURCES: Annual Financial Reports; Texas Higher Education Coordinating Board.

ALTERNATIVE FUNDING METHODS

The function of the formula methodology proposed here is to define a reasonable eligibility threshold to receive supplementary funds and to factor in local tax circumstances in determining the amount of those funds.

To qualify as a recipient district, a district should meet both of the following criteria:

- **Effort**—A district should demonstrate significantly above-average effort to raise local funds, defined as having a Maintenance and Operations tax rate at or exceeding $0.31 per $100 valuation (i.e., approximately in the top one-third of all districts' tax rates).
- **Result**—A district should have a below-average levy of tax funds, defined as having Maintenance and Operations tax revenue per penny divided by contact hours equal to or less than $0.13 (i.e., approximately in the bottom one-third of the range of all districts' values).

These two eligibility criteria are intended to establish a threshold ensuring only those districts that make a significantly above-average effort to raise local funds, but nonetheless experience significantly below-average tax yield, qualify for the supplemental funding.

Based on these two criteria, the following eight districts would be eligible for supplementary funding: Clarendon College, Frank Phillips College, Howard College, Kilgore College, Paris Junior College, Ranger College, South Plains College, and Vernon College. The supplement value for these qualifying districts would be determined following these four steps:

- Determine tax revenue per penny (TRPP) by dividing the total tax yield by the pennies constituting the tax rate. So if a district has a tax revenue yield of $10 million and a tax rate of $0.10, the tax revenue per penny is $1 million. Using the TRPP as a common unit allows better comparisons to be made among districts with widely varying tax rates.
- Divide each district's TRPP by its contact hours to determine its TRPP per contact hour (TRPP-CH). Dividing the TRPP by contact hours provides an idea of the "real" value of each TRPP in relation to a district's educational output.
- Determine the cost of supplementing the eligible district's tax income up to a level that would have

been generated assuming a median TRPP-CH value for the district. This step calculates the full cost of providing supplementary funds sufficient to bring the district's TRPP-CH up to the median level for all districts. As such, the further a district's TRPP-CH value is from the median TRPP-CH value, the greater its maximum possible supplement becomes.

- Prorate this maximum amount by the value of the district's tax rate divided by 100. This results in the supplement amount. This proration rewards districts for their relatively high tax effort. The higher the tax rate, the greater the share allowable of the maximum amount calculated in step three.

Applying this methodology (see **Figure 349**) to the 50 districts would provide $10.7 million annually to the eight qualifying districts. This would entail redirecting about 1.3 percent of the total state formula contribution from the generic instruction and administration formula.

Another option would establish a separate fund solely for the Small Institution Supplement, and avoid any reduction from the generic formula for this item. Alternatively, a proration based on whatever funds the Legislature makes available is also possible. For example, if $10.7 million is available in the biennium, each qualifying district would receive 50 percent of the values calculated by this formula.

One possible problem that could occur with setting clear eligibility criteria to receive a Small Institution Supplement is certain districts would have an incentive to raise their tax rates to qualify for the additional funds. However, there are likely significant local political concerns districts must weigh prior to raising tax rates. Because community college trustees are locally elected, the local concerns about tax increases are likely to carry greater salience with the trustees. In fact, in some districts, the tax rate increase may require a formal referendum.

FISCAL IMPACT OF THE RECOMMENDATIONS

The cost to the state would depend on the source of the supplemental funds. If generic formula dollars are redirected to fund any portion of this supplement, then there would be no cost to the state above amounts the Legislature provides in

FIGURE 349
FORMULA SUPPLEMENT BASED ON DISTRICT PROPERTY TAX WEALTH

	ANALYSIS OF TAX REVENUE			DETERMINATION OF QUALIFICATION				FUNDING
DISTRICT	TAX DOLLARS PER CONTACT HOUR	TAX DOLLARS PER PENNY	REVENUE PER PENNY/CH	EFFORT: TAX RATE AT/OVER $0.31/$100?	RESULT: RPP/CH AT/UNDER $0.13?	QUALIFY FOR SUPPLEMENT?	DIFFERENCE BETWEEN DISTRICT AND MEDIAN RPP/CH	DOLLARS TO ATTAIN MEDIAN RPP/CH, MULTIPLIED BY TAX RATE
Clarendon College	$0.63	$15,578	$0.0288	YES	YES	YES	($0.2152)	$560,571
Frank Phillips College	$1.69	$53,019	$0.0767	YES	YES	YES	($0.1673)	$560,186
Howard College	$1.61	$174,361	$0.0769	YES	YES	YES	($0.1670)	$1,662,906
Kilgore College	$1.59	$302,897	$0.0968	YES	YES	YES	($0.1472)	$1,238,601
Paris Junior College	$1.15	$133,317	$0.0580	YES	YES	YES	($0.1860)	$1,674,393
Ranger Junior College	$0.43	$7,786	$0.0180	YES	YES	YES	($0.2260)	$562,805
South Plains College	$1.73	$340,725	$0.0801	YES	YES	YES	($0.1639)	$3,258,583
Vernon College	$1.47	$93,128	$0.0672	YES	YES	YES	($0.1768)	$1,171,273

Notes: Contact hour data is from the Summer 2007, Fall 2007, and Spring 2008 semesters, as reported by THECB; tax income excludes taxes for General Obligation Bonds and other debt service; includes only Maintenance and Operation tax rates.
Rates taken from TACC survey. Statewide Median TRPP-CH: 0.2440.
Sources: Annual Financial Reports; Texas Higher Education Coordinating Board.

formula funding. If any portion of the supplement dollars is appropriated separately in addition to the generic formula appropriation, these "new" dollars would represent a cost to the state equal to amounts funded for the supplement. The recommended Small Institution Supplement amount generated by this proposed methodology would be $21.4 million per biennium. Since this supplement would remove the need to fund the Small Institution Supplement for the two districts now receiving these funds, the $21.4 million value would be reduced somewhat.

There would be no cost to the public community colleges as a group if the funding for the supplement were external to the generic formula contribution. There would be a slight generic formula reduction for the 42 non-qualifying districts to the degree the generic formula total is reduced to provide supplement funds.

The introduced 2010–11 General Appropriations Bill does not incorporate the recommended Small Institution Supplement funding methodolgy.

MAKE EVERY YEAR A BASE PERIOD IN FORMULA FUNDING FOR PUBLIC COMMUNITY COLLEGES

The state's formula funding contribution to public community colleges is allocated by using each district's pro rata share of total contact hours generated in a base period. A base period is composed of the sequential summer, fall and spring semesters of alternating years. Contact hours generated in this base period year are used for formula allocation purposes, while those contact hours generated in the non-base period years (or "inter-base periods") are not currently used or reviewed for any purpose.

Because state formula funding contributions are allocated using contact hours, public community colleges can increase their generation of contact hours in a base period to ensure a potentially higher allocation. By revising the funding formula to use the contact hours generated in the academic year immediately prior to each fiscal year, Texas can provide incentives for all districts to offer consistent levels of course offerings every year.

FACTS AND FINDINGS

- Seven of eight inter-base periods reflected a lower overall percentage of contact hour change relative to the base period immediately preceding it. In four of these seven inter-base periods there was a negative percentage change in contact hours generated from the preceding base period.
- From 1990 to 2008, public community colleges consistently generated an increase in the number of contact hours from inter-base periods to base periods.

CONCERNS

- The state has a reasonable expectation districts will provide a consistent educational effort equally in both years of the biennium, i.e., in both base period and non-base period years. Thus, loading certain courses in base period years while reducing course offerings in non-base period years runs counter to this expectation, and may adversely affect the fairness of the state's formula funding process, to the extent the formula allocation is affected by any loading of contact hours in base period years.
- Those districts who provide relatively steady course offerings to their students could receive a smaller share of formula funding to the degree the district's relative share of state formula dollars is reduced by those districts loading contact hours in base period years.
- To the degree a district reduces its course offering in non-base years, students may experience some measure of increased difficulty enrolling in required courses.

RECOMMENDATION

- **Recommendation 1:** Include a rider in the 2010–11 General Appropriations Bill directing the Legislative Budget Board to be in a position to implement a new community college formula allocation methodology starting in the 2012–13 biennium using the contact hours generated in the academic year immediately prior to each fiscal year.

DISCUSSION

Historically, the incentives created by the structure of state support for community colleges significantly affected the manner and volume of educational offerings. Prior to 1974, state funding of public community colleges was based on a legislatively set dollar amount per full-time-student equivalent enrolled in the fall semester. Only transferable, academic-based courses could be counted for state funding. As a result, most community college districts offered few spring and almost no summer courses, and almost all courses offered were academic, rather than vocational/technical.

When the demand for higher education required offering courses year-round, the Texas legislature responded in the early 1970's by inaugurating the state's current contact hour-based formula system. Section 130.003 of the Texas Education Code establishes a formula funding allocation intended to supplement local funding efforts by public community colleges:

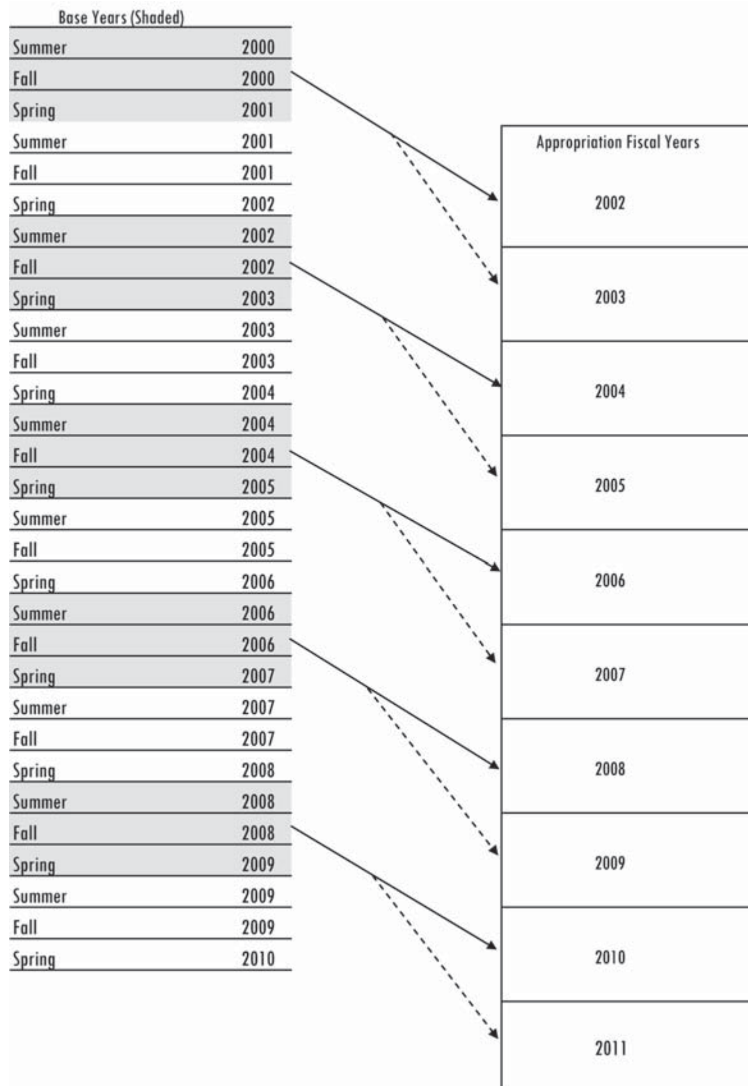
> Education Code, Section 130.003. STATE APPROPRIATION FOR PUBLIC JUNIOR COLLEGES. (a) There shall be appropriated biennially from money in the state treasury not otherwise appropriated an amount sufficient to

> supplement local funds for the proper support, maintenance, operation, and improvement of those public junior colleges of Texas that meet the standards prescribed by this chapter. The sum shall be allocated on the basis of contact hours within categories developed, reviewed, and updated by the coordinating board.

Because this system funded contact hours generated in all semesters, districts were able to receive state funding for those courses offered in the spring and summer semesters. The provision of year-round courses was increasingly the norm at community colleges in the 1970s. However, in implementing the new contact hour-based allocation system, the state opted to allocate its formula contributions using a snapshot of contact hours generated each alternating year known as base period years. As a result, only half of the contact hours generated by districts would ever be used to allocate future state contributions.

The current system used to allocate formula funds to public community college districts is shown in **Figure 350**. Contact hours generated in the academic periods falling between June 2006 and May 2007 were used to determine the formula funding allocation for fiscal years 2008 to 2009. In this system, base year periods alternate with inter-base year periods. The skipped year currently is not counted toward the formula funding allocation.

FIGURE 350
TIME TABLE FOR ALLOCATING FORMULA FUNDS, FISCAL YEARS 2002 TO 2011



SOURCE: Legislative Budget Board.

Since state contributions are apportioned using contact hours generated in a base period, some districts may be able to secure a greater portion of whatever formula funding the state makes available by maximizing contact hour generation in base periods.

A review of the contact hours generated by districts from 1990–91 through the 2007–08 cycle shows most public community colleges generated more contact hours during a base period than during an inter-base period.

Figure 351 shows seven of eight inter-base periods had a lower overall percentage of contact hour change relative to the base period immediately preceding it. The figure also shows that in four of the seven inter-base periods there was a decrease in the contact hours generated relative to the base period preceding it. **Figure 351** also shows all base periods had a higher overall percentage of contact hour change relative to the inter-base periods preceding them.

If contact hour generation was not being managed, the expected change from inter-base period years to base period years would be more consistent with the change from base period years to inter-base period years. Assuming there is an even chance the contact hour change in a given year would be greater than the percentage change in the previous year, there is a less than 1 percent probability the pattern observed would emerge.

Figure 352 shows which districts have reported contact hour decreases in an inter-base period relative to a preceding base period. Of the nine inter-base period years reviewed, three districts showed reduced contact hour growth in eight inter-base periods, and 11 districts reported reduced contact hour growth in seven inter-base periods. These trends indicate at least one-third of the public community colleges since 1990 likely adjusted course offerings to increase the number of contact hours generated in a base period.

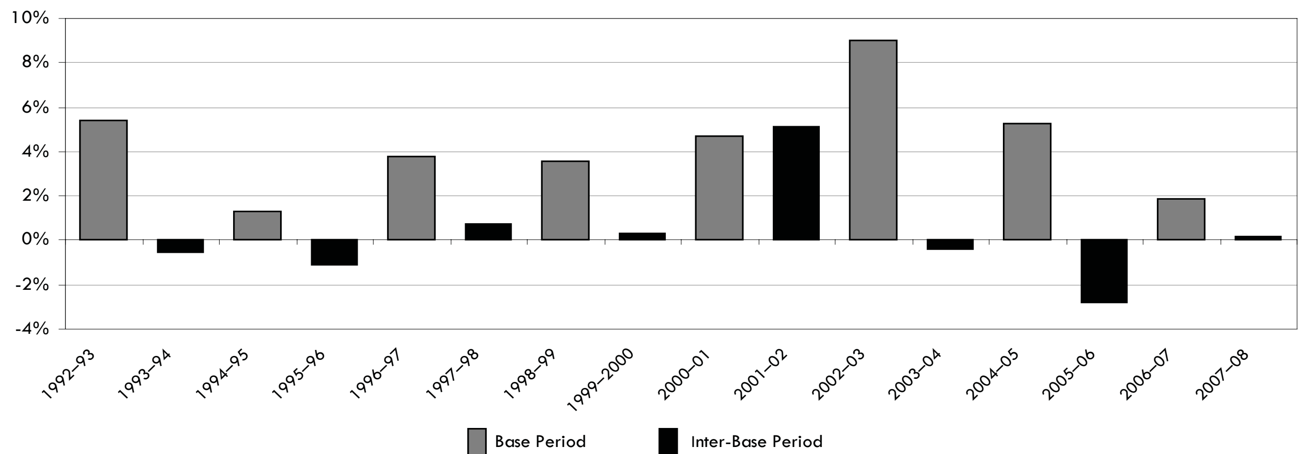
Figure 352 also shows districts with relatively flat or declining growth rates in contact hour generation are more likely to load contact hours in base period years. For example, **Figure 352** shows that of the seven districts showing absolute declines in contact hours since 1990, five are among the districts consistently showing reduction in contact hour change relative to the preceding base period year.

However, **Figure 352** indicates the majority of districts do not load certain course offerings in base period years. These districts could lose relative formula share to the degree the overall formula allocation is affected by those districts loading their contact hours in base period years.

Additionally, to the degree certain courses were not offered in inter-base years, students may experience increased difficulty in getting all the classes they need to complete their degree, transfer or certification plans in a timely manner.

Although contact hour growth slowed or even contracted in inter-base period years, **Figure 353** shows the overall trend has been one of contact hour growth. Between 1990 and 2008, the number of public community college contact hours generated increased by 43.3 percent.

FIGURE 351
PUBLIC COMMUNITY COLLEGES
ANNUAL PERCENTAGE CHANGE IN CONTACT HOURS FROM PREVIOUS YEAR/PERIOD, 1992–2008



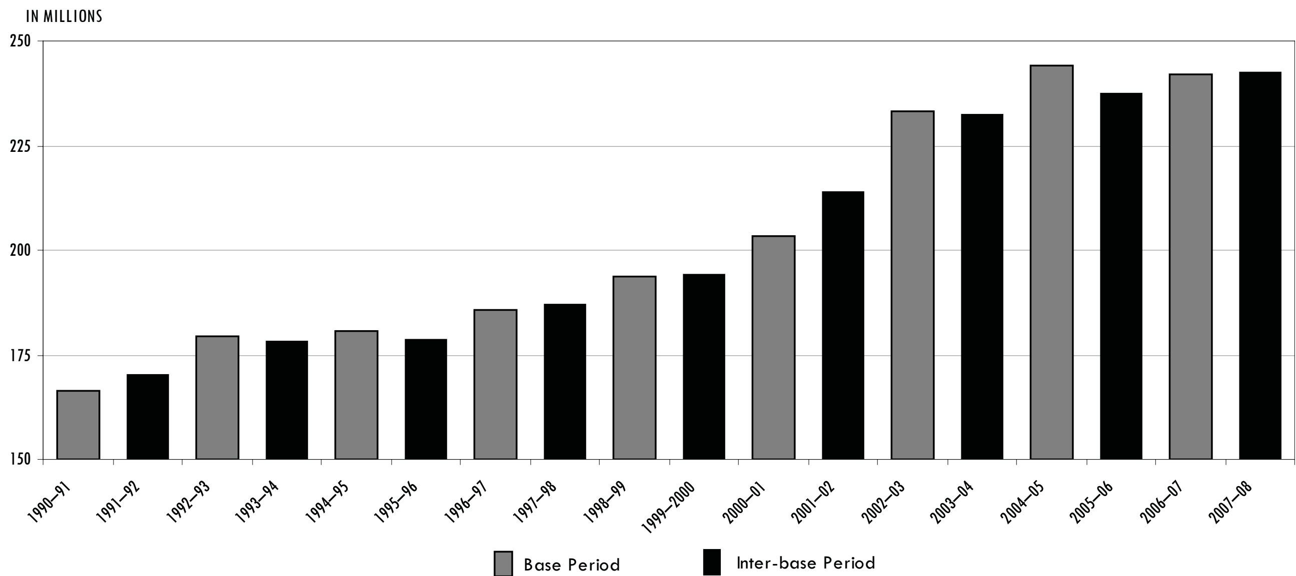
Source: Legislative Budget Board.

FIGURE 352
DISTRICTS REPORTING CONTACT HOUR DECREASES IN THE INTER-BASE PERIOD RELATIVE TO THE PRECEDING BASE PERIOD

DISTRICT	NUMBER OF INTER-BASE PERIODS SHOWING REDUCED CH CHANGE	PERCENTAGE OF INTER-BASE PERIODS SHOWING REDUCED CH CHANGE	CHANGE IN CONTACT HOURS SINCE 1990 (MEDIAN =34.0%)
Kilgore College	8	88.9%	14.0%
McLennan Community College	8	88.9%	28.6%
Vernon College	8	88.9%	33.2%
Alvin Community College	7	77.8%	(0.4%)
Clarendon College	7	77.8%	(1.1%)
Coastal Bend College	7	77.8%	2.9%
Galveston College	7	77.8%	(1.9%)
Hill College	7	77.8%	75.9%
Northeast Texas CC	7	77.8%	34.9%
Odessa College	7	77.8%	(20.0%)
Ranger Junior College	7	77.8%	(26.4%)
Victoria College	7	77.8%	2.1%
WesternTexas College	7	77.8%	34.8%
Wharton County Junior College	7	77.8%	36.1%
Amarillo College	6	66.7%	42.4%
Angelina College	6	66.7%	50.0%
Brazosport College	6	66.7%	(5.2%)
Central Texas College	6	66.7%	58.9%
Del Mar College	6	66.7%	0.3%
Frank Phillips College	6	66.7%	3.2%
Houston Community College	6	66.7%	24.4%
San Jacinto College	6	66.7%	36.1%
Southwest Texas Junior College	6	66.7%	55.0%
Cisco Junior College	5	55.6%	40.1%
College of the Mainland	5	55.6%	(4.2%)
Dallas County CC District	5	55.6%	25.1%
Howard College	5	55.6%	36.9%
Laredo Junior College	5	55.6%	20.4%
Lee College	5	55.6%	9.5%
Panola College	5	55.6%	13.2%
Tarrant County Junior College	5	55.6%	36.9%
Texarkana College	5	55.6%	5.4%
Weatherford College	5	55.6%	119.8%
Midland College	4	44.4%	47.7%
Paris Junior College	4	44.4%	46.9%
South Plains College	4	44.4%	57.6%
Texas Southmost College	4	44.4%	37.4%
El Paso Community College	3	33.3%	22.2%
Grayson County College	3	33.3%	24.5%
Navarro College	3	33.3%	129.8%
Temple Junior College	3	33.3%	89.6%
Trinity Valley CC	3	33.3%	30.2%
Tyler Junior College	3	33.3%	14.2%
Alamo Community College	2	22.2%	29.7%
Austin Community College	2	22.2%	49.1%
North Central Texas College	2	22.2%	123.4%
Lone Star College	1	11.1%	166.3%
South Texas CC	1	11.1%	1682.5%
Blinn College	0	0.0%	84.1%
Collin County CC	0	0.0%	149.2%

Source: Legislative Budget Board.

FIGURE 353
PUBLIC COMMUNITY COLLEGES
CONTACT HOURS, 1990–2008

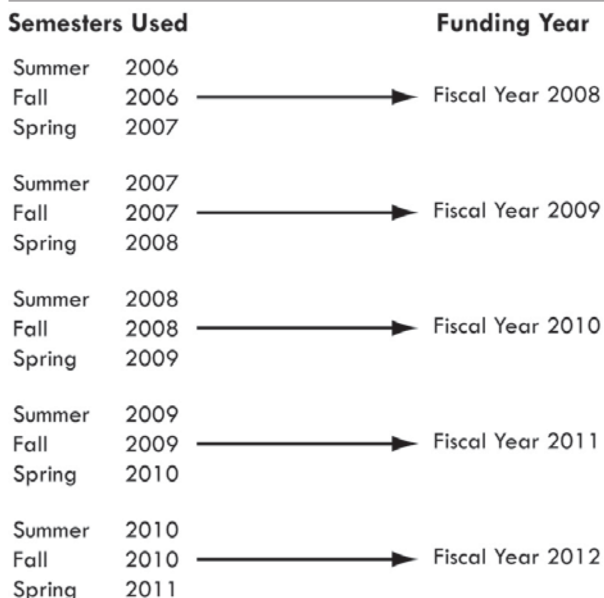


SOURCE: Legislative Budget Board.

PROPOSED ALLOCATION METHODOLOGY FORMULA

Recommendation 1 directs the Legislative Budget Board (LBB) to be in a position to implement a new community college formula allocation methodology starting in the 2012–13 biennium using the contact hours generated in the academic year immediately prior to each fiscal year. **Figure 354** graphically presents the proposed formula model.

FIGURE 354
PROPOSED FORMULA MODEL



SOURCE: Legislative Budget Board.

This proposed model uses the contact hours generated in the academic year immediately prior to each fiscal year to allocate the fiscal year's formula contributions.

To implement Recommendation 1, the Texas Higher Education Coordinating Board (THECB) would run the community college formula annually using the contact hour data generated in the academic year prior to each fiscal year. THECB, with approval from the LBB, would apportion the total state formula contribution on a pro rata basis using the results of each year's formula run.

For example, if the proposed revised method had been in place during the Eightieth Legislature, 2007, THECB would have used the contact hours generated in summer 2006, fall 2006, and spring 2007 to allocate the fiscal year 2008 funds. The contact hours generated in summer 2007, fall 2007, and spring 2008 would have been used to apportion the fiscal year 2009 funds. Post-session contact hour audits would be required annually.

The proposed model would give public community colleges incentives to offer a steady volume of educational offerings each year, which benefits students.

By incorporating all of the contact hours generated by the public community colleges into the state funding process, this model would allow the Legislature's biennial appropriation

to be based on two years of data, rather than the single historical year data.

Using the most current contact hour data would direct state formula contributions to those public community colleges experiencing the greatest relative contact hour growth and could reduce or eliminate the need to set aside funds for dramatic enrollment growth.

FISCAL IMPACT OF THE RECOMMENDATION

Since this recommendation would require the LBB develop for the Eighty-second Legislature, 2011, a detailed method of implementing this shift in how contact hours would be used to allocate state formula contributions, the fiscal impact for the 2010–11 biennium is insignificant.

Should the Eighty-second Legislature, 2011, decide to implement this shift, basing the allocation of state formula contributions on the contact hours generated in the year immediately prior to the fiscal year would not change the level of the state's annual appropriation and thus would not entail a direct cost or savings to the state. Such a shift would, however, result in some degree of reallocation of formula dollars among the 50 districts from year to year.

Furthermore, any need for "dramatic enrollment growth" set-aside funding would conceivably be reduced, because allocating formula funding using the latest contact hour data would direct state dollars toward those districts generating the most contact hours.

Community college districts accustomed to budgeting biennially established state contribution levels would have to adjust their fiscal practices to reflect a degree of variability in state contribution levels between fiscal years.

The introduced 2010–11 General Appropriations Bill includes a rider to implement the recommendation.

ELIMINATE CHILD NUTRITION PROGRAM FISCAL DEFICITS THROUGH INCREASED ACCOUNTABILITY

Despite reimbursements from the federal government for child nutrition programs, more than 71 percent of Texas independent school districts collectively spent nearly $30 million more than they received in food service revenues for these programs during the 2006–07 school year. Consequently, more than 50 percent of school districts collectively transferred more than $27.9 million of general funds into food services budgets. Even after budget transfers, more than 30 percent of the school districts' child nutrition programs had either a zero or a negative fund balance at the end of the 2006–07 school year.

Transferring funds to supplement its Child Nutrition Program because of program deficits affects the district's budget and may affect its instructional or other operational programs. The Texas Department of Agriculture administers the program while the Texas Education Agency is the federal funding pass-through agency. The Texas Education Agency does not consider the financial status of Child Nutrition Programs in the state's financial rating system and districts may be unaware of their financial standings. In addition, neither the Texas Department of Agriculture nor the Texas Education Agency is aware of how many district programs have deficits. Both the Texas Education Agency and the Texas Department of Agriculture are not required to review financial data to identify districts facing deficits and provide them with industry benchmarks to assist them.

By holding the state's Child Nutrition Program accountable to district stakeholders to be self-supporting, collaboratively having the two agencies involved in the Child Nutrition Program to coordinate and identify districts needing financial monitoring, including providing them with financial industry benchmarks, Texas public school districts may better ensure their general funds are directed toward instructional or other operational programs.

CONCERNS

- Although Texas public school districts report their child nutrition programs' financial information in audited financial statements, the information is not maintained in the state's financial rating system resulting in less accountability for the food service program.
- The Texas Education Agency and the Texas Department of Agriculture do not review the Child Nutrition Programs' financial information to identify non-self-supporting child nutrition programs being supplemented by general funds, or child nutrition programs' fund balance when the program's expenditures exceed revenues, potentially affecting funding for instructional and operational programs.
- Neither the Texas Department of Agriculture nor the Texas Education Agency review, develop, or publish Child Nutrition Program financial industry benchmarks, such as labor and food costs, to measure a district's performance against benchmarks.

RECOMMENDATIONS

- **Recommendation 1:** The Texas Education Agency should consider adding a non-critical indicator in the Financial Integrity Rating System of Texas to capture a school district's Child Nutrition Program's financial status, and report the operation's net revenue after expenditures (excluding transfers and ending fund balance).
- **Recommendation 2:** The Texas Education Agency and the Texas Department of Agriculture should jointly analyze all financial Child Nutrition Program district-level data including revenues, expenditures, labor, food and other costs to identify programs that are supplemented with general funds when a Child Nutrition Program's expenditures exceed their revenues. The results of the analysis should be reported to the Governor and the Legislative Budget Board.
- **Recommendation 3:** The Texas Education Agency and the Texas Department of Agriculture should collaboratively develop and publish Child Nutrition Program financial industry benchmarks, measuring district performance against benchmarks, and develop a process to assist Child Nutrition Programs not meeting benchmarks.

DISCUSSION

The National School Lunch Program (NSLP) officially began in 1946 followed by the School Breakfast Program (SBP) in

1966. In 1998, the U.S. Congress also expanded NSLP to include reimbursements for snacks served to children in after school educational and enrichment programs. The United States Department of Agriculture (USDA) regulates the states' child nutrition programs (CNPs) but allows states to administer their program in a manner that best works for each state. For example, Federal Law, Section 210.9(1) and (2) regulates a food service operation regarding its ability to make money and indicates that a program should "maintain a nonprofit school food service and observe the limitations on the use of nonprofit school food service revenues set forth in Section 210.14(a) and (b)… and should limit its net cash resources to an amount that does not exceed three months average expenditures for its nonprofit school food service or such other amount as may be approved in accordance with Section 210.19(a)."

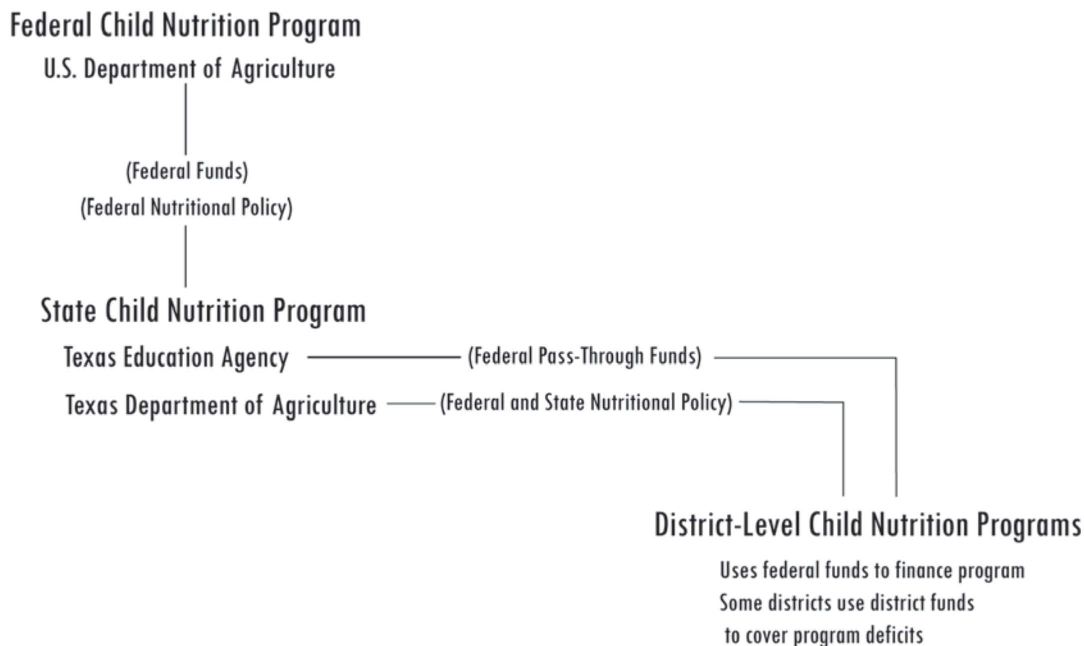
While Texas complies with USDA regulations, the Texas Department of Agriculture (TDA) expanded the school district-level child nutrition programs in Texas to include a Texas Public School Nutrition Policy. Some policy directives include: refraining from selling or serving foods of minimal nutritional value, restricting portion size, providing a daily offering of fruits and vegetables, and prohibiting deep-fat frying. TDA purposefully chose to administer the program beyond USDA's regulations in order to bring a larger focus to nutrition standards. **Figure 355** shows the Child Nutrition Program's structure.

In the 2006–07 school year, Texas child nutrition programs served more than 1,000 public school districts, fed approximately 4.5 million students annually and will yield Texas more than $2.1 billion in federal funding for the 2009–10 biennium.

The federal program reimburses school districts for providing meals to students who qualify to eat a free or reduced-price meal. Minimal reimbursements are also given for students who pay full price. USDA adjusts reimbursement rates annually for the NSLP and SBP programs to account for inflation. In July 2008, USDA adjusted meal reimbursements for free, reduced, and regular priced meals for all categories: breakfast, lunch, and snacks. **Figure 356** shows the reimbursement rates for school years 2007–08 and 2008–09 for breakfast and lunch.

Child nutrition programs in today's economy are becoming more challenging for districts to operate. A program's primary budget drivers are labor and food costs. According to industry standards, approximately 40 percent of a school district's child nutrition budget should constitute labor costs, while 40 percent should represent the program's food costs. Added to these expenses are costs such as transporting and storing food items and commodities (USDA surplus agricultural

FIGURE 355
CHILD NUTRITION PROGRAM STRUCTURE IN TEXAS, FISCAL YEAR 2008



Source: Legislative Budget Board.

FIGURE 356
USDA MEAL REIMBURSEMENT RATES, SCHOOL YEARS 2007–08 AND 2008–09

SCHOOL YEARS	BREAKFAST FREE	BREAKFAST REDUCED	BREAKFAST PAID	LUNCH FREE	LUNCH REDUCED	LUNCH PAID
2007–08	$1.35	$1.05	$0.24	$2.47	$2.07	$0.23
2008–09	$1.40	$1.10	$0.25	$2.57	$2.17	$0.24

Source: Texas Department of Agriculture.

food supplies provided to school CNPs), staff training, furnishing and replacing equipment for new and old cafeterias, and keeping up with ever-changing mandates to support federal and state nutrition requirements. Successful school CNPs minimize costs by implementing industry benchmarks such as Meals-Per-Labor-Hour ratios for allocating optimum staff ratios and periodically conducting food cost analysis to ensure efficiencies in operation.

Although not a recommended practice, Texas public school districts sometimes supplement their food service operation with general funds. Local board and administrative decisions in some instances may be the reason expenditures in the department continue to exceed revenues. For example, districts may choose to supplement the program rather than raise meal prices. This practice may in turn impact other programs in the district since funds are being redirected to support the food service program.

TARGETED SCHOOL PERFORMANCE REVIEWS

To gain a better understanding of administrative and financial challenges facing district-level child nutrition programs in Texas, Legislative Budget Board (LBB) staff conducted reviews of child nutrition programs in five school districts (Crane, Early, Pecos-Barstow-Toyah, Port Arthur, and Rio Grande City) with assistance by MGT of America, Inc. Criteria for district selection included: enrollment size, wealth per pupil, geographic location, revenue lost per meal served, positive or negative fund balance, and general funds transferred into the CNP's budget. Districts selected for site visits were those that displayed an operation whose expenditures exceeded their revenues as shown in **Figure 357**.

Financial data from the Public Education Information Management System (PEIMS) for all 1,031 Texas public school districts was analyzed to gain a statewide understanding of the financial status of CNPs.

In school year 2006–07, data reported to TEA indicated that 728 Texas public school districts out of 1,018 school districts with CNPs reporting information, or 71.5 percent, had a deficit of CNP revenues over expenditures compared to 290 districts (28.5 percent) that had revenues that were greater than or equal to the expenditures as shown in **Figure 358**.

In school year 2006–07, 522 districts whose expenditures exceeded their revenues collectively transferred more than $27.9 million from districts' general funds. According to TEA, more than 30 percent of the school districts' child nutrition programs had either a zero or a negative fund balance at the end of the 2006–07 school year. The general fund is used to show transactions resulting from operations and activities from a variety of revenue sources. While it is not certain that all of the transfers were for correcting a deficit, this was the case for all such transfers in the districts LBB staff reviewed.

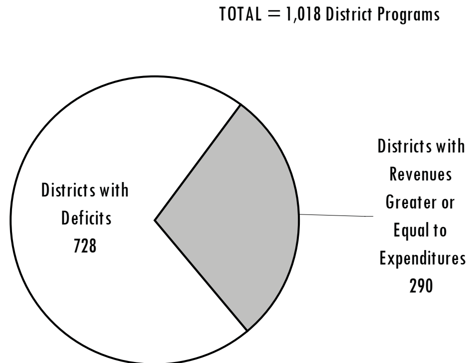
Figure 359 shows the categories of CNPs' financial status in the 2006–07 school year. Nearly half of Texas public school

FIGURE 357
DIVERSE TARGETED TEXAS PUBLIC SCHOOL DISTRICTS FOR 2005–06 SCHOOL YEAR*

DISTRICT	ENROLLMENT SIZE	REVENUES	EXPENSES	REVENUES MINUS EXPENDITURES	TRANSFERS FROM GENERAL FUND	ENDING FUND BALANCE
Crane	911	$261,541	$475,401	($213,860)	$213,862	$0
Early	1,316	$530,447	$716,327	($185,880)	$165,845	$1,119
Pecos-Barstow-Toyah	2,195	$835,871	$1,063,336	($227,465)	$227,465	$0
Port Arthur	9,211	$4,046,716	$4,374,787	($328,071)	$0	($328,063)
Rio Grande City	9,723	$6,093,922	$7,499,710	($1,405,788)	$0	($45,752)

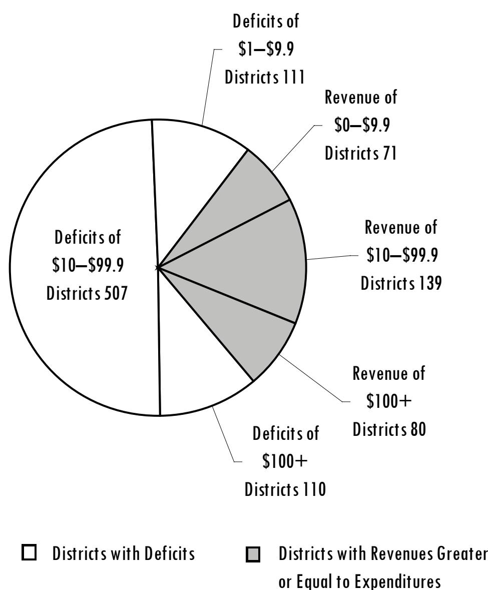
*Amounts in this figure were the latest financial information available at the time of district selection.
Source: Texas Education Agency.

FIGURE 358
STATEWIDE TEXAS PUBLIC SCHOOL DISTRICT CHILD NUTRITION PROGRAMS' FINANCIAL STATUS, 2006–07 SCHOOL YEAR



SOURCE: Texas Education Agency.

FIGURE 359
STATEWIDE TOTAL OF TEXAS PUBLIC SCHOOL DISTRICTS CHILD NUTRITION PROGRAMS' FINANCIAL STATUS BY DOLLARS, 2006–07 SCHOOL YEAR

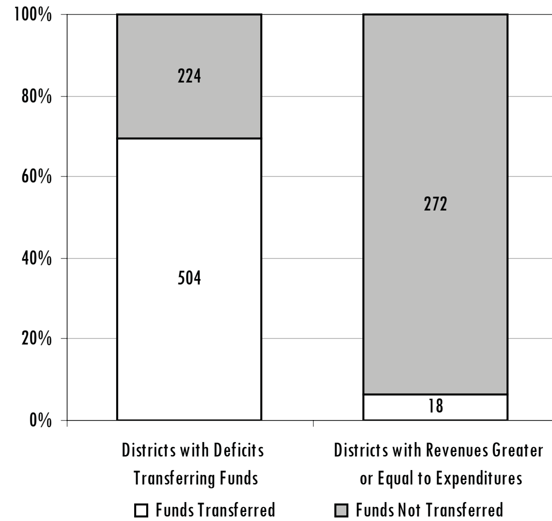


SOURCE: Texas Education Agency.

districts (507 of 1,018) had expenditures that exceeded revenues between $10,000 and $99,999 in their CNP, and only 139 (14 percent) had revenues that were greater than or equal to the expenditures.

Figure 360 shows the percentage of districts with a CNP that transferred general funds (18 districts or 6 percent) compared to those districts where revenues exceeded or were equal to expenditures in the 2006–07 school year. While 504 of the 728 districts or 69 percent transferred funds where expenditures exceeded revenues compared to 224 districts that did not transfer funds.

FIGURE 360
CHILD NUTRITION PROGRAMS BY DISTRICTS PERCENTAGE OF TRANSFERS FROM GENERAL FUNDS INTO CHILD NUTRITION PROGRAMS' BUDGET, 2006–07 SCHOOL YEAR



SOURCE: Texas Education Agency.

In addition, the five Texas public school districts reviewed were found to have food service expenditures exceeding revenues from nearly $186,000 to more than $1.4 million. Three of the five districts transferred general funds to supplement the program, with one district transferring every year since the inception of the program in 1969. Two other Texas public school districts transferred general funds to the food service budget for each of the last five years. Both districts were found to have excessive food service staff compared to industry benchmarks and to not have conducted thorough food cost analyses to understand how to be more efficient. The superintendent of one of the districts stated that the funds transferred for nearly a decade could have been put to use in other areas, such as contracting for two more teachers or to buy two or three new buses, but instead was spent to supplement the food service program.

Two of the Texas public school districts reviewed whose expenditures exceeded their revenues were found to have extenuating circumstances (one-time overspending on equipment or a hurricane disaster) that may have caused their programs to be less efficient. Nonetheless, CNPs that are not self-supporting financially impact other district

programs, such as instructional programs, and impede the district's efforts to meet the goal of spending 65 percent of the budget on instruction.

CNPs allocating general funds to help supplement the CNP may be out of step with the state's financial rating system, the Financial Integrity Rating System of Texas, (School FIRST), since the primary goal of the rating system is to improve the management of school districts' financial resources and to encourage Texas public schools to manage financial resources better in order to provide the maximum allocation possible for direct instructional purposes.

The Seventy-seventh Legislature, 2001, authorized the implementation of a financial rating system, School FIRST. In accordance with Texas Education Code, Chapter 39, Subchapter I, (a) "each school district must be assigned a financial accountability rating by TEA." Presently the rating system includes 24 indicators that help determine a Texas public school district's School FIRST rating shown in **Figure 361**. The indicators are grouped into five areas: Critical Indicators (1–6), Fiscal Responsibility and Academic Performance (7–12), Budgeting (13–17), Personnel (18–20), and Cash Management (21–24).

In August 2005, the Governor issued an executive order (RP47) requiring every Texas public school district in the state to spend at least 65 percent of its funds directly on classroom instruction. According to the order, the Governor directed TEA to "create and implement a comprehensive financial accountability system to ensure transparency and fiscal efficiency in school district operations. The accountability system added an indicator (#13) establishing a requirement that 65 percent of school district funds be expended for instructional purposes as defined by the National Center for Education Statistics."

Figure 362 shows the five potential ratings Texas public school districts may be assigned under the financial rating system.

According to TEA's division of Financial Audits, the School FIRST system sanctions Texas public school districts not in compliance. School FIRST sanctions given to school districts rated "Substandard Achievement" can range from writing a corrective action plan to having a financial monitor placed in the district, as shown in **Figure 363**.

While this system holds Texas public school districts accountable for finances through use of indicators, the system excludes the reporting of any CNP financial information. District stakeholders and some administrators may be unaware of the financial status of the CNP because its financial status is not measured in School FIRST or made public. For example, one Texas public school district reviewed by the LBB staff was found to have transferred over the past several years nearly a quarter of a million dollars annually, or $201 per student, from the district's general fund to supplement the operations of the CNP.

Recommendation 1 would require TEA to add a non-critical indicator to School FIRST capturing each Texas public school district's CNP financial status and report the operation's net revenue after expenditures (excluding transfers and ending fund balance). By placing an indicator in the financial accountability rating system, TDA, TEA, Regional Education Service Centers, and local school district officials will become aware of the program's financial status and will have an opportunity to find ways to remedy the situation before the district finds it necessary to transfer supplemental funds to maintain the operation. In addition, the program will be accountable to all stakeholders, increasing the likelihood of the program being self-supporting. Texas Education Code, Section 39.203, requires Texas public school districts to prepare and distribute an annual financial management report and provide the public an opportunity to comment on the report. The report must include management performance based on the comparison of the district's performance on the indicators adopted in School FIRST.

COLLABORATION BETWEEN AGENCIES INVOLVED WITH CHILD NUTRITION PROGRAMS

Most states' child nutrition programs are administered by the state's education agency. The exceptions are Texas and New Jersey. These two states have opted to place the program in separate agencies.

In 2003, Texas transferred the administration of the CNP from TEA to TDA where a division was added for the program. Federal reimbursement funding for Texas public school districts participating in the breakfast, lunch, and snack programs, however, remained the responsibility of TEA. USDA provides State Administrative Expense (SAE) funding to states to help administer the program. TDA received more than $42 million in SAE funds for the 2008–09 biennium. **Figure 364** shows the total funds for both agencies for the 2008–09 biennium and the amount requested for the 2010–11 biennium. In addition to the base request, TDA has also requested $50 million as an exceptional

FIGURE 361
SCHOOL FIRST INDICATORS AND INDICATOR AREAS, 2007–08 SCHOOL YEAR

NUMBER	INDICATORS
CRITICAL INDICATORS	
1.	Was the total fund balance less reserved fund balance greater than zero in the General Fund?
2.	Was the Total Unreserved Net Asset Balance in the Governmental Activities column in the Statement of Net Assets greater than zero?
3.	Were there no disclosures in the Annual Financial Report and/or other sources of information concerning default on bonded indebtedness obligations?
4.	Was the Annual Financial Report filed within one month after November 27th or January 28th deadline depending upon the district's fiscal year end date (June 30th or August 31st)?
5.	Was there an unqualified opinion in the Annual Financial Report?
6.	Did the Annual Financial Report not disclose any instance(s) of material weaknesses in internal controls?
FISCAL RESPONSIBILITY AND ACADEMIC PERFORMANCE	
7.	Did the district's academic rating exceed Academically Unacceptable?
8.	Was the three-year average percent of total tax collections (including delinquent) greater than 98%?
9.	Did the comparison of PEIMS data to like information in Annual Financial Report result in an aggregate variance of less than 3 percent of expenditures per Fund Type (data quality measure)?
10.	Were debt related expenditures (net of IFA and /or EDA allotment) less than $250.00 per student? (If the district's five-year percent change in students was a 7% increase or more or if property taxes collected per penny of tax effort were more than $200,000, then the district receives 5 points.)
11.	Was there no disclosure in the Annual Audit Report of material noncompliance?
12.	Did the district have full accreditation status in relation to financial management practices? (e.g., no master or monitor assigned)
BUDGETING	
13.	Was the percent of operation expenditures expended for instruction more than or equal to 65%? (Functions 11, 36, 93, and 95) (phased in over three years: 55% for 2006–07; 60% for 2007–08; and 65% for 2008–09)
14.	Was the percent of operating expenditures expended for instruction more than or equal to 65%? (Functions 11, 12, 31, 33, 36, 93, and 95)
15.	Was the percent of operation expenditures and other uses less than the aggregate of budgeted total revenues, other resources and fund balance in General Fund?
16.	If the district's aggregate fund balance in the General Fund and Capital Projects Fund was less than the zero, were construction projects adequately financed? (Were construction projects adequately financed or adjusted by change orders or other legal means to avoid creating or adding to the fund balance deficit situation?)
17.	Was ratio of cash and investments to deferred revenues (excluding amount equal to net delinquent taxes receivable) in the General Fund greater than or equal to 1:1? (If deferred revenues are less than net delinquent taxes receivable, then the district receives 5 points.)
PERSONNEL	
18.	Was the administrative cost ratio less than the threshold ratio?
19.	Was the ratio of students to teachers within the ranges according to district size?
20.	Was the ratio of student to total staff within the ranges according to district size?
CASH MANAGEMENT	
21.	Was the total fund balance in the general Fund more than 50% and less than 150% of optimum according to the fund balance and cash flow worksheet in the Annual Financial Report?
22.	Was the decrease in undesignated unreserved fund balance less than 20% over two fiscal years? (If 1.5 times optimum fund balance is less than total fund balance in General Fund or if total revenues exceeded operating expenditures in General Fund, then the district receives 5 points.)
23.	Was the aggregate total of cash and investments in the General Fund more than $0?
24.	Were investment earnings in all funds (excluding Debt Service Fund and Capitol Projects Fund) more than $20.00 per student?

Source: Texas Education Agency.

FIGURE 362
SCHOOL FIRST RATINGS SYSTEM, 2007–08 SCHOOL YEAR

RATING	SCORING SYSTEM
1. Superior Achievement	Score greater than 75 and "YES" to indicator 7.
2. Above Standard Achievement	Score of 65 to 75 OR greater than 75 and "NO" to indicator 7.
3. Standard Achievement	Score of 55 to 65 points.
4. Substandard Achievement	If less than 55 points OR if the district answered "NO" to indicators 1, 2, 3, 4, 5, and 6. The commissioner of education may apply sanctions to a district that is assigned a "Substandard Achievement" rating.
5. Suspended–Data Quality	If serious data quality issues are disclosed by the commissioner of education, a "Suspended–Data Quality" rating shall be assigned to the school district. The "Suspended–Data Quality" rating will be assigned until the district successfully resolves the data quality issues. The commissioner of education may apply sanctions to a district that is assigned a "Suspended–Data Quality" rating.

NOTE: Indicators 1, 2, 3, 4, 5, and 6 are critical indicators whose financial ratings are determined by answering simply "YES" or "NO." If the district answers "NO" to these indicators, the district's rating is automatically "Substandard Achievement."
SOURCE: Texas Education Agency.

FIGURE 363
SCHOOL FIRST SANCTIONS, 2008

YEAR	SANCTIONS
1	Districts rated substandard in the first year must write a corrective action plan within six months.
2	Districts rated substandard in the second consecutive year must write a corrective action plan every quarter.
3	Districts rated substandard in three consecutive years in the School FIRST system are assigned a financial monitor by TEA. The monitor's hourly wage and travel expenses must be covered by districts assigned a monitor.

SOURCE: Texas Education Agency.

FIGURE 364
PROGRAM FUNDING FOR THE STATE CHILD NUTRITION PROGRAM, 2008–09 AND 2010–11 BIENNIA

AGENCY	FUND TYPE	2008–09 (IN MILLIONS)	2010–11 REQUESTED (IN MILLIONS)
Texas Department of Agriculture	General Revenue Fund	$2.3	$2.6
	State Administrative Expenses (SAE)	42.6	48.0
	Total Method of Finance	**$44.9**	**$50.6**
Texas Education Agency	General Revenue Fund	$28.8	$29.3
	Federal School Lunch Fund 171, SBP, NSLP	2,593.6	2,978.6
	Total Method of Finance	**$2,622.4**	**$3,008.0**

NOTE: Totals may not add up due to rounding.
SOURCES: Legislative Budget Board; Texas Education Agency; Texas Department of Agriculture.

item to reward schools for best practices and to support nutrition education.

Both agencies assume a portion of the program either through administration or as a funding pass-through for federal funds. Likewise, both agencies also capture reporting information through separate databases. TDA uses the Child Nutrition Programs Information Management System (CNPIMS) database to capture information reported by Texas public school district programs regarding their average daily participation rates for free, reduced, and paid meals. TEA captures a CNP's expenditures and revenues through PEIMS, including salaries/wages, extra duty pay/overtime, contracted and professional services, food expenses, non-food expenses, items for sale, USDA donated commodities, and general supplies. Audited financial statements are reported to TEA by each Texas public school district including CNP information. Finally, all reimbursement claims are processed by the central office of the Child Nutrition Program's Division at TDA while TEA transfers funding to school districts at TDA's request.

TEA and TDA have a memorandum of understanding (MOU) to share information. However, interviews by LBB staff with both agencies indicated that neither agency is aware of how many Child Nutrition Programs' expenditures

exceeded their revenues as TDA mainly focuses on the compliance and nutrition side of the program while TEA is responsible for sending districts their reimbursement funds. Additionally, TEA's School Financial Audits division is required to report information to TDA regarding CNP finances only when a Texas public school district has exceeded its mandated fund balance limit of three months of operating expenditures. Once a district surpasses its fund balance amount, TEA notifies TDA and TDA sends a letter to the non-compliant district regarding the matter. The non-compliant district is then required to take action to reach the appropriate levels mandated by federal law. TEA is not required to report when a district's food service expenditures exceed revenues.

Since TEA does not routinely review other PEIMS data it collects regarding a CNP's financial expenses and TDA does not need that level of information, neither agency has knowledge of which or how many Texas public school districts are facing major or minor financial problems to the extent of needing to tap into their general funds to supplement the program and keep it operating.

Recommendation 2 would suggest that TEA and TDA jointly analyze all financial Child Nutrition Program district-level data including revenues, expenditures, labor, food, and other costs to identify programs that are supplemented with general funds when a Child Nutrition Program's expenditures exceed their revenues. The results of the analysis should be reported to the Governor and the LBB. Timing of the analysis and reporting would be at the discretion of the agencies involved.

When a Texas public school district's CNP expenditures exceed revenues, it is important that CNP standards be evaluated against benchmarks, since food and labor costs are the two major cost drivers in a program's budget. Providing financial industry benchmarks can help Texas public school districts focus on exactly where their programs need assistance. For example, a Texas school district reviewed was found to be spending 116 percent of its CNP revenue on labor and 96 percent on food costs when an industry benchmark indicates that both areas should be in the 40 percent of revenue range to be efficient. This particular CNP had not conducted a thorough cost analysis to determine the department's efficiency. The manager was aware that the program was overstaffed due to an earlier salary study conducted by a professional organization but did not know how far from the suggested labor and food industry benchmark the program was in both areas in order to make adjustments. Further, it was unclear to the manager what the industry benchmark stipulated. Consequently, the district was transferring large amounts of general funds annually to assist the CNP. Many experienced CNP consultants recommend benchmarks that focus on cost controls within the program. Cost controls may include criteria for a balanced budget that allows no more than:

- 40 percent for labor including fringe benefits;
- 40 percent for food including paper supplies and commodity value;
- 7 percent for administrative costs including district office salaries;
- 6 percent for direct costs including utilities and maintenance;
- 4 percent for indirect costs including garbage and telephone;
- 1 percent for equipment replacement; and
- 2 percent for profit to be retained in a fund balance.

Recommendation 3 proposes that TEA and TDA collaboratively develop and publish Child Nutrition Program industry financial benchmarks, measuring Texas public school districts' performance against benchmarks, and develop a process to assist CNPs not meeting benchmarks. An additional option may be for both agencies to use the 20 Regional Education Service Centers (RESCs) to provide local school CNPs with the benchmarks in their training sessions, since TDA already provides technical assistance and training for CNPs to Texas public school districts by contracting with the RESCs.

FISCAL IMPACT OF THE RECOMMENDATIONS

These management recommendations would result in no fiscal impact in the 2010–11 biennium since they can be accomplished with existing appropriations.

IMPROVE THE EFFECTIVENESS OF THE INSTRUCTIONAL FACILITIES ALLOTMENT

The Texas Legislature established the Instructional Facilities Allotment program to help public school districts pay bond debt or lease purchases for qualified projects consisting of new construction of, or renovations of, instructional facilities. School districts must apply to the Texas Education Agency to obtain program assistance. Program application rounds occur on an annual basis when the Legislature provides appropriations for new awards. For each district application receiving a program award, the amount of assistance is based on a state share of the state guaranteed tax revenue yield of $35 per student in average daily attendance per penny of local tax effort. The state share amount is the difference between the guaranteed yield amount and the district share which is the district's tax revenue yield. When the state share is not zero, the district is eligible to receive program assistance. To determine program effects on school district instructional facilities capital projects, Legislative Budget Board staff conducted a program survey of 164 districts and eight facilities management reviews of districts that recently applied for but did not receive program awards, as well as interviews with seven districts with multiple program round awards.

Many districts apply with qualified projects but are not eligible to receive program aid because their property valuations have increased to a level that exceeds the state guaranteed yield of $35. The state can improve the effectiveness of the program by reviewing the state guaranteed yield level.

CONCERN

- The state's level of assistance related to the guaranteed yield for the instructional facilities program has not changed since 1999 while school district property valuations have increased. As a result, fewer school districts are eligible to receive state program aid for qualified projects and fewer students benefit from state assistance.

RECOMMENDATION

- **Recommendation 1:** The Texas Legislature should review the performance and impact of the Instructional Facilities Allotment program and consider increasing the state guaranteed yield rate of $35 per penny of tax effort per unweighted student in average daily attendance.

DISCUSSION

The Instructional Facilities Allotment Program (IFA), administered by the Texas Education Agency (TEA), was established by the enactment of legislation by the Seventy-fifth Legislature, 1997, (Texas Education Code, Section 46.001–013) to provide state aid to districts in making debt payments on qualified projects consisting of bonds or lease-purchase agreements for the construction or renovation of instructional facilities. Districts must apply to TEA in order to receive program funding. The program assists low property wealth districts needing help building facilities because of their difficulty in generating adequate tax revenue from property tax collections to pay for district debt service in financing instructional school facilities. The program provides assistance by equalizing district tax burden based on a state guaranteed tax revenue yield of $35 per student per penny of local tax effort.

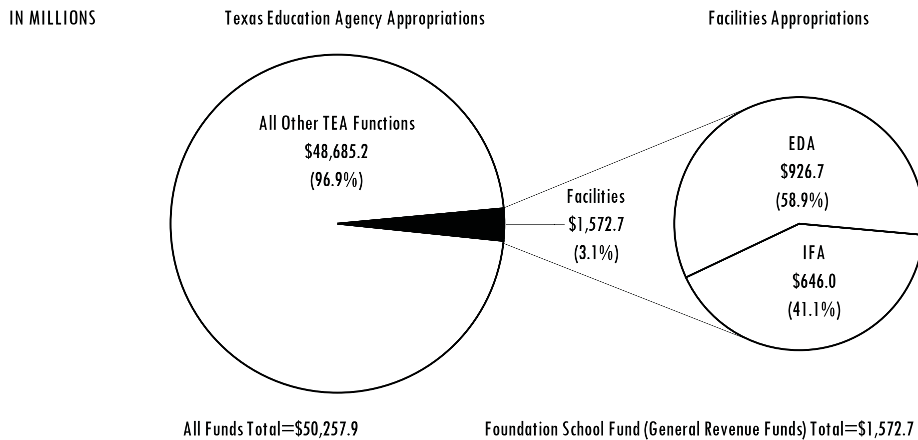
The IFA program consists of ongoing and newly authorized IFA awards. Ongoing IFA consists of program aid awarded in prior years and does not require the district to reapply to continue receiving program assistance. For newly authorized IFA awards, TEA administers an annual application round when the Legislature appropriates new award funds.

PROGRAM FUNDING

For the 2008–09 biennium, the total facilities appropriation amounted to 3.1 percent of TEA's total appropriations. The IFA program was 41.1 percent of the facilities appropriation (see **Figure 365**) at $646.0 million ($558.5 million ongoing IFA and $87.5 million in newly authorized IFA), providing state aid to 408 districts. The Existing Debt Allotment (EDA) program is the other TEA administered state program assisting districts with school facilities debt service payments, but does not require application.

Appropriations funding for newly authorized IFA has fluctuated since program inception. In fiscal year 1997, the program received a $170 million appropriation. In more recent years, the program received appropriations of $20 million for IFA applications for Round 7 (June 2004), $50

FIGURE 365
ALL FUNDS FACILITIES APPROPRIATION, 2008–09 BIENNIUM



NOTE: Texas Education Agency (TEA); Instructional Facilities Allotment (IFA); Existing Debt Allotment (EDA).
SOURCE: Legislative Budget Board.

million for Round 8 (June 2006), and $87.5 million for the Round 9 (June 2008) application cycle (see **Figure 366**).

FIGURE 366
IFA SUMMARY OF APPROPRIATIONS 1996–97 TO 2008–09 BIENNIA

BIENNIUM	IFA ONGOING (IN MILLIONS)	IFA NEWLY AUTHORIZED (IN MILLIONS)	IFA ROUND	IFA ONGOING AND NEWLY AUTHORIZED (IN MILLIONS)
1996–97	$0.0	$170.0	1	$170.0
1998–99	$200.0	$200.0	2, 3	$400.0
2000–01	$396.0	$100.0	4, 5	$496.0
2002–03	$512.8	$100.0	6	$612.8
2004–05	$506.5	$20.0	7	$526.5
2006–07	$542.0	$50.0	8	$592.0
2008–09	$558.5	$87.5	9	$646.0

NOTE: Instructional Facilities Allotment (IFA).
SOURCE: Legislative Budget Board.

Figure 367 shows the actual state assistance of IFA and the number of corresponding school districts receiving program aid for both ongoing and newly authorized debt. The state IFA funding for each year is not a cumulative summation of the amounts awarded for each round because the state amount is dependent on attendance, debt service, and property value fluctuations each year.

IFA PROGRAM MECHANICS

Districts with prior IFA round awards continue to receive state assistance on IFA debt until fully paid without having to reapply. For new program awards, TEA uses an annual application process when the Legislature appropriates funds for new IFA applications. Districts seeking program assistance must apply to TEA for IFA funding after a successful bond election but before issuance, board authorization of a lease-purchase, or refinancing IFA bond debt. Debt qualifies for IFA assistance if it meets TEA's criteria for new construction or renovations of instructional facilities. Examples of projects that qualify for IFA are shown in **Figure 368**.

FIGURE 367
ACTUAL STATE AMOUNT FOR IFA PROGRAM AND DISTRICTS FUNDED, FISCAL YEARS 1998 TO 2008

FISCAL YEAR	STATE IFA FUNDING (IN MILLIONS)	NUMBER OF DISTRICTS (ONGOING AND NEWLY AUTHORIZED DEBT)
1998	$64.5	115
1999	$119.1	224
2000	$175.3	269
2001	$221.4	315
2002	$253.0	374
2003	$288.5	408
2004	$272.4	408
2005	$284.4	406
2006	$275.5	406
2007	$311.6	408
2008	$284.4	408

NOTE: Instructional Facilities Allotment (IFA).
SOURCE: Texas Education Agency.

The IFA assistance level a district is eligible to receive is dependent upon many elements, including the district's property values reported by the Comptroller's Property Tax

FIGURE 368
INSTRUCTIONAL FACILITIES ALLOTMENT EXAMPLES OF QUALIFIED PROJECTS, 2008

SITE CONDITIONS	
COMPONENT	**QUALIFIED**
Acquisition	Site acquisition for a new school, if funded from bond proceeds.
Infrastructure	Infrastructure and utility extensions to instructional facilities.
Parking	Parking area that is a component of a new or expanded instructional facility. Replacement of a parking area that is consumed by the expansion of an instructional facility. Addition to an existing parking area if in conjunction with an expansion of an instructional facility.
Landscaping	Landscaping for a new instructional facility. Replacement of a landscaped area that is consumed by the expansion of an instructional facility.
Playgrounds	Playgrounds at elementary schools. Playground equipment attached to the ground. Playing fields used exclusively for curriculum purposes.
Covered Walkways	Covered walkways, new or renovated, that connect instructional facilities.
Demolition	Demolition costs to prepare the site of an instructional facility.
CLASSROOMS AND SUPPORT FACILITIES	
COMPONENT	**QUALIFIED**
Classrooms	New construction, addition, or renovation of general classrooms. New construction, addition, or renovation of specialty classrooms required by the curriculum. Specialty classrooms can include science labs, language and computer labs, vocational shops, home economics, band, choir, music, drama, art, ROTC, etc.
Libraries	Library and media center space.
Kitchens, Cafeterias, Assembly Spaces, Lecture Rooms, Physical Education Space	Instructional kitchens, cafeterias, assembly spaces or lecture rooms with less than 150 seats, gymnasia or other space for physical education instruction, etc.
Auditoriums, Performing Arts Centers, Fine Arts Centers	Seating for up to 150 students in auditoriums, performing arts centers, and fine arts centers. The stage, if it is an integral part of a drama curriculum.
Offices and Workrooms	School administration, counselor, and teacher offices and workrooms if an integral part of a new school. Additions of offices/workrooms in proportion to addition of instructional space. New administration, counselor, and teacher offices and workrooms as part of an addition only if part of a significant instructional addition and only if the existing office/workroom areas are renovated into instructional areas. Renovations of offices/workrooms if entire school is renovated.
Portable or Manufactured Buildings	Portable or manufactured buildings if considered real property and if used for instructional purposes.
PHYSICAL EDUCATION/ATHLETIC FACILITIES	
COMPONENT	**QUALIFIED**
Gymnasiums	Playing surface, perimeter, and seating up to 150 for gymnasiums used primarily for curriculum purposes.
Dressing Areas/Locker Rooms	Dressing areas/locker rooms in gymnasiums necessary for the physical education curriculum.
Weight Rooms	Weight rooms as part of gymnasium/work out areas if an integral part of the physical education curriculum.
Concession Areas	Concession areas only if primary daily use is as a cafeteria snack bar or school vending area.
Miscellaneous Athletic Facilities	Playing fields used exclusively for physical education curriculum purposes.

FIGURE 368 (CONTINUED)
INSTRUCTIONAL FACILITIES ALLOTMENT EXAMPLES OF QUALIFIED PROJECTS, 2008

ELECTRICAL, TECHNOLOGY, AND COMMUNICATION	
COMPONENT	**QUALIFIED**
Wiring, Cabling, Connections	Wiring, cabling, and related permanent fixtures in instructional areas. For instructional areas, all major service connections to main building entry (or "head-in room") and/or to a technology center (interior wiring included up to outlet).
Intercom Systems	Intercom and public announcement systems in instructional areas.
Cabinets, Shelving, Lab Stations	Built-in cabinets and shelving, and permanently fixed science lab stations, in instructional areas.
Equipment & Fixtures	Fixed, permanent equipment and fixtures in instructional areas. Built-in kitchen equipment and fixtures.
MAJOR REPAIR AND REMODEL	
COMPONENT	**QUALIFIED**
Repair/Remodel	Repair/remodel of instructional facilities, such as HVAC retrofit, roofing, interior space partitioning, electrical, plumbing, related architectural finishes, etc.
ADA Renovation	Renovation of instructional facilities for compliance with Americans with Disabilities Act (ADA) requirements.
Other Facilities	Agriculture barns, greenhouses, etc., as required by the curriculum.
FEES AND CONTINGENCIES	
COMPONENT	**QUALIFIED**
Fees	Professional fees for design in proportion to the qualified instructional portion of a facility.
Issuance Costs	Issuance costs for debt in proportion to the qualified portion of the debt.
Contingency Funds	Contingency funds if reserved for and used on qualified purposes.

SOURCE: Texas Education Agency.

Division (CPTD), unweighted student average daily attendance (ADA), and amount of annual debt service. The program guarantees $35 per student in state and local revenue for each cent of local tax effort, to pay the debt service on bonds for qualified projects. For each application receiving a program award, the state share amount is the difference between the guaranteed yield amount and the district share, which is the district's tax revenue yield per student per penny of local tax effort. When the state share is not zero, the district is eligible to receive program assistance. The amount of debt service eligible for IFA is proportional to the percentage of the state share of the guaranteed yield. The eligible debt service has a ceiling of $250 per ADA and a floor of $100,000 for districts receiving awards.

The interaction of these elements influencing IFA assistance levels is complex and best understood through examples in **Figures 369, 370, and 371**. The examples are based on a spreadsheet published by TEA to help districts estimate IFA funding. The data for the example district in **Figures 369, 370, and 371** is based on an assumption that the district passed a bond issue during the biennium and makes a payment on the debt during the second year of the biennium.

Impact of Property Values on IFA State Share: The IFA state share amount is inversely proportional to changes in property values. Decreased property values increase the state's share of the amount eligible for IFA and increased property values decrease the state's share. **Figure 369** shows the impact of property values on the amount of IFA funding available to an example district. When the example district's CPTD value goes down from $3 billion to $2 billion, the state share increases from 42.9 percent to 61.9 percent. If the CPTD value goes up to $4 billion, the state share drops from 42.9 percent to 23.8 percent (see **Figure 369**).

Impact of ADA on IFA State Share: The IFA state share amount is directly proportional to changes in ADA. The ADA of the district affects one of the limit parameters used to determine the amount of IFA eligible debt payments in addition to the share amounts of the state and district. The higher ADA increases the ADA limitation on eligible debt payments, decreases local revenue per ADA per penny, and increases the state's share of funding. The lower ADA

FIGURE 369
INVERSE RELATIONSHIP BETWEEN DISTRICT PROPERTY VALUES AND IFA FUNDING

DESCRIPTION OF FACTOR	EXAMPLE DISTRICT	LOWER PROPERTY VALUES	HIGHER PROPERTY VALUES
2007–08 Debt Service Payment	$0	$0	$0
2008–09 Debt Service Payment	$4.5 million	$4.5 million	$4.5 million
2008–09 Projected ADA	15,000	15,000	15,000
2007 CPTD Value	**$3.0 billion**	**$2.0 billion**	**$4.0 billion**
Highest Debt Service Payment	$4.5 million	$4.5 million	$4.5 million
ADA Limitation	$3.8 million	$3.8 million	$3.8 million
Limitation on Assistance	$3.8 million	$3.8 million	$3.8 million
Revenue from Penny of Tax Effort	$300,000	$200,000	$400,000
Revenue per Penny per ADA	$20.00	$13.33	$26.67
State's Share of $35 Yield	$15.00	$21.67	$8.33
State's Share as a Percentage	42.9%	61.9%	23.8%
Local Share of IFA	$2.1 million	$1.4 million	$2.9 million
State Share of IFA	**$1.6 million**	**$2.3. million**	**$892,857**

NOTES: Instructional Facilities Allotment (IFA); Average Daily Attendance (ADA); Comptroller Property Tax Division (CPTD).
SOURCES: Legislative Budget Board; Texas Education Agency.

decreases the limitation on eligible debt payments and decreases the state's share of IFA funding. **Figure 370** shows the relationship of ADA on IFA funding for an example district. When the district's ADA increases from 15,000 to 20,000 students, the state share increases from 42.9 percent to 57.1 percent. When ADA decreases to 10,000 students, the state share decreases to 14.3 percent.

Impact of Debt Payment on IFA State Share: The amount of the district's debt payment affects one of the limits on IFA eligible debt and affects the state's share. The lower debt payment reduces the state's share while the higher debt payment has no impact because of the ADA limitation on assistance and the district's tax revenue per penny per ADA. **Figure 371** presents an example of the effect on the IFA funding. When the example district's debt service decreases from $4.5 million to $3.5 million, the state share amount decreases from $1.6 million to $1.5 million. When the debt service increases to $5.5 million, the state share amount remains the same at $1.6 million.

The funding elements of property values, ADA, and debt payment interact and impact the calculations determining the amount of district debt eligible for IFA funding and/or

FIGURE 370
DIRECT RELATIONSHIP BETWEEN DISTRICT ADA AND IFA FUNDING

DESCRIPTION OF FACTOR	EXAMPLE DISTRICT	HIGHER ADA	LOWER ADA
2007–08 Debt Service Payment	$0	$0	$0
2008–09 Debt Service Payment	$4.5 million	$4.5 million	$4.5 million
2008–09 Projected ADA	**15,000**	**20,000**	**10,000**
2007 CPTD Value	$3.0 billion	$3.0 billion	$3.0 billion
Highest Debt Service Payment	$4.5 million	$4.5 million	$4.5 million
ADA Limitation	$3.8 million	$5.0 million	$2.5 million
Limitation on Assistance	$3.8 million	$4.5 million	$2.5 million
Revenue from Penny of Tax Effort	$300,000	$300,000	$300,000
Revenue per Penny per ADA	$20.00	$15.00	$30.00
State's Share of $35 Yield	$15.00	$20.00	$5.00
State's Share as a Percentage	42.9%	57.1%	14.3%
Local Share of IFA	$2.1 million	$1.9 million	$2.1 million
State Share of IFA	**$1.6 million**	**$2.6 million**	**$357,143**

NOTES: Instructional Facilities Allotment (IFA); Average Daily Attendance (ADA); Comptroller Property Tax Division (CPTD).
SOURCES: Legislative Budget Board; Texas Education Agency.

FIGURE 371
IMPACT OF DEBT PAYMENT ON IFA FUNDING

DESCRIPTION OF FACTOR	EXAMPLE DISTRICT	LOWER DEBT PAYMENT	HIGHER DEBT PAYMENT
2007–08 Debt Service Payment	$0	$0	$0
2008–09 Debt Service Payment	**$4.5 million**	**$3.5 million**	**$5.5 million**
2008–09 Projected ADA	15,000	15,000	15,000
2007 CPTD Value	$3.0 billion	$3.0 billion	$3.0 billion
Highest Debt Service Payment	$4.5 million	$3.5 million	$5.5 million
ADA Limitation	$3.8 million	$3.8 million	$3.8 million
Limitation on Assistance	$3.8 million	$3.5 million	$3.8 million
Revenue from Penny of Tax Effort	$300,000	$300,000	$300,000
Revenue per Penny per ADA	$20.00	$20.00	$20.00
State's Share of $35 Yield	$15.00	$15.00	$15.00
State's Share as a Percentage	42.9%	42.9%	42.9%
Local Share of IFA	$2,142,857	$2,000,000	$2,142,857
State Share of IFA	**$1.6 million**	**$1.5 million**	**$1.6 million**

NOTES: Instructional Facilities Allotment (IFA); Average Daily Attendance (ADA); Comptroller Property Tax Division (CPTD).
SOURCES: Legislative Budget Board; Texas Education Agency.

the state's IFA share amount. The district has management control over one element, debt payment, but not the other elements of ADA and property values.

Application Ranking and Adjustment Methodology: Each annual application process that TEA conducts is considered an IFA round. Upon deadline for receipt of IFA applications in a round, and if the IFA amount for the round is less than the total request from IFA applications, TEA ranks applications in order of property wealth per student in average daily attendance (ADA) to allocate assistance (Education Code Section 46.006 (a) through (g)). TEA awards state assistance beginning with the district with the lowest property wealth rank and continues in ascending order until all available funds appropriated by the Legislature are awarded. TEA favorably adjusts a district's ranking if the district has no outstanding debt, substantial student growth, previously unfunded IFA applications, or has significant impacts resulting from federal military base realignment and closures. Rankings are adjusted for each of the factors as presented in **Figure 372**. A district's wealth per student ranking may be reduced if any or all of the factors are met.

Appropriations for IFA rounds historically have not always funded all IFA applicant districts' eligible debt. However, out of the $87.5 million appropriation for IFA Round 9 in fiscal year 2009, TEA awarded $78.1 million to all IFA eligible applications totaling 182 awards for 160 districts.

IFA GUARANTEED YIELD

Because the state's level of assistance for IFA related to the state's guaranteed yield has not changed since 1999 and school district property valuations have increased, fewer school districts are eligible to receive state program aid for qualified projects. The IFA program's current guaranteed yield of $35, established in 1999 and corresponded to approximately the 90th cumulative student percentile, is estimated to correspond to the 60th cumulative student percentile for fiscal year 2010, resulting in fewer districts being eligible to receive IFA assistance and IFA recipients getting relatively less assistance with rising property valuations.

Since the IFA program's implementation in 1997, the state adjusted the IFA guaranteed yield once in 1999 from $28 per ADA to $35 per ADA for each penny of local tax effort. The $35 yield corresponded to the tax revenue raised per penny for districts around the 90th cumulative student percentile of total students in the state in fiscal year 2000 using estimated figures in 1999. **Figure 373** shows the $35 yield corresponding to numbers for fiscal year 2000 using actual figures to date. The 90th cumulative student percentile is determined by ranking all districts from lowest to highest property wealth per ADA and adding up the student enrollments of each district up the ranking order until the sum corresponding to 90 percent of the total Texas student enrollment is reached. The yield at the 90th percentile is equal to the yield for the corresponding district in the ranked order at that percentile. According to actual fiscal year 2000 figures, 886 (86 percent)

FIGURE 372
IFA ELIGIBLE APPLICATION ADJUSTMENT FACTORS TO WEALTH PER STUDENT RANKINGS, 2008

ADJUSTMENT FACTOR	CONDITION	PERCENTAGE REDUCTION TO WEALTH PER STUDENT
1. Does the district have a previously unfunded IFA eligible application?	YES	10%
2. Has the district experienced substantial growth in student enrollment in the preceding 5-year period?	10% to less than 15%	5%
	15% to less than 30%	10%
	30% or more	15%
3. Does the district have outstanding debt at the time of IFA application?	YES	10% (applied before adjustments 1–2)
4. Must the district construct, acquire, renovate, or improve one or more instructional facilities to serve the children of military personnel transferred to a military installation in or near the district under the Defense Base Closure and Realignment Act of 1990 (10 U.S.C. Section 2687)?	YES	25% (applied before adjustments 1–3)

NOTE: Instructional Facilities Allotment (IFA).
SOURCE: Texas Education Code.

FIGURE 373
STUDENT PERCENTILES AND CORRESPONDING YIELD LEVELS
FISCAL YEAR 2000 ACTUAL

LEVELS	YIELD PER PENNY PER ADA	CUMULATIVE PERCENTILE OF TOTAL STUDENTS IN STATE	NUMBER OF TOTAL STUDENTS AT CUMULATIVE PERCENTILE	CORRESPONDING DISTRICT WEALTH PER ADA	PERCENTAGE OF TOTAL DISTRICTS AT OR BELOW YIELD	NUMBER OF DISTRICTS AT OR BELOW YIELD
Guaranteed Yield Level	$35	91%	3,341,618	$350,829	86%	886

NOTE: Average Daily Attendance (ADA).
SOURCE: Legislative Budget Board.

districts out of 1026 total districts were IFA eligible at the $35 yield, which corresponded to 3,341,618 students (91 percent) out of a total of 3,669,933.

Impact of Guaranteed Yield on IFA Eligible Districts and State Share: Property value wealth per student ADA statewide is projected to rise 85.6 percent over the 10 years from fiscal years 2000 to 2010 (see **Figure 374**).

As wealth per ADA increases, the number of districts statewide that are eligible to receive IFA funding under the $35 guaranteed yield decreases as does the number of students eligible to benefit from the IFA state aid. From fiscal years 2000 to 2010, LBB staff estimates the number of IFA eligible districts will drop by 302 districts, from 886 eligible districts (86 percent of total) to 584 eligible districts (57 percent of total). LBB staff estimates the corresponding number of students able to benefit from IFA eligibility will drop by 718,708 students from 3.3 million students (91 percent of total) in fiscal year 2000 to 2.6 million students (60 percent of total) in fiscal year 2010 (compare **Figures 373 and 375**). For the 2010–11 biennium, an additional 241 districts would be eligible for newly authorized IFA appropriations at the $60 yield corresponding to the 90th total student percentile (see **Figure 375**).

TEA did not award all of the available IFA appropriation in IFA Round 9 in 2008 because many districts submitting qualifying IFA applications were ineligible due to being too wealthy. These districts had property wealth per ADA that

FIGURE 374
COMPARISON OF WEALTH PER ADA STATEWIDE, FISCAL YEARS 2000 AND 2010

STATEWIDE	2000 FISCAL YEAR(ACTUAL)	2010 FISCAL YEAR (PROJECTED)	PERCENTAGE INCREASE
ADA	3,669,933	4,378,405	19.3%
Assessed Property Wealth	$746.4 billion	$1,653.1 billion	121.5%
Wealth per ADA	$203,371	$377,555	85.6%

NOTE: Average Daily Attendance (ADA).
SOURCE: Legislative Budget Board.

FIGURE 375
STUDENT PERCENTILES AND CORRESPONDING YIELD LEVELS, FISCAL YEAR 2010 ESTIMATED

LEVELS	YIELD PER PENNY PER STUDENT	CUMULATIVE PERCENTILE OF TOTAL STUDENTS IN STATE	NUMBER OF TOTAL STUDENTS AT CUMULATIVE PERCENTILE	CORRESPONDING DISTRICT WEALTH PER ADA	PERCENTAGE OF TOTAL DISTRICTS AT OR BELOW YIELD	NUMBER OF DISTRICTS AT OR BELOW YIELD	NUMBER OF DISTRICTS ABOVE $35 YIELD
GYL	$35	60%	2,622,910	$350,721	57%	584	0
GYL plus $1	$36	61%	2,684,565	$360,458	58%	596	12
GYL plus $5	$40	67%	2,929,714	$401,075	63%	652	68
GYL plus $10	$45	73%	3,187,745	$450,152	69%	706	122
GYL plus $25	$60	90%	3,950,017	$603,870	80%	825	241

NOTES: Average Daily Attendance (ADA); Guaranteed Yield Level (GYL).
SOURCE: Legislative Budget Board.

was high enough to generate a tax yield greater than the IFA guaranteed yield cap of $35 per penny per ADA. TEA awarded about $78.1 million in IFA state aid for Round 9, which was about $9.4 million less than the $87.5 million appropriation available for the 2008–09 biennium. If the guaranteed yield were higher, more of the submitted IFA applications with qualified projects would have been eligible to receive IFA state aid in Round 9.

For an IFA eligible district, the district's rising property value reduces the state's share and increases the district's share of the district's IFA eligible debt service payment. As previously shown in **Figure 369**, the district with lower property values is eligible for a higher state share of IFA, thus relieving the local tax burden. With higher property values, more local tax dollars must be collected in order to receive the state share of IFA. As a result, rising property values diminish the dollar and percentage amount of state assistance received by districts for IFA qualified facilities, resulting in the cost of such facilities being borne more by the districts.

Impact of Guaranteed Yield Increase: Figure 376 shows an example of the impact of increasing the guaranteed yield from $35 up to the 90th student percentile estimate of $60 for fiscal year 2010. The example shows that increasing the yield to $60 provides the district with a state share that increases from 42.9 percent to 66.7 percent.

FIGURE 376
EXAMPLE OF IMPACT OF INCREASING THE GUARANTEED YIELD FROM $35 TO $60 ESTIMATED FISCAL YEAR 2010

DESCRIPTION OF FACTOR	$35 GUARANTEED YIELD (CURRENT)	$60 GUARANTEED YIELD (INCREASED)
2007–08 Debt Service Payment	$0	$0
2008–09 Debt Service Payment	$4.5 million	$4.5 million
2008–09 Projected ADA	15,000	15,000
2007 CPTD Value	$3.0 billion	$3.0 billion
Highest Debt Service Payment	$4.5 million	$4.5 million
ADA Limitation	$3.8 million	$3.8 million
Limitation on Assistance	$3.8 million	$3.8 million
Revenue from Penny of Tax Effort	$300,000	$300,000
Revenue per Penny per ADA	$20.00	$20.00
State's Share of Yield	**$15.00**	**$40.00**
State's Share as a Percentage	42.9%	66.7%
Local Share of IFA	$2.1 million	$1.3 million
State Share of IFA	**$1.6 million**	**$2.5 million**

NOTES: Average Daily Attendance (ADA); Comptroller Property Tax Division (CPTD); Instructional Facilities Allotment (IFA).
SOURCE: Legislative Budget Board.

LOCAL PERSPECTIVE AND IMPACT

LBB staff utilized facilities management school reviews, district site visits and interviews, and a statewide IFA survey to determine the impact of receiving or not receiving IFA. LBB contracted with SCRS, Inc. (i.e., primary contractor) and FEA Associates for assistance in conducting the reviews and survey.

Facilities Management Reviews: The LBB conducted facilities management school reviews in eight districts (see **Figure 377**) with unfunded IFA eligible applications in Round 7 (2004) or 8 (2006) to asses the impact of not receiving IFA awards. Districts were selected according to criteria including location in the state, student enrollment and growth rates, and level of property tax rates.

The reviews found that most districts reviewed implemented their facilities bond projects by issuing bonds and passing a tax rate to support the bonds without IFA assistance for projects in Round 7 or 8 applications. The districts reported that when their IFA eligible projects went unfunded, they had expectations for getting EDA funding for the same projects if the Legislature made funding available. Two out of the eight districts utilized architectural prototypes in facilities construction to reduce costs. Most of the districts, six out of the eight, used Capital Appreciation Bonds (CABs) as a debt instrument in structuring their facilities bonds. CABs are tax-backed long-term debt with compounded annual interest requiring no payments on principal or interest until maturity.

In the IFA school reviews, all districts reported rising construction costs as a major factor impacting their building programs, especially when their IFA eligible applications went unfunded. Borger ISD reported that not getting IFA, coupled with rising construction costs, forced them to implement their capital plan in phases, which further increased their exposure to rising construction costs over time, and reduced their ability to implement green building designs in new buildings to conserve energy and improve environmental quality. Implementing in phases caused timing restrictions, which eclipsed their opportunity to recycle building materials from schools being demolished to use in existing schools.

Figure 378 shows the school districts included in the facilities management reviews with their corresponding enrollment and adjusted property wealth per ADA for Round 8 with the oldest application presented first. Van Alstyne ISD (VAISD) data is from Round 7. Districts with more than one row in **Figure 378** correspond to multiple IFA applications.

In order to fund the selected districts, the funding available for Round 7 and Round 8 would need to be increased by $24 million and $24.8 million, respectively (see **Figure 378**).

Seven of the eight districts reviewed reported that not receiving the IFA funding had no impact on the completion of the facilities program for their district. While these districts were able to fund their facilities program, the lack of IFA funding required these districts to have higher tax rates than if they had received IFA funding.

All eight districts levied a tax rate higher than that required if the district had received IFA funding in order to implement their capital plans. The exact tax rate levied depends upon the bond debt structure adopted by the district. For illustrative purposes, LBB staff calculated the projected tax impact of not receiving IFA funding for these districts. The IFA funding presented in **Figure 379** is for Round 8, except for VAISD that applied only for Round 7. The taxable values are the

FIGURE 377
DISTRICTS RECEIVING FACILITIES MANAGEMENT REVIEWS, FISCAL YEAR 2008

DISTRICT	SIZE	INTEREST AND SINKING TAX RATE 2006	PERCENTAGE ADA CHANGE 2002–06	UNFUNDED IFA ROUND NUMBER 2004–06	REGIONAL EDUCATION SERVICE CENTER
Borger ISD	Mid-size	$0.30	(5.0%)	8	16 – Panhandle
Kountze ISD	Small	$0.39	4.0%	8	5 – East
Nixon-Smiley CISD	Small	$0.03	1.0%	7, 8	13 – Central
Royse City ISD	Mid-size	$0.29	44.0%	7, 8	10 – North
Sharyland ISD	Large	$0.20	38.0%	8	1 – Valley
United ISD	Large	$0.21	24.0%	7, 8	1 – South
Van Alstyne ISD	Small	$0.32	15.0%	7	10 – North
Ysleta ISD	Large	$0.21	(0.5%)	7, 8	19 – Southwest

NOTES: District size ranges: small (less than 1,600 students), mid-size (1,600 to less than 5,000), large (5,000 or greater); Independent School District (ISD); Consolidated Independent School District (CISD); Average Daily Attendance (ADA); Instructional Facilities Allotment (IFA).
SOURCES: Legislative Budget Board; Texas Education Agency.

FIGURE 378
ENROLLMENT AND ADJUSTED WEALTH PER ADA TO UNFUNDED IFA ELIGIBLE APPLICATIONS
FACILITIES MANAGEMENT REVIEW DISTRICTS, FISCAL YEAR 2008

DISTRICT	2007–08 ENROLLMENT	INITIAL WEALTH PER ADA	FINAL WEALTH PER ADA RANKING
Ysleta ISD	45,049	$111,763	$111,763
Nixon-Smiley CISD	1,003	$141,190	$127,071
Royse City ISD	4,144	$186,353	$142,560
Kountze ISD	1,363	$144,681	$144,681
Van Alstyne ISD	1,415	$165,104	$148,593
United ISD	39,009	$184,826	$149,709
Sharyland ISD	8,897	$185,233	$157,448
Royse City ISD	4,144	$186,353	$158,400
Borger ISD	2,759	$176,135	$158,521
United ISD	39,009	$184,826	$166,343

Notes: Independent School District (ISD); Consolidated Independent School District (CISD); Average Daily Attendance (ADA); Instructional Facilities Allotment (IFA).
Source: Texas Education Agency.

FIGURE 379
PROJECTED TAX RATE IMPACT OF NOT RECEIVING REQUESTED IFA FUNDING
FACILITIES MANAGEMENT REVIEW DISTRICTS, FISCAL YEAR 2008

DISTRICT	IFA FUNDING REQUESTED	TAXABLE VALUE (IN MILLIONS)	PENNY OF TAX EFFORT	PROJECTED ADDITIONAL TAX RATE IMPACT
Nixon-Smiley CISD	$58,392	$143.3	$14,327	$0.0408
Kountze ISD	$197,253	$221.5	$22,152	$0.0890
Van Alstyne ISD	$184,833	$269.0	$26,903	$0.0687
Borger ISD	$315,316	$457.3	$45,732	$0.0689
Royse City ISD	$566,468	$756.2	$75,618	$0.0749
Sharyland ISD	$904,913	$1,707.3	$170,730	$0.0530
Ysleta ISD	$5,581,850	$5,315.9	$531,594	$0.1050
United ISD	$4,411,459	$7,984.0	$798,397	$0.0553

Notes: Independent School District (ISD); Consolidated Independent School District (CISD); Instructional Facilities Allotment (IFA).
Sources: Legislative Budget Board; Texas Education Agency.

values for the 2006 or 2004 tax year, as appropriate. The penny of tax effort is calculated by dividing the taxable value by 100 and multiplying by $0.01. The projected additional tax rate impact is calculated by dividing the IFA funding by the penny of tax effort. **Figure 379** shows the projected impact on these districts for the first year after the application was not funded.

The projected tax rate impact of having unfunded IFA eligible applications ranged from $0.0408 to $0.1050 per $100 assessed valuation in additional local property tax increases (**Figure 379**).

District Site Visits and Interviews: LBB staff visited and interviewed administrators in seven districts (see **Figure 380**) with three or more rounds of funded IFA applications to determine the impact of regularly receiving IFA. The districts were chosen to represent districts with various student sizes, student growth rates, and locations around the state as close as possible to the eight reviewed districts to enhance comparative analysis.

During the site visits, districts reported that having funded IFA projects was integral to the success of their building programs because of their low property wealth. The districts faced significant challenges with a low tax base in meeting facility needs by passage of a bond without state assistance. Some of the districts used architectural prototypes for

FIGURE 380
DISTRICTS IN SITE VISITS AND INTERVIEWS, FISCAL YEAR 2008

DISTRICT	SIZE	INTEREST AND SINKING TAX RATE 2006	PERCENTAGE ADA CHANGE	UNFUNDED IFA ROUND NUMBER 2004–06	REGIONAL EDUCATION SERVICE CENTER
Alief ISD	Large	$0.220	14%	3, 5, 6	4 – Southeast
Crystal City ISD	Mid-size	$0.310	(2%)	4, 5, 6, 8	20 – South
La Feria ISD	Mid-size	$0.245	6%	3, 4, 5, 6, 8	1 – Valley
Mercedes ISD	Large	$0.200	8%	4, 6, 7, 8	1 – Valley
Southside ISD	Mid-size	$0.320	9%	3, 4, 6, 7, 8	20 – Central
Tornillo ISD	Mid-size	$0.265	20%	3, 5, 8	19 – Southwest
Valley View ISD	Mid-size	$0.245	45%	4, 5, 6, 7 8	1 – Valley

NOTES: District size ranges: small (less than 1,600 students), mid-size (1,600 to less than 5,000), large (5,000 or greater); Independent School District (ISD); Average Daily Attendance (ADA); Instructional Facilities Allotment (IFA).
SOURCES: Legislative Budget Board; Texas Education Agency.

reducing construction costs for facilities. Almost all of the districts used CABs in their bond debt structure.

Statewide IFA Survey: LBB staff conducted a statewide survey of districts that had unfunded eligible IFA applications in Round 7 or 8 to assess the impact of not receiving IFA awards. LBB staff distributed the survey to 164 districts. A total of 84 districts responded for a response rate of 51 percent.

The survey shows that districts are significantly impacted when their IFA eligible applications go unfunded. The survey asked districts what the impact was of not receiving IFA funding. As shown in **Figure 381**, 36 percent had significant impacts to their projects: 17 percent did not fund any of the projects and 19 percent reduced the scope of the projects.

FIGURE 381
IMPACT OF NOT RECEIVING IFA FUNDING
IFA SURVEY JULY 2008

SURVEY QUESTION

What was the impact of not receiving IFA funding on the projects contained in the application?

RESPONSES	NUMBER	PERCENTAGE
Did not fund any of the projects included in the application	13	17%
Reduced the scope of the projects included in the application	15	19%
Funded all the projects included in the application	49	64%
TOTAL	**77**	**100%**

NOTE: Instructional Facilities Allotment (IFA).
SOURCE: Legislative Budget Board.

Out of these survey respondents with unfunded IFA eligible applications, the survey asked how not receiving IFA impacted projects submitted in their unfunded IFA applications (see **Figure 382**). Of the 64 districts that were able to fund some or all the projects without IFA assistance, one district levied a higher tax rate than the tax rate proposed in the bond election. In order to fund some or all the projects, more than 71 percent of the districts levied the tax rate proposed in the bond election, 8 percent structured the bonds differently than planned to fit the tax rate proposed in the bond election, and 19 percent used other methods. The other methods included proposing a not-to-exceed tax rate, not considering IFA funding, making debt service payments first, then receiving EDA funding, and using maintenance and operations funds.

FIGURE 382
REACTION TO NOT RECEIVING FUNDING FOR IFA ELIGIBLE APPLICATIONS, IFA SURVEY JULY 2008

SURVEY QUESTION

In order to fund these projects included in the bond election and IFA application, the district:

RESPONSES	NUMBER	PERCENTAGE
Levied the tax rate proposed in the bond election	46	71%
Levied a higher tax rate than the tax rate proposed in the bond election	1	2%
Structured the bonds differently than planned to fit the tax rate proposed in the bond election	5	8%
Other	12	19%
TOTAL	**64**	**100%**

NOTE: Instructional Facilities Allotment (IFA).
SOURCE: Legislative Budget Board.

Most (56 respondents or 80 percent) of the 70 respondents believe the IFA program needs to be changed. The respondents provided comments recommending changes to IFA, including increased funding, different ranking criteria for IFA funding, and combining the IFA and EDA programs. The most frequent comment was the recommendation to

increase IFA funding, either by increasing the guaranteed yield or the total IFA appropriation level, or both. The respondents suggested more IFA funding to help pay for rising construction costs, allow more districts to become eligible for IFA, and to reduce the number of unfunded IFA eligible applications. Many IFA survey respondents believe that increasing the state guaranteed yield would better maintain the state's share of IFA facilities funding and the number of districts eligible for IFA assistance as property values increase.

FISCAL IMPACT OF THE RECOMMENDATION

Recommendation 1 suggests the Texas Legislature review the IFA program and consider increasing the IFA guaranteed yield. The recommendation would have no fiscal impact unless the Legislature were to increase the guaranteed yield.

LBB staff estimated the costs of increasing the current guaranteed yield rate of $35 per penny of tax effort per unweighted ADA to $36, $40, $45, and $60. For the 2010–11 biennium, state costs would range from $20.1 million for a $36 guaranteed yield to $316.0 million for a $60 guaranteed yield (see **Figure 383**).

FIGURE 383
GUARANTEED YIELD INCREASES AND PROJECTED INCREMENTAL COSTS, INSTRUCTIONAL FACILITIES ALLOTMENT PROGRAM, 2010–11 BIENNIUM

GUARANTEED YIELD PER ADA PER PENNY	TOTAL BIENNIAL SAVINGS/(COST) (IN MILLIONS)	BIENNIAL SAVINGS/(COST) INCREASE OVER CURRENT LAW (IN MILLIONS)
$35 (current law)	($616.8)	($0.0)
$36	($636.9)	($20.1)
$40	($709.1)	($92.3)
$45	($781.8)	($165.0)
$60	($932.8)	($316.0)

NOTE: Average Daily Attendance in Students (ADA).
SOURCE: Legislative Budget Board.

The introduced 2010–11 General Appropriations Bill does not reflect any changes as a result of this recommendation.

INFORM PUBLIC SCHOOL DISTRICTS OF AVAILABLE RESOURCES TO REDUCE SUPPORT COSTS

From fiscal years 2004 to 2007, support costs for Texas public schools increased at an annual average rate of 6.1 percent, compared to the 5.4 percent statewide average rate for all operating expenditures. Among urban and suburban school districts, support costs (expenditures for non-instructional services, such as facilities maintenance and operations) increased annually by over 7 percent during the same period. Small urban and rural districts were especially affected by these costs, which accounted for approximately 20 percent of their operating expenditure growth.

The state helps school districts manage support costs by providing energy conservation services and purchasing cooperatives. However, awareness and use of the services provided by the State Energy Conservation Office is significantly lower than its capacity to serve school districts. Also, not all school districts take full advantage of purchasing cooperatives statewide, which are a source of less expensive goods and services. Establishing a coordinated marketing initiative to inform school districts of energy conservation services and purchasing cooperatives could increase their use by districts, and thereby reduce the impact of support costs on their operating budgets.

FACTS AND FINDINGS

- ♦ From fiscal years 2004 to 2007, statewide utility expenditures, a subset of non-student-related support costs, increased at an annual average rate of 11.6 percent. This increase is more than double the 5.4 percent growth rate for total operating expenditures, and the 5.2 percent rate for instruction expenditures.
- ♦ None of the school district community-related categories (e.g., major urban, rural, etc.) showed a percentage of operating costs for instruction greater than 61.5 percent in fiscal year 2007. Given this starting point and the cost driver trends noted above, many school districts will find it difficult to allocate 65 percent of their operating budgets to instruction in future years.

CONCERNS

- ♦ In fiscal year 2007, 44 more school districts could have used the energy conservation services available to them. A survey of school districts that have experienced substantial facility and utility cost increases found most were unaware of the State Energy Conservation Office (SECO) and its services.
- ♦ Some school districts lack the staff to search for the best values offered by purchasing cooperatives. School districts indicated by telephone survey they would benefit from and access a central source of general information regarding all purchasing cooperatives available to them.

RECOMMENDATIONS

- ♦ **Recommendation 1:** The Texas Comptroller of Public Accounts and the Texas Education Agency should coordinate a statewide publicity effort in which both agencies distribute e-mail notifications, print material, and create web-based information to direct more attention to SECO's energy conservation services. The Texas Comptroller of Public Accounts should make printed material available to the Texas Education Agency for distribution at events attended by school district facility staff.
- ♦ **Recommendation 2:** The Texas Comptroller of Public Accounts should establish and maintain a central source of general information about all of the purchasing cooperatives that serve school districts, their membership requirements, and the general commodities and services they offer.
- ♦ **Recommendation 3**: The Texas Comptroller of Public Accounts and the Texas Education Agency should send e-mail messages to school districts notifying them of the new web-based central information source about purchasing cooperatives that can serve districts.

DISCUSSION

During this decade, public school districts in Texas have faced a variety of financial challenges. According to a February 2006 study by Moak, Casey and Associates, employee compensation, health insurance, and general operating costs were some of the most significant expenditures affecting school district budgets from fiscal years 2002 to 2004. In recent newspaper articles, school

district staff have repeatedly cited rising fuel, energy, and other support costs as significant cost drivers.

Since fiscal year 2004, support cost increases have outpaced overall expenditure growth not only statewide but also among certain school district community types. As indicated in **Figure 384**, community types are delineated by their location in counties with certain population ranges, as well as by the number of students they serve. For this analysis, student population is represented by the number of students in average daily attendance.

Figure 385 shows the difference between average annual growth rates for all cost categories compared to increase rates for the support category. This category includes expenditures for student and non-student-related support. The support cost growth rate from fiscal years 2004 to 2007 was greater than the increase rate for all categories. This discrepancy is even more significant for smaller districts. Small urban and rural district support cost growth rates, 5.6 percent and 5.1 percent, respectively, were higher than their total spending increase rates, 4.6 percent and 3.9 percent, respectively.

A sharper distinction emerges by separating student-related from non-student-related support costs. **Figure 386** provides definitions for these and other cost categories. The first four categories correspond to the function categories used by the Texas Education Agency. The facility maintenance and operations category is a subset of the non-student-related support function; the utilities category is a subset of facility maintenance and operations.

Figure 387 shows expenditures for each function by community type. The first column indicates the percentage each function represented of total spending in fiscal year 2007. The second column identifies the percentage of total spending growth associated with increases in the student and non-student-related functions from fiscal year 2004 to fiscal year 2007. Comparing the two columns indicates whether a function was a more significant cost driver than its share of total function expenditures would suggest.

The non-student-related support category shows the greatest discrepancies between a function's share of total expenditures and the extent to which its growth caused total expenditures to increase. Among small urban and rural districts, this category represented 13.5 percent and 13.3 percent of all total expenditures, respectively. Expenditure increases for these districts, however, accounted for approximately 20 percent of the total expenditure growth. Statewide, the discrepancy was less pronounced, a 13 percent share and a 16 percent impact.

FIGURE 384
SCHOOL DISTRICT COMMUNITY TYPE DEFINITIONS

TYPE	DEFINITION
Major Urban:	The state's largest school districts serving the six metropolitan areas of Houston, Dallas, San Antonio, Fort Worth, Austin, and El Paso. Major urban districts have the greatest average daily attendance in counties with populations exceeding 725,000 and in which more than 35 percent of students are economically disadvantaged.
Suburban	School districts in and around major urban areas. In general, they are contiguous with major urban districts.
Urban:	Districts whose average daily attendance is greater than 5,000 and do not fit any of the criteria above.
Small Urban:	Districts whose average daily attendance is between the statewide median and 5,000.
Rural:	Districts whose average daily attendance is less than the state median and do not fit any of the criteria above.

Sources: Legislative Budget Board; Texas Education Agency.

FIGURE 385
MAJOR SUPPORT AND TOTAL COST CATEGORIES AVERAGE ANNUAL PERCENTAGE CHANGE, FISCAL YEARS 2004 TO 2007

COMMUNITY TYPE	SUPPORT CATEGORIES AVERAGE ANNUAL PERCENTAGE CHANGE	ALL CATEGORIES AVERAGE ANNUAL PERCENTAGE CHANGE
Statewide	6.1%	5.4%
Major Urban	3.7%	3.5%
Suburban	7.3%	6.7%
Urban	7.1%	6.3%
Small Urban	5.6%	4.6%
Rural	5.1%	3.9%

Sources: Legislative Budget Board; Texas Education Agency.

FIGURE 386
FUNCTION AND EXPENDITURE CATEGORY DEFINITIONS

CATEGORY	DEFINITION
Instruction	Classroom instruction; extracurricular activities; payments to fiscal agent/member districts of Shared Services Arrangements; payments to Juvenile Justice Alternative Education Programs.
Leadership and Administration	Management of instruction, campus activities, and services; as well as overall school district administration.
Student-Related Support	Instructional resources and media services; curriculum development and instructional staff development; guidance, counseling, and evaluation services; health services; transportation; food services.
Non-Student-Related Support	Facilities maintenance and operations; security and monitoring services; data processing services.
Facility Maintenance and Operations	Management and maintenance of facilities; facility-related services such as utilities, property insurance, and goods such as supplies, tools, and vehicles.
Utilities	Electricity, natural gas, telecommunications, and facility-related fuels. This is a subset of facility maintenance and operations.

SOURCE: Texas Education Agency.

FIGURE 387
MAJOR FUNCTION CATEGORIES BY COMMUNITY TYPE, PERCENTAGE OF TOTAL FUNCTIONS, AND PERCENTAGE OF TOTAL FUNCTIONS INCREASE, FISCAL YEARS 2004 TO 2007

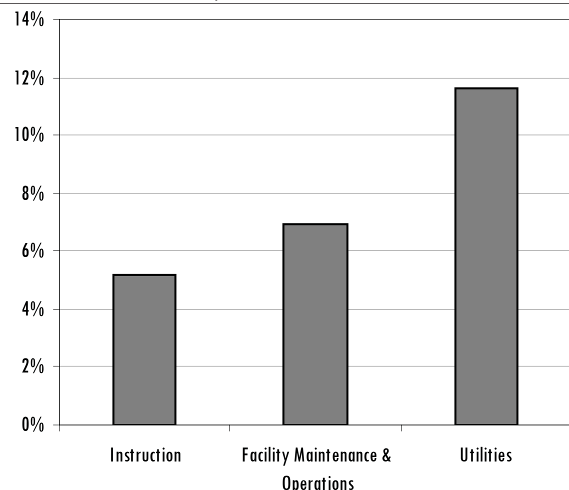
	INSTRUCTION	LEADERSHIP AND ADMINISTRATION	STUDENT-RELATED SUPPORT		NON-STUDENT-RELATED SUPPORT	
COMMUNITY TYPE	PERCENTAGE OF ALL FUNCTIONS	PERCENTAGE OF ALL FUNCTIONS	PERCENTAGE OF ALL FUNCTIONS	PERCENTAGE OF ALL FUNCTIONS INCREASE	PERCENTAGE OF ALL FUNCTIONS	PERCENTAGE OF ALL FUNCTIONS INCREASE
Statewide	60.5%	10.4%	16.1%	16.4%	13.0%	16.0%
Major Urban	59.7%	10.2%	17.0%	18.4%	13.0%	13.9%
Suburban	61.5%	10.1%	15.8%	16.7%	12.6%	14.1%
Urban	60.0%	10.1%	16.9%	16.7%	13.0%	16.7%
Small Urban	60.3%	11.0%	15.2%	14.2%	13.5%	20.1%
Rural	61.2%	12.8%	12.7%	13.0%	13.3%	20.0%

SOURCES: Legislative Budget Board; Texas Education Agency.

This analysis reveals that from fiscal years 2004 to 2007, the impact of non-student-related support costs was almost double its share of total expenditures for certain types of school districts. While instructional costs consume the highest percentage of school district expenditures, support costs are playing a larger role in driving up expenditures, especially among small urban and rural districts.

Differing growth rates for two support cost subsets, facilities maintenance and operations and utilities, versus instruction costs partially accounted for rising support costs overall. **Figure 388** shows the average annual percent change in these two subsets, as well as instruction. From fiscal years 2004 to 2007, facility maintenance and operation costs increased on average approximately 7 percent, while utility costs grew by 11.6 percent. Instruction expenditures, however, increased at a much slower rate, 5.2 percent.

FIGURE 388
COMPARISON OF INSTRUCTION, FACILITY MAINTENANCE AND OPERATIONS, AND UTILITIES AVERAGE ANNUAL PERCENTAGE CHANGE, FISCAL YEARS 2004 TO 2007



SOURCES: Legislative Budget Board; Texas Education Agency.

It is also important to note that the instruction category represented less than 65 percent of total expenditures among all of the community types. None of them had a cost share for instruction greater than 61.5 percent in fiscal year 2007. Given this starting point and the support cost trends mentioned below, the ability of school districts to allocate 65 percent of their operating budgets to instruction, as mandated by Governor's Order RP-47 issued in August 2005, may be significantly constrained in the future.

Rising support costs will probably continue causing school districts to allocate additional funding for non-instructional services. To address this problem, school districts will have to find effective ways to control utility and other major support costs. As the analysis above indicated, small urban and rural districts have an even greater need to reduce these costs.

DISTRICT RESPONSES TO RISING UTILITY COSTS

To gather additional information regarding the specific causes of facility-related expenditure increases and district cost control strategies, Legislative Budget Board staff conducted a phone survey of 20 school districts—one from each service center region and community type. All districts were at the $1.50 tax rate cap from fiscal years 2004 to 2006, when property tax reform legislation was enacted. Also, their facility maintenance and operation or utility cost increases significantly exceeded the growth rates for their community type cohorts.

Facility conditions and expansion and utility costs were often cited as primary expenditure factors. Many districts have 20- to 40-year-old buildings that require highly skilled and compensated employees, such as plumbers and carpenters. New construction also resulted in adding custodial and maintenance staff. The most common explanation for facility-related expenditure growth, however, was utility cost increases.

Districts noted that electric and water rates have risen dramatically since 2004. Electric rates for Bay City, an urban district near the Gulf coast, have increased 30 percent since 2004. Water rates for west Texas districts have also risen significantly. For example, Midland's water rate doubled in 2007.

To conserve energy, districts installed centrally controlled energy management systems. They also installed, replaced, or retrofitted lighting, heating and cooling units, and energy control equipment. Many campuses did not use air conditioning during the summer. Some districts implemented recommendations from energy service consultants, but in some cases payments to these firms reduced short-term conservation savings.

IMPROVING ENERGY CONSERVATION

School districts can obtain energy conservation guidance and financing through the State Energy Conservation Office (SECO), which is a division of the Comptroller of Public Accounts (CPA). The office offers a variety of energy efficiency programs that significantly reduce energy use and costs. These include free preliminary energy assessments (PEAs) from state-contracted engineering firms and low interest financing for energy-related equipment through the LoanSTAR program. SECO provided 21 school districts with PEAs and three districts with LoanSTAR loans during the 2006–07 biennium. Agency staff estimate that $747,387 in total annual savings will result from school districts using loan proceeds to purchase efficient energy-related equipment.

Of the 20 districts surveyed, however, 12 did not use or were unaware of the services offered by SECO. These were either small urban or rural school districts, which need energy management advice because they lack employees with this expertise. Also, nine of the districts exceeded the statewide average annual increase of 12 percent for utility expenditures from fiscal years 2004 to 2007

The SECO has enough funding to serve about three times as many districts as it did in fiscal year 2007. In addition to the 21 school districts provided preliminary energy assessments, it could have assisted 44 more. Funding for these assessments comes from interest on the oil-overcharge escrow account in the state Treasury. Conducting assessments for additional districts, therefore, would not require the appropriation of General Revenue Funds.

There is no statewide coordinated effort to publicize SECO's services. The Texas Education Agency (TEA) neither provides this information to school districts at public events nor does the agency include related content on its website. Although SECO-contracted engineers notify school districts periodically, a statewide marketing initiative would expand awareness to more school districts by notifying top administrators and energy managers at all school districts. As noted previously, SECO has the capacity to serve substantially more districts than it did in fiscal year 2007.

Recommendation 1 addresses the concern that many school districts may be unaware of SECO by proposing a coordinated, statewide publicity effort. TEA and CPA should provide a

combination of mass e-mails to school districts, printed materials distributed at appropriate TEA workshops and conferences, and website information about SECO. E-mail notification should occur semi-annually because of school district employee turnover. TEA's website would highlight SECO services along with a link to the office's website. CPA would make printed materials available to TEA for distribution at events attended by school district facility staff.

SCHOOL DISTRICT USE OF PURCHASING COOPERATIVES

A purchasing cooperative is a mechanism for organizations to pool their collective purchasing power and obtain lower prices as well as reduce administrative workload. The cooperative negotiates volume discounts and offers a greater variety of products and services than many school districts can obtain individually. A survey conducted by the National Institute of Governmental Purchasing indicated that the majority of cooperative members save at least 10 percent on their cooperative purchases. The Cooperative Purchasing Network, based in Houston's Region 4 education service center, can save school districts 15 percent or more through its product discounts. Items offered by cooperatives include food service products, information technology, school buses and other vehicles, and instructional and maintenance supplies.

Cooperative purchasing also reduces administrative costs. Their contracting procedures comply with state competitive bidding requirements, making separate competitive bidding by a school district unnecessary. Although some purchasing cooperatives charge annual fees for overhead costs, price discounts and administrative savings can more than offset participation fees.

Of the 20 regional education service centers in Texas, 15 administer multi-regional purchasing cooperatives. Four centers serve multiple regions, two of which also serve other states. Cooperatives typically maintain product lists that school districts can search to find the best value from contracted vendors. In some cooperatives, member districts order products directly from participating vendors. Other cooperatives, such as Region 4's Cooperative Purchasing Network, directly process orders for school districts. The Texas Association of School Board's "Buy Board" offers an online purchasing system similar to common Internet shopping sites.

The state of Texas purchasing cooperative allows local governments and school districts to buy products at the same discounted prices offered to state agencies. School districts can also take advantage of the Texas multiple award purchasing system, which accesses federal and other public entities' discount programs. Also, the Department of Information Resources offers an information technology cooperative for school districts, local governments, and state agencies.

INCREASING USE OF COOPERATIVES

School district survey respondents indicated they would like to have access to information about all of the available cooperatives. This view was voiced more often by small urban and rural school district respondents. Larger school districts have sufficient staff to search for the best values, but smaller districts do not. A central information source would permit districts to identify cooperatives statewide, their broad product categories, membership eligibility and fees, and potentially other details such as product discounts.

CPA's purchasing cooperative website is the most appropriate location for this information. The state's website is a well-organized and respected purchasing tool, and school districts frequently access the website. Also, CPA and TEA staff have contact information for relevant staff at school districts and education service centers, making it possible to notify them about available purchasing cooperatives.

Recommendation 2 would require the CPA's purchasing cooperative website to list all of the purchasing cooperatives serving school districts, their membership requirements and fees, broad commodity and service categories offered, and direct links to their websites. Cooperatives should be consulted before the site is created so that it gives school districts useful information without impeding purchasing administration.

Under Recommendation 3, CPA and TEA would send out a mass e-mail message to school districts notifying them of the new website. The message would also include general information about the range of commodities and services these cooperatives offer.

FISCAL IMPACT OF THE RECOMMENDATIONS

There would be no significant fiscal impact from implementing Recommendations 1, 2, and 3. Modifications to TEA's and CPA's websites, as well as distributing information about SECO and the new purchasing cooperative webpage can be accomplished with the agencies' current resources.

The introduced 2010–11 General Appropriations Bill does not include any adjustments as a result of these recommendations.

IMPROVE THE STATE TRANSPORTATION ALLOTMENT PROGRAM FOR PUBLIC SCHOOL TRANSPORTATION

State statute entitles Texas independent school districts and county-operated transportation systems to a funding allotment for four transportation programs. The funding amount for the regular education program is based on a funding formula. This allotment represents approximately 1 percent of the Foundation School Program. Since the current funding structure was implemented, the cost for a district to operate transportation services increased without a corresponding increase in state funding, resulting in some districts diverting funds from other sources or reducing transportation services to students.

The current funding structure for transportation services has not changed and the funding amounts for each program have not increased since the program was implemented in 1984. Additionally, the student eligibility criteria and provisions of the program have not been updated since that time. Without this update and review, there is no way of knowing if the state is achieving the Legislature's intent regarding funding of transportation services. By increasing the state transportation allotment and conducting an analysis of the district cost covered by state allotment, Texas could increase the availability of transportation services to students.

FACTS AND FINDINGS

- In school year 2002–03, transportation costs incurred by school districts were approximately $920 million, and increased to approximately $1.1 billion by school year 2006–07, nearly a 25 percent increase. During the same period, the state allotment was $305 million and decreased slightly to $302 million.
- The funding structure for transportation services have not changed since 1984. In addition, the state transportation allotment declined from covering approximately 70 percent to 80 percent of districts' transportation costs to covering approximately 26 percent in school year 2006–07.

CONCERNS

- The cost of school district transportation continues to increase with no corresponding increase in state funding. To compensate, some districts are diverting funds from other school operations, increasing the number of students required to walk to school or reducing bus routes, which decreases the number of students receiving transportation services.
- Although the Texas Education Code requires the Commissioner of Education to consider factors affecting the actual costs of providing transportation services, it does not require a regular report of this information or an analysis of the district cost covered by the state allotment. Without such a report and analysis, the Legislature lacks the information necessary to make informed budget decisions regarding this allotment.

RECOMMENDATIONS

- **Recommendation 1:** The Texas Legislature should consider increasing the state transportation allotment for the regular, special, and private transportation programs.
- **Recommendation 2:** The Commissioner of Education should compare the total district transportation costs and the state transportation allotment for each preceding school year. The commissioner should prepare a report summarizing findings regarding the transportation allotment program and submit the report to the Legislative Budget Board and the Governor prior to each regular legislative session.

DISCUSSION

In accordance with Texas Education Code, Section 42.155, through the General Appropriations Act (GAA), the Legislature allocates a transportation cost allotment to eligible districts for transporting students to and from school for regular, special education, and private transportation programs. An additional allotment is provided for career and technology transportation programs but the amount is based on the regular transportation program allotment and is not specified in the GAA. In addition to these four transportation programs, districts are permitted to apply for up to 10 percent of their regular transportation program allotment for students subject to hazardous traffic conditions when walking to school.

Districts receive the regular transportation allotment for regular eligible students defined in Texas Education Code,

Section 42.155 (b), as a student who resides two or more miles beyond the student's campus of regular attendance. This allotment is based on "linear density," which is the average number of regular eligible students transported daily divided by the approved daily route miles. The special education program transports students who are eligible for special education services as defined in Texas Education Code, Section 29.003, and who would be unable to attend classes without special transportation services. The districts' allotment for special education transportation is based on the previous school year's cost-per-mile.

Districts are eligible to apply for and upon approval from the Commissioner of Education to receive an additional allotment of up to 10 percent of the district's regular transportation allotment for transporting students who reside within two miles of the student's campus of attendance and are subject to hazardous traffic conditions when walking to school. Texas Education Code, Section 42.155 (d), states that "a hazardous condition exists where no walkway is provided and children must walk along or cross a freeway or expressway, an underpass, an overpass or a bridge, an uncontrolled major traffic artery, an industrial or commercial area, or another comparable condition."

The state aid for the transportation allotment is disbursed through the Foundation School Program (FSP) to eligible Texas districts. Districts subject to the wealth-sharing provisions of Texas Education Code, Chapter 41, are entitled to the allotment but do not receive state aid for it, rather paying for the entitlement with local revenue. To receive the allotment, districts must submit, via the web-based FSP, two reports to the Texas Education Agency (TEA): School Transportation Operations Report, designed to establish a cost-per-mile; and the School Transportation Route Services Report, which includes information on ridership and mileage for regular, special, and career and technology transportation programs. The hazardous conditions miles are determined from information provided in these reports. The data for both reports is for the preceding school year, which is the basis for funding for the current school year. The transportation allotment is about 1 percent of the FSP.

Figure 389 shows for the regular program the linear density groups, the allotment per mile of approved route, and the number and percentage of districts in each group for school year 2006–07.

FIGURE 389
REGULAR PROGRAM, DISTRIBUTION OF DISTRICTS BY LINEAR DENSITY GROUP, SCHOOL YEAR 2006–07

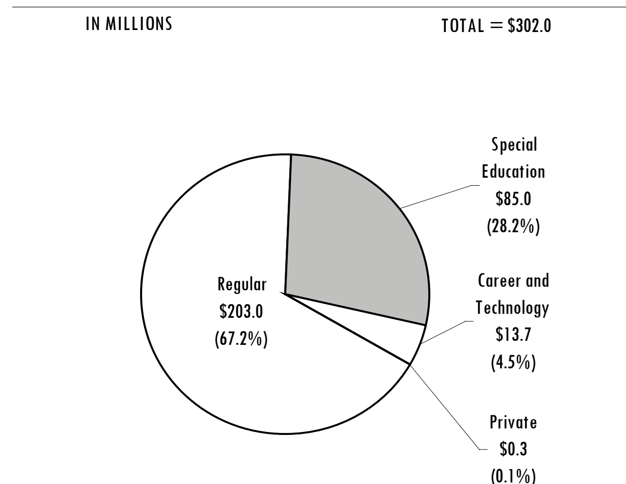
LINEAR DENSITY GROUP	ALLOTMENT PER MILE OF APPROVED ROUTE	NUMBER OF DISTRICTS PER GROUP	PERCENTAGE OF DISTRICTS PER GROUP
2.40 and above	$1.43	22	2%
1.65 to 2.40	$1.25	77	8%
1.15 to 1.65	$1.11	145	15%
0.90 to 1.15	$0.97	144	15%
0.65 to 0.90	$0.88	172	18%
0.40 to 0.65	$0.79	174	18%
Less than 0.40	$0.68	207	22%
TOTAL		**941***	

*Represents districts eligible to receive the transportation cost allotment at the established allotment per linear density group. The Route Services Report data from 2005–06 was used to determine the districts' allotment per mile of approved route for 2006–07.
NOTE: Numbers may not add due to rounding.
SOURCE: Texas Education Agency.

The regular transportation program accounts for almost 70 percent of the transportation allotment. The special transportation program accounts for about 28 percent and the career and technology and private transportation programs account for less than 5 percent of the allotment. **Figure 390** shows the percentage of allotment by program using school year 2006–07 data.

FIGURE 390
PERCENTAGE OF ALLOTMENT BY PROGRAM, FISCAL YEAR 2006–07

IN MILLIONS TOTAL = $302.0



NOTE: Numbers may not add due to rounding.
SOURCE: Texas Education Agency.

PERFORMANCE REVIEW AND SURVEY OF SCHOOL DISTRICTS

In May 2008, Legislative Budget Board (LBB) staff, in conjunction with Management Partnership Services, Inc., reviewed five public school districts and surveyed 480 school districts regarding school transportation operations in Texas. Results of the survey demonstrate that the rising cost of fuel caused some districts to change their transportation program. There were 239 district responses to this survey. Some districts reported that due to the increased cost of fuel they reduced field trips and field trip distances, reduced bus routes, increased student walking distances, diverted funds from other school operations, deferred bus replacement plans and reduced planned bus maintenance. Similar adjustments have been reported by the districts reviewed. These districts continued to provide services but were concerned that the increased fuel and bus purchase cost and other transportation-related cost may result in further adjustments, which could lead to fewer students accessing transportation services.

STATE FUNDING COMPARED TO DISTRICT COST

The linear density groups and the allotment per mile of approved route for transportation services have not changed since 1984 when, according to TEA, the state provided approximately 70 percent to 80 percent of total district transportation costs to eligible districts. As districts continue to experience an increase in transportation costs, the state's transportation allotment has either marginally increased or decreased, leaving districts to carry the majority of the financial burden for providing school transportation services.

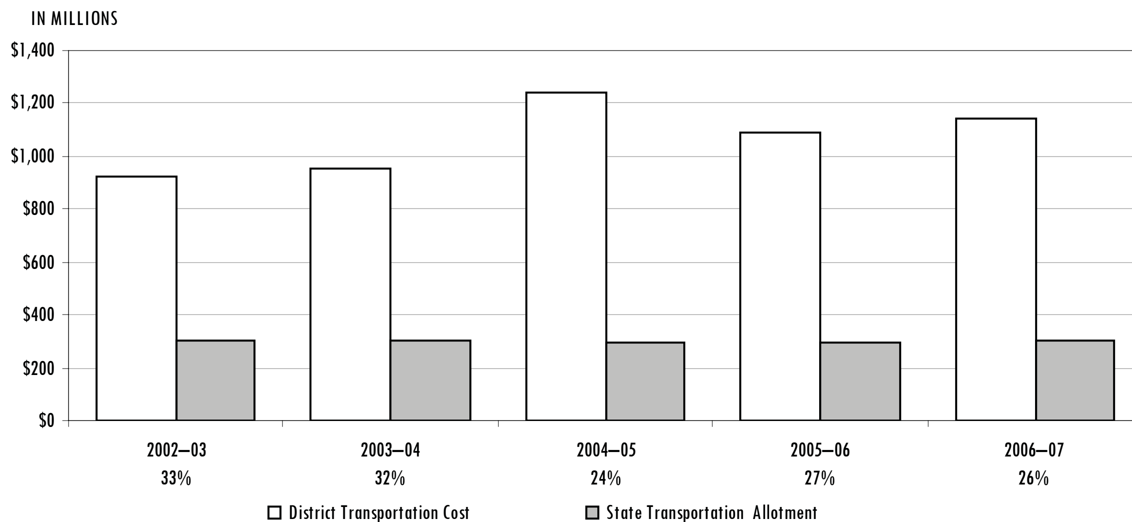
From school years 2002–03 to 2006–07, the allotment covered an average of 28 percent of the district cost, with 2002–03 (33 percent) being the greatest. **Figure 391** shows the comparison of total district cost to the allotment from school years 2002–03 to 2006–07.

DISTRICT TRANSPORTATION EXPENDITURES

District transportation expenditures are reported to TEA in the following five general categories:

- Salaries and Benefits—job-related professional and non-professional employees.
- Purchased and Contracted Services—utilities, lease/rental of equipment, and public or commercial contracts for professional services. For example, when districts contract for transportation services, all expenditures are reported in the purchased and contracted services category.
- Supplies and Materials—maintenance and operation of vehicles and facilities.
- Annual Depreciation/Other Operating Expenses—annual depreciation on purchase of fixed/capital assets (vehicles, facilities, and major equipment

FIGURE 391
TOTAL DISTRICT TRANSPORTATION COST* COMPARED TO STATE TRANSPORTATION ALLOTMENT, SCHOOL YEARS 2002–03 TO 2006–07



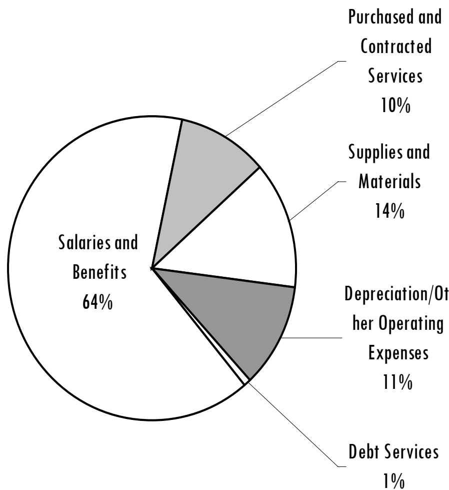
*Includes salaries and benefits, purchased and contracted services, supplies and materials, annual depreciation/other operating expenses, and debt service.
Source: Texas Education Agency.

acquisitions), employee travel, registration and membership fees, subscriptions, and insurance.

- Debt Service—annual interest expense on loans and leases or lease-purchases for student transportation related items.

Figure 392 shows the average transportation expenditures statewide for school years 2002–03 to 2006–07. Overall, the salaries and benefits category accounts for the greatest expense to districts when providing transportation services, 64 percent. The other categories each account for less than 15 percent of transportation expenditures.

FIGURE 392
PERCENTAGE OF DISTRICTS AVERAGE TRANSPORTATION EXPENDITURES BY CATEGORY, SCHOOL YEARS 2002–03 TO 2006–07



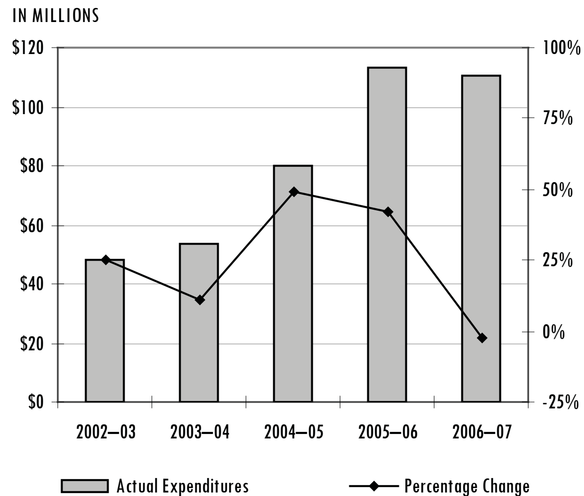
SOURCE: Texas Education Agency.

Included in the supplies and materials expenditure category, the gasoline and other fuels expenditures have increased by $62 million from school years 2002–03 to 2006–07. **Figure 393** shows the actual gasoline and other fuel expenditures as reported to TEA's Public Education Information Management System by districts from school years 2002–03 to 2006–07.

INCREASE STATE TRANSPORTATION ALLOTMENT

As the district transportation cost continues to increase with no corresponding state funding, districts are struggling to provide transportation services to students. To compensate, some districts are diverting funds from other school operations, increasing the number of students required to

FIGURE 393
GASOLINE AND OTHER FUELS EXPENDITURES AND PERCENTAGE CHANGE, SCHOOL YEARS 2002–03 TO 2006–07



SOURCE: Texas Education Agency.

walk to school, or reducing bus routes, which decreases the number of students receiving transportation services.

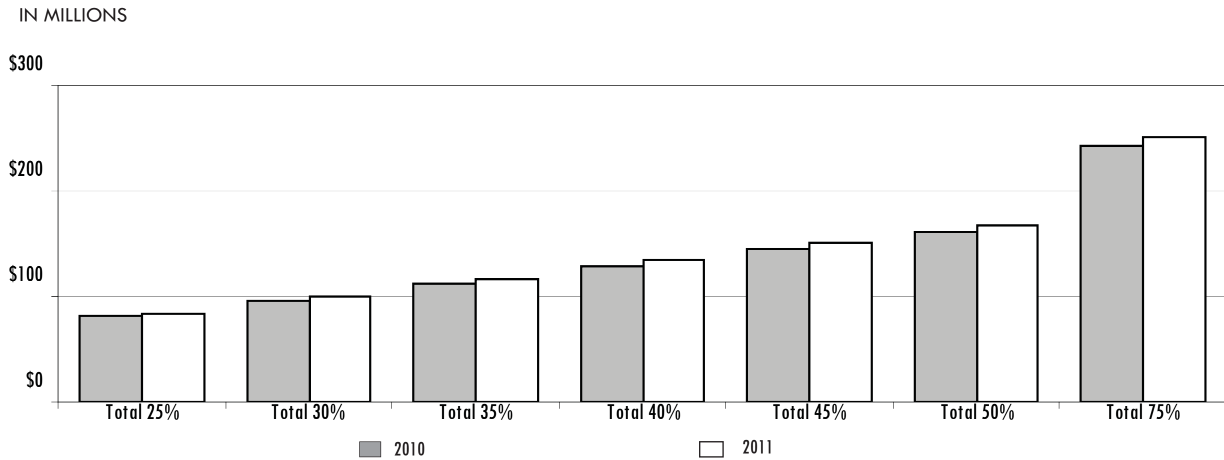
Without a change in the state's transportation allotment, districts have had to continue to provide transportation services, even as they have experienced nearly a 25 percent increase in costs over a five-year period. If the Legislature were, for example, to increase the linear density allocation per mile of approved route by 25 percent, the additional cost would be $164 million during the 2010–11 biennium.

Figure 394 shows the estimated state cost for fiscal years 2010 and 2011 of increasing the current allotment by between 25 percent up to 75 percent. Increasing the allotment by 75 percent would allow the state to cover an estimated 50 percent of district cost.

Figure 395 shows for the regular program an example of a 25 percent increase in the allotment per mile of approved route for each linear density group.

The other transportation programs' reimbursement rates would also reflect the 25 percent increase. The maximum mileage rate for special transportation would increase from $1.08 to $1.35 per mile and the private rate would increase from $0.25 to $0.32 per mile with a maximum of $1,020 per eligible student, up from the current $816. The career and technology program rate is based on the regular program reimbursement, thus this program would automatically experience an increase.

FIGURE 394
INCREASED COST OF SELECTED PERCENTAGE INCREASES IN THE TRANSPORTATION ALLOTMENT, FISCAL YEARS 2010 AND 2011



Source: Legislative Budget Board.

FIGURE 395
25 PERCENT INCREASE IN THE REGULAR PROGRAM ALLOTMENT PER MILE OF APPROVED ROUTE, FISCAL YEARS 2010 AND 2011

LINEAR DENSITY GROUP	PROJECTED ALLOTMENT PER MILE OF APPROVED ROUTE
2.40 and above	$1.79
1.65 to 2.40	$1.56
1.15 to 1.65	$1.39
0.90 to 1.15	$1.21
0.65 to 0.90	$1.10
0.40 to 0.65	$0.99
Less than 0.40	$0.85

Source: Legislative Budget Board.

Recommendation 1 suggests that the Texas Legislature consider increasing the state transportation allotment for the regular, special, and private transportation programs.

REGULAR ANALYSIS OF TRANSPORTATION ALLOTMENT

Although the Texas Education Code requires the Commissioner of Education to consider factors affecting the actual costs of providing transportation services, it does not require a regular report of this information or an analysis of the district cost covered by the state allotment. Without such a report and analysis, the Legislature lacks the information necessary to make informed budget decisions regarding this allotment.

The Texas Education Code, Section 42.155 (c), requires that in determining the cost for the transportation allotment the Commissioner of Education shall consider factors affecting the actual cost of providing transportation services in each district or county. This statute does not require that a report be provided to the Legislature.

Recommendation 2 would direct the Commissioner of Education to compare the total district transportation costs and the state transportation allotment for each school year. Additionally, the commissioner should prepare a report summarizing findings regarding the transportation allotment program, submit the report to the Legislative Budget Board and the Governor prior to each regular legislative session.

FISCAL IMPACT OF THE RECOMMENDATIONS

Costs related to Recommendation 1 would depend on the level at which the Legislature might choose to fund school transportation. Recommendation 2 does not have any fiscal impact on the introduced 2010–11 General Appropriations Bill as it is assumed that TEA could cover the cost of the transportation analysis and report within existing appropriations.

The introduced 2010–11 General Appropriations Bill does not address the recommendations.

IMPLEMENTING THE SCHOOL BUS LAP/SHOULDER SEAT BELT REQUIREMENT

Policy issues related to equipping school buses with seat belts have been a topic of debate since the late 1980s. Arguments have been made for and against the installation of seat belts, and states have attempted to balance the operational and cost issues with concerns for student safety. Some states have addressed the issue by enacting legislation requiring buses to be equipped with either lap or lap/shoulder seat belts. Texas joined the ranks of these states in 2007 by enacting legislation during the Eightieth Legislature that requires public school districts to begin purchasing buses with lap/shoulder seat belts, starting in September 2010. However, this legislative initiative can only be implemented if the Texas Legislature appropriates funds specifically for reimbursing school districts for expenses incurred in complying. The Legislature has not appropriated funds for this purpose.

Analysis of transportation issues by Legislative Budget Board staff in May 2008 found that most districts are waiting to implement the requirement of purchasing school buses with lap/shoulder seat belts until the Legislature appropriates funding. As the issue of funding seat belts is considered, it is important to consider whether to fund the cost for the actual seat belts alone, or to also fund the cost of additional operational expenses that districts may incur. Reimbursement for districts that purchased buses with lap/shoulder seat belts prior to the appropriation of funding will also be an issue. As options for reducing cost related to seat belts on school buses, the Legislature may consider offering monetary incentives for districts that comply, or implementing a statewide coordinated bus purchase process. Moreover, the issue of liability of bus drivers who may be unsuccessful in requiring students to wear seat belts is not addressed in statute.

FACTS AND FINDINGS

- ♦ The Texas Legislature has neither identified nor appropriated funding for reimbursement of school districts for expenses incurred for purchasing school buses and school activity buses equipped with lap/shoulder seat belts. According to the Texas Transportation Code, Section 547.701, if this funding is not appropriated districts will not be required to implement this school transportation safety measure.
- ♦ Texas has a decentralized bus purchasing process. Districts are allowed, but not required, to purchase school buses through the State of Texas Cooperative Purchasing Program, but only 18 districts have done so from September 2006 to May 2008. Most districts in the state purchase buses through other means and obtain bids independently.
- ♦ The Texas Education Code, Section 22.0511, lacks language regarding liability of bus drivers when injuries are incurred by a student who may not be wearing or properly wearing a seat belt.

DISCUSSION

The Eightieth Legislature, 2007, addressed the issue of seat belts on public school buses by enacting House Bill 323. This legislation states:

> A bus operated by or contracted for use by a school district for the transportation of schoolchildren shall be equipped with a three-point seat belt for each passenger, including the operator. This subsection applies to:
>
> (1) each bus purchased by a school district on or after September 1, 2010, for the transportation of schoolchildren; and
>
> (2) each school-chartered bus contracted for use by a school district on or after September 1, 2011, for the transportation of schoolchildren.

House Bill 323 further states:

> "the changes made by Section 2 of this Act do not take effect unless the Legislature appropriates money specifically for the purpose of reimbursing school districts for expenses incurred in complying with that section."

This language from House Bill 323 was incorporated into the Texas Transportation Code, Section 547.701. The Texas Legislature has neither identified nor appropriated funding for reimbursing school districts for expenses incurred when purchasing school buses and school activity buses equipped with lap/shoulder seat belts for the transportation of students.

EFFECT OF NEW FEDERAL RULE ON LAP/SHOULDER SEAT BELTS

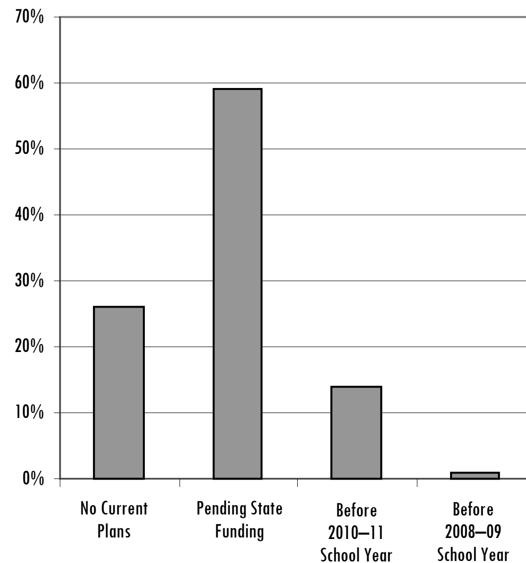
On October 15, 2008, the National Highway Traffic Safety Administration (NHTSA), a federal regulatory agency, made a final ruling on the use of lap/shoulder seat belts on school buses. The key components of the ruling related to seat belts are to: require lap/shoulder belts on small school buses (defined as a bus with a gross vehicle weight rating of 10,000 pounds or less), which are required by federal law to have at least lap belts; and set performance standards for seat belts voluntarily installed on large school buses (defined as a bus with a gross vehicle weight rating of greater than 10,000 pounds). NHTSA stated that each state or local jurisdiction may decide whether to install seat belts on the large school buses. The ruling will be effective three years after the date it is placed in the Federal Register, approximately late 2011.

PERFORMANCE REVIEW AND SURVEY OF SCHOOL DISTRICTS

The Legislative Budget Board (LBB) staff, in conjunction with Management Partnership Services, Inc (MPS), conducted reviews of five Texas school districts focusing on school transportation operations in May 2008. While these reviews were inclusive of all district transportation operations, LBB staff specifically inquired about the steps these districts were taking to implement lap/shoulder seat belts in their bus fleet. The independent school districts (ISDs) reviewed were: City View, Hallettsville, Somerset, Texas City, and Brazosport. At the time of the reviews, none of the districts had taken measures to budget for the purchase of buses with lap/shoulder seat belts. City View ISD which contracts for student transportation with Durham School Services, a national transportation services provider, has no plans to implement lap/shoulder seat belts. However, a neighboring district using the same contract provider, is preparing to purchase all new buses with lap/shoulder seat belts. Neither Brazosport ISD nor Texas City ISD indicated that any action had been taken in this area.

In addition to the district reviews, LBB staff surveyed 490 districts. The 239 districts that responded represented a broad range of school districts in Texas including small, medium, and large districts in urban, suburban, and rural communities. In response to the question "When do you plan to start equipping buses with seat belts?", 26 percent of the respondents stated that they have no plans to do so, and 59 percent plan to only when the state makes funding available. However, 15 percent of the respondents are taking some action before the established deadlines in this law, which could be before funding is appropriated. **Figure 396** shows the responses to this survey question.

FIGURE 396
PLANS BY DISTRICTS SURVEYED FOR EQUIPPING BUSES WITH LAP/SHOULDER SEAT BELTS, MAY 2008



Source: Legislative Budget Board.

COST OF ADDING LAP/SHOULDER SEAT BELTS TO SCHOOL BUSES

The cost of equipping all new school buses with lap/shoulder seat belts is dependent on the number of buses purchased and the increase in cost over buses without seat belts. The following estimate uses statewide vehicle data reported to the Texas Education Agency (TEA) annually by school districts and seat belt cost estimates from bus vendors approved by the Texas Department of Public Safety.

There are four bus types: A, B, C, and D. As shown in **Figure 397**, a Type C bus is the most common type of bus used in Texas school districts for to and from school transportation services. The second most common bus is Type D, which is usually the school activity bus. In school year 2006–07, there were more than 37,000 buses used for transporting Texas students; nearly 29,000 of which were Type C (about 76 percent).

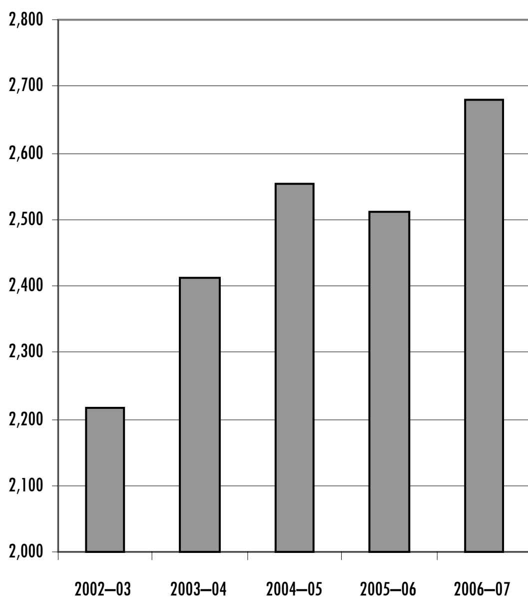
As shown in **Figure 398**, districts statewide purchased more than 2,000 buses annually during school years 2002–03 to 2006–07. This number is a combination of the new and used buses with the new bus purchases being the majority. From school years 2004–05 to 2006–07, district bus purchases

FIGURE 397
SUMMARY OF STATEWIDE REGULAR AND SPECIAL ROUTE BUSES OPERATED BY TEXAS SCHOOL DISTRICTS, SCHOOL YEARS 2004–05 TO 2006–07

SCHOOL BUSES TYPE	2004–05	2005–06	2006–07
Type A Van conversion or body constructed utilizing a cutaway front-section vehicle with a left side driver's door. The Type A bus shall be no more than 10,000 pounds and not exceed 19,500 gross vehicle weight rate (GVWR). The entrance door is behind the front wheels.	3,052	2,989	2,922
Type B Constructed utilizing a stripped chassis. The entrance door is behind the front wheels and has a GVWR of greater than 10,000 pounds.	1,010	909	735
Type C Body installed upon a flat back cowl chassis or an integrated conventional chassis/body combination, with a hood and front fender assembly and a GVWR of more than 10,000 pounds. The engine is in front of the windshield and the entrance door is behind the front wheels.	26,493	27,457	28,505
Type D Body installed upon a chassis, with the engine mounted in the front, mid-bus, or rear with a GVWR of more than 10,000 pounds. The engine may be behind the windshield and beside the driver's seat; it may be at the rear of the bus, behind the rear wheels; or between the front and rear axles. The entrance door is ahead of the front wheels.	5,407	5,526	5,437
TOTAL	**35,962**	**36,881**	**37,599**

NOTE: Type A buses are typically small special route buses, and the Type B, C, and D buses are typically large buses.
SOURCES: Texas Education Agency; Texas Department of Public Safety.

FIGURE 398
SUMMARY OF STATEWIDE ANNUAL BUS PURCHASES BY TEXAS SCHOOL DISTRICTS, SCHOOL YEARS 2002–03 TO 2006–07



SOURCE: Texas Education Agency.

exceeded 2,500 buses each school year. On average, districts purchased 2,474 buses per year from school years 2002–03 to 2006–07.

LBB staff surveyed the Texas approved bus vendors and received responses from four vendors that sell buses from the three manufacturers: IC Corporation, Blue Bird Body Company, and Thomas Built Buses. The vendors were asked to provide a cost estimate for the addition of lap/shoulder seat belt restraints when purchasing a 71-passenger Type C model bus. The additional cost for lap/shoulder seat belt restraints ranged from $9,300 to $14,000 per 71-passenger bus with the average being $12,433. Federal rule requires that when using lap/shoulder seat belts, manufacturers must allow for 15 inches per student on each seat.

Assuming that equipping a 71-passenger bus with lap/shoulder seat belt restraints would result in an additional cost of approximately $12,433 and assuming an annual purchase of 2,500 buses, the statewide annual increase in cost for buses with seat belts would be $31.1 million. Assuming districts continue to purchase buses at the same rate and the Type C model bus continues to be the most common bus used to transport Texas students, it could take approximately 15 years to replace the 37,599 buses in Texas with lap/shoulder seat belts.

Many leaders in the school transportation industry are concerned that districts may not only incur the cost of the seat belts but also lose seating capacity, require additional staff, and incur additional maintenance and operation costs. The loss of seating capacity could reduce the number of riders per route, which could decrease a district's reimbursable

mileage rate. Losing seating capacity could also require additional buses and drivers to operate additional bus routes, leading to increased maintenance and operation cost. These additional costs may vary by district and can be determined only as districts begin to purchase buses with lap/shoulder seat belts and make changes to routes and other transportation operations.

SELECTED POLICY OPTIONS

During the LBB staff transportation reviews of five Texas school districts, local school officials and consultants offered several suggestions for consideration. Options to consider when moving forward with the implementation of lap/shoulder seat belts on Texas school buses include providing a monetary incentive for districts and coordinating the purchasing of buses.

MONETARY INCENTIVE

As an option for reducing costs related to requiring seat belts in school buses, the Legislature may consider making the lap/shoulder seat belt requirement optional for large school buses, since the NHTSA now requires the lap/shoulder seat belts only for small buses. If districts were to purchase large school buses with lap/shoulder seat belts, districts could be offered a monetary incentive for doing so, even if not a full reimbursement.

Implementing this incentive would require an amendment to the Texas Transportation Code. This change would build in a reporting requirement for districts to receive the monetary incentive through either statute or regulation. To receive this incentive, districts would be required to develop and submit a comprehensive seat belt policy and a bus replacement plan and schedule to TEA. This plan and schedule would clearly identify the buses for which replacements will include a lap/shoulder seat belt system.

Over the years, the LBB found while conducting school district reviews that many districts lack bus replacement plans and schedules which is vital to an efficient and effective transportation program. Development of a formal bus replacement schedule can assist districts as they budget for replacing buses with lap/shoulder seat belts by projecting the expected change in annual capital costs associated with adding the seat belts. Districts would then be able to establish a more informed policy choice regarding the cost/benefit trade-offs of purchasing buses with lap/shoulder seat belts. Bus replacement plans and schedules could also help districts better manage fleet inventories and control maintenance costs by replacing buses once they reach the end of their life cycle. Improved control over maintenance costs and financial incentives by the state may result in total cost reductions that are sufficient to offset the incremental cost of equipping the buses with lap/shoulder seat belts.

COORDINATED BUS PURCHASING

Establishing a coordinated bus purchasing process could create an opportunity for the state to help districts reduce the cost of bus purchases by absorbing some of the additional cost associated with the lap/shoulder seat belts. Chapter 34 of the Texas Education Code states "a school district may purchase school motor vehicles through the comptroller or through competitive bidding." Since it is not mandatory to purchase buses through the Comptroller of Public Accounts (CPA), most districts in the state purchase buses through other means and obtain bids independently. According to CPA, from September 2006 to May 2008, 18 districts purchased buses through the CPA sealed bid process.

For districts to use this process, as a member of the CPA's Cooperative Purchasing Program, they complete the school bus purchase requisition form and submit it to CPA. Once this form is completed, CPA staff issues an Invitation for Bid (IFB). Once the vendors respond to the IFB, CPA staff review the bid to ensure the requested bus specifications are met. Based on the lowest bid, CPA staff recommends which bid to accept. CPA staff did not have data from districts to determine if their prices were competitive with bids districts receive on their own, but they believed that they were obtaining lower prices. When asked about having a more coordinated (contracted) bus purchasing process, CPA staff indicated that it could be done, but to take advantage of lower rates due to bulk purchases, it would have to be mandatory for districts to purchase from the contract.

In September 2008, LBB staff obtained information from other states that have a state coordinated bus purchase process. Of the states that responded, Florida indicated that they have a state bid process, and districts are required to purchase through this process. The prices for the buses are set annually, recognizing that there are increasing expenses that continue to affect the cost of buses. The state negotiates the prices for the buses, but districts are responsible for contacting the vendor to order. Florida staff could not quantify how much revenue is saved by using this process but believes that they are saving the districts money. The state maintains the competitiveness of the process by using the lowest bid as the base, and other bids within 10 percent of the lowest bidder

are allowed to remain on the vendor list. Bids that exceed the 10 percent threshold are rejected and removed from the vendor list.

It may be beneficial for Texas to consider a mandatory state coordinated bus purchase process, realizing that the true savings of this process can only be determined while negotiating the contract prices for buses. The process used in Florida could serve as a model for Texas.

IMMUNITY FROM LIABILITY

Texas Education Code, Section 22.0511, which addresses the issue of immunity from liability as it relates to school district employees and volunteers, states that this law does not apply to the operation, use, or maintenance of any motor vehicle. As this exemption may be valid in some instances, the Legislature should consider if it wants district bus drivers held liable in the event a student is not wearing or is improperly wearing a seat belt and is injured or killed during an accident. According to transportation consultants, this is a concern of transportation personnel that view seat belt usage as a potential safety concern due to drivers whose attention may be diverted from the road to students who are not wearing a seat belt or are improperly using a seat belt. States such as California and New Jersey have specific language regarding the liability of operators tasked with requiring students to wear seat belts.

For example, California's law states that "no person, school district, or organization, with respect to a school bus equipped with passenger restraint systems pursuant to this section, may be charged for a violation of this code [seat belt law] or any regulation adopted thereunder requiring a passenger to use a passenger restraint system, if a passenger on the school bus fails to use or improperly uses the passenger restraint system." New Jersey also addresses this issue by stating that "nothing in this section [seat belt law] shall make the owner or operator of a school bus liable for failure to properly adjust and fasten a seat belt or other child restraint system that is in conformity with applicable federal standards for a passenger who sustains injury as a direct result of the passenger's failure to comply with the requirement established by this section."

STABILIZE PARTICIPATION IN EDUCATOR INCENTIVE PAY PROGRAMS

Texas is operating three programs representing the largest effort at educator incentive pay, or pay for performance, undertaken by any state. All three programs, the Governor's Educator Excellence Grant program, the Texas Educator Excellence Grant program, and the District Awards for Teacher Excellence, provide funds to local entities to support the implementation and operation of locally developed incentive pay plans that conform to certain broad parameters established by the state.

Although these programs are relatively new and outcomes-based evaluations have not yet been completed, examination of the participating campuses between grant cycles in the Texas Educator Excellence Grant program, in particular, reveals a high level of turnover in participating campuses. Two factors are driving the majority of this turnover: the inherent volatility of a performance metric, which is one criterion for participation for certain campuses, and the elimination of participating statutorily eligible campuses from participation in subsequent years due to funding constraints.

Given the commitment of time and effort represented by the application process and the development of local incentive plans, the volatility in eligibility or the notion that an eligible campus may not receive funding for more than one year may deter initial participation by some campuses. Furthermore, if a policy goal of the program is to provide longer-term state support for the development of incentive pay systems, then the high rate of turnover runs contrary to that goal. Finally, a high level of inconsistency in the sample of participating campuses across time renders any longitudinal analysis conducted as part of the statutorily required evaluation of the program less meaningful.

By amending state statute to modify program eligibility requirements and adopting a policy that guarantees funding for a period of time for participating campuses that remain eligible, Texas can stabilize the population of participating campuses.

CONCERN

- There is significant turnover in the population of participating campuses for the Texas Educator Excellence Grant program from year to year. Two factors are driving the majority of this turnover: the inherent volatility of the measure of Comparable Improvement, which is a criterion for participation for campuses rated Academically Acceptable in the state accountability system, and the elimination of participating statutorily eligible campuses from participation in subsequent years due to funding constraints.

RECOMMENDATIONS

- **Recommendation 1:** Amend Texas Education Code, Section 21.653 to change the statutory eligibility requirements to allow campuses that initially qualify for participation in the Texas Educator Excellence Grant program under the Comparable Improvement criterion to remain statutorily eligible regardless of whether they are ranked in the top quartile in Comparable Improvement in subsequent grant cycles so long as they continue to exhibit positive trends in improvement in student achievement.
- **Recommendation 2:** Adopt a policy requiring that participating campuses that remain statutorily eligible participate in the Texas Educator Excellence Grant program for at least two years and guaranteeing funding for that period, contingent on the availability of state funds. This recommendation could be implemented by the Texas Education Agency as a program policy.

DISCUSSION

The Governor's Educator Excellence Grant program (GEEG) was established by an Executive Order (RP 51) issued on October 27, 2005. The order directed the Commissioner of Education to establish a performance-based pay grant program that would direct funding to participating campuses to provide differential pay to employees based on student performance. The Executive Order stipulated that grants be awarded to campuses with high numbers of economically disadvantaged students and that the criteria established by the Commissioner for participation require that at least 75 percent of funds received through the program be provided as compensation to classroom teachers. The order directed that the Texas Education Agency (TEA) set aside at least $10 million in total to fund the program.

In response to the Executive Order, TEA created GEEG, a three-year non-competitive grant program providing funds targeted at 99 high-poverty, high-performing campuses, funded with $10 million in Federal Funds (Title II and Title V discretionary funds). The first cycle of grant awards was distributed for the 2006–07 school year. The final cycle of grant awards is being distributed in the 2008–09 school year.

In June 2006, the Seventy-ninth Legislature, Third Called Session, enacted comprehensive public education finance and policy reform legislation. As part of the reform package included in that legislation, the Legislature created two statewide incentive pay grant programs to be administered by TEA. The first, established by Texas Education Code (TEC), Chapter 21, Subchapter N, Awards for Student Achievement, and subsequently named the Texas Educator Excellence Grant (TEEG) program by TEA, was first funded in fiscal year 2007 with $100 million in General Revenue Funds. The statute stipulates that only campuses that rank in the top half in the state in percentage of economically disadvantaged students enrolled and that are rated exemplary or recognized or in the top quartile in Comparable Improvement in the state accountability system are eligible to receive funding. Statute further requires that 75 percent of funds received by a campus under the grant be used for incentive pay for classroom teachers. The requirements of campus plans stipulated for both TEEG and GEEG are identical.

The first grants were made to campuses in fiscal year 2007 for payments in the 2006–07 school year, based on student performance in the 2004–05 school year. The second cycle of grants was awarded in fall 2007 for payments during the 2007–08 school year based on student performance in the 2005–06 school year. Subsequent grant cycles will be awarded in the fall of the school year to which the awards apply, with eligibility based on student performance two years prior. Campus eligibility is based on campus accountability ratings or improvement on the Texas Assessment of Knowledge and Skills (TAKS) two years prior to the year of the grant awards; however, the incentives are paid according to the local plans based on performance during the school year in which the grant is awarded.

For both GEEG and TEEG, campuses have discretion in the design of the campus incentive plan within certain parameters. The statute governing TEEG stipulates that campus plans must have the following characteristics:

- must provide that 75 percent of grant awards be dedicated to incentive payments to classroom teachers, with a suggested payment amount between $3,000 and $10,000 per teacher;
- must provide that incentive payments be based primarily on student achievement as measured by objective quantifiable measures and on collaboration with faculty and staff contributing to student achievement on the campus; and
- may allow that other factors such as assignment to a subject designated by the state or the district as a shortage area and/or demonstration of ongoing initiative, commitment, professionalism, and other activities that contribute to improved student achievement be considered in determining a teacher's eligibility for an incentive payment.

The campus plan must be developed by a campus-level committee and approved by a district-level committee. The plan must be submitted by the district on behalf of the campus; and the district must provide evidence of teacher-involvement in the development of the plan, letters of support from at least three classroom teachers on the campus applying, and evidence that the plan has been publicly available and presented at a regular meeting of the district's board of trustees.

The statutory basis for the second incentive pay grant program established by the 2006 legislation is found in TEC, Chapter 21, Subchapter O, Educator Excellence Awards, subsequently named District Awards for Teacher Excellence (DATE) by TEA. Grants made by the Commissioner of Education under the DATE program are made to school districts (as opposed to grants made to individual campuses under the other two programs), and all school districts and charter schools are eligible to apply for funding.

In the DATE program, a district-level committee must develop a local awards plan. The plan may provide for participation of all campuses in the district or select campuses, but a majority of classroom teachers assigned to a participating campus must approve the plan. The plan must flow at least 60 percent of funds to award classroom teachers who improve student achievement. The remaining funds may be used for a variety of purposes, including providing stipends for mentors, those teaching in shortage areas, those teaching in hard-to-staff schools, and those holding advanced degrees; providing awards for other campus personnel; and/or implementing

components of the Milken Family Foundation's Teacher Advancement Program.

Statute directs that $840 per classroom teacher in fiscal year 2008 and $1,000 per classroom teacher in subsequent years be deposited to the Educator Excellence Fund (a fund within the General Revenue Fund) to finance both the TEEG, at $100 million per year, and the DATE programs, with the remaining balance, beginning in fiscal year 2008. However, the Eightieth Legislature, 2007, opted to provide $97.5 million in General Revenue Funds for TEEG in each fiscal year of the 2008–09 biennium and to delay implementation of DATE until fiscal year 2009. The Eightieth Legislature, 2007, appropriated $147.8 million in fiscal year 2009 to fund the first cycle of grants under the DATE program.

TEA has contracted with the National Center on Performance Incentives at Vanderbilt University's Peabody College to evaluate the effectiveness of GEEG and TEEG and is currently reviewing responses to the request for proposals to evaluate the DATE program. For TEEG and DATE, evaluations are statutorily required. The year-one reports for GEEG and TEEG include data on the composition of campus plans, first year implementation, and survey results regarding effects of the program and participant attitudes toward it. Both reports are available on TEA's website. The complete year-two TEEG and GEEG reports are scheduled to be available during fall 2008 in time for the Eighty-first Legislative Session, 2009, and will provide the first analysis of student achievement outcomes on participating campuses.

TEEG STATUTORY ELIGIBILITY AND DETERMINATION OF GRANT AWARDS

State statute stipulates that a campus is eligible for grant funding under the TEEG program if the percentage of economically disadvantaged students enrolled is in the upper 50 percent for the state and if the campus is rated Exemplary or Recognized in the state accountability system or is rated Academically Acceptable and demonstrates Comparable Improvement in either reading or math.

Comparable Improvement is determined annually by comparing campuses with a peer group matched by campus type and according to various campus demographics. These peer groups of 40 campuses each are compared based on student improvement in performance from one year to the next on the TAKS in reading and mathematics. Each student's TAKS score in each subject is compared with a calculation of what that student's expected test score would be based on a standard projection methodology (described in the TEA Accountability Manual) as applied to his or her prior year TAKS score. The relationship between the expected and the actual test scores for the campus is converted into a metric referred to as the Texas Growth Index (TGI). The average TGI for each campus is calculated, and campuses in the 40-campus peer group are ranked according to the average campus TGI. Campuses that fall within the top quartile in this ranking are considered to have achieved Comparable Improvement. A campus may achieve Comparable Improvement in one subject area tested, but not the other (one instance of Comparable Improvement), or in both reading and math (two instances of Comparable Improvement). Note that a campus that achieves Comparable Improvement in a given year may not have improved its TAKS passing rate. Comparable Improvement only measures the relative increase in student performance as compared with peer campuses, regardless of whether or not students have passed or failed a TAKS assessment.

DETERMINATION OF GRANT AWARDS

For each cycle of grant awards, TEA determines statutory eligibility by first separating all campuses by campus type—elementary, middle school, high school, or all grades campuses—and determining the top 50 percent in the percentage of economically disadvantaged students enrolled for each campus type. TEA opted to select the top 50 percent in percentage of economically disadvantaged students by campus type in order that the various campus types would be proportionally represented in the eligibility list, and the agency opted to make campus grants such that the universe of grant recipients would include a proportion of each campus type that mirrors that of the state as a whole. After ensuring that campuses meet the percentage economically disadvantaged criterion, campus accountability ratings are examined.

Once the total list of statutorily eligible campuses is determined, TEA ranks campuses within each campus type by the percentage of economically disadvantaged students (highest to lowest) and determines campus grant amounts based on campus enrollment, with a minimum campus grant amount of $40,000. Funding is allocated to each campus, beginning with the campuses in each campus type at the top of the rank-ordered list and moving down through the list until the total funding available is expended or the remainder is insufficient to fully fund the allocation for the next campus on the list. The amount of the enrollment-based allocation is determined by TEA according to assumptions regarding the

number of teachers per campus, the proportion of teachers likely to receive awards, and assumed average individual award amounts.

TEEG CAMPUS TURNOVER

Overall, well over half of the Cycle 1 TEEG campuses did not participate in Cycle 2. One major driver of turnover in participating campuses between cycles is volatility in the population of campuses eligible under the Comparable Improvement criterion. The second major driver of participant turnover is a consequence of the funding allocation procedure under which not all campuses that receive grants in a given grant cycle and that remain statutorily eligible receive grants in subsequent cycles.

TEEG TURNOVER AND THE MEASURE OF COMPARABLE IMPROVEMENT

Of the Cycle 1 participants that were excluded from Cycle 2 participation due to failure to meet statutory eligibility requirements related to accountability ratings, 67 percent were Academically Acceptable campuses that had qualified for Cycle 1 based on the Comparable Improvement measure, remained Academically Acceptable in the second year, but failed to meet Comparable Improvement requirements in the second year. Analysis of the Comparable Improvement measure contained in the year-one evaluation report highlights methodological concerns regarding the measure itself. While it is beyond the scope of this review to examine the specific methodology of the Comparable Improvement measure in detail, its inclusion as a criterion of eligibility warrants further consideration.

Measures of improvement can be problematic as comparison tools because as overall achievement increases, the degree of improvement year over year is expected to decline—though improvement may continue to occur. So a campus could qualify for TEEG under the Comparable Improvement criterion in one year, continue to improve the following year, but not be ranked in the top quartile for Comparable Improvement, which would render the campus ineligible to participate even though the campus is performing better than it was performing when it initially qualified for participation. This circumstance may be addressed in part by campuses attaining sufficient improvement to earn a higher state accountability rating. However, TEEG requires that in order for a campus rated Academically Acceptable to be eligible to participate, it need only be ranked in the top quartile of Comparable Improvement for either reading or math. There may be other factors contributing to a campus' failure to attain at least a Recognized rating unrelated to its annual improvement in either or both of those areas.

Recommendation 1 would amend the statute governing TEEG to allow campuses rated Academically Acceptable that initially qualified under the Comparable Improvement criterion to remain eligible regardless of their Comparable Improvement ranking so long as they maintain a positive improvement trend in student achievement. This policy would continue to reward campuses that have significant achievement gains in one year and that continue to improve in subsequent years, but would recognize the inherent difficulty of maintaining a high rate of improvement over time.

TEEG TURNOVER DUE TO FUNDING CONSTRAINTS

Campuses that are statutorily eligible to participate do not receive funding if they fall too low on the rank-test of the percentage of economically disadvantaged students served due to lack of available funding. Between Cycles 1 and 2 of the program, 266 statutorily eligible campuses, representing 37 percent of the total number of Cycle 1 campuses that did not participate in Cycle 2, were dropped from the program because of budget constraints. Although these campuses met both student population and achievement requirements, they were ranked below the point in the ranking of eligible campuses by percentage of economically disadvantaged students served at which total funds available had been allocated. Given the commitment of time and effort required by the application process and the development of the campus incentive plan, the possibility that state funding may be unavailable after one year of participation even if the campus meets all requirements may be a deterrent to initial participation, particularly for campuses on which the student body comprises a proportion of economically disadvantaged students that is close to the cut-off point for statutory eligibility. This volatility may not be a concern if the policy goal of the program is either to provide short-term or one-time grants to campuses to establish a performance-based pay program that would then be continued with local funds or to provide short-term or one-time grants to provide ad hoc performance bonuses. However, if the program goal is to provide longer term state support, then achieving more stability in the program would better support that goal.

To achieve stability, recommendation 2 would direct TEA to require that campuses remaining statutorily eligible participate for two consecutive grant cycles, similar to a requirement the agency established for the DATE program,

and to guarantee that those campuses receive awards under the program, contingent on the availability of state funding. While this policy would limit the openness of the program to new participants each year, it would provide some assurance of sustainability to campuses that engage in the process of developing a plan.

In addition to addressing issues specifically related to previously participating campuses being excluded due to methodological issues with eligibility criteria or due to budget constraint, establishing a more stable participant list would also improve the quality of analysis possible in the statutorily required evaluation. The more volatility there is in the sample of participating campuses over time, the less meaningful any longitudinal analysis will be. There are methodological tools available to compensate for volatility to a certain extent, but more conclusive results would be possible with a larger sample of districts that participate for multiple years.

DATE PROGRAM ELIGIBILITY AND DETERMINATION OF GRANT AWARDS

All school districts and charter schools are statutorily eligible to participate in the DATE program. TEA added the following additional requirements for participation:

- Participating school districts are required to engage in a one-year planning process that includes participation in technical assistance.
- Participating school districts are required to commit to two consecutive grant cycles (two years of implementing their local plan) provided that funding continues to be available.
- Participating school districts are required to provide a 15 percent match in either funding or in-kind services.

According to TEA, the matching requirement and the two-cycle required commitment were established to promote program sustainability and to achieve school district buy-in. These policies were vetted with stakeholders in meetings and information sessions held throughout calendar year 2007. The matching requirement mirrors requirements of other performance pay programs such as the Milken Family Foundation's Teacher Advancement Program (TAP) and the federal Teacher Incentive Fund.

The DATE program is first funded for fiscal year 2009, with participating districts required to submit a notice of intent to apply by October 27, 2007; 518 districts indicated intent to apply. However, 304 districts have since opted out, failed to complete required technical assistance, failed to submit an application, or were denied approval for their plans by their local school boards. Of the districts that opted out after having completed an application and the required technical assistance, TEA reports that 31 percent opted out due to concerns regarding the amount of funding available or concerns about the availability of future state funding; 19 percent opted out due to lack of local support from teachers, school boards, or the local implementation committee; and 17 percent opted out because of the 15 percent matching requirement. After attrition, 213 school districts and charter schools, serving a little less than half the total students in average daily attendance (ADA) in the state, are participating in the program for the 2008–09 school year, representing about 17 percent of the total number of school districts and charter schools.

DETERMINATION OF GRANT AWARDS

DATE funding is distributed to participating districts based on the number of students in average daily attendance (ADA). For fiscal year 2009, the total amount of funding available allowed for a distribution of $71 per ADA. District grant awards range from around $4,400 to over $13 million for school year 2008–09, with the average award being slightly less than $700,000. In subsequent grant cycles, the distribution rate could be adjusted up or down depending on the number of participants and the total amount of funding available. This variability could present a concern for school districts that may be reliant on state funding for sustainability of a long-term program.

Since the DATE program is being newly implemented in the current school year, it seems premature to recommend structural changes to the program. Given the focus on funding-related issues among the districts that opted out of participation, the relatively low participation rate may be improved over time, assuming the program continues to be funded through the appropriations process for the 2010–11 biennium.

FISCAL IMPACT OF THE RECOMMENDATIONS

None of the recommendations have any fiscal impact on the introduced 2010–11 General Appropriations Bill.

DEVELOPMENT OF THE TEXAS VIRTUAL SCHOOL NETWORK

The rising demand for and supply of online learning programs in Texas demonstrates their ability to play an integral role in educating public school students. Recognizing the significance of this trend, the Eightieth Legislature, 2007, enacted Senate Bill 1788, which requires the Texas Education Agency to establish a statewide network linking students, their home school districts, and online learning programs; and to ensure that the network allows students to take high-quality courses taught by certified instructors. The legislation also mandates that the Texas Education Agency develop the network, known as the Texas Virtual School Network, so that students can use it to take online courses by January 2009.

FACTS AND FINDINGS

- As of November 1, 2008, 152 Texas public school teachers received online instructor approval from four professional development organizations, and 59 courses have been approved for online education.
- As of November 1, 2008, three online learning programs, one of which is a school district and two are multi-district consortia, had entered negotiations with the Texas Education Agency and its partner organizations to be network providers. The agency expects all of the agreements will be finalized before the spring 2009 course delivery.
- The Texas Education Agency has requested an appropriation of $18 million in General Revenue Funds for the 2010–11 biennium that would provide free tuition for up to 15,000 students, as well as funding for Texas Virtual School Network central operations and course reviews. Although the network may eventually have the capacity to serve that many students, the funding proposal does not address any specific policy objective.
- Based on a survey of 13 online learning programs, Texas could address online learning policy objectives, such as reducing course and teacher shortages, at estimated funding levels ranging from $2.4 million to $25.1 million.

DISCUSSION

Online learning programs, or virtual schools, allow public school students to take courses via the Internet without being in a classroom. Students participate in online learning to take courses not offered on their campus or to earn core or elective credits after school. Online learning programs, a form of distance education, allow students to meet regular or early graduation requirements, retake courses for credit recovery, and allow more time for extracurricular and other activities.

Online learning programs typically include the following characteristics:

- Asynchronous—teacher-student learning activities and communication occur at different times.
- Separate locations—teachers and students access the online learning system in different places.
- Web based—students receive instruction and content primarily via the Internet.

Because of the benefits offered by online learning programs, student demand for such programs has grown significantly in the last four years. For example, Florida Virtual School, the nation's largest state-administered online program, served 52,000 students in school year 2006–07, more than double the number participating in school year 2004–05. The Michigan Virtual School, which a non-profit organization manages, experienced an enrollment increase of 78 percent from school years 2004–05 to 2006–07. Course registrations at two state-administered online learning programs, Utah's Electronic School and Wisconsin's Virtual School, increased by 141 percent and 100 percent, respectively, from school years 2004–05 to 2006–07.

Several online learning programs in Texas have also experienced rapid growth. The Plano Independent School District (ISD) eSchool's course registrations more than doubled between school years 2004–05 and 2006–07. The SUPERNet Virtual School, a consortium of small school districts, had experienced a growth rate of 42 percent from school years 2003–04 to 2006–07. Student course registrations in the Lubbock ISD online program tripled between school years 2004–05 and 2007–08.

SURVEY OF TEXAS ONLINE LEARNING PROVIDERS

To better understand the extent of online learning programs, Legislative Budget Board staff surveyed 13 program providers: 10 school districts, two consortia, and one institution of higher education. **Figure 399** shows the results of the survey. Eight of the 13 providers began serving students prior to school year 2004–05. Five of them served students in or before school year 2001–02. Despite the growth-related challenges facing virtual schools, such as expanding the pool of appropriately trained online teachers, these providers have successfully expanded their service capacity in response to student needs.

Plano ISD is the oldest and largest of the 10 district providers surveyed. It had 3,538 course registrations, 3,296 from its own schools and 242 from other districts and private schools in school year 2007–08. The district's tuition ranged from $230 for courses in which textbooks were required to $300 for those using purchased courseware. To administer the program, Plano ISD budgeted $563,428 for school year 2007–08 operations. The second largest program, Lubbock ISD, had 1,489 registrations—1,334 from its schools and 155 from other districts and private schools.

Several school districts set tuition rates based on family income and enrollment status. Lubbock, Carrollton-Farmers Branch, Amarillo, and Birdville charged rates of $25 to $75 for students eligible for the federal free and reduced price lunch program. Birdville, Lubbock, and Pasadena charged non-district students at rates that were $50, $100, and $150 higher than in-district students, respectively.

FIGURE 399
TEXAS ONLINE LEARNING PROVIDERS, SCHOOL YEAR 2007–08

ONLINE LEARNING PROGRAM PROVIDER	SCHOOL YEAR STARTED	HIGH SCHOOL STUDENTS SERVED	STUDENT PARTICIPATION RATE	COURSE REGISTRATIONS	TUITION RATE STRUCTURE
Amarillo ISD[1]	2003–04	226	2.8%	275	$50–$100
Birdville ISD[2]	2007–08	178	2.7%	216	$25–$100–$150
Carrollton-Farmers Branch IS0[3]	2006–07	327	4.4%	398	$75–$150
Deer Park ISD	2007–08	108	2.9%	214	$175
Houston ISD[4]	2001–02	153	0.3%	311	$200–$225–$300
Lewisville ISD	2006–07	167	1.2%	391	No Tuition
Lubbock ISD[5]	2002–03	111	1.4%	1,489	$50–$100–$200
Northside ISD	2001–02	76	0.3%	76	No Tuition
Pasadena ISD[6]	2004–05	178	1.4%	318	$100–$250
Plano ISD[7]	2000–01	2,176	18.0%	3,538	$230–$260–$300
SUPERNet Consortium[8]	2002–03	175	1.8%	322	$7,145 annual
Texas Virtual School - Region 4 Consortium[9]	2001–02	258	2.2%	767	$325–$350
Texas Tech University College of Outreach and Distance Education	1999–2000	6,103	NA	8,428	$125

[1]Amarillo ISD tuition: $50 for economically disadvantaged students; $150 for all other students.
[2] Birdville ISD tuition: $25 for economically disadvantaged students; $100 for district students; $150 for non-district students.
[3]Carrollton-Farmers Branch offered free tuition during the fall and spring semesters. It began charging tuition of $75 to economically disadvantaged students, and $150 for all other students in summer 2008.
[4]Houston ISD tuition: $200 for regular courses; $225 for foreign language; $300 for Advanced Placement courses.
[5]Lubbock ISD tuition: $50 for economically disadvantaged students; $100 for district students; $200 for non-district students. Students served based on spring semester data.
[6]Pasadena ISD tuition: $100 for district students; $250 for non-district students.
[7]Plano ISD tuition: varies by cost factors such as commercial curriculum fees and textbook requirements.
[8]SUPERNet allocates each district 45 student slots for an entire year at the $7,145 rate. Districts that are not part of the consortium are charged $200 per semester per student. Students served based on fall semester data.
[9]Texas Virtual School tuition: $325 for regular courses; $350 for Advanced Placement courses. Students served based on spring semester data.
Sources: Legislative Budget Board; Amarillo ISD; Birdville ISD; Carrollton-Farmers Branch ISD; Deer Park ISD; Houston ISD; Lewisville ISD; Lubbock ISD; Northside ISD; Pasadena ISD; Plano ISD; SUPERNet consortium; Texas Virtual School, ESC Region; Texas Tech University.

The two consortia, the Texas Virtual School and SUPERNet, serve mainly small, rural districts. The Texas Virtual School, which had 767 course registrations in school year 2007–08, is a partnership of 14 Education Service Centers (ESCs), and is administered by the Region 4 ESC. Its tuition for Advanced Placement courses, $350, is $25 higher than the rate for regular courses. The SUPERNet consortium consists of 18 school districts. It had 322 registrations from students attending small east Texas school districts in school year 2007–08. School districts paid an annual rate of $7,145 per student for 45 course slots. According to its staff, the actual semester cost is approximately $200—the rate it charges non-participating districts.

The Texas Tech University College of Outreach and Distance Education is among several higher education-affiliated organizations offering online courses to public school students. The others are The University of Texas at Austin and the Texas Association of Community Colleges, whose Virtual College of Texas provides dual credit online courses to high school students through their local community and technical colleges. Texas Tech University has been providing distance education courses for approximately 30 years and began offering K–12 online courses in 1999. It served 12,472 students statewide and had 23,381 course registrations in school year 2007–08. According to program staff, its low tuition rate of $125 per course reflects an economy of scale, management experience resulting in streamlined operations, and efficiencies such as in-house curriculum development.

DEVELOPMENT OF THE TEXAS VIRTUAL SCHOOL NETWORK

To give more students the opportunity to benefit from high-quality online learning, the Eightieth Legislature, 2007, enacted Senate Bill 1788. This legislation requires TEA to develop a network linking online learning providers with school districts whose students want to register for their courses. In response to this legislation, TEA created the Texas Virtual School Network (TVSN) in collaboration with ESCs Region 10 (Dallas) and Region 4 (Houston) and the Harris County Department of Education. TEA has allocated $2.3 million in Foundation School Program funds for the biennium to these entities, using transfer authority granted by Rider 31, General Appropriations Act, 2008–09 biennium.

Figure 400 shows each entity's role and budget allocation for fiscal years 2008 and 2009. TEA assigned most of the TVSN's development and management responsibilities to ESC Region 10. Under the agency's implementation plan, Region 10 is responsible for creating and coordinating the course registration and financial transaction systems, establishing agreements with online provider and home school districts, and reporting performance to TEA. Region 10 contracts with the Harris County Department of Education for management of the network's technology infrastructure. It should be noted that the network does not deliver online courses. Internet connections between students, home school districts, and their providers will perform that function.

Five entities provide professional development required by TEA for online teaching. ESCs in Region 4 and 10, as well as the Harris County Department of Education, Texas A&M University Center for Distance Education, and the Education Development Center (EDC), a non-profit organization, offer this training. For example, ESC Region 4 conducts a five-week training for $500.

ESC Region 4 is also responsible for coordinating the review of proposed online courses. Online course providers submit proposed courses to Region 4, which then reviews them for alignment with the Texas Essential Knowledge and Skills and the National Standards of Quality for Online Courses. Region 4 then transmits approved course information to Region 10 for entry into the statewide catalog. Providers can revise and re-submit courses if they are initially rejected. As of November 1, 2008, 59 courses had been approved by Region 4.

One of the TVSN's primary functions is to facilitate interaction between home school districts, their students, and the online course provider. To initiate the registration process, the home school district's on-site coordinator selects appropriate courses for students from the network's catalog. Course registrations must be approved by the home district's financial approver. The online provider receives the registration and course payment and assigns the student to a teacher who begins online instruction on a specific start date. During the semester, the on-site coordinator, typically a school counselor, monitors the student's progress and helps address any online learning problems. After the course is completed, the provider district transmits the student's grade to the home district.

TEA drafted a plan with milestones indicating progress towards development of an online network delivery by January 2009. **Figure 401** shows a network development timeline based on the agency's TVSN implementation plan.

FIGURE 400
TEXAS VIRTUAL SCHOOL NETWORK ADMINISTRATIVE ROLES AND BUDGET ALLOCATIONS, 2008–09 BIENNIUM

		BUDGET ALLOCATIONS	
ENTITY	ROLE	FISCAL YEAR 2008	FISCAL YEAR 2009
Texas Education Agency	Administering Authority Network Development and Oversight	$2,300,000 allocated to Regions 10 and 4.	
Education Service Center Region 10 (Dallas)	Central Operations Creates and maintains overall network system. Approves provider and home district contracts. Coordinates provider and receiving district interaction, course registration, performance reporting, and financial transactions.	$750,000 from the $2.3 million allocation	$1,000,000 from the $2.3 million allocation
Harris County Department of Education	Creates and manages technology infrastructure. Provides professional development enabling instructors to teach online.	Allocated a portion of Region 10's budget. Receives teacher training fee revenue.	
Education Service Center Region 4	Creates and coordinates course review process.	$250,000 from the $2.3 million allocation	$300,000 from the $2.3 million allocation
	Provides professional development enabling instructors to teach online.	Receives teacher training fee revenue.	
Education Development Center, Inc.	Provides professional development enabling instructors to teach online.	Receives teacher training fee revenue.	
Education Service Center Region 11	Provides professional development enabling instructors to teach online.	Receives teacher training fee revenue.	
Texas A&M University Center for Distance Education	Provides professional development enabling instructors to teach online.	Receives teacher training fee revenue.	
Online Course Provider	Requests course approval; contracts with Region 10; creates course catalogue, teaches students online, interacts with Region 10 and home districts. Receives course tuition fees from Region 10.	Receives tuition fees from home district via Region 10.	
Home/Receiving Districts	Designates on-site coordinator and paying agent to manage course registrations and payments. Identifies and registers appropriate courses for students; monitors their progress. Sends tuition payments to Region 10.	Sends tuition fees to online course provider via Region 10.	

Sources: Legislative Budget Board; Texas Education Agency.

FIGURE 401
TEXAS VIRTUAL SCHOOL NETWORK DEVELOPMENT TIMELINE

Establish policies and procedures. Select central operations, course review, and professional development entities. Establish a central operation system, technology infrastructure; and a process for course review and professional development. Conduct initial TVSN-related professional development sessions.	Begin network-marketing efforts. Conduct course reviews. Continue development of technology infrastructure and operating procedures. Negotiate and contract with approved provider and home districts. Coordinate student registration.	Begin grades 9–12 course delivery. Continue network development and marketing efforts so that the TVSN can also serve middle school students in school year 2009–10.
APRIL 2008–JULY 2008	**AUGUST 2008–DECEMBER 2008**	**JANUARY 2009**
According to TEA staff, these milestones have been achieved.	According to TEA staff, these milestones have or can be achieved on schedule. As of November 1, 2008, TVSN central operations is negotiating with 3 online providers, and Region 4 had approved 59 courses.	

Sources: Legislative Budget Board; Texas Education Agency.

From April 2008 to September 2008, TEA and its partner organizations focused on establishing a system that integrates key elements of the network. This effort involved selecting entities that would review proposed courses, conduct professional development, and manage the network's central operations and technology infrastructure. By June 2008, professional development organizations began training sessions, which resulted in 152 teachers gaining approval to conduct online courses. During summer 2008, TEA prepared to launch a marketing program to encourage school districts and students to participate in the TVSN.

TEA anticipates completion of course reviews and registrations in time for providing online instruction during the spring 2009 semester. To meet this goal, the agency will have to finalize agreements with online providers. As of November 1, 2008, 59 courses had been approved, and negotiations with three online providers were being conducted. The agency expects to complete this process before January 2009.

TUITION SUBSIDY FUNDING ESTIMATES

TEA's Legislative Appropriation Request includes a proposal to appropriate $18 million for the 2010–11 biennium to expand network services. The agency would continue to allocate appropriations to other entities—approximately $1.8 million to $1.9 million for central operations and $350,000–$500,000 for course reviews. Proposed tuition subsidies would provide free online courses for 7,500–10,000 students in fiscal year 2010 and for 10,000–15,000 students in fiscal year 2011.

The agency's funding request reflects its projection of future online course capacity, but not any particular policy objective. State and school districts have created online learning programs in response to course or teacher shortages and students need to retake courses for a better grade. Funding scenarios can be developed that align with specific goals related to these needs.

Figure 402 shows funding estimates associated with four policy goals. Funding levels were calculated assuming 2 percent of a particular student population will participate in the TVSN. This is the average participation rate for all online programs except Plano ISD, which had an 18 percent participation rate. The first column, which applies the participation rate to the overall high school student population, is a base of reference for the other estimates. The number of students served is multiplied by two tuition rates. As indicated previously in **Figure 399**, with one exception, all of the online providers charged $300 or less for their courses. A tuition subsidy for two semesters would cost the state about $14.9 million and $22.4 million for three semesters. Senate Bill 1788 allows online providers to charge up to $480 per semester. At that tuition rate, an appropriation of $23.9 million would cover two semesters, and $35.8 million would cover three semesters.

The first two scenarios correspond to problems encountered by school districts and students that lead to online learning participation. According to TEA data, an estimated 1,345 high school campuses lacked at least three or more Advanced Placement and specific core courses in school year 2007–08. These core courses are the math, science, English, and social studies courses included in the recommended high school graduation program. These campuses lacked at least 10,019 Advanced Placement and specific core courses. Assuming a 20:1 student-classroom ratio, 200,380 students did not have access to Advanced Placement and specific core courses on those campuses. In other words, a significant shortage of these courses affected an estimated 200,380 students. If 2 percent of the students took an online course, the cost for two semesters is approximately $2.4 million at the $300 rate and $3.8 million at the $480 rate.

Students often enroll in online courses because their campus does not have certified teachers for the courses they want. This shortage is reflected in the number of teachers assigned to courses for which they were not certified. Approximately 17,072 full-time-equivalent teachers met this definition in school year 2006–07. Using the same 20:1 ratio, an estimated 170,323 students were enrolled in those teachers' courses. The cost to provide those students a free online two semester course is $4.1 million and $6.6 million at the $300 and $480 rates, respectively.

The third scenario, credit recovery, considers the number of students who failed courses in any of the subject areas required for graduation. TEA data indicate that 872,995 students fell into this category in school year 2007–08. Applying the same factors mentioned above results in cost estimates of $10.5 million and $16.8 million to provide a $300 and $480 course for two semesters.

The TVSN has the potential to address other needs such as specific curriculum for the learning disabled or after school opportunities for at-risk youth. As the network develops, TEA may see an increasing demand for online courses from these student populations. If so, the agency could facilitate their use of online learning by asking providers to survey

them. It could identify which courses are most appropriate and suggest ways to accommodate different learning styles. Altering online learning courses in response to this information could address another goal of these programs—to make effective teaching more accessible to all students.

FIGURE 402
TEXAS VIRTUAL SCHOOL NETWORK TUITION SUBSIDY FUNDING SCENARIOS

	STATEWIDE ESTIMATE	COURSE SHORTAGE	TEACHER SHORTAGE	CREDIT RECOVERY
HIGH SCHOOL STUDENTS	1,244,387	200,380	341,443	872,995
Participation Rate	x 2%	x 2%	x 2%	x 2%
Students Served	24,888	4,008	6,829	17,460
RATE PER SEMESTER				
Provider Survey	$300	$300	$300	$300
Fall and Spring Semesters	x 2	x 2	x 2	x 2
ANNUAL COST	**$14,932,644**	**$2,404,560**	**$4,097,322**	**$10,475,940**
Fall, Spring, Summer Semesters	x 3	x 3	x 3	x 3
ANNUAL COST	**$22,398,966**	**$3,606,840**	**$6,145,983**	**$15,713,910**
Senate Bill 1788 Maximum	$480	$480	$480	$480
Fall and Spring Semesters	x 2	x 2	x 2	x 2
ANNUAL COST	**$23,892,230**	**$3,847,296**	**$6,555,715**	**$16,761,504**
Fall, Spring, Summer Semesters	x 3	x 3	x 3	x 3
ANNUAL COST	**$35,838,346**	**$5,770,944**	**$9,833,572**	**$25,142,256**

SOURCES: Legislative Budget Board; Texas Education Agency.

EFFECTIVENESS OF THE SELF-ASSESSMENT SURVEY FOR TECHNOLOGY PLANNING IN PUBLIC SCHOOLS

Technology planning in Texas public school districts is critical for providing students with adequate technology and computer skills. To address this need, the Texas Education Agency developed a self-assessment survey for technology that school districts submit annually to the agency. Districts can use the survey to help campuses and teachers identify technology needs, measure their progress, and plan for bringing any needed technology into their schools.

Recent technology reviews of three districts and a survey of additional districts found that districts are not consistently using the survey for technology planning. By not using this resource to its full capabilities, districts may be limiting their ability to provide students a technology-rich education.

FACTS AND FINDINGS

- Many districts are not using the self-assessment survey for technology to identify technology needs on their campuses or to plan the implementation of technology in their districts.
- The self-assessment survey for technology includes statements that may be too vague, broad, or subjective to provide precise responses.
- Once campuses complete the self-assessment survey for technology, there may be little or no feedback from district administration on their performance on the survey.

DISCUSSION

Texas Education Code, Section 32.001, requires the State Board of Education to develop a long-range plan for technology and further requires that biennial reports be completed and provided to the Governor and Legislature on the progress toward implementation of this plan. The original plan, the Long-Range Plan for Technology, 1988–2000, was implemented in 1988.

Since the state implemented the first plan, changes in technology and changes in legislation have required updates to the plan. In 1996, the State Board of Education implemented the Long-Range Plan for Technology, 1996–2010, and enactment of the federal No Child Left Behind Act of 2001 led to the 2002 Update to the Long-Range Plan for Technology, 1996–2010. The latest update to the plan, the Long-Range Plan for Technology, 2006–2020, was completed in 2006.

School districts develop technology plans to assess and evaluate their current technology, determine areas of need, set goals, objectives and strategies to meet those needs, and to estimate the cost of achieving objectives. Technology plans also include the required components of Title II, Part D of the No Child Left Behind Act and correlate strategies with the Texas Long-Range Plan for Technology, 2006–2020.

To aid school districts in developing these technology plans, the Texas Education Agency (TEA) introduced the e-Plan system to help with the submission of technology plans for all school districts. This plan is a template-based system that ensures technology plans satisfy both federal and state requirements for technology.

As a component of the technology plan submission, school districts annually complete an online self-assessment survey for technology (School Technology and Readiness or STaR Chart) for each of their campuses. TEA developed the STaR Chart to help districts rate their campuses in the four key areas of Teaching and Learning; Educator Preparation and Development; Leadership, Administration, and Instructional Support; and Infrastructure for Technology at one of four levels of progress: Early Tech, Developing Tech, Advanced Tech, or Target Tech.

Districts submit their technology plan to TEA, which includes their STaR Chart, to be eligible to request E-Rate funding. E-Rate funding is a discount that districts receive through the federal Universal Service Fund, which provides funds for purchasing telecommunications equipment. Regional Education Service Centers provide training for districts at different times during the summer on the e-Plan and STaR Chart process.

Figure 403 shows that most districts follow similar methods to complete the STaR Chart. Teachers receive training and have a specified deadline for completing the STaR Chart. Teachers' responses are checked by district administration to ensure they finish the survey, and district administration has a role in monitoring the STaR Chart process for compliance in completing the survey.

FIGURE 403
SURVEY RESPONSES: STaR CHART COMPLETION PROCESS, MAY 2008

PROCEDURE	DISTRICTS USING THIS PROCEDURE
Teachers receive training on filling out the survey.	64.5%
Teachers complete online STaR Chart survey by a specified deadline.	91.2%
Teacher responses are monitored to ensure that all teachers complete the survey as required.	65.4%
District administration monitors STaR Chart process to ensure compliance.	82.0%

Source: Legislative Budget Board.

Legislative Budget Board (LBB) staff and a consulting firm (SDSM, Inc.) conducted technology reviews in Moody Independent School District (ISD), Sealy ISD, and Lufkin ISD to learn more about technology planning and STaR Chart usage in school districts. Moody is a small district of approximately 800 students with three campuses in McClennan County; Sealy has about 2,600 students on four main campuses in Austin County; and Lufkin is in Angelina County and has approximately 8,600 students on 14 campuses. All three districts rated themselves on the STaR Chart in earlier stages of technology development.

LBB staff and SDSM, Inc., also distributed technology surveys to 491 school districts and received approximately 237 responses, which represents about 23 percent of all school districts in Texas.

STaR CHART AS A PLANNING TOOL

The STaR Chart provides districts with information on many aspects of technology in schools, including classroom use, staff professional development, equipment and infrastructure, and budgeting and administrative support. Some survey comments about the STaR Chart included the following:

- works just fine;
- helps district pay attention to technology;
- is a very helpful tool and a reasonably convenient process; and
- appears to be satisfactory at this time.

However, there is concern whether the districts are using the STaR Chart information effectively. **Figure 404** shows school district survey responses to the question: "Overall, how helpful is the STaR Chart to your district's technology efforts?" Districts' responses were divided, with 52.6 percent believing the STaR Chart was helpful or very helpful, while 47.4 percent indicated it was not helpful or only somewhat helpful.

FIGURE 404
SURVEY RESPONSES: STaR CHART AS A HELPFUL TOOL TO DISTRICT'S TECHNOLOGY EFFORTS, MAY 2008

RESPONSE	PERCENTAGE OF DISTRICTS
Not helpful	5.7%
Somewhat helpful	41.7%
Helpful	42.1%
Very helpful	10.5%

Source: Legislative Budget Board.

In districts where the STaR Chart was viewed as being very helpful, staff identified the STaR Chart as a tool that was used in the planning process. Comments included the following:

- is a good resource;
- used when updating technology plan every year;
- provides a good benchmarking tool;
- helps with identifying teacher proficiencies for staff development;
- identifies areas that need targeting;
- helps in comparing campuses; and
- used in planning with technology committee.

In reviewing the survey information about actual school district use of the STaR Chart, 76.8 percent of districts surveyed reported it was used consistently to obtain E-Rate or grant funding. As for a planning document, over 57 percent of the respondents said it consistently served as a planning foundation for the district's long-range technology plan, while almost 43 percent of districts felt it was only somewhat used or not used at all for this function. The majority of districts (62.3 percent) said it was only somewhat used in developing specific strategies in the Campus Improvement Plans or District Improvement Plan, two key documents that districts use for planning.

Regarding their use of information compiled during the STaR Chart process, staff in each of the three school districts visited indicated that the primary use of the STaR Chart was to qualify for E-Rate funding and to meet the state and federal requirements. Staff indicated that the process did not provide much useful information that district technology

staff or campus principals could use. Administrative staff in one district stated that only high school teachers used the information for grant proposals.

STaR CHART STATEMENTS

The STaR Chart contains statements in various Focus Areas, and school district staff are asked to identify the statements that most closely resemble their current situation. **Figure 405** displays a portion of the STaR Chart showing three of the six Focus Areas under the Key Area of Teaching and Learning and the corresponding statements for a rating of Developing Tech—one of the four choices for Level of Progress.

The three districts where the LBB conducted technology reviews cited the subjectivity of some statements in the STaR Charts as a significant problem for both completing the STaR Charts and interpreting the results. Technology staff in the first district stated that the process was ineffective because the assessment statements are too broad and subjective. Teachers were not clear how to complete the assessments. Staff stated that the process could be effective if more objective terms were used. Principals indicated some of the same concerns—the process was not effective, performed only because it was required, and that some descriptors were not clear. These principals indicated that they did not clearly understand how they should use the survey.

Staff in the second district said that there was not a clear understanding of the assessment terms in the STaR Chart. Principals indicated that the responses might skew the report because "teachers don't take it very seriously." It was "just another thing they have to do." Principals stated that teachers lacked an understanding of what they are being asked to measure. Teachers indicated that the survey was too broad and would be more informative if it was organized by subject matter or grade level. Teachers in a focus group in the third district indicated that they were not sure about how to respond to some of the assessment statements in the STaR Chart.

Some comments from the survey said that the STaR Chart was fine as it was and needed no changes. Other survey respondents mentioned the subjectivity of the statements in the STaR Chart as a significant problem for both completing and interpreting the results. Comments included the STaR Chart survey statements being too vague, broad, or subjective to provide accurate responses. Some respondents felt that the STaR Chart language was not as clear as needed. Respondents also provided the following additional comments:

- more specific questions needed;
- too broad to give useful information;
- questions need to be in plain English;
- reduce complexity of available answers;
- infrastructure questions are difficult for teachers to answer;
- more use of layman terms; and
- make it more task-oriented so that it could be used as a planning tool to meet goals.

STaR CHART FEEDBACK

The completed STaR Charts are available in three types of reports on TEA's website. These reports provide information for individual campuses and districts, and state summaries.

The Statewide Summary Data report provides a statewide campus average of Level of Progress (Early, Developing, Advanced, or Target Tech) in each of the four Focus Areas

FIGURE 405
STaR CHART KEY AREA: TEACHING AND LEARNING, 2008

LEVELS OF PROGRESS	PATTERNS OF CLASSROOM USE	FREQUENCY/DESIGN OF INSTRUCTIONAL SETTING USING DIGITAL CONTENT	CONTENT AREA CONNECTIONS
Developing Tech	Teachers primarily use technology to direct instruction, improve productivity, model technology skills, and direct students in the use of productivity applications for technology integration. Students use technology to access, communicate and present information.	Most teachers have regular weekly access and use of technology and digital resources for curriculum activities in the classroom, library, or lab.	Most teachers use technology to support content objectives.

SOURCE: Texas Education Agency.

(Teaching and Learning; Educator Preparation and Development; Leadership, Administration, and Instructional Support; and Infrastructure for Technology) for school years 2002–03 to 2007–08. The Campus Data Search report provides similar information on the STaR Chart by campus or district. It also has an advanced search that allows users to search by grade level, proficiency in Level of Progress, and other criteria.

The LBB survey also provided some comments from school districts about the STaR Chart reporting features including the following:

- need better reporting capabilities;
- provide feedback with analysis as a possible improvement; and
- allow more ways reports can be generated utilizing different criteria.

Teachers may not be receiving much feedback from their administration on the STaR Chart survey results for their campuses. Staff in all three school districts that received technology reviews said that they did not receive any feedback on the STaR Charts, which they saw as a barrier in using the survey.

ENHANCE AND STRENGTHEN SAFETY IN SCHOOL DISTRICTS

When addressing safety challenges in school districts, the role that federal, state, and local agencies play in providing the necessary assistance is important. The Texas School Safety Center and the Texas Education Agency–Division of Health and Safety are responsible for addressing safety in public schools and independent school districts.

Texas public schools and school districts are required to have emergency operation plans in place and submit security audits to the Texas School Safety Center. However, state statute does not clearly define what constitutes a complete and accurate report, or identify which officials should be responsible for emergency operation plans and security audits. Despite the requirement for these reports, the overall status of school safety of each school district is unknown. Another challenge is that school safety consultants are not required to register or present their background, education, experience, and/or credentials.

Requiring school districts to submit a statewide school safety progress report following the submission of the statutorily required Security Audits submitted every three years, including the creation of a school safety planning committee at each school, would provide assistance in measuring and monitoring school districts' current status and progress in meeting strategic goals and planning for school safety on a more complete and accurate basis. In requiring school safety consultants to register, the Texas School Safety Center will have additional information about the consultants' experience with school districts. Finally, documenting the existence of and improving memoranda of understanding and mutual aid agreements between districts and local and regional authorities would clarify the financial and communication efforts defined for each party.

CONCERNS

- There are no state criteria or guidelines that exist regarding the use of emergency operation plans, security audits, or other required reports in measuring or monitoring a school district's status and progress in meeting strategic goals, planning, or objectives for school safety. Consequently, no assessment is made regarding school districts' progress in addressing school safety concerns.
- State statute does not specify the development of criteria or guidelines to assist in identifying or designating the official(s) responsible for drafting, developing, and updating emergency operation plans at each school, and for providing the required information to the school district for the submission of security audits and other required reports. Without required schoolwide and community input, the emergency operation plans, security audits, and other required reports can be inaccurate, or incomplete; the comprehensive needs and resources of the school may not be addressed.
- School safety consultants provide security assessments, security audits, and other similar services with no oversight by the state. The consultants are not required to register or present their background, education, experience, and/or credentials as bona fide agents equipped with the necessary skills and expertise to provide services to schools and school districts. Without this registration, the state lacks information about the consultants' direct experience in working with school districts.
- Despite school districts being encouraged by eight state and local independent agencies to pursue memoranda of understanding or mutual aid agreements with local and regional authorities, including emergency first responders, it is not known which school districts have agreements in place, or with whom they have such agreements. Without such agreements, the financial interests and investments of the school districts would not be protected, and the coordinated efforts and lines of communication between all parties involved would not be enhanced.

RECOMMENDATIONS

- **Recommendation 1:** Amend Texas Education Code, Section 37.202(1), to require the Texas School Safety Center to establish and develop the criteria and guidelines for a statewide school safety progress report, which would provide the current school safety status of every school district in the state.
- **Recommendation 2:** Amend Texas Education Code, Section 37.108(a)(b), to require the Texas School

Safety Center to establish the criteria and guidelines for formation of a school safety planning committee at each campus within a school district with the responsibility of drafting, developing, and updating an emergency operations plan for each school.

- **Recommendation 3:** Amend Texas Education Code, Section 37.202, to require that the Texas School Safety Center serve as the central registration site for all school safety consultants that provide services to school districts. School safety consultants should provide their background, education, experience and credentials, and register with the Texas School Safety Center.
- **Recommendation 4:** Amend Texas Education Code, Section 37.212, to require the Texas School Safety Center to establish and develop the criteria and minimum guidelines required for school districts to enter into memoranda of understanding and mutual aid agreements regarding school safety with other local and regional authorities, including emergency first responders.

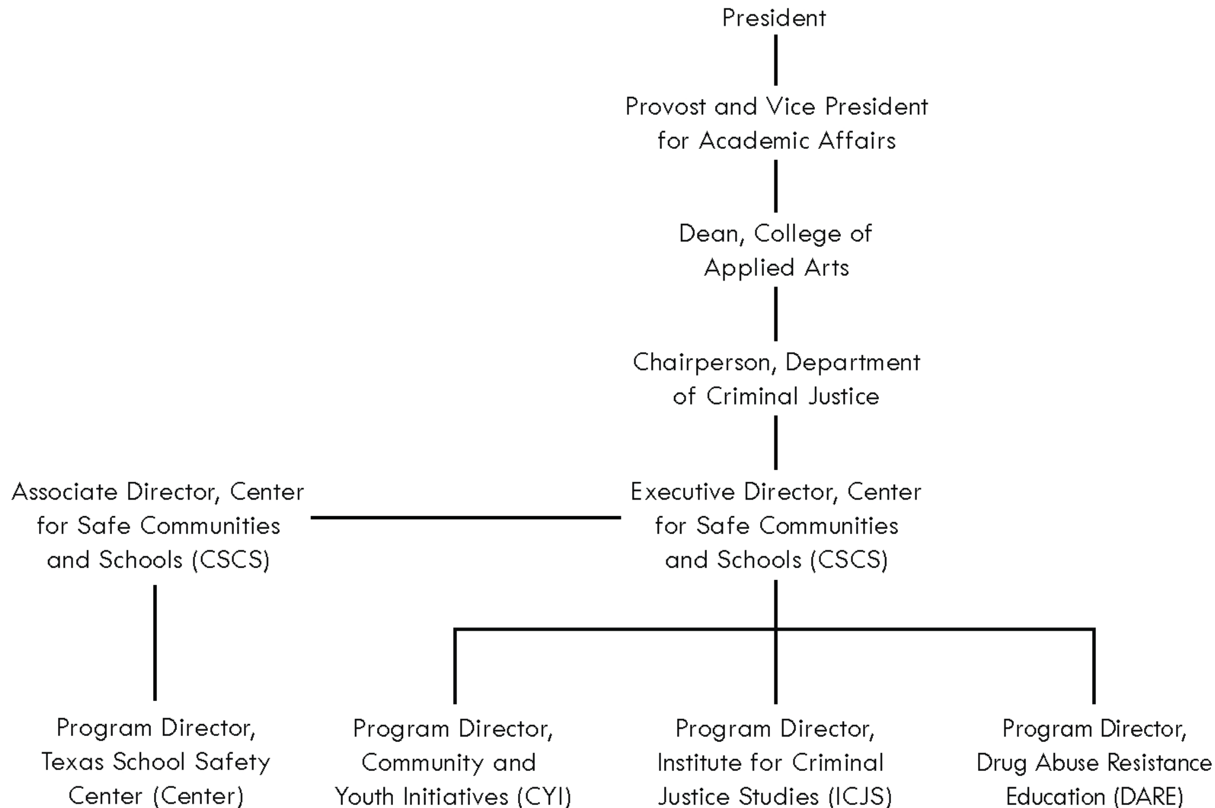
DISCUSSION

The Texas School Safety Center was established in 1999 by the Governor through a grant from the Governor's Office, and was housed in the Center for Initiatives in Education within the Department of Education at Southwest Texas State University. In June 2004, the center was relocated to the Center for Safe Communities and Schools (CSCS) where it has remained as an integral component of the CSCS within the Department of Criminal Justice at Texas State University – San Marcos. The organizational location of the Texas School Safety Center within the university structure is shown in **Figure 406**.

The Seventy-seventh Legislature, 2001, enacted legislation establishing the Texas School Safety Center. The center has two primary responsibilities:

- to serve as a central location for school safety information, including research, training, and

FIGURE 406
ORGANIZATIONAL CHART
THE TEXAS SCHOOL SAFETY CENTER AT TEXAS STATE UNIVERSITY – SAN MARCOS



SOURCE: Center for Safe Communities and Schools at Texas State University – San Marcos.

technical assistance related to successful school safety programs; and

- to serve as a resource for the prevention of youth violence and the promotion of safety in the state.

The Texas School Safety Center is charged with conducting safety training that includes: development of a positive school environment and proactive safety measures to address local concerns, school safety courses for law enforcement officials, and security criteria for instructional facilities. The center also collects school safety data for the state and provides a report to the public.

The Seventy-ninth Legislature, 2005, amended the Texas Education Code, Section 37.108, to require that each school district adopt a multi-hazard emergency operations plan (EOP) no later than March 1, 2006. Furthermore, all school districts are required to undergo a first round of Security Audits by September 1, 2008, with security audits being conducted at least once every three years using security audit procedures developed by the center or a comparable public/private entity. The results of the audits must be reported to the center.

The Texas School Safety Center's board of directors, as shown in **Figure 407**, is composed of 15 members. Statutory responsibilities of the board include annually submitting a report to the Governor, the Legislature, the State Board of Education (SBOE), and the Texas Education Agency (TEA). The annual report must include any findings made by the center regarding school safety and the center's functions, budget information, and strategic planning initiatives.

Since 1999, the Texas School Safety Center has carried out its directive solely with grants received from the Criminal Justice Division (CJD) from fiscal years 2000 to 2005. Grants to fund center programs continued from CJD for fiscal years 2006 and 2007 with additional grants from TEA and the Governor's Division of Emergency Management (GDEM) during fiscal year 2006, and from TEA during fiscal year 2007. The Eightieth Legislature, 2007, appropriated $3 million for the 2008–09 biennium with unexpended balance authority for fiscal year 2009. **Figure 408** shows a history of funding for the center.

SCHOOL SAFETY PROGRESS REPORT

The Texas School Safety Center has the statutory responsibility of serving as the central location for school safety information, which includes research on successful school safety programs. Section 37.216 of the Texas Education Code requires the center to submit findings regarding school safety and the center's functions, budget information, and strategic planning initiatives to the Governor, the Legislature, the

FIGURE 407
TEXAS SCHOOL SAFETY CENTER – BOARD OF DIRECTORS MEMBERSHIP

MEMBER	ALTERNATE
Attorney General	Attorney General's designee
Education Commissioner	Commissioner's designee
Executive Director of the Texas Juvenile Probation Commission	Executive Director's designee
Executive Director of the Texas Youth Commission	Executive Director's designee
The Commissioner of the Department of State Health Services	Commissioner's designee
Commissioner of Higher Education	Commissioner's designee

The following members appointed by the Governor with the advice and consent of the Senate:

- A juvenile court judge;
- A member of a school district's board of trustees;
- An administrator of a public primary school;
- An administrator of a public secondary school;
- A member of the state parent-teacher association;
- A teacher from a public primary or secondary school;
- A public school superintendent who is a member of the Texas Association of School Administrators;
- A school district police officer or a peace officer whose primary duty consists of working in a public school; and
- Two members of the public.

Source: Legislative Budget Board.

FIGURE 408
TEXAS SCHOOL SAFETY CENTER BUDGET HISTORY, TEXAS STATE UNIVERSITY – SAN MARCOS, FISCAL YEARS 2000 TO 2008

FISCAL YEAR	GOVERNOR'S OFFICE, CRIMINAL JUSTICE DIVISION	GOVERNOR'S DIVISION OF EMERGENCY MANAGEMENT, TEXAS DEPARTMENT OF HOMELAND SECURITY	TEXAS EDUCATION AGENCY	2008–09 GENERAL APPROPRIATIONS ACT, STRATEGY C.1.4, SCHOOL SAFETY CENTER, TEXAS STATE UNIVERSITY – SAN MARCOS	TOTAL
2000	$500,497	$0	$0	$0	$500,497
2001	$508,139	$0	$0	$0	508,139
2002	$500,000	$0	$0	$0	500,000
2003	$560,000	$0	$0	$0	560,000
2004	$560,000	$0	$0	$0	560,000
2005	$459,219	$0	$0	$0	459,219
2006	$460,000	$600,000	$100,000	$0	1,160,000
2007	$460,000	$0	$356,042	$0	816,042
2008	$0	$0	$350,000	$1,500,000	1,850,000
TOTAL AMOUNT FOR FISCAL YEARS 2000–08					**$6,913,897**

SOURCE: Texas State University - San Marcos.

State Board of Education (SBOE), and TEA on an annual basis. However, the safety status of school districts is not assessed, nor is progress toward addressing school safety concerns identified in emergency operation plans (EOPs), security audits, and other reports. This is due to lack of guidelines regarding the use of EOPs, and security audits. As a result, the lack of a progress report with criteria and/or guidelines measuring progress or the lack of progress fails to bring to the forefront the importance of schools and school districts meeting strategic goals, planning, and/or objectives for school safety.

Recommendation 1 would amend Section 37.202(1) of the Texas Education Code assigning responsibility to the Texas School Safety Center with the authority to develop the criteria for a statewide school safety progress report, which should provide an updated, current school safety status of every school district in the state based on their EOPs, submitted Security Audits, and other required reports. The submission frequency of a statewide school safety progress report to the Governor, the Legislature, the SBOE, and TEA should follow the submission of the statutorily required Security Audits submitted every three years.

NEED FOR COMPLETE AND ACCURATE REPORTING

Schools and school districts are required by Section 37.108(a)(b) of the Texas Education Code to have an EOP in place and to submit Security Audits addressing mitigation, preparedness, response, and recovery as defined by the commissioner in conjunction with the Governor's Office of Homeland Security. Nonetheless, officials at the Texas School Safety Center confirmed that there are no established criteria for what constitutes a complete, accurate report. Officials at the center and at a Regional Education Service Center commented that there are EOPs that do not address hazards that are particular to the needs and resources of the campus or school district. Examples include campuses and school districts along the Texas coast not including hurricane evacuation plans in their emergency planning, but having hurricane plans appear in EOPs in districts located in the Texas panhandle. Other oddities have included maps of the school not matching the floor plans of the school generating the report. These inconsistencies suggest the possibility of template(s) being passed along between schools and school districts throughout the state where the only difference between the plans in place is the name and address of the school(s) and school district(s) involved. The inaccuracy and incomplete status of reports to the Texas School Safety Center lead to question the accuracy of the annual report submitted.

In addition, despite emphasis on parental involvement in schools, there is no group at each school required to oversee schoolwide safety issues. There are no guidelines to assist in identifying or designating the official(s) responsible for drafting, developing, and updating EOPs. Interviews with officials at the Texas School Safety Center, and with campus and school district administrators at the Annual School

Safety Summit, suggest that some schools rely on the efforts of a single school administrator or teacher to develop the EOP. Other schools may obtain assistance from a law enforcement official in the community. While their efforts should be applauded, the liability is too great for one individual to be left with the responsibility of assuring the safety of every administrator, teacher, staff, and student at each school given the many factors, situations, and scenarios that must be considered in such a crisis.

Recognizing the importance of school community input on safety issues, California requires a schoolsite council or a school safety planning committee at each school with the responsibility of writing and developing a comprehensive school safety plan relevant to the needs and resources of that particular school. The schoolsite council or school safety planning committee is composed of: the principal or his/her designee; a teacher or teachers; other school personnel, such as a custodian; a parent or parents of pupils attending the school; and in secondary schools, pupils attending the school and other members if desired. Furthermore, the schoolsite council is required to consult with a representative from a law enforcement agency in the writing and development of the comprehensive school safety plan. Regardless of whether it is the schoolsite council or the school safety planning committee writing and developing the comprehensive school safety plan, California recognizes the importance in seeking input from various members of the community. School safety is an issue requiring not only the attention of first responders in a community, but the entire school community.

Recommendation 2 would amend Section 37.108(a)(b) of the Texas Education Code requiring the Texas School Safety Center to establish the criteria and guidelines for formation of a school safety planning committee at each campus within a school district. This committee would be responsible for drafting, developing, and updating an emergency operations plan and for providing the required information to the school district for the submission of security audits and other required reports by each school district to the center. Each report should be reviewed for accuracy and completeness using criteria and guidelines established by the center relevant to the needs and resources of that particular school. Furthermore, the end result would be a heightened awareness of safety conditions at each school, with coordination and communication between school administrators, staff, teachers, parents, students, and first responders being brought to a higher level. Finally, adoption of this recommendation would allow for greater accuracy of the reports being submitted by the Texas School Safety Center to the Governor, the Legislature, the SBOE, and TEA.

SCHOOL SAFETY CONSULTANTS

To assist school districts in maintaining safe schools, the Texas School Safety Center developed the campus safety and security audit toolkit. The kit contains recommendations and instructions for conducting the audit, including a comprehensive campus safety and security audit tool. This tool includes an intruder assessment, as well as the following three optional survey instruments: (1) a staff climate survey, (2) a parent survey and (3) a student climate survey. The school safety audit checklist addresses the following areas:

- safety and security of site and building exterior;
- access control;
- safety and security of building interior;
- type and extent of monitoring and surveillance;
- communication and information security;
- development of emergency operations plans; and
- school climate and culture (including development and enforcement of policies).

School districts are obtaining specialized assistance in completing EOPs and security audits from school safety consultants. While there are no laws currently licensing and/or regulating school safety consultants, these individuals are encouraged by the U.S. Department of Homeland Security (DHS) and the GDEM at the Texas Department of Homeland Security (TxDHS) to seek both Incident Command System (ICS) and National Incident Management System (NIMS) certification. According to DHS officials, NIMS was developed so responders from different jurisdictions and disciplines can work together to respond better to natural disasters and emergencies, including acts of terrorism at the local level requiring the assistance of state and/or federal authorities. The benefits of NIMS certification include a unified approach to incident management; standard command and management structures; and emphasis on preparedness, mutual aid, and resource management. Coursework to obtain NIMS and ICS certification is offered by agencies such as the center, GDEM, the Central Texas School Safety Consortium, the Council of Area Governments, and the Harris County Department of Education–the Center for Safe and Secure Schools (HCDE–CSSS).

The number of school safety consultants operating within the boundaries of the state is unknown given that the field is relatively new and no individualized category for who is entering and/or leaving the career currently exists. What is known is that any school and/or school district may call upon a school safety consultant, including from out-of-state, for assistance in having EOPs in place, submitting Security Audits, and other required reports. According to officials from the Central Texas School Safety Consortium and Regional Education Service Center XVIII (Region 18), services provided by these school safety consultants mainly come from retired and/or former federal, state, county, and/or local law enforcement officials from across the country. Agencies, such as the Central Texas School Safety Consortium and Region 18, are concerned about the type and quality of services provided by these consultants. Since neither the identity nor the number of school safety consultants operating in Texas is known, information developed and provided by the Texas School Safety Center in the form of a campus safety and security audit toolkit may or may not be reaching school safety consultant officials operating in the state.

Recommendation 3 would amend Section 37.202 of the Texas Education Code requiring that the Texas School Safety Center serve as the central registration site for all school safety consultants operating within the boundaries of the state. School safety consultants should provide their credentials and register with the center as bona fide agents equipped with the necessary skills and expertise to provide the service(s) they are being requested to render by schools and/or school districts. The recommendation will serve a twofold purpose: (1) it will help record and keep track of the number of school safety consultants operating within the state; and (2) it will provide the center the opportunity to encourage these school safety consultants to seek ICS and NIMS certification, as recommended. The Texas School Safety Center's findings would be made part of the annual report submitted to the Governor, the Legislature, the SBOE, and TEA.

COOPERATION WITH LOCAL AND REGIONAL AUTHORITIES

Recognizing the vulnerability of school communities to damage, injury, and loss of life and property resulting from disasters and civil emergencies, Section 37.212 of the Texas Education Code grants the Texas School Safety Center the authority to address discipline and safety issues in the state. The center also promotes cooperation between state agencies, institutions of higher education, and any local juvenile delinquency prevention council. Providing mutual aid in the form of personnel, supplies, and equipment during disasters and civil emergencies as well as during cleanup periods is critical to any coordinated effort if conducted in a timely manner.

According to interviews with officials at the Texas School Safety Center, it actively encourages all school districts to promote memoranda of understanding (MOUs) or mutual aid agreements (MAAs) with local and regional authorities. The pursuit of MOUs and MAAs by school districts is also a concept encouraged by officials at the TxDHS, the GDEM, TEA, Region 18–ESC, the Central Texas School Safety Consortium, Texas Association of Regional Councils, the Department of State Health Services (DSHS) Division for Prevention and Preparedness Services, and HCDE–CSSS. Officials from HCDE–CSSS advised that reimbursement of school districts by the federal government for aid provided to other agencies in the event of a disaster or civil emergency requires that MOUs and/or MAAs be in place. Despite the promotion and encouragement from all these agencies for school districts to pursue these agreements with local and regional authorities, the lack of criteria and guidelines for school districts to enter into MOUs and MAAs makes it difficult to determine which school districts have agreements in place or with whom they have such agreements.

Recommendation 4 would amend Section 37.212 of the Texas Education Code requiring that the Texas School Safety Center establish and develop the criteria and minimum guidelines required for school districts to enter into MOUs or MAAs regarding school safety with other local and regional authorities, including emergency first responders. The establishment of criteria and guidelines will make it possible for the center to monitor the development of these important agreements and to provide accurate information to policymakers. The recommendation would provide the school district with the required information as to what should be included in the agreements and with whom the school districts should be signing an agreement. Moreover, the financial interests and investments of the school districts will be protected if and when an application for reimbursement is submitted to the federal government. MOUs and/or MAAs will enhance any coordinated effort and increase the lines of communication between all parties involved.

FISCAL IMPACT OF THE RECOMMENDATIONS

The proposed recommendations may result in increased costs involving computer software and staff time for creating and

maintaining a central registration site for school safety consultants; and for the establishment and development of criteria and guidelines for a statewide school safety progress report, for school safety planning committees, and for memoranda of understanding.

The Texas School Safety Center would be expected to absorb the additional costs with existing appropriations.

None of the recommendations are reflected in the introduced 2010–11 General Appropriations Bill.

IMPROVE STATE OVERSIGHT AND SUPPORT OF SCHOOL DISTRICT CURRICULUM MANAGEMENT SYSTEMS

Public school districts in Texas use various instructional tools to bridge the gap between the state's required learning standards and the state's mandatory assessment exam used to measure student performance on the required standards. Because the state's learning standards are broad and repeated across grade levels, they require interpretation by school districts, a process that districts engage in on a continual basis. This interpretation results in different implementations of the learning standards across the state. Although recent curriculum management reviews of 10 Texas school districts found that many school districts develop and/or purchase curriculum management systems to implement the standards, there is no state oversight and some districts cannot afford this expense. Without state oversight and a system configured to categorize curriculum-related expenditures, it is impossible to estimate the funds necessary to support curriculum management systems or curriculum development at the state-level.

Texas can address the gap between the required learning standards and the mandatory assessment exam by amending state statute, appropriating additional funds to the Texas Education Agency, and improving the oversight of related expenditures.

CONCERNS

- Texas' required learning standards lack content specificity. These broad learning standards lead school districts to design and/or purchase curriculum management systems in order to further clarify the state's learning standards and meet local needs. This ambiguity results in inconsistent implementation of the learning standards across the state.
- School districts do not receive assistance or information related to the multiple curriculum management systems used and developed throughout the state.
- Smaller and mid-sized school districts are more limited in choice and options in regards to designing and/or purchasing curriculum management systems. These districts may not have the budget, staffing, or infrastructure to support internal development of a curriculum management system and curricula or funds to purchase externally developed systems and curricula.
- The amount of expenditures by districts for curriculum-related efforts is undeterminable because curriculum-related expenditure data may be categorized under various instruction-related categories in Texas Education Agency's information management system. Therefore, estimating the funds necessary to support curriculum management systems or curriculum development at the state-level is difficult.

RECOMMENDATIONS

- **Recommendation 1:** Amend the Texas Education Code, Section 7.021(b), to require that the Texas Education Agency include clarifiers, such as exemplar activities and qualifying statements, which provide specificity to the foundation and enrichment curriculum established by the State Board of Education as directed by the Texas Education Code, Section 7.102(c).
- **Recommendation 2:** Amend the Texas Education Code, Section 7.021(b), to require that the Texas Education Agency evaluate and develop a list of curriculum management systems that conform to the state's required learning standards (Texas Essential Knowledge and Skills) for use by districts.
- **Recommendation 3:** Include a contingency rider in the 2010–11 General Appropriations Bill that appropriates $408,000 in General Revenue Funds to the Texas Education Agency for evaluating and developing a list of curriculum management systems that conform to the Texas Essential Knowledge and Skills for use by districts.
- **Recommendation 4:** Appropriate $2.5 million in General Revenue Funds to the Texas Education Agency and include a rider in the 2010–11 General Appropriations Bill directing the agency to use $2.5 million for the purpose of issuing competitive grants to assist school districts with implementing curriculum management systems.

- **Recommendation 5:** The Texas Education Agency should consider identifying the costs associated with curriculum management systems and determining a method to collect financial data which reflects curriculum costs when rewriting its information management system.

DISCUSSION

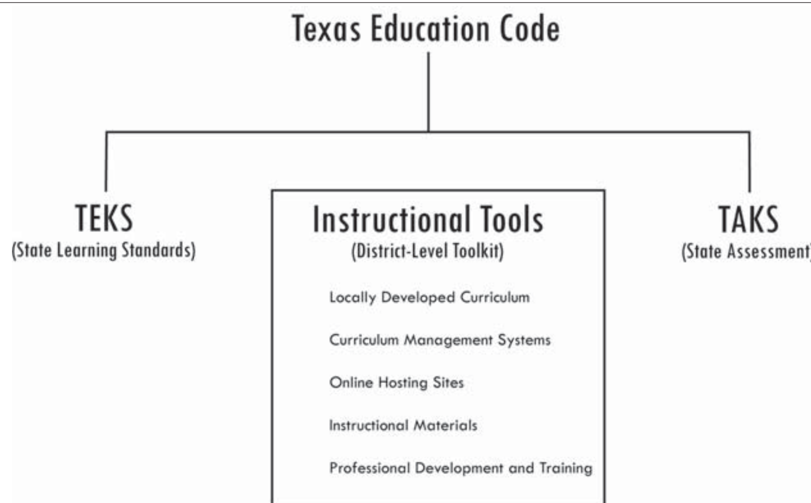
Through the authority of the State Board of Education (SBOE) and the Texas Education Agency (TEA), the state of Texas provides school districts with the Texas Essential Knowledge and Skills (TEKS), the state's required learning standards. The curriculum standards are subdivided into Foundation and Enrichment curriculum. As defined by the Texas Education Code, Section 28.002, foundation curriculum subjects include English language arts (ELA), mathematics, science, and social studies. Enrichment curriculum subjects include areas such as health, physical education, fine arts, and economics. The TEKS provide the framework for the Texas Assessment of Knowledge and Skills (TAKS), the state mandatory assessment exam used to measure student performance on the required standards.

According to TEA, a thorough understanding of the TEKS is essential for student success in the classroom and on the state assessment. The TAKS are administered in reading, math, writing, science, social studies, and English language arts (ELA) in Grades 3 to 11 at different intervals throughout the year. The TAKS are not inclusive of all TEKS content strands or TEKS objectives within the tested strands. Moreover, the test administration schedule is dependent upon the grade level and subject being tested. For instance, during the 2007–08 school year, students in Grade 5 were tested in reading, math, and science in March, April, and May respectively, while students in Grade 4 were tested in reading, math, and writing in April and February. Given that not all TEKS standards are included on the TAKS, one-to-one alignment between the standards and the assessment does not exist. Thus, school districts are responsible for bridging the gap between the state's established learning standards and the required assessment.

School districts use a variety of instructional tools in order to bridge this gap, as shown in **Figure 409**. Instructional tools may include, but are not limited to: textbooks, instructional materials, locally developed curriculum, professional development and training, and curriculum management systems. These materials have been developed and are offered by TEA, Regional Education Service Centers (RESCs), and private vendors.

A district's instructional toolkit is often contingent on the size, wealth, resources, and leadership of the district. Primarily, the instructional materials districts use are not prescribed by the Texas Education Code with the exception of textbooks, which are the only instructional tool guaranteed to districts by SBOE and TEA. The Texas Constitution, Article VII, Section 3, requires SBOE to set aside sufficient money to provide free textbooks for all students attending public schools in the state. While school districts are guaranteed textbooks, other instructional tools are dependent

FIGURE 409
BRIDGING THE GAP BETWEEN THE TEXAS ESSENTIAL KNOWLEDGE AND SKILLS AND THE TEXAS ASSESSMENT OF KNOWLEDGE AND SKILLS, SCHOOL YEAR 2007–08



Source: Legislative Budget Board.

on a district's ability to purchase and/or design materials, programs, and training to fit their needs. Therefore, districts across the state use a variety of instructional tools to teach the TEKS and master the TAKS.

CURRICULUM MANAGEMENT SYSTEMS

Legislative Budget Board (LBB) staff, in conjunction with Resources for Learning, Inc. (RFL) personnel, conducted a targeted review of 10 Texas school districts to gain a broad perspective about curriculum and curriculum management systems implemented across the state. In addition to onsite work in districts, the nine RESCs in which these districts reside were visited by LBB staff to gather additional information about their roles in curriculum development with their area districts. The remaining 11 RESCs were also surveyed to garner similar information.

Figure 410 shows information for the 10 school districts selected for review by LBB. Consideration for school district selection was based on student enrollment, student performance, RESC affiliation, location, and level of curriculum implementation. For purposes of this report, curriculum types include the following categories:

- internally developed by districts; and
- externally developed by RESCs and private vendors.

In reference to the types of curriculum used by the districts, the five largest districts included in this review, which include Katy, Plano, Hurst-Euless-Bedford, Alvin, and Bryan, have been engaged in long-term, comprehensive local curriculum development efforts over the last decade. In addition, four of the five districts have more recently moved to automated curriculum management systems that were either purchased or developed internally. Alvin ISD is now piloting a system with plans for full implementation in the 2009–10 school year. Of the remaining districts, Schertz-Cibolo-Universal City and Diboll chose to buy externally developed curriculum management system packages in which curriculum content was already developed and embedded in a management system after attempting to write curriculum locally in previous years. The remaining three districts, which include Harlandale, Port Neches-Groves, and Hamilton, recently initiated efforts to enhance local curriculum development. Harlandale and Port Neches-Groves had either purchased or were looking at automated systems, while Hamilton is using curriculum materials developed through their involvement in a curriculum cooperative.

Figure 411 shows that across all TAKS tests and grades tested, most of the districts in the targeted review performed above the state average in school years 2002–03 to 2006–07. The districts generally show a trend of increasing student performance over the period. In addition, the eight districts with either internally developed or externally developed curriculum management systems generally performed above the state average across all core subject areas and made improvements across student group performance. While improvements in student performance across the districts in the targeted reviews cannot be attributed directly to district

FIGURE 410
TARGETED REVIEW DISTRICT PROFILES, SCHOOL YEAR 2007–08

DISTRICT	TOTAL STUDENTS	REGIONAL EDUCATION SERVICE CENTER	CURRICULUM AND INSTRUCTION (C&I) PER-PUPIL EXPENDITURES	PERCENTAGE OF OVERALL OPERATING EXPENDITURES DESIGNATED TO C&I	CURRICULUM TYPE
Katy	54,402	4	$4,204	66.8%	Internally Developed
Plano	53,683	10	$4,460	69.0%	Internally Developed
Hurst-Euless-Bedford	20,392	11	$3,991	66.9%	Internally Developed
Alvin	15,329	4	$3,755	61.9%	Internally Developed
Bryan	14,827	6	$3,652	63.1%	Internally Developed
Harlandale	14,200	20	$3,756	53.2%	Internally Developed
Schertz-Cibolo-Universal City	10,358	13	$3,640	61.3%	Externally Developed
Port Neches-Groves	4,636	5	$3,978	64.4%	Internally Developed
Diboll	1,850	7	$3,706	57.1%	Externally Developed
Hamilton	848	12	$4,458	61.8%	Externally Developed

Source: Texas Education Agency.

FIGURE 411
STUDENT PERFORMANCE INDICATORS, PERCENTAGE OF STUDENTS ACHIEVING TAKS MET STANDARD
SCHOOL YEARS 2002–03 TO 2006–07

DISTRICT	2002–03	2003–04	2004–05	2005–06	2006–07
Katy	67%	75%	78%	82%	83%
Plano	74%	81%	84%	87%	88%
Hurst-Euless-Bedford	55%	67%	73%	79%	82%
Alvin	53%	64%	72%	76%	77%
Bryan	44%	51%	56%	61%	65%
Harlandale	35%	42%	48%	53%	58%
Schertz-Cibolo-Universal City	53%	68%	70%	77%	79%
Port Neches-Groves	56%	64%	70%	74%	74%
Diboll	39%	53%	60%	67%	72%
Hamilton	46%	60%	68%	76%	79%
STATE	**47%**	**57%**	**62%**	**67%**	**70%**

Source: Texas Education Agency.

curriculum management system activities, anecdotal evidence indicates that districts attributed some of the improvements in student achievement to the instructional tools used in the districts.

Districts' practices vary in regards to curriculum and curriculum development. Many Texas school districts engage in local curriculum development efforts, while others purchase curriculum products from external vendors such as RESCs and private companies. Additionally, some school districts partner together in cooperatives to produce and/or purchase curriculum materials. A commonality found across reviewed school districts is the desire to further specify and delineate the TEKS for instruction. Curriculum management systems are just one tool that school districts use to accomplish this task.

A curriculum management system is not defined by TEA or within the Texas Education Code. For purposes of this report, a curriculum management system is defined as an online, computer-based system that links and aligns all teaching, learning, and assessment components. It provides a comprehensive, consistent, fully integrated platform that facilitates stakeholders at all levels in maintaining a continuous focus on improving student learning and mastery. While the specific components of these systems may vary based on individual district needs, curriculum management system components often include a data warehouse, curriculum, instructional resources, assessment exams, and in-depth customizable reporting. Other than variation in components and structure, curriculum management systems may also differ in formation. During targeted reviews, definitions of a curriculum management system differed based on the district visited. Some districts considered a paper and binder structure to be a curriculum management system, while others specified that a system should have automated features.

Based on the definition above, curriculum management systems in Texas can be internally or externally developed by districts, RESCS, or vendors. Although specific information related to district curriculum practices is not captured at a state-level, the targeted reviews identified that 7 out of the 10 districts reviewed have internally developed curriculum management systems. Moreover, 8 of the 10 reviewed districts are using curriculum management systems. Interviews with RESCs also indicate that in addition to the 10 districts reviewed, many other districts participate in the process of local development. In addition, the targeted reviews found that the larger districts included in the reviews have been engaged in long-term, comprehensive local curriculum development efforts since the early 1990s. Local curriculum development in these districts was organized, supported, and aligned with a detailed, long-term plan for curriculum development and was fully integrated into district practice. With school board support, these districts allocated significant resources with well-organized staffing to facilitate ongoing curriculum development resulting in a comprehensive and standardized curriculum and uniform implementation districtwide.

Decisions to automate curriculum and implement centralized curriculum management systems were linked to the need to

incorporate ongoing, systematic analysis of performance data in the daily decisions of individual teachers, as well as campus- and district-based decision-making. Ideally, these systems could provide easy access to historical and current performance data, allowing teachers to modify instruction according to student needs. Results from assessments that were developed as part of the curriculum could be used to inform instructional approaches. In addition, district and campus staff could use these systems' various reporting functions to guide curriculum development/review/revision activities, identify staff training needs, monitor curriculum delivery, and provide feedback to teachers.

Fieldwork conducted for the targeted review also indicates that RESCs develop curriculum management systems and curriculum-related supports both in cooperative arrangements and individually. As shown in **Figure 412**, CSCOPE, Curriculum Leadership Cooperative (CLC), and Comprehensive Curriculum Assessment Professional Development (CCAP) are examples of curriculum management systems developed through RESCs. Cooperative

FIGURE 412
CURRICULUM MANAGEMENT SYSTEMS DEVELOPED THROUGH REGIONAL EDUCATION SERVICE CENTERS, FALL 2008

NAME	CURRICULUM LEADERSHIP COOPERATIVE (CLC)	CSCOPE	COMPREHENSIVE CURRICULUM ASSESSMENT PROFESSIONAL DEVELOPMENT (CCAP)
Description	Developed through Region 5.	Developed through the Texas Education Service Center Curriculum Cooperative (TESCCC).	Developed by Region 4 in partnership with 8 RESCs and 4 school districts.
Participating RESCs	Regions 3, 5, 9, 12, 14, and 17	Regions 1, 2, 6, 7, 8, 10, 13, 16, 19, and 20	Regions 3, 4, 5, 7, 9, 10, 12, 14, and 15
Number of Districts Participating	250	345	24
Types of Documents/ Services Offered	CLC provides the following: • standards-based scope and sequences; • benchmarks and goals; • skill spreadsheets and resources (PreK–12); • vertically/horizontally aligned; and • reflect national and statewide academic standards and skills.	CSCOPE provides the following: • CSCOPE - Systemic Curriculum Model (K–12, Aligned to TEKS); • Curriculum Developer (Software to House and Manipulate the Curriculum); • FAKSONLINE (Assessment Software); and • Campus Leadership Team Training (Including Spot a Leader).	CCAP provides the following: • Online Student Assessment Management System; • Online Curriculum/ Instruction System; • Online Professional Development System (Available February 2009); and • Student Special Populations (Available Spring 2009).
Price	Each RESC has an individualized pricing structure. Participating RESCs may not charge districts less than what RESC 5 charges their member districts. School districts are charged based on University Interscholastic League (UIL) high school classifications. The fee structure for Region 5 follows: • $3,500–1A and 2A classifications; • $7,500–3A and 4A classifications; and • $15,000–5A classification.	CSCOPE components must be purchased together as a total systematic approach. Participating districts must purchase technology services which include a start-up fee and annual technology subscription. Fees are assessed as follows: • Annual Support & Curriculum Development Fee: Average Daily Attendance (ADA) x $7; • Technology One-Time Set-Up Fee: $1,000 to $7,000 (fee based on the number of campuses within the district); and • Technology Annual Subscription: $2,500–$8,100 (same as above).	CCAP prices range depending on type of service needed. Components may be purchased separately. Online Student Assessment Management System: • $6 per ADA Online Curriculum/ Instruction System (Released May 2009): • $10 per ADA
Price for Participating RESCs	Each RESC pays a maintenance fee. The largest maintenance fee is $18,000 (Region 12). Other RESCS pay approximately $10,000.	RESCs pay an annual development fee of $200,000 for CSCOPE. This price will decrease over time.	RESCs do not pay an annual fee.

Source: Legislative Budget Board.

arrangements among the RESCs differ along with the curriculum management system products. For example, CSCOPE was developed through the Texas Education Service Center Curriculum Cooperative (TESCCC) with each of the 10 RESCs involved responsible for a component of the product. CLC was developed by Regional Education Service Center V (Region 5) to provide support for districts within the region. Since its inception in 1990, other RESCs and districts have joined CLC for support. Conversely, CCAP was primarily developed through Regional Education Service Center IV (Region 4) with eight other RESCs and four school districts partnering for support. All of the RESC-developed curriculum management system products provide comprehensive curriculum, assessment, and data management materials in addition to support for product implementation to school districts through contracts with RESCs participating in the cooperatives. However, curriculum management system costs vary based on the product, the RESC providing the support, and the size of the school district purchasing the product.

In addition to the RESC-developed curriculum management systems mentioned above, several RESCs design and market curriculum-based materials for school districts in their region, Texas, and nationwide. For example, Region 4, which specializes in curriculum guide development and training, offers customized classroom assessment, base curriculum guide development, and accompanying professional development for teachers at a cost of $1,000 per subject per grade level requested. Additionally, Regional Education Service Center VII (Region 7) and Regional Education Service Center XV (Region 15) have designed curriculum tools for districts in their regional area. Region 7 elected to lead school districts in their region through the process of writing local curriculum. Curriculum specialists at Region 7 work with participating districts to develop clarifiers for TEKS standards, create teachable bundles, and align standards across grade levels. Conversely, Region 15 purchased Kilgo Scope & Sequence documents for use by regional school districts.

Finally, some districts use curriculum management systems created by private vendors and integrate district-created curriculum components to produce a complete curriculum system. Seven of the ten districts visited during the targeted reviews used online curriculum hosting sites for part of their curriculum management systems. Those seven districts used nine separate private vendors to provide these services. Online curriculum hosting sites are most commonly purchased by districts when establishing a curriculum management system. These hosting sites serve as an instructional management system that acts as a warehouse for the TEKS and local district curriculum. The system often provides a framework for the development of curriculum at the district level. Although hosting sites differ depending on the vendor, systems may have the following components:

- **Lesson Plans** – Teachers can create weekly lesson plans using the state standards, district curriculum, and common strategies and structures.
- **Assessments** – Districts may align district assessments to curriculum standards and district curriculum. The assessment component may allow for immediate feedback to teachers and district personnel to inform instructional and curricular decisions.
- **Monitoring** – Principals and district officials may monitor the implementation of the TEKS and district curriculum through individual schools and teachers.
- **Collaboration** – Allows teachers in the district to share lesson plans and activities which may facilitate professional learning communities.

Online curriculum hosting sites are a critical component for districts in creating and maintaining automated curriculum management systems. Since districts often lack the internal capacity to develop these hosting sites, they rely on private vendors to build and supply these systems. In order to post curriculum management systems developed locally, school districts must subscribe to online hosting sites to store their data. On average, the range of cost per pupil paid to hosting companies by school districts is $6 to $10; for a mid-size district this results in an annual cost of approximately $45,000.

CURRICULUM-RELATED FINANCIAL AND PERSONNEL RESOURCES

School districts devote significant financial and personnel resources to curriculum development and management. Districts rely on a number of funding sources to design and/or purchase these materials. Collecting specific information related to curriculum costs is difficult mainly because districts are not required to account for expenditures as "curriculum" under the Public Education Information Management System (PEIMS). Curriculum-related expenditures may be classified under various instruction-related categories. Analysis by LBB staff indicates that the amount spent for curriculum-related development and management systems is

largely driven by district size. Smaller districts are more limited in choice and options as they may not have the budget, staffing, or infrastructure to support internal development of systems and curricula or cannot purchase externally developed systems and curricula.

Curriculum-related costs may fall into four categories: (1) initial/start-up costs, (2) other costs, (3) ongoing/maintenance costs, and (4) costs for curriculum personnel. **Figure 413** shows the types of costs that typically fall into these four categories.

FIGURE 413
COST CATEGORIES RELATED TO CURRICULUM EXPENDITURES, SCHOOL YEAR 2007–08

COST CATEGORY	COSTS INCLUDED
Initial/Start-Up	• Costs to develop/purchase curriculum management systems • Costs for curriculum development • Costs for curriculum-related professional development • Costs for supplemental curriculum-related materials
Other	• Costs for expenditures not included in any other categories such as purchasing curriculum-related materials like textbooks, supplemental programs, and assessment item test banks
Ongoing/Maintenance	• Costs to develop/purchase curriculum management systems • Costs for curriculum development • Costs for curriculum-related professional development • Costs for supplemental curriculum-related materials
Curriculum Personnel	• Salaries for administrative and campus-based personnel with curriculum-related job responsibilities

Source: Legislative Budget Board.

Initial costs for curriculum management systems include the initial license fees, subscription fees paid to private vendors for externally purchased systems or investments in district resources to internally develop curriculum management systems, and hardware/resources purchased to accommodate the curriculum management system. Other costs include purchases for curriculum-related materials to supplement the current system. Ongoing costs for these systems include recurring subscription or licensing fees, and internal expenses for maintaining the system. Curriculum personnel costs include salaries for the chief instructional officer and directors of curriculum and subject area specialist/coordinators for each of the four core areas.

Figure 414 shows the types of costs involved in curriculum management systems and curriculum-related activities and the significant financial investments undertaken by many districts in this area which vary widely depending on each district's student enrollment. The costs provided in this section are a best estimate based on documentation the districts were able to provide and should not be taken as total investments in curricula. Collecting total curriculum-related costs was difficult as many of the costs for a district's curriculum management and development system are typically included in instructional budgets; detailed information is not readily accessible or stored electronically. For example, in certain school districts, teachers contract to write curriculum during the summer; however, the expenditures are not entered into any sort of system that tracks them individually. To provide this information, the districts manually reviewed the contracts to separate contracts for curriculum development from contracts for professional development. Additionally, while districts can develop local codes to track such expenses, this is not common practice. The more common approach found across the 10 districts included in this review was for the school board to approve the budget with a curriculum line item, and the director of curriculum level position to have full discretion over the allocation of those funds. In the few cases where the district did break out curriculum, it represented a small percentage of the overall instructional budget, which is made up primarily of salaries.

Figure 414 shows that the dates for major curriculum development or curriculum management-related activities ranged from 15 years ago to as recently as the 2007–08 school year. *Initial/Start-Up costs* of developing or purchasing curriculum management systems, which include subscription fees, investments in hardware, and initial training, can total up to $6 million spent as evidenced by Plano ISD expenditures in this category. *Other costs* include expenditures such as purchasing curriculum-related materials like textbooks, supplemental programs, and assessment item test banks. All districts did not separately report other expenditures. However, six districts reported these types of expenses. *Ongoing/Maintenance annual costs* include licensing fees and system updates. This category includes expenses up to $1 million for larger school districts such as Katy ISD. Additionally, six of the ten districts spend over $100,000 per

FIGURE 414
TARGETED DISTRICTS' CURRICULUM COSTS, SCHOOL YEARS 1993–94 TO 2007–08

DISTRICT	TOTAL STUDENTS 2007–08	INITIAL YEAR OF IMPLEMENTATION	INITIAL/START-UP COSTS	OTHER COSTS	ONGOING/ MAINTENANCE ANNUAL COSTS	ANNUAL CURRICULUM PERSONNEL
Katy	54,402	1998–99	$2.3 million	$35,000	$1.0 million	$1.6 million
Plano	53,683	1993–94	6.0 million	NA	496,667	1.5 million
Hurst-Euless-Bedford	20,392	2003–04	657,244	414,883	114,071	536,709
Alvin	15,329	1997–98	108,114	NA	240,025	623,954
Bryan	14,827	2004–05	167,998	89,831	204,516	449,464
Harlandale	14,200	2004–05	847,249	200,671	145,746	534,095
Schertz-Cibolo-Universal City	10,358	2007–08	139,300	NA	13,200	339,960
Port Neches-Groves	4,636	2000–01	159,714	98,565	76,177	113,340
Diboll	1,850	2006–07	24,488	74,789	94,669	97,322
Hamilton	848	2005–06	23,764	NA	10,692	NA
TOTAL			**$10.4 million**	**$913,739**	**$2.4 million**	**$5.8 million**

NOTE: NA=These categories are not applicable to the district.
SOURCE: Legislative Budget Board.

year in ongoing costs to maintain and revise their curriculum management systems. *Annual curriculum personnel costs* include positions at three levels: chief instructional/curriculum officer level, director level, and coordinator level. In classifying district staff according to these levels, annual salaries for curriculum-related staff in the four core areas can total over $1 million in expenditure in large districts, such as Katy and Plano ISDs. Other districts, including Hurst-Euless-Bedford, Bryan, and Harlandale ISDs, reported annual salary expenditures of approximately $500,000 for their curriculum department staff.

THE TEKS LACK SPECIFICITY

The TEKS outline subject specific concepts for grades K–12 and provide minimum content expectations. These standards provide a baseline learning framework for districts to follow for instruction, but do not provide the components of a curriculum. Curriculum is a written plan for learning that enables students to demonstrate mastery and application of performance objectives based on clearly defined knowledge and skills. It contains a greater level of content specificity which may include scope and sequence documents, curriculum guides, or lesson plans. According to the 10 districts visited during the targeted reviews, the TEKS are broad and do not provide content specificity. As a result, school districts supplement the TEKS by developing a "local" curriculum either through designing curriculum in-house or purchasing a product from an external source.

Staff in every district included in the targeted reviews cited the need for more specificity in the TEKS as a major concern. Because the TEKS are broad and repeated across grade levels, they require interpretation, which often results in inconsistent instruction within and across districts. Thus, districts spend great amounts of money and time attempting to refine the TEKS. Some staff characterized this effort as "reinventing the wheel" district by district. Staff also said that depth not breadth in defining the TEKS was required. While some larger districts reported that staff had benefited from local work to articulate the TEKS more specifically, staff recognized that all districts did not have the resources to engage in these processes. Further, local efforts still reflected individual district interpretations of the TEKS to some extent, and did not address inconsistency in interpretations within districts and across the state. Overall, districts reported the need for state support to clarify and streamline the written, taught, and tested curriculum.

Much effort in district curriculum development work is focused on narrowing the TEKS to provide more specificity. Given that the broad concepts of the TEKS are often repeated from one grade level to the next, districts must decide what should be taught when, and what mastery at one level and readiness for the next level means. **Figure 415** shows a section from the Science TEKS for Grades 3, 4, and 5. For example, Science Objective 3.2 (third grade) states, "Scientific processes. The student uses scientific inquiry methods during field and laboratory investigations." It is followed by five

FIGURE 415
TEXAS ESSENTIAL KNOWLEDGE AND SKILLS (TEKS), SCIENTIFIC PROCESSES OBJECTIVES FOR GRADES 3 TO 5, SCHOOL YEARS 2007–08

TEKS – SCIENCE

GRADE 3	GRADE 4	GRADE 5
(2) *Scientific processes.* The student uses scientific inquiry methods during field and laboratory investigations.	(2) *Scientific processes.* The student uses scientific inquiry methods during field and laboratory investigations.	(2) *Scientific processes.* The student uses scientific methods during field and laboratory investigations.
The student is expected to: (A) plan and implement descriptive investigations including asking well-defined questions, formulating testable hypotheses, and selecting and using equipment and technology; (B) collect information by observing and measuring; (C) analyze and interpret information to construct reasonable explanations from direct and indirect evidence; (D) communicate valid conclusions; and (E) construct simple graphs, tables, maps, and charts to organize, examine and evaluate information.	The student is expected to: (A) plan and implement descriptive investigations including asking well-defined questions, formulating testable hypotheses, and selecting and using equipment and technology; (B) collect information by observing and measuring; (C) analyze and interpret information to construct reasonable explanations from direct and indirect evidence; (D) communicate valid conclusions; and (E) construct simple graphs, tables, maps, and charts to organize, examine, and evaluate information.	The student is expected to: (A) plan and implement descriptive and simple experimental investigations including asking well-defined questions, formulating testable hypotheses, and selecting and using equipment and technology; (B) collect information by observing and measuring; (C) analyze and interpret information to construct reasonable explanations from direct and indirect evidence; (D) communicate valid conclusions; and (E) construct simple graphs, tables, maps, and charts using tools including computers to organize, examine, and evaluate information.

Source: Texas Education Agency.

student expectations that range from planning and implementing investigation to organizing and evaluating information. Science Objective 4.2 and Objective 5.2 are both stated in a similar manner. Thus, teachers and curriculum writers must determine how the scientific processes objectives look different at each grade.

With many districts writing their own curriculum, the lack of specificity in the TEKS results in implementation of widely differing curricula throughout the state, with significant time and resources spent making educated guesses about what is intended by the TEKS as written. The lack of specificity in the TEKS leads school districts to delineate the standards through curriculum-related materials and curriculum management systems. All five districts implementing centralized curriculum developed documents internally to further define the TEKS. Additionally, the three districts purchasing externally developed curriculum cited TEKS specificity as informing their selection.

Moreover, districts stated that they use the TAKS release tests to create specificity within their local curriculum. Beginning in 2001, TAKS tests were released every other year. The TAKS release tests help districts determine the level of specificity for the TEKS objectives, as well as the TEKS objectives that are problematic for students. The enactment of Senate Bill 1031 by the Eightieth Legislature, 2007, amended the Texas Education Code so that TAKS tests will be released every three years instead of every other year, effective for the 2008–09 school year as approved by the State Board of Education (SBOE) in September 2008. The effect of this legislation is that districts will have less opportunity and fewer resources to assist them in specifying curriculum and preparing students to master the TEKS.

In the mid-1990s, TEA funded specific curriculum-related activities and grants to assist with TEKS implementation and understanding. From 1996 to 2003, TEA funded Centers for Educator Development (CEDs) with the intent of assisting teachers with the implementation of the newly developed TEKS. Eight CEDS were established for foundation and enrichment subject areas, including reading and language arts, mathematics, social studies, science, bilingual and ESL, languages other than English, fine arts, and career and technology. CEDs designed training and materials to further the development of teachers with regard to the standards. Typically, CEDs used the training of trainers model whereby master teachers and subject experts were trained by the individual CED to deliver the training sessions to other teachers in the field. After the funding for CEDs ceased in

2003, most centers were unable to sustain their activities with the exception of the Center of Educator Development for Fine Arts (CEDFA), which has continued activities through alternative funding sources and support from Fine Arts educators.

The TEKS specific activities funded through the CEDs assisted teachers in understanding and implementing the new TEKS standards. In addition, these activities added the specificity required to interpret the broad learning standards. According to many districts, this type of assistance by TEA is still necessary.

Recommendation 1 proposes amending the Texas Education Code, Section 7.021(b), to require the Texas Education Agency (TEA) include clarifiers, such as exemplar activities and qualifying statements, which provide more specificity to the foundation and enrichment curriculum established by SBOE. TEA could create more specificity by designing and providing supporting documentation such as curriculum frameworks or student guides to clearly define and specify the TEKS as well as the level of mastery expected at each grade. During the targeted reviews, district staff identified specific areas of the TEKS that needed attention. These areas include middle school/high school transition in mathematics and science where student performance gaps are most prevalent.

To guide the development of the clarifiers above, TEA should consider that these new resources be developed by educators and undergo a review process by teachers and administrators. During the targeted reviews, district staff reported that researcher practitioners and practicing educators—in particular, teachers and curriculum specialists—were the most qualified to lead the development of the TEKS-clarifying resources and that these staff members had the depth of content-area knowledge required to develop high quality educator resources. The development of some of these resources might require multiyear processes with review and revision by broader groups of stakeholders.

LIMITED ROLE OF THE TEXAS EDUCATION AGENCY

TEA has a limited role with regards to curriculum management systems implemented statewide. The agency does not assist in guiding the development or evaluation of the multiple curriculum management systems used and developed throughout the state. Hence, school districts rely on advice and support from alternate entities, such as Regional Education Service Centers (RESCs), private vendors, and other school districts, when making decisions regarding implementation or creation of these systems. The agency's role with regards to curriculum management system implementation is limited, resulting in the lack of oversight of curricular materials used in districts across the state.

Defined by the Texas Education Code, oversight of curriculum-related issues in Texas is structured as such—the State Board of Education (SBOE) determines many of the curriculum-related policies directed to school districts, while TEA administers and facilitates the process. Specifically related to curriculum activities, SBOE establishes learning standards, issues textbook proclamations, and approves conforming/nonconforming lists for instructional materials. In contrast, TEA is involved in providing curriculum-related support through instructional materials, textbook adoption and requisition, and professional development. TEA facilitates and organizes curriculum-related functions to assist Texas school districts with implementation of the Texas Essential Knowledge and Skills (TEKS). Within TEA, the Curriculum Division provides information and guidance to districts in the foundation and enrichment subject areas. In addition, TEA provides leadership and governance for the process by which textbooks are approved for state purchase and coordinates the requisition and distribution of instructional materials. TEA staff also designs professional development activities to coordinate with changes in the TEKS, as well as requirements for school districts.

While the activities of SBOE and TEA cover a wide variety of curriculum-related areas, they do not address more targeted support for implementing the TEKS through the use of curriculum management systems. During the targeted reviews, district staff indicated that educators, especially at mid-sized and small districts, were in need of adaptable curricular resources. Many districts are using curriculum management systems to fill this need. District staff reported that the automated functions of these systems were linked to the need to incorporate ongoing, systematic analysis of performance data in the daily decisions of individual teachers, as well as campus- and district-based decision-making. Moreover, automated systems assist district staff in responding to new college readiness standards and accountability standards based on the ongoing changes made to the TEKS.

Revisions to the TEKS occur roughly every eight years according to a schedule set by the SBOE. Recent changes in the TEKS include the Mathematics TEKS in 2005, the English Language Arts (ELA) TEKS in 2007, and the Science TEKS and Career and Technical Education TEKS revisions occurring during 2008. Considering the continual revisions

to the TEKS, districts need support in determining how the changes in the learning standards impact their instruction, as well as the district's local curriculum.

The state of Maryland has recognized the importance of providing support for curriculum management systems and newer forms of educational technology. From 2002 to 2006, the Maryland Department of Education funded an Educational Technology grant to establish a multidimensional curriculum management implementation model. Ten Maryland Local Education Agencies (LEAs) joined together, forming a Curriculum Management System Consortium (CMSC), with the goals of improving student performance in their respective LEAs and developing tools to assist other LEAs interested in curriculum management systems. According to CMSC documentation, the premise of the grant was that a "robust, well-implemented curriculum management system will improve student achievement through the transparent integration of technology tools and digital content that are aligned to state standards." All grant activities were aligned with Maryland technology standards, professional development standards, and the Voluntary State Curriculum (VSC). The LEAs involved in the grant program analyzed student achievement with a focus on data-driven decision making, evaluated the use of curriculum management tools, and provided professional development opportunities for selected teachers and administrators.

Currently, TEA is not actively involved in targeted professional development efforts or activities related to curriculum management. However, a variety of factors suggest that TEA should have more involvement in supporting curriculum management systems in districts. Primarily, since the early 1990s, many large districts (over 6,000 student enrollment) have invested considerable resources into curriculum development and implementation of automated systems to facilitate greater uniformity, communication, sharing, monitoring, and refinement processes for ongoing curriculum development. However, mid-sized and small districts may not have the resources or staffing in many cases to commit to an effort to build a strong internally developed centralized curriculum.

Additionally, districts' capacity to update and revise the curriculum at the local level, especially with the frequency that new standards or revisions are published at the state level, is also limited. Districts require support in identifying ways to delineate the TEKS and examples for how to align curriculum across grade levels.

Recommendation 2 proposes amending the Texas Education Code, Section 7.021(b), to require that the Texas Education Agency evaluate and develop a list of curriculum management systems that conform to the Texas Essential Knowledge and Skills for use by districts. The evaluation of curriculum management systems should include systems developed by individual districts, systems developed by Regional Education Service Centers (RESCs), and RESC cooperatives.

The Texas Education Agency (TEA) has a well developed and refined process for evaluating both instructional materials and programs, including textbooks and grant programs. Within this process, TEA staff organizes the logistics, travel/accommodation arrangements, and the actual evaluation materials. Likewise, TEA staff, which include subject area experts along with administrative personnel, facilitate the evaluation. The TEA evaluation process includes using outside subject-area experts as evaluators. Evaluators use TEA-created rubrics and evaluation tools to either award a grant or place a textbook on a "conforming" or "non-conforming" list. TEA has both the staff and the expertise to facilitate an evaluation process, similar to the current process used for the evaluation of textbooks, for curriculum management systems.

Recommendation 3 proposes including a contingency rider in the 2010–11 General Appropriations Bill to fund TEA activities associated with evaluation of curriculum management systems. Contingent of the passage of legislation related to Recommendation 2, the rider would appropriate no more than $408,000 in General Revenue Funds in fiscal year 2010 to implement the provisions of the legislation.

Costs under this recommendation would include travel, accommodations, and per diem for evaluators; rental of facilities for evaluation activities; and costs for production of evaluation materials.

LIMITED FINANCIAL RESOURCES OF SMALLER DISTRICTS

A majority of the school districts in Texas have student enrollments less than 5,000 students. Sixty-five percent (666 out of 1,031) of the districts in Texas are classified as small districts, with student enrollments of 1,600 students or less. An additional 19 percent (199 out of 1,031) of school districts are classified as mid-sized districts, with student enrollments between 1,601 and 4,999. Targeted school district reviews revealed that smaller school districts are more limited in choice and options in regards to curriculum development and management. Often these districts may

not have the budget, staffing, or infrastructure to support internal development of a curriculum management system and curricula or funds to purchase externally developed systems and curricula.

Financial information collected during targeted reviews illustrates that larger districts often spend more money on curriculum-related expenditures and curriculum development than smaller districts. As shown in **Figure 6**, many of the larger districts have spent over $1 million on total curriculum-related costs associated with development of current curriculum management systems. However, smaller districts in the targeted reviews had fewer curriculum-related expenditures with many of the districts opting to purchase an externally-developed system or participate in a regional curriculum cooperative to create curriculum documents. In addition, larger districts often have heavily-staffed instructional teams. These teams may include curriculum content specialists, curriculum coordinators, and other specialized personnel. In contrast, many of the smaller districts in the targeted reviews had either recently added curriculum-related staff positions to assist with development or implementation, or had instructional teams which consisted of the instructional principals and district leadership.

Additionally, the state's network of 20 Regional Education Service Centers (RESCs) was a key source of external assistance used by almost all of the districts included in the targeted reviews; three of the ten districts have student enrollments less than 5,000 students. Many smaller districts report their reliance on RESCs for low-cost support in curriculum and utilize other RESCs when the service center for their region did not provide the required services. However, many such curriculum-related services and products have been discontinued or have become outdated in the move to develop new proprietary products. The former Capital Area Curriculum Consortium (CACC) facilitated by Region 13 is a good example of this situation. The CACC provided districts with opportunities to collaboratively develop curriculum documents together at little cost. One district visited during the targeted reviews worked with the CACC to develop curriculum materials. District staff reported that the CACC process helped the district to develop rigor, terminology, and vertical and horizontal alignment. This service was especially valuable in addressing teacher isolation in small, rural districts. This service was discontinued, however, with the move to offer CSCOPE. As a result, the district was left with incomplete curricular materials.

While many districts in Texas are engaged in local development of curriculum and/or curriculum management systems, smaller districts are often at a disadvantage in regards to curriculum development efforts given fewer resources and personnel. Mid-sized and smaller school districts could benefit from assistance with local curriculum development efforts.

Recommendation 4 would appropriate $2.5 million to the Texas Education Agency for the purpose of issuing grants to assist school districts with implementing curriculum management systems. The $2.5 million would provide an estimated 25 grants to school districts within five student enrollment categories. Fiscal impact was determined by assuming that five grants will be made to each enrollment category. Grant awards may range from $9,000 per district, with student enrollment of 1,600 or less, to $300,000 per district, with student enrollment at 50,000.

A grant program would assist districts unable to develop or purchase these systems with the resources necessary to support the initial costs associated with the process. For many districts, the initial start-up costs for implementing a curriculum management system are prohibitive given that districts are often required to purchase hardware and/or software for system implementation along with initial training and technical assistance.

When establishing the criteria for the curriculum management system grants, TEA might consider several factors in order to maximize the amount of funding and design an effective program. **Figure 416** shows a sample grant structure for the curriculum management system grants.

CURRICULUM-RELATED EXPENDITURE DATA IS UNDETERMINABLE THROUGH THE PUBLIC EDUCATION INFORMATION MANAGEMENT SYSTEM

Collecting specific information related to curriculum development and maintenance costs is difficult since districts are not required to account for expenditures as "curriculum" under the Public Education Information Management System (PEIMS). Specifically, TEA does not require districts to report expenditures on curriculum separately from other instructional expenditures. Therefore, curriculum expenditures generally are coded as instruction (Function 11) or instruction-related (Functions 12 and 13). If purchases are for hardware or software, they may also be incorporated into a bond issue. This is particularly important for high-wealth districts because debt service is not subject to recapture.

FIGURE 416
CURRICULUM MANAGEMENT SYSTEM GRANTS
SAMPLE GRANT STRUCTURE, 2008

GRANT STRUCTURE CONSIDERATIONS

STUDENT ENROLLMENT:
In an effort to assist different ranges of student enrollment, TEA might consider awarding grants based on student enrollment categories. For example:

Category 1	Districts with less than 1,600 students
Category 2	Districts with 1,600 to 3,000 students
Category 3	Districts with 3,000 to 7,500 students
Category 4	Districts with 7,500 to 20,000 students
Category 5	Districts with 20,000 to 50,000 students

DISTRICT DEMOGRAPHICS:
TEA might consider student demographic and performance data, which may demonstrate a high need for additional intervention, when awarding grants.

PRICING STRUCTURE OF CURRICULUM MANAGEMENT SYSTEMS:
Currently, curriculum management systems and online curriculum hosting sites are priced by average daily attendance (ADA) to account for technology storage space, instructional material production, and initial training costs. Average costs for these systems range from $6–$10 per ADA. Since the purpose of this grant is to assist school districts in implementing curriculum management systems, TEA might consider $6 per ADA price in calculating grant awards.

SOURCE: Legislative Budget Board.

The *Financial Accountability System Resource Guide (FASRG)* provides detailed definitions of each of these three functions; however, abbreviated definitions are provided below:

- **Function 11 Instruction.** This function is used for activities that deal directly with the interaction between teachers and students. This function includes expenditures/expenses for direct classroom instruction and other activities that deliver, enhance, or direct the delivery of learning situations to students. Sample expenses include salaries and related expenditures/expenses associated with classroom teachers, teacher aides, and classroom assistants.

- **Function 12 Instructional Resources and Media Services.** This function is used for expenditures/expenses that are directly and exclusively used for resource centers, establishing and maintaining libraries, and other major facilities dealing with educational resources and media. Sample expenses include salaries and related expenditures/expenses associated with librarians and library aides and assistants.

- **Function 13 Curriculum Development and Instructional Staff Development.** This function is used for expenditures/expenses that are directly and exclusively used to aid instructional staff in planning, developing, and evaluating the process of providing learning experiences for students. Expenditures and expenses include in-service training and other staff development for instructional or instructional-related personnel (Functions 11, 12, and 13) of the school district. This function also includes expenditures and expenses related to research and development activities that investigate, experiment with, and/or follow through with the development of new or modified instructional methods, techniques, procedures, and services. Sample expenses include staff that research and develop innovative, new, or modified instruction; fees for outside consultants conducting in-service training or staff development for instructional and instructional-related staff; curriculum coordinators (not responsible for supervising instructional staff); and supplies, materials, and equipment for curriculum development or in-service training.

A further difficulty in tracking curriculum expenditures is that documentation related to curriculum expenditures is not always readily accessible or stored electronically in many districts. For example, district contracts with teachers to write curriculum may not be entered into any sort of system that stores or tracks them. Providing an accurate rendering of funding spent on curriculum would thus require district personnel, in many cases, to locate paper contracts and manually enter the data to generate reports.

While districts can develop local codes to track such expenses, this is not common practice. The more common approach found across the 10 reviewed districts included in the targeted reviews was for a school board to approve the district's budget with a curriculum line item and give the director of curriculum (or similar position) full discretion over the allocation of those funds. Internal budgeting and state required accounting codes and procedures would not capture these expenditures separately. In the few districts that did break out curriculum expenditures, they represented a small percentage of the overall instructional budget, primarily salaries.

TEA is now redesigning and rewriting PEIMS. Since the introduction of PEIMS in the 1987–88 school year, changes have been made to the system; nonetheless, incompatibility issues have resulted in non-integration of new technology features. As outlined by TEA, the current redesign and rewrite process consists of four phases: (1) replacement of the server; (2) mainframe data migration; (3) format remediation; and (4) enhanced reporting capabilities. TEA is in phase one with expected completion of the entire project in August 2009. The project is funded through the enactment of House Bill 1, Eightieth Legislature, 2007.

Recommendation 5 proposes that TEA should consider identifying the costs associated with curriculum management systems and determining a method for collecting financial data which reflects curriculum costs when rewriting PEIMS. TEA will have to gather detailed expenditure data from representative districts to capture the level of specificity required to develop more precise reporting mechanisms. Districts could be selected to represent varying types of curriculum systems in use across the state (for example, internally developed and externally developed), the various stages of implementation (start-up, maintenance), and the various types of districts (size and geographic location) in the state. Working with representative districts to capture curriculum costs proactively over a multi-year period would provide the state with solid representations of what different types of curriculum systems cost in order to generate reliable per-student estimates.

FISCAL IMPACT OF THE RECOMMENDATIONS

Recommendations 1 and 2 have no significant fiscal impact for the 2010–11 biennium. Recommendations 3 and 4 would cost $2.9 million in General Revenue Funds for the 2010–11 biennium. Recommendation 5 has no significant fiscal impact in the 2010–11 biennium.

Recommendation 1 would amend the Texas Education Code to require that the Texas Education Agency shall include clarifiers which provide more specificity to the foundation and enrichment curriculum established by the State Board of Education. No fiscal impact is associated with this recommendation.

Recommendation 2 would amend the Texas Education Code to require that TEA evaluate and develop a list of curriculum management systems that conform to the Texas Essential Knowledge and Skills for use by districts.

Recommendation 3 would include a contingency appropriation rider in the 2010–11 General Appropriations Bill for activities associated with passage of legislation related to evaluation and development of a list of curriculum management systems by the Texas Education Agency. This rider would appropriate $408,000 for the 2010–11 biennium. The estimate of $408,000 in fiscal year 2010 includes $363,000 travel and accommodations associated with curriculum management system evaluators. Costs include $85 per person for accommodations and $36 per person per diem. Estimates are based on 150 evaluators for four weeks. This figure also includes $40,000 for rental of facilities to host the curriculum management system evaluation process. This cost calculation assumes the rental of facilities for four weeks. Additionally, this figure includes $5,000 for evaluation material production by TEA staff in preparation for the curriculum management system evaluation process. Given that the process in Recommendation 3 is identical to a process TEA now uses, there would be no additional administrative costs associated with this recommendation.

Recommendation 4 would appropriate $2.5 million for the purpose of issuing competitive grants to school districts to assist with the implementation of curriculum management systems. The $2.5 million in fiscal years 2010 and 2011 includes estimates for 25 grants to school districts within five student enrollment categories. The fiscal impact is estimated by assuming that five grants would be made to each

enrollment category. Grants would be awarded based on Average Daily Attendance (ADA) counts. Currently, curriculum management systems and online curriculum hosting sites are priced by ADA to account for technology storage space, instructional material production, and initial training costs. Average costs for these systems range from $6 to $10 per ADA. Since the purpose of this grant is to assist school districts in implementing a curriculum management system, $6 per ADA price is used in calculating grant awards. Grant awards may range from $9,000 per district, with student enrollment of 1,600 or less, to $300,000 per district, with student enrollment at 50,000. This grant program is subject to appropriations.

Recommendation 5 directs that the Texas Education Agency consider the need for collecting financial data reflecting curriculum costs when rewriting the Public Education Information Management System (PEIMS). No fiscal impact is associated with this recommendation since the Texas Education Agency is already in the process of rewriting the system.

The introduced 2010–11 General Appropriations Bill does not address these recommendations.

INCREASE THE USEFULNESS OF THE TEXAS EDUCATION AGENCY'S BEST PRACTICES CLEARINGHOUSE

The Best Practices Clearinghouse is an online collection of successful techniques, methodologies, and programs (best practices) from Texas public schools. The Texas Education Agency manages the Clearinghouse, which is available on its website. Statutory limitations on which schools and school districts may contribute to the collection are based on school accountability ratings. This limits the number of school districts eligible to contribute to this resource to only 31 percent. As of October 2008, the Clearinghouse recognized 29 best practices from 18 school districts. Additionally, 34 percent of these submissions are from one school district. Topics are limited to practices related to instruction, dropout prevention, public school finance, resource allocation, and business practices.

The Clearinghouse serves as a repository of knowledge, experience, and information that other school districts and schools may use to replicate these successes within their district or campus. By encouraging more submissions to the Clearinghouse through broadening who may contribute to it, increasing which topics may be recognized, and providing incentives, the capacity of the Clearinghouse to serve as a collection of public school best practices increases, as does its usefulness to the public education institutions it serves.

CONCERNS

- Best practice submissions to the Clearinghouse are restricted to Texas public schools with specific school accountability that prevents a majority of public schools from contributing.
- Best practice submissions to the Clearinghouse are restricted to five topics: instruction, dropout prevention, public school finance, resource allocation, and business practices. This excludes best practice submissions from other critical school district functional areas, such as food service or transportation.
- The low number of contributions to the Clearinghouse from eligible school districts, campuses, and open-enrollment charter schools reduces the usefulness of the resource.

RECOMMENDATIONS

- **Recommendation 1:** Amend Texas Education Code, Section 7.009(b), to remove language limiting which public schools may submit best practices based on school accountability rating.
- **Recommendation 2:** Amend Texas Education Code, Section 7.009(a), to replace best practice topic categories with broader categories encompassing a greater range of topics.
- **Recommendation 3:** Amend Texas Education Code, Section 7.009, to create a Clearinghouse Incentive Award to school districts, campuses, and open-enrollment charter schools that submit eligible practices to the Clearinghouse.
- **Recommendation 4:** Include a contingency rider in the 2010–11 General Appropriations Bill that appropriates $500,000 of General Revenue Funds per fiscal year to the Texas Education Agency for the Clearinghouse Incentive Award to be distributed at the discretion of the agency.

DISCUSSION

The Best Practices Clearinghouse (the Clearinghouse) was established by the Seventy-ninth legislature, Third Called Session, 2006. The Texas Education Agency (TEA) is required to establish an online clearinghouse of information related to best practices of school districts, campuses, and open-enrollment charter schools within a range of specified topics.

Development and management of the Clearinghouse is performed by TEA's Data Development, Analysis & Research division with the Clearinghouse website residing on the agency's website. Additionally, the agency is aided in the performance of these responsibilities through contract with a third-party consultant who assists the agency in developing, implementing, and maintaining the Clearinghouse.

TEA defines a "best practice" as a technique, methodology, program, or other intervention that through action research or empirical research demonstrates a positive result. Texas Education Code, Section 7.009(b), authorizes the agency to solicit and collect best practices from the following institutions:

- Legislative Budget Board (LBB);
- Centers for Education Research; and
- School Districts, Campuses, and Open-Enrollment Charter Schools.

The LBB provides the Clearinghouse access to the database *A+ Ideas for Managing Schools*. This database contains more than 1,000 practices identified through school district management and performance reviews conducted by the agency. The enactment of legislation by the Seventy-ninth Legislature, Third Called Session, 2006, established the Centers for Education Research. These centers are responsible for conducting public education research. To date, no best practices have been submitted from this source. Finally, TEA solicits school districts, campuses, and open-enrollment charter schools to submit practices.

TEA uses modified American Evaluation Association program evaluation standards to evaluate the practices submitted to the Clearinghouse. Practices that demonstrate a positive result and meet an evidence standard are placed on the agency's Clearinghouse website. The criteria for this evidence standard includes sufficient information about the practice, a data gathering procedure, and appropriate evaluation of both quantitative and qualitative information.

BEST PRACTICE CONTRIBUTOR ELIGIBILITY

Best practice submissions to the Clearinghouse are restricted to schools and school districts with specific school accountability and financial accountability ratings. Campuses, school districts, or open-enrollment charter schools must be rated Exemplary or Recognized to be eligible to submit a practice to the Clearinghouse. The Texas Education Agency manages the Accountability Rating System and updates the ratings annually based on statutory provisions in Texas Education Code, Section 39.072(a).

Certain submissions to the Clearinghouse within topics related to business and resource management require the contributing school district to have a School FIRST rating of Superior Achievement, Above Standard Achievement, or Standard Achievement. This rating is detailed within Texas Education Code, Section 39.202(a), that directs the commissioner of education to develop and implement a financial accountability rating system for school districts. Developed in 2003, the School Financial Integrity Rating System of Texas (School FIRST) has five ratings: (1) Superior Achievement, (2) Above Standard Achievement, (3) Standard Achievement, (4) Substandard Achievement, and (5) Suspected Due to Data Quality.

According to TEA, the Exemplary or Recognized eligibility requirement is a significant barrier to collecting best practices. For example, the dropout prevention category does not have any identified best practices since few districts that have responded to a dropout problem are eligible to submit a best practice. Additionally, this eligibility requirement does not consider significant performance increases from school districts, campuses, and open-enrollment charter schools with lower accountability ratings nor does it allow for submission of a best practice within the public school finance, resource allocation, and business practices topics since neither campuses nor open-enrollment charter schools are rated under School FIRST.

Figure 417 shows the frequency of district accountability ratings by ranges of student enrollment. Based on the

FIGURE 417
DISTRICT ACCOUNTABILITY RATING FREQUENCY BY ENROLLMENT RANGES
2008 ACCOUNTABILITY RATINGS

	ENROLLMENT RANGES						
ACCOUNTABILITY RATING	0–1,001	1,001–5,000	5,001–10,000	10,001–50,000	50,001+	TOTAL NUMBER	PERCENTAGE
			ELIGIBLE TO SUBMIT A BEST PRACTICE				
Exemplary	26	1	2	0	0	29	3%
Recognized	195	60	13	15	4	287	28%
ELIGIBLE TOTAL	**221**	**61**	**15**	**15**	**4**	**316**	**31%**
			NOT ELIGIBLE TO SUBMIT A BEST PRACTICE				
Academically Acceptable	314	259	57	62	12	704	68%
Academically Unacceptable	9	2	0	0	0	11	1%
NOT ELIGIBLE TOTAL	**323**	**261**	**57**	**62**	**12**	**715**	**69%**

NOTE: This excludes state-administered districts.
SOURCE: Texas Education Agency.

submission requirements defining who may submit to the Clearinghouse, only 31 percent of all school districts are eligible to submit a best practice. Additionally, only 15 of the 77 school districts with student enrollments between 10,001 and 50,000 (19 percent) and only four of the 16 school districts with student enrollment over 50,000 (25 percent) are eligible to submit a best practice. According to TEA, none of the 10 major urban and only 6 of the 78 major suburban school districts are eligible to contribute to the Clearinghouse based on the Exemplary or Recognized requirement.

A public education institution's accountability or School FIRST rating, while indicative of general academic or financial performance, may have little bearing on the submitted practice. Since the evidence standard used by the agency to evaluate Clearinghouse submissions bases its evaluation on the practice's merits and judges that merit within the context of the submitting institution, the burden of proof is on the submitting institution to provide enough supporting evidence to identify that practice as a "best" practice. This separates the best practice evaluation criteria from the institution's accountability or School FIRST rating, removing the need for such a requirement. Instead, these regulations act as barriers to submissions from more school districts, campuses, and open-enrollment charter schools.

Recommendation 1 would amend Texas Education Code, Section 7.009(b), to remove provisions limiting best practice submissions eligibility to Exemplary or Recognized school districts, campuses, and open-enrollment charter schools and School FIRST rating requirements.

CLEARINGHOUSE TOPIC CATEGORIES

Submissions to the Clearinghouse are restricted to the following topics listed in Texas Education Code, Section 7.009(a):

- instruction;
- dropout prevention;
- public school finance;
- resource allocation; and
- business practices.

According to TEA, the agency broadly interprets topic content boundaries from statutory language to allow the largest range of eligible content submissions. At present, 22 of the 29 listed best practices reside within the Instruction topic representing 75 percent of all best practices.

Despite the flexible interpretation of topic content boundaries, the statutory language limiting practice submissions to specific topics narrowly restricts the contribution of equally valid and useful practices within school district functional areas that are not listed. These include functions such as transportation or food service that play critical and necessary roles in school district management and administration and where the dissemination of best practices in these topics could prove helpful to the state's public schools.

Additionally, two other sections of the Texas Education Code were amended by the Eightieth Legislature, 2007, requiring TEA to incorporate into the Clearinghouse practices related to school bus safety (Texas Education Code, Section 34.102(b)) and to include results from an evaluation of high school completion and success grants (Texas Education Code, Section 39.360(c)). This statutory language was included in the Texas Education Code in locations separate from the section establishing the Clearinghouse, does not specify how these topics should be incorporated into the Clearinghouse, and does not indicate under which topic they would reside.

Recommendation 2 would amend Texas Education Code, Section 7.009(a), to replace best practice topic categories with broader categories that encompass a greater range of topics. These category definitions and content boundaries would be developed by TEA providing the agency with the flexibility to modify the content as the Clearinghouse is populated with more practices. This would allow the organization and content of the Clearinghouse to be determined by the submitting districts, rather than letting pre-defined Clearinghouse categories determine its framework and what types of practices can be included.

FEW CONTRIBUTIONS TO THE CLEARINGHOUSE

TEA's stated goal for the Clearinghouse is to provide examples of best practices to schools and stakeholders. To submit a best practice, a contributor must complete a Notification of Interest to Submit form and provide evidence that the best practice demonstrated a positive change. TEA or a contractor then works with the interested contributor to explain the process and help collect detailed information about the best practice. Site-specific strategies and procedures for implementation must also be included that explain how the practice could be replicated by another district or campus.

As of October 2008, the Clearinghouse had identified 29 unique best practices submitted from 18 school districts with one school district accounting for 34 percent of all best practices. There have been no best practices identified from charter schools. The agency has indicated that 11 additional best practices are to be included in the near future.

Recommendation 3 would amend Texas Education Code, Section 7.009, to create a Clearinghouse incentive award to school districts, campuses, and open-enrollment charter schools submitting practices to the Clearinghouse that meet the evidence standard. Providing a tangible reward to submit a best practice can generate additional motivation for more Texas public schools to submit practices.

Recommendation 4 proposes a contingency rider to be included in the 2010–11 General Appropriations Bill that would appropriate $500,000 in General Revenue Funds per fiscal year to the Texas Education Agency for the Clearinghouse incentive award to be distributed at the discretion of the agency.

FISCAL IMPACT OF THE RECOMMENDATIONS

The total 2010–11 biennial fiscal impact of all recommendations is $1 million in General Revenue Funds. Recommendations 1, 2, and 3 do not have any significant fiscal impact. **Figure 418** shows a fiscal impact of Recommendation 4, which is a cost of $500,000 in General Revenue Funds per fiscal year to fund the Clearinghouse Incentive Award. Distribution of these funds is at the discretion of TEA.

FIGURE 418
PROBABLE SAVINGS/(COST) IN GENERAL REVENUE FUNDS
2010–11 BIENNIUM

FISCAL YEAR	PROBABLE SAVINGS/(COST) IN GENERAL REVENUE FUNDS
2010	($500,000)
2011	($500,000)

SOURCE: Legislative Budget Board.

The introduced 2010–11 General Appropriations Bill does not reflect any changes as a result of these recommendations.

IMPROVE TEXAS PUBLIC SCHOOL DISTRICTS' ACCESS TO STAFFING GUIDELINES TO ENHANCE FINANCIAL EFFICIENCY

In school year 2006–07, payroll costs represented more than 78 percent of Texas independent school district expenditures ($28.5 billion of $36.3 billion), making it critical that school district officials monitor and evaluate the effectiveness and efficiency of staffing levels.

To help make staffing decisions, district officials may use staffing ratios from either industry standards, what is developed internally, or what is mandated by statute. However, ratio guidelines are diverse in emphasis and not readily available to all school districts. There is no central location for district staff seeking assistance regarding staffing guidelines. Few guidelines exist in statute, so districts have little basis for deciding how to staff various positions. An ad hoc approach to staffing can be expensive since staff is the largest expense in a district's budget. Nonetheless, Texas public school districts are held accountable for meeting staffing ratios in the state's financial rating system, but are not given guidelines on how to best achieve those ratios, nor are they required to conduct a staffing analysis to determine the appropriate number and type of staff needed by a district.

By identifying or developing staffing guidelines for positions where none exist, by centralizing those guidelines for better access, and by providing guidance to Texas public school districts that consistently receive substandard scores in the financial rating system, districts will be better able to achieve financial efficiencies in staffing.

CONCERNS

- ♦ Staffing guidelines in Texas public school districts have not been fully identified for all school district positions and there is no comprehensive summary of guidelines available in one location for school staff to access.
- ♦ The Texas Education Agency holds Texas public school districts accountable for meeting staffing ratios related to three personnel indicators in the state's financial rating system, yet does not provide districts with specific guidelines on how the ratios can be achieved. Districts receive no assistance in targeting the areas of operation where staffing changes should be made.
- ♦ Texas public school districts rated substandard in three consecutive years in the state's financial rating system are assigned a financial monitor by the Texas Education Agency, but the districts are not required to conduct a staffing analysis to identify areas where steps may be taken to create efficiencies.

RECOMMENDATIONS

- ♦ **Recommendation 1:** The Texas Education Agency in consultation with appropriate professional associations should identify school district positions that lack staffing guidelines, develop guidelines for these positions, and post a comprehensive summary of guidelines on the agency's website.
- ♦ **Recommendation 2:** The Texas Education Agency should provide guidelines demonstrating how Texas public school districts can achieve the staffing ratios required for the three personnel indicators in the financial rating system.
- ♦ **Recommendation 3:** When the Texas Education Agency assigns a financial monitor to a Texas public school district, it should require that a staffing analysis be conducted comparing the actual number and type of staff to the comprehensive summary of staffing guidelines posted on the agency's website.

DISCUSSION

Since payroll costs comprise the largest percentage of a school district's budget, Texas public school districts are confronted with ensuring staff resources effectively and economically support the delivery of a high quality education to students while not overextending the district financially. Data reported to the Texas Education Agency (TEA) by Texas public school districts in the Public Education Information Management System (PEIMS) indicates that while payroll costs in school districts during school years 2003–04 to 2006–07 decreased slightly as a share of total costs, other operating costs increased (see **Figure 419**). In school year 2006–07, the state spent 78.4 percent of total expenditures on payroll costs.

Teachers account for the largest percentage of total salary expenditures at nearly 62 percent of payroll costs, followed

FIGURE 419
PERCENTAGE OF ACTUAL FINANCIAL EXPENDITURES NON-CHARTER TEXAS PUBLIC SCHOOL DISTRICTS, SCHOOL YEARS 2003–04 TO 2006–07

TOTAL EXPENDITURES (ALL FUNDS)	2003–04	2004–05	2005–06	2006–07
Payroll Costs*	79.5%	79.1%	78.5%	78.4%
Other Operating Costs**	20.5%	20.9%	21.5%	21.6%

*Payroll Costs (Object Code 6100) = gross salaries or wages and benefit costs for all employees (including contract buyouts and employee allowances).
**Other Operating Costs (Object Codes 6200–6400) = services rendered to school districts by firms, individuals, and other organizations; supplies and materials including fuel for vehicles; other reading materials (not including the cost of state-adopted textbooks); food service supplies; and other expenses necessary for the operation of Texas public school districts.
Note: Excludes Capital Outlay and Debt Service.
Source: Texas Education Agency.

by auxiliary employees at slightly more than 15 percent. Professional support personnel such as counselors, librarians, diagnosticians, therapists, nurses, department heads, and specialists make up nearly 12 percent of the payroll, whereas educational aides comprise 4.6 percent, campus administrators comprise nearly 5 percent, and central administrators account for more than 2 percent of the total payroll as shown in **Figures 420 and 421**.

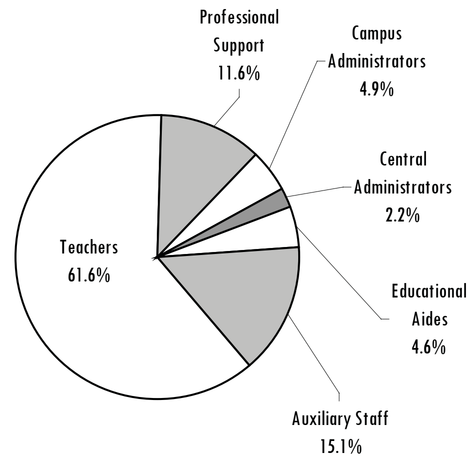
FIGURE 420
SALARY EXPENDITURES (ALL FUNDS) NON-CHARTER TEXAS PUBLIC SCHOOL DISTRICTS, SCHOOL YEARS 2003–04 TO 2006–07

SALARY EXPENDITURES (ALL FUNDS)	2003–04	2004–05	2005–06	2006–07
Teachers	61.4%	61.2%	61.2%	61.6%
Auxiliary Staff	15.8%	15.6%	15.4%	15.1%
Professional Support	11.2%	11.4%	11.5%	11.6%
Campus Administrators	4.8%	4.9%	5.0%	4.9%
Educational Aides	4.7%	4.7%	4.7%	4.6%
Central Administrators	2.2%	2.2%	2.2%	2.2%

Note: These totals may not add to 100 percent due to rounding.
Source: Texas Education Agency.

Texas public school districts use a variety of methods to determine how to efficiently place staff for instructional and operational purposes. One form of aid for district officials is staffing guidelines. Staffing guidelines come from a variety of sources: mandated staffing ratios through statutes, school district self-developed policies and formulas, or suggested industry guidelines.

FIGURE 421
TEXAS PUBLIC SCHOOL DISTRICT EMPLOYEE CATEGORIES BY PERCENTAGE OF TOTAL, SCHOOL YEAR 2006–07



Source: Public Education Information Management System, Texas Education Agency.

While the Texas Education Code mandates student-to-staff ratios for some positions, it does not address all positions in a school district. The statute requires Texas public school districts to follow specific staffing ratios for teachers, counselors, librarians, childcare givers, and special education, as shown in **Figure 422**. For example, Texas Education Code, Section 25.112 (a) requires a specific student-to-teacher-ratio in grades Kindergarten through 4 but is silent regarding the same ratio in grades 5 through 12. The statute is also silent regarding what ratios or guidelines to use in operational areas of the district.

Districts develop internal policies or formulas to specifically address staffing needs not covered by statute. The creation of these formulas may include an analysis of data, enrollment, availability of funds, and school performance. Districts that take time to create such formulas are likely to be more effective in ensuring that district staff is carefully allocated. However, school districts do not always regulate or update their own policies to guarantee they remain applicable. For example, a large Texas public school district reviewed by Legislative Budget Board (LBB) staff found that the district's internal staffing formula for placement of campus assistant principals had not been updated in several years. The policy to place two assistant principals in each elementary and middle school was developed in the early 1990s when the district was in a period of high growth. However, as enrollment decreased in some of the elementary schools, or smaller enrollment schools were built, the policy was not adjusted, and the district was found to have 25 more

FIGURE 422
TEXAS EDUCATION CODE STAFFING RATIO REQUIREMENTS, SCHOOL YEAR 2007–08

TEXAS EDUCATION CODE SECTION	TEXAS EDUCATION CODE EXCERPT
Section 25.112 (a)	"Except as otherwise authorized by this section, a school district may not enroll more than 22 students in a Kindergarten, first, second, third, or fourth grade class."
Section 29.057 (c)	"The maximum student-to-teacher ratio shall be set by the agency (TEA) and shall reflect the special educational needs of students enrolled in the programs."
Section 33.002 (b)	"A school district with 500 or more students enrolled in elementary school grades shall employ a counselor certified under the rules of the State Board of Educator Certification for each elementary school in the district. A district shall employ at least one certified counselor for every 500 elementary school students in the district."
Section 33.021*	"The Texas State Library and Archives Commission, in consultation with the State Board of Education, shall adopt standards for school library services."
Section 33.903 (e)	TEA "may not consider a school district's application for funding unless the application ... specifies that the district's child care program outlined in the application will maintain a ratio of not less than one caregiver per 20 students in kindergarten through grade three and a ratio of not less than one caregiver per 25 students in grades four through eight ... ."

*Standards include staffing guidelines for librarians and library aides.
Source: Texas Education Code.

elementary assistant principals than the Southern Association of Colleges and Schools (SACS)/Council of Accreditation and School Improvement (CASI) guidelines recommended.

Another school district reviewed by LBB staff had a total of 77 more personnel than industry guidelines recommended in both professional and classified areas. In this case, the district was spending approximately $1.3 million annually on salaries and benefits for positions that were not needed. The district's biggest budget item, payroll costs, was not being analyzed to ensure efficiencies.

Conversely, Texas public school districts that do not create their own staffing guidelines may rely on professional organizations, such as the SACS/CASI, National Association of School Nurses (NASN), *American School and University M & O Cost Study*, Texas Association of School Business Officials, Texas Elementary Principals and Supervisors Association (TEPSA), or the National Center for Education Statistics, to help guide them in staffing a particular department. These organizations have developed guidelines using a matrix, enrollment guide, square footage guide, and other mechanisms to determine the number of staff needed to efficiently fill certain positions.

Some organizations house guidelines on their websites for districts to access, but the guidelines may only be accessible to paying members, may have not been updated to represent the latest and most efficient guideline, or may not comprehensively cover all personnel in a district. Finally, there is no central location where Texas public school administrators can avail themselves of a comprehensive list of guidelines for a multitude of school personnel, both professional and classified, such as those discussed below.

SCHOOL INSTRUCTIONAL PERSONNEL

SACS, an accrediting organization that has developed a set of quality guidelines for accreditation that would apply to all public schools accredited by CASI, uses a Human Resources Standard that provides districts with an enrollment-based staffing standard for some professional positions within a school district. For example, SACS recommends 0.5 Administrative or Supervisory Assistant for each elementary school with 500 to 749 students, 1 for 750 to 999, 1.5 for schools with 1,000 to 1,249, and 2 for schools with an enrollment size of 1,250 to 1,499 as shown in **Figure 423**.

SCHOOL COUNSELORS

The effectiveness of a district's guidance and counseling program is directly related to the counselor-to-student ratio within the program. Counselor-to-student ratios are determined in part by the characteristics of the students being served. Texas Education Code, Section 33.002, requires school districts with 500 or more enrolled elementary students to employ a certified counselor for each 500 students. Alternatively, the Texas School Counselor Association, Texas Association of Secondary School Principals, and Texas Elementary Principals and Supervisors Association all recommend a counselor for every 350 students.

FIGURE 423
SOUTHERN ASSOCIATION OF COLLEGES AND SCHOOLS HUMAN RESOURCES STAFFING STANDARD FOR SCHOOLS, 2005

MEMBERSHIP	1–249	250–499	500–749	750–999	1,000–1,249	1,250–1,499	1,500–UP
Administrative Head	1.0	1.0	1.0	1.0	1.0	1.0	1.0
Administrative or Supervisory Assistants	0	0.5 (Secondary) 0 (Elem)	1.0 (Secondary) 0.5 (Elem)	1.5 (Secondary) 1.0 (Elem)	2.0 (Secondary) 1.5 (Elem)	2.5 (Secondary) 2.0 (Elem)	1 full-time equivalent will be added where needed for each additional 250 students over 1,500.
Guidance Professionals	0.5	1.0 (Secondary) 0.5 (Elem)	1.5 (Secondary) 1.0 (Elem)	2.0 (Secondary) 1.5 (Elem)	2.5 (Secondary) 2.0 (Elem)	3.0 (Secondary) 2.5 (Elem)	See above.
Library or Media Specialists	0.5	1.0	1.0	1.0	2.0 (Secondary) 1.0 (Middle-Elem)	2.0 (Secondary) 1.0 (Middle-Elem)	See above.
Support staff for Administration, library media, or technology	1.0 (Secondary) 0.5 (Elem)	2.5 (Secondary) 1.0 (Elem)	4.0 (Secondary) 1.5 (Elem)	4.5 (Secondary) 2.5 (Elem)	5.0 (Secondary) 3.0 (Elem)	5.5 (Secondary) 3.0 (Elem)	6.0 (Secondary) 3.0 (Elem)

Source: Southern Association of Colleges and Schools.

LIBRARIANS

Libraries play a special role in providing enrichment to students. Libraries staffed by both a librarian and an aide are most likely to offer high priority services, such as collaborative planning and teaching with teachers, providing staff development to teachers, facilitating information skills instruction, and providing reading incentive activities.

Texas Education Code, Section 33.021, requires the Texas State Library and Archives Commission (TSLAC), in consultation with the State Board of Education, to adopt standards for school library services and requires school districts to consider the standards in developing, implementing, or expanding library services. In May 1997, TSLAC adopted the *School Library Programs: Stamdards amd Guidelines for Texas*. The guidelines were evaluated in 2002 with revisions approved by TSLAC in March 2004. School districts are not required to comply with the TSLAC library standards. Rather, as the Commissioner of Education has indicated, "the standards are to be used as guidelines." **Figure 424** shows TSLAC's recommended school library staffing guidelines for four categories of standards: exemplary, recognized, acceptable, and below standard.

SCHOOL NURSES

The National Association of School Nurses recommends that the number of nurses per campus should be influenced by multiple factors, such as social, economic, and cultural status of the community; special health problems; the mobility of people in the community; and a ratio of one nurse per number of students. With that in mind, the association recommends one nurse for every 750 students.

CUSTODIANS

The Association of Physical Plant Administrators publication, *Custodial Staffing Guidelines, Second Edition*, establishes custodial staffing levels based on five defined levels of cleaning. For example, Level 2, ordinary tidiness, establishes a staffing level of one custodian for every 20,000 square feet of facility space.

Similarly, the National Center for Education Statistics' *Planning Guide for Maintaining School Facilities* provides square footage expectations for various levels of cleaning in educational buildings. **Figure 425** shows cleaning standards used for an eight–hour work period commensurate with desired cleaning levels and uniqueness of campus facilities.

MAINTENANCE STAFF

A standard published in the *American School and University M & O Cost Study*, April 2008, indicates that a ratio of one maintenance staff to 107,439 square feet of space is an appropriate guide to use when staffing maintenance personnel. Maintenance personnel may include electricians, heating ventilation air conditioning technicians, general maintenance workers, and grounds crews.

FIGURE 424
TEXAS STATE LIBRARY AND ARCHIVES COMMISSION
SCHOOL LIBRARY STANDARDS FOR PROFESSIONAL AND PARAPROFESSIONAL STAFFING, 2004

	STANDARD			
AREA	EXEMPLARY	RECOGNIZED	ACCEPTABLE	BELOW STANDARD
Staffing, Professional	**At least:**	**At least:**	**At least:**	**Less than:**
0–500 ADA	1.5 Certified Librarians	1.0 Certified Librarian	1.0 Certified Librarian	1.0 Certified Librarian
501–1,000 ADA	2.0 Certified Librarians	1.5 Certified Librarians	1.0 Certified Librarian	1.0 Certified Librarian
1,001–2,000 ADA	3.0 Certified Librarians	2.0 Certified Librarians	1.0 Certified Librarian	1.0 Certified Librarian
2,001+ ADA	3.0 Certified Librarians + 1.0 Certified Librarian for each 700 students	2.0 Certified Librarians + 1.0 Certified Librarian for each 1,000 students	2.0 Certified Librarians	2.0 Certified Librarians
Staffing, Paraprofessional	**At least:**	**At least:**	**At least:**	**Less than:**
0-500 ADA	1.5 paraprofessionals	1.0 paraprofessional	0.5 paraprofessionals	0.5 paraprofessionals
501–1,000 ADA	2.0 paraprofessionals	1.5 paraprofessionals	1.0 paraprofessional	1.0 paraprofessional
1,001–2,000 ADA	3.0 paraprofessionals	2.0 paraprofessionals	1.5 paraprofessionals	1.5 paraprofessionals
2,001+ ADA	3.0 paraprofessionals and 1.0 paraprofessional for each 700 students	2.0 paraprofessionals and 1.0 paraprofessional for each 1,000 students	2.0 paraprofessionals	2.0 paraprofessionals

Source: Texas State Library and Archives Commission.

FIGURE 425
NATIONAL CENTER FOR EDUCATION STATISTICS GUIDELINES FOR CUSTODIAL SERVICES, 2003

LEVEL OF CLEANING	DESCRIPTION	EXPECTED SQUARE FOOTAGE	WORK PERIOD
Level 1	Hospital environment, Corporate Suite	10,000–11,000	8 Hrs
Level 2	Upper level for schools, Special Ed areas, Restrooms, Kinder areas, Food Service, etc.	18,000–20,000	8 Hrs
Level 3	Norm for most school areas, acceptable by most professionals, does not pose health issues	28,000–31,000	8 Hrs

Note: Two additional levels (4 and 5) are not shown in Figure 7 because they are not acceptable standards for school districts.
Source: *Planning Guide for Maintaining School Facilities*, School Facilities Maintenance Task Force, National Forum on Education Statistics and the Association of School Business Officials International, sponsored by the National Center for Education Statistics and the National Cooperative Education Statistics System.

FOOD SERVICES STAFF

One method to control labor costs in school food service operations is to set and use formal productivity standards at each campus. The measure of productivity most often used in school food service is Meals-Per-Labor-Hour (MPLH). MPLH is the number of meal equivalents served in a given period divided by the total hours worked during that period and is a standard used to measure the efficiency of not only school districts, but hospitals, restaurants, and other food service operations as well. Meal equivalents are lunches plus an equivalent number of breakfast and a la carte sales. Child nutrition program directors and school business managers use meal equivalents as the unit of productivity for school child nutrition programs when evaluating efficiency and formulating staffing patterns for budgeting. To maximize productivity, kitchen staffing is aligned with MPLH guidelines, and employee work schedules are adjusted when the number of meals served does not coincide with the number of hours scheduled. Scheduled labor hours can be increased or decreased based on the variance from MPLH guidelines.

Prior to using the MPLH guidelines, a district operation must identify whether the district is using a conventional system or a convenience system for food production. Conventional preparation requires more staff than convenience preparation because it uses fewer processed items with more items prepared from scratch, such as raw vegetables and homemade breads.

Figure 426 shows the recommended MPLH standards for conventional and convenience cooking systems.

Figure 427 shows the standard conversion rates used to calculate meal equivalents.

FIGURE 426
RECOMMENDED MEALS PER LABOR HOUR (MPLH) STANDARDS, 2000

NUMBER OF EQUIVALENTS	CONVENTIONAL SYSTEM		CONVENIENCE SYSTEM	
	LOW PRODUCTIVITY	HIGH PRODUCTIVITY	LOW PRODUCTIVITY	HIGH PRODUCTIVITY
Up to 100	8	10	10	12
101–150	9	11	11	13
151–200	10–11	12	12	14
201–250	12	14	14	15
251–300	13	15	15	16
301–400	14	16	16	18
401–500	14	17	18	19
501–600	15	17	18	19
601–700	16	18	19	20
701–800	17	19	20	22
801–900	18	20	21	23
901+	19	21	22	23

Source: *School Food Service Management for the 21st Century, 5th Edition.*

FIGURE 427
CONVERSION RATE FOR MEAL EQUIVALENTS CATEGORY CONVERSION RATE, 2000

MEAL	EQUIVALENT
Lunch Meal	One lunch equals one equivalent
Breakfast Meals	Three breakfasts equal one equivalent
Ala Carte Sales	Sales divided by $3.00 equal one equivalent

Source: *School Food Service Management for the 21st Century, 5th Edition.*

BUS DRIVERS AND MECHANICS

The *Transit Cooperative Research Program Report 54: Management Toolkit for Rural and Small Urban Transportation Systems* recommends staffing with 10 percent extra drivers as "cover" drivers in the public transit industry and one mechanic to maintain 5 to 20 body-on-chassis buses and 15 to 30 vans.

TECHNOLOGY TECHNICIANS

Successful integration of technology depends on efficient support. Effective technology organizations maintain critical mass, a level of staffing necessary to perform all functions adequately. These organizations provide a level of staff based on an evaluation of all duties that need to be performed. In 2005, the Michigan Department of Education funded a project to identify staffing guidelines for its schools to maintain effective educational technology programs. The project team adopted industry benchmarks for the education field and developed the *Michigan Technology Staffing Guidelines*. These staffing guidelines consider the amount of equipment to be maintained; the number of software applications that are installed and maintained on each computer; the number of staff required to handle website content, telephone, video and other non-computer technologies; and the number of management, administrative, and administrative support staff. The *Guidelines* also consider environmental factors that may require additional support, such as the physical size of the district as well as the age and condition of computers and buildings. **Figure 428** shows these guidelines in the computer and software support areas.

As evidenced by these staffing guidelines, many guides are available either through statute or industry standard; however, there are still many that do not exist. Texas statutes are silent regarding teacher-to-student ratios in grades 5 through 12, as well as other non-instructional staff ratios.

Recommendation 1 directs TEA in consultation with appropriate professional associations to identify school district positions that lack staffing guidelines, develop guidelines for these positions, and post a comprehensive summary of all guidelines on the agency's website. TEA should also research and consider what other states are doing in terms of guidelines for staff placements. Some states mandate what the staff ratios should be, while other states allow districts to create their individual methodologies.

FIGURE 428
TECHNOLOGY STAFFING GUIDELINES, 2005

STAFFING AREA GUIDELINE	CALCULATION ASSUMPTIONS USED/FORMULA	STAFFING LEVEL GUIDELINES
Computer Support = (number of workstations and peripherals in use full time)/500	Number of workstations: 3,056 Number of printers: 1,261 Percentage of full-time use: 0.4 [4 (3,056 + 1,261)]/500	3.5
Support provided outside Technology Services Department	Assumes that technology coordinators at all schools combined provide equivalent of 1.0 staff in this area	0.0
TOTALS FOR COMPUTER SUPPORT		**3.5**
User Support = number of users/1000. Users are pro-rated based on determination of their frequency of use high end: 1 multiplier medium: 0.5 multiplier occasional: 0.25 multiplier	Number of high-end users (daily use – 50%–100%): 82 Number of medium users (daily use – 10%–50%): 4,181 Number of occasional users (10% or less): 2,697 [50+.5(4,181)+.25(2,697)]/1000	2.9
Support provided outside Technology Services Department	Assumes that technology coordinators at all schools combined provide equivalent of 1.0 staff in this area	0.0
TOTALS FOR SOFTWARE APPLICATIONS SUPPORT		**2.9**

SOURCE: Michigan Technology Staffing Guidelines.

Virginia mandates a staffing standard for technology staff. Standard Two of the Standards of Quality, Section 22.1-153.13.2 of the Code of Virginia states the following: "Local school boards shall employ two positions per 1,000 students in grades kindergarten through 12, one to provide technology support and one to serve as an instructional technology resource teacher." The Code of Virginia also states, "Local school boards shall employ five positions per 1,000 students in grades Kindergarten through five to serve as elementary resource teachers in art, music, and physical education."

Tulsa Public Schools System issues a staffing plan for its public schools. Specific procedures are issued within the staffing plan to determine instructional allocations of teacher-to-student ratios as shown in **Figure 429**. In addition, formulas are used for the placement of custodians, and MPLH is used to determine staff in the child nutrition program. Security officers are allocated by school.

Seattle Public Schools provide a list of staff per enrollment size for elementary, middle and high schools, with a total of core staff needed for each school.

GUIDANCE REGARDING STAFFING RATIOS WITHIN THE STATE'S FINANCIAL RATING SYSTEM

The Seventy-seventh Legislature, 2001, authorized the implementation of a financial accountability rating system, School Financial Integrity Rating System of Texas (FIRST). Texas Education Code, Chapter 39, Subchapter I, (a) states "each school district must be assigned a financial accountability rating by the TEA." Presently the rating system includes 24 indicators that help determine a Texas public school district's School FIRST rating. The indicators are grouped into five areas: Critical Indicators (1–6), Fiscal Responsibility and Academic Performance (7–12), Budgeting (13–17), Personnel (18–20), and Cash Management (21–24).

FIGURE 429
TULSA PUBLIC SCHOOLS STAFFING PLAN, SCHOOL YEAR 2006-07

GRADE LEVEL	NUMBER OF STUDENTS	NUMBER OF TEACHERS
Pre–Kindergarten	19.8	0.5
Kindergarten–Grade 3	19.8	1.0
Grades 4 and 5	20.8	1.0
Grade 6	20.8	1.0
Grades 7 and 8	23.5	1.0
Grades 9–12 (High School)	24.0	1.0

SOURCE: Tulsa Public Schools.

Texas public school districts are held accountable for meeting staffing ratios within School FIRST. Personnel indicators within the system cite required staffing ratios, but districts are not given specific guidelines on how to best achieve those ratios. Under the accountability system, financial ratings are determined by TEA's analysis of staff and student data, and budgetary and actual financial data reported to the agency

for the fiscal year. The primary goal of the rating system is to improve the management of school districts' financial resources and to encourage Texas public schools to manage financial resources in a manner that provides the maximum allocation possible for direct instructional purposes.

Personnel indicators 18, 19 and 20 are for reporting financial information regarding personnel staffing ratios such as administrative cost ratios per student, student-to-teacher ratios, and student-to-total-staff ratios.

Figure 430 shows the criteria for indicator 18 regarding administrative costs as defined in TEA's Financial Accountability System Resource Guide. The indicator asks the district to determine whether "the administrative cost ratio was less than the threshold ratio." Administrative costs include costs classified in the Public Education Information Management System functions 21 (Instructional Leadership) and 41 (General Administration). The administrative cost ratio is calculated by dividing administrative cost by instructional costs, expressed as a percentage.

FIGURE 430
SCHOOL FIRST INDICATOR 18, 2007
ADMINISTRATIVE COST RATIO

AVERAGE DAILY ATTENDANCE (ADA) GROUP	ADMINISTRATIVE COST RATIO (A)
10,000 and Above	11.05%
5,000 and Above	12.50%
1,000 to 4,999	14.01%
500 to 999	15.61%
Less than 500	26.54%
Sparse	3.614%

NOTE: Formula used is (A>B). (A) Acceptable Administrative Cost Ratio is greater than the (B) Administrative Cost Ratio of the District. The administrative cost ratio is determined by dividing the non-federal operating expenditures in general administration and instructional leadership by expenditures in instruction, instructional resources, curriculum, and guidance and counseling functions.
SOURCE: Texas Education Agency.

Both indicators 19 and 20 are based on student enrollment size. Indicator 19 asks the district to determine whether the ratio of students to teachers is within the ranges shown in **Figure 431.** Indicator 20 asks the district to determine whether the ratio of students to total staff is within the range shown in **Figure 432**.

Districts are assigned one of five ratings as shown in **Figure 433**.

FIGURE 431
SCHOOL FIRST INDICATOR 19, 2007
STUDENT-TO-TEACHER RATIO

DISTRICT STUDENT ENROLLMENT (A)		RANGES FOR RATIOS FOR STUDENT-TO-TEACHER	
		LOW	HIGH
	<500	7:1	22:1
500	999	10:1	22:1
1,000	4,999	11.5:1	22:1
5,000	9,999	13:1	22:1
=>10,000		13.5:1	22:1

NOTE: Formula used to derive this ratio is (A / B) where A = Number of students; B = Number of teacher full-time-equivalent positions.
SOURCE: Texas Education Agency.

FIGURE 432
SCHOOL FIRST INDICATOR 20, 2007
TOTAL STAFF-TO-STUDENT RATIO

DISTRICT STUDENT ENROLLMENT (A)		RANGES FOR RATIOS FOR TOTAL STAFF-TO-STUDENT	
		LOW	HIGH
	<500	5:1	14:1
500	999	5.8:1	14:1
1,000	4,999	6.3:1	14:1
5,000	9,999	6.8:1	14:1
=>10,000		7:1	14:1

NOTE: Formula used to derive this ratio is (A / B) where A = Number of students; B = Number of total staff full-time-equivalent positions.
SOURCE: Texas Education Agency.

Within two months of the issuance of the final rating, each school district holds a public meeting to distribute a financial management report that explains the district's performance under each of the indicators. The district is encouraged to provide in the financial management performance report additional information that will be beneficial to taxpayers, especially information explaining special circumstances, if any, that may have affected the district's performance under one or more of the indicators.

School districts are held accountable for several measures including student-to-total staff ratios. Texas public school districts assigned a substandard rating within the system are sanctioned with penalties ranging from corrective action plans to placing a financial monitor in the district.

According to TEA's division of Financial Audits, districts that are rated Substandard Achievement face sanctions as seen in **Figure 434**.

FIGURE 433
SCHOOL FIRST RATINGS SYSTEM, 2008

RATING	SCORING SYSTEM
Superior Achievement	Score greater than 75 and "YES" to Indicator 7.
Above Standard Achievement	Score of 65 to 75 OR greater than 75 and "NO" to Indicator 7.
Standard Achievement	Score of 55 to 65 points.
Substandard Achievement	If less than 55 Points OR If the district answered "NO" to indicators 1, 2, 3, 4, 5, and 6. The commissioner of education may apply sanctions to a district that is assigned a substandard achievement rating.
Suspended Data Quality	If serious data quality issues are disclosed by the commissioner of education, a "Suspended—Data Quality" rating shall be assigned to the school district. The Suspended—Data Quality rating will be assigned until the district successfully resolves the data quality issues. The commissioner of education may apply sanctions to a district that is assigned a Suspended—Data Quality rating.

NOTE: In Indicators 1, 2, 3, 4, 5, and 6, a district's financial rating is determined by answering "YES" or "NO." If the district answers "NO" to each of these indicators, the district's rating is automatically Substandard Achievement.
SOURCE: Texas Education Agency.

FIGURE 434
SCHOOL FIRST SANCTIONS, 2008

YEAR	SANCTIONS
Year 1	Districts rated substandard in the first year must write a corrective action plan within six months.
Year 2	Districts rated substandard in the second consecutive year must write a corrective action plan every quarter.
Year 3	Districts rated substandard in three consecutive years in the School FIRST system are assigned a financial monitor by the Texas Education Agency. The monitor's hourly wage and travel expenses must be covered by the district assigned a monitor.

SOURCE: Texas Education Agency.

Districts continuing to receive substandard achievement ratings may be assigned a financial monitor whose purpose is to assist the district in correcting its financial status. In spite of this, a district overstaffed does not receive comprehensive assistance regarding staffing guidelines. According to TEA, a monitor may simply tell the district to conduct a staffing comparison of peer districts or may be directed to view a professional organization's website for ideas regarding staffing guidelines. Merely conducting a staffing comparison with a peer district may not reveal whether the peer district itself is following the most efficient staffing methodologies. Additionally, viewing a website may also prove problematic if the website does not house staffing guidelines for specific positions needed by the district or if the district does not have a membership to access the website's information.

Districts facing financial problems due to overstaffing often do not conduct a systematic staffing analysis since they are not required to do so. One district, facing a sizeable financial budget deficit indicated that while its student enrollment had declined in 2005–06, the district currently had more staff now than it did in 2005–06 when enrollment began declining. A former superintendent recently stated, "Declining enrollment, inappropriate staffing levels and failure to accurately determine funding are common basic indictors often found in Texas districts experiencing financial difficulties." It is therefore critical that districts conduct a periodic staffing analysis to ensure efficiencies.

Recommendation 2 suggests that TEA should provide guidelines demonstrating how Texas public school districts can achieve the staffing ratios required for the three personnel indicators in the financial rating system.

Recommendation 3 states when TEA assigns a financial monitor to a Texas public school district, it should require that a staffing analysis be conducted comparing the actual number and type of staff to the comprehensive summary of staffing guidelines posted on the agency's website. Conducting such an analysis will better assist a district in identifying which departments are overstaffed or understaffed and help the district make corrections in order to be financially efficient.

FISCAL IMPACT OF THE RECOMMENDATIONS

These management recommendations would result in no fiscal impact in the 2010–11 biennium since they can be accomplished with existing appropriations.

PROVIDE PUBLIC SCHOOL DISTRICTS A COMPREHENSIVE SCHEDULE OF REPORTING REQUIREMENTS

Public school districts report data to many entities including the Texas Education Agency and other state and federal agencies. Districts report information in many educational, financial, and operational areas. Districts are challenged to be aware of different reporting requirements and deadlines, which may change periodically and occur throughout the school year. The reporting demand is magnified for smaller districts, which may rely on a limited number of staff to stay informed about reporting requirements and deadlines.

The Texas Education Agency and regional education service centers provide information about many of the reporting requirements, but the agency does not provide districts with a comprehensive schedule of reporting requirements with deadlines from all organizations. Without a comprehensive schedule of reports and data requested by the Texas Education Agency and others, districts must maintain their own schedule for reporting requirements in order to comply with various regulations and to avoid missing funding opportunities to provide all the educational programs they can for their students.

CONCERN

- ♦ School districts, particularly smaller ones with a limited number of staff, may be challenged with staying informed about all of the reporting requirements and deadlines, especially as existing ones are updated or new ones are added.

RECOMMENDATION

- ♦ **Recommendation 1:** The Texas Education Agency should develop and maintain a comprehensive schedule of school district reporting requirements with deadline dates for data reported to the Texas Education Agency and other agencies or organizations.

DISCUSSION

Public school districts report information to the Texas Education Agency (TEA) and other agencies. The most commonly known of these reporting requirements is the Public Education Information Management System (PEIMS). This database tracks information from school districts about district finances, staff, and students in four submission periods during the year:

- Fall/Submission 1;
- Midyear/Submission 2;
- Summer/Submission 3; and
- Extended/Submission 4.

School districts report other information to TEA that includes student assessment testing data, state funding information, financial audits, health and safety data, state and federal grant expenditures, and program compliance reports.

In addition, districts provide information to agencies or organizations other than TEA. **Figure 435** shows some information that school districts provide electronically or in written form to these other organizations.

FIGURE 435
EXAMPLES OF SCHOOL DISTRICT REPORTING TO AGENCIES OR ORGANIZATIONS OTHER THAN TEA, OCTOBER 2008

AGENCY/ENTITY	TYPE OF INFORMATION
Texas Department of Agriculture	Child Nutrition Program data
Regional Education Service Center 12	Technology plans and School Technology and Readiness (STaR) Charts
IRS and Teacher Retirement System	Employee personnel information
School Safety Center at Texas State University	Security audits
Texas Workforce Commission	Employment data
Office of Civil Rights (U.S. Department of Education)	Student data
Texas State Center for Early Childhood Development	Student testing data

Source: Legislative Budget Board.

TEA also requests reporting information from districts who participate in pilot programs or particular state and federal grants. From September 2007 to August 2008, there were approximately 130 of these data requests that were sent to school districts. **Figure 436** shows some of the types of information collected electronically or in written form in these cases with the responsible TEA division.

FIGURE 436
DATA REPORTING FOR GRANT OR PILOT PROGRAMS, SEPTEMBER 2007 TO AUGUST 2008

TEA DIVISION	TYPE OF INFORMATION
Planning, Grants and Evaluation	Texas Fitness Now Progress Report
Student Assessment	Student Assessment Online Student Survey
College and Career Readiness	GEAR UP Instruments
IDEA Coordination	Visual Impairment Registration Consent Form
State Funding	Bus Accident Reporting System
State Initiatives	Communities in Schools Program Rule Revision
Programs for At-Risk Youth	Optional Extended Year Program Final Progress Report
State Initiatives	Educator Retention and Shortage Survey
Instructional Materials and Educational Technology	Vision 2020 Grant Surveys for Virtual Learning
No Child Left Behind Program Coordination	School Improvement Program Campus Compliance Report
Health and Safety	School Health Survey
School Finance	Health Care Funding Application
Programs for At-Risk Youth	Investment Capital Fund Final Progress Report
College and Career Readiness	Collaborative Dropout Reduction Pilot Program
Planning and Grant Reporting	Texas Educator Excellence Grant Progress Report

Source: Texas Education Agency.

ROLE OF TEA IN REPORTING PROCESS

TEA informs school districts about reporting requirements in several ways. TEA posts information on topics including data collections on the Internet on its Communications and Publications webpage under Correspondence to Districts that has letters that are sent to school districts. There is a Forms link on this webpage for non-mandatory forms used to assist school districts, citizens, or businesses in performing their duties. Some examples of the forms available on this webpage include ones for Career and Technology Education, Charter Schools, Driver Training, Legal, PEIMS, School Finance, Special Education, and Textbooks. There is also a Grants link on the website with information about grants and their reporting process. TEA has information on its Financial webpage about data collection requirements that business managers in school districts can review. TEA has an e-mail address for each district for sending e-mail correspondence and can also follow up important notices with letters to school districts.

Another method TEA uses to communicate with districts is self-subscribing "listservs," where individuals can subscribe to an automated e-mail mailing list from the agency in various topic areas. Members of the school community and the general public receive e-mail updates from TEA through these listservs. For example, TEA's letters to districts, known as To the Administrator Addressed letters, are distributed to school leaders through a listserv e-mail. Another listserv provides updates on educator standards. Multiple staff in a school district may sign up for the same listserv. **Figure 437** shows a sample list of some of the 64 listservs available on TEA's website that are free of charge and provide information, in some instances, on reporting requirements.

There are other times when TEA distributes information to districts through the U.S. mail, which typically occurs when districts are being notified of a sanction and are given an appeals deadline.

TEA does not have a listing of information that is required to be reported to other entities. The other entities may have their own notification process.

REGIONAL EDUCATION SERVICE CENTERS

Regional education service centers (RESCs) play an important role in school district reporting. Texas Education Code, Section 8.001, establishes 20 RESCs throughout the state and gives the Commissioner of Education oversight authority over the RESCs. The purpose of the RESCs is to assist school districts in the following:

- improving student performance,
- operating more efficiently and economically, and
- implementing initiatives assigned by the Legislature or the Commissioner of Education.

TEA communicates with the RESCs through e-mail and To the Administrator Addressed letters that are posted on TEA's website. TEA has staff in different program areas such as Special Education, No Child Left Behind, State Initiatives, Curriculum, Student Assessment, and Grants. TEA staff communicate with RESC personnel in these various program areas. TEA staff generally do not travel to the RESCs; however, RESC staff do come to TEA headquarters periodically for training and various types of meetings. TEA also uses the Texas Education Telecommunications Network

FIGURE 437
SAMPLE OF TEA LISTSERVS, OCTOBER 2008

LISTSERV	TYPE OF INFORMATION
To the Administrator Addressed Correspondence	This listserv will notify subscribers when a new correspondence is added to the index on the TEA General Correspondence Web Page.
Bilingual/ ESL Education	Members of the Bilingual/ESL listserv will receive updates on Bilingual Education and English as a second language policy, programs, assessment, instructional related information, latest research, professional development, and instructional materials.
Dropout Prevention	Subscribers to this listserv will receive periodic updates on agency programs and initiatives about dropout prevention and related topics.
Educator Standards	The Educator Standards listserv will provide information and announcements pertinent to educator preparation programs.
English Language Arts/Reading	The subscribers to this listserv will receive monthly updates with the most current information on curriculum, assessment, teacher certification, professional development, as well as other issues related to English language arts and reading in Texas.
Gifted/Talented Education	The Gifted/Talented listserv will provide updates about programs and services related to gifted education.
High School Equivalency Program (HSEP)	Subscribers to the HSEP listserv will receive information about events, such as changes in the law and rules, new Texas Education Agency documents, changes to the HSEP website, and other useful news.
Mathematics	Subscribers to the Mathematics listserve will receive updates with current information on curriculum, TAKS, professional development, the Texas Math Initiative, and other issues related to mathematics education.
Safe and Drug-Free Schools and Communities Programs	Subscribers to the Title IV–Safe and Drug-Free Schools and Communities Program listserv will receive program updates, clarification on legal issues, and be notified of workshops, conference sessions, and trainings to be conducted by Agency program staff.
Special Education Updates	This listserv will notify subscribers when new information is posted in the Special Education area of the TEA Website.
Instructional Materials	The Instructional Materials listserv will deliver the latest news and information from the Texas Education Agency's Division of Instructional Materials and Educational Technology.
No Child Left Behind (NCLB)	Subscribers to the NCLB listserv will receive program updates, clarification on legal issues, and be notified of workshops, conference sessions, and trainings to be conducted by the Division of NCLB Program Coordination staff.
Texas Reading Initiative	Subscribers to this listserv will receive information specific to the Texas Reading Initiative, a component of our state legislation housed within the Student Success Initiative that supports reading achievement in Grades K-5.

Source: Texas Education Agency.

(TETN) for face-to-face meetings, training, and conferences among TEA and RESC program personnel.

RESCs communicate with school districts in their region and provide information and training and other services to their districts. RESCs have different contacts for various program areas and use optional listserv updates in different program areas to inform school districts of deadlines and important dates. School districts provide the RESCs with their district staff contacts in different programs for the listservs, and RESC personnel periodically visit districts in their region.

HOW DISTRICTS MANAGE REPORTING REQUIREMENTS

Districts manage reporting requirements in different ways depending on their size. Larger districts may have more personnel to maintain schedules for reporting requirements. The chief financial officer or business manager can review financial data, and various instructional or curriculum staff can review the more program specific types of reporting. In smaller districts, much of the reporting responsibilities may fall on a limited number of staff, primarily the superintendent and business manager. Districts usually have PEIMS staff to handle the PEIMS reporting.

Districts keep track of reporting requirements and deadlines using various resources. Superintendents and district staff

rely on information from TEA through the listservs and the Correspondence to Districts webpage that posts all notification letters to school districts and regional education service centers. RESCs play a major role through their contact with districts about reporting deadlines. Many school districts, particularly smaller ones, depend on their RESCs for notices on upcoming events and reporting deadlines.

Districts use other resources to help them gather information on reporting. Organizations such as the Texas Association of School Business Officials (TASBO), the Texas Association of School Administrators (TASA), the Texas Association of School Boards (TASB), and private businesses provide current news and legislative updates. Districts receive some information free of charge but must pay to use other services.

Additionally, reporting requirements may vary among districts based on the pilot programs or grants they are receiving. For example, a district participating in a grant or pilot program on dropout prevention may have additional reporting requirements for this program that other districts not participating in the program would not.

Staff in some districts develop a reporting calendar as a starting point and identify all items that they need to report. When additional reporting items are added, they update their calendar by adding the new requirements. School district staff also attend conferences offered by professional organizations on topics like assessment testing or compensatory education to stay informed about changes in programs and in their reporting requirements.

OTHER RESOURCES FOR DISTRICTS

There are some optional tools that school districts can use to stay informed about reporting requirements and deadlines. For example, RESC VI (Region 6) provides schedules and calendars by department on its website to help school district staff keep track of reporting deadlines. **Figure 438** shows an example listing for the Federal Program Director Calendar activities for August and includes reporting items that should occur during this period.

School districts report a vast amount of information to TEA and other agencies and organizations. Each year there are reporting requirements that are added or changed, challenging districts to keep up with the reporting requirements and their deadlines. The effort is intensified for smaller districts with a reduced number of staff. Although actual reporting requirements would vary somewhat from district to district due to different student characteristics and needs, TEA does not provide a basic listing of reporting requirements for school districts that could serve as a starting point to help districts keep up with reporting requirements, comply with various regulations, and avoid missing funding opportunities for educational programs for their students.

FIGURE 438
REGION 6 FEDERAL PROGRAM DIRECTOR CALENDAR– AUGUST ACTIVITIES, AUGUST 2008

1. Final Expenditure Report for NCLB Consolidated Application, Title I School Improvement, and Rural and Low-Income Schools (15)
2. Submit eGrants NCLB Consolidated Compliance Report
3. Submit Gun Free Schools District Report
4. Document New Hire Credentials for Teachers and Paraprofessionals
5. Send Parents' Right-to-Know Information
6. Obtain SBDM Schedules from Campus Administrators-Add Agenda Items, As Appropriate
7. Prepare NCLB Consolidated Application, If Submitting for September 4th Deadline
8. Contact Private Schools Regarding Services
9. Schedule the Title I, Part A Meeting for Parents
10. Ensure School-Parent Compacts are Signed and Teachers Conference with Parents Regarding the Compact
11. Anticipate AYP Results
12. Begin Year-Long Planning Process for Campuses That Will Change to Schoolwide; Document Planning Meetings
13. Migrant NGS: Facility Updates and Contact Information (30th)

Source: Regional Education Service Center VI.

Recommendation 1 directs TEA to develop and maintain a comprehensive schedule of school district reporting requirements. This schedule would assist school districts by providing a comprehensive listing of reporting requirements that are required to be reported to TEA and other agencies and organizations. Such a schedule could be the beginning point for school districts, and each district could then add the additional reporting requirements that were specific to their district, such as ones for particular grants or pilot programs that their district was participating in.

TEA could develop the format for this schedule of reporting requirements in an appropriate manner, possibly by calendar deadline date, department, or other means. Attention could also be given to the level of detail if the document became too large.

TEA is redesigning its website in fall 2008 to contain a calendar of submission deadlines, meetings, and testing dates. Adding a reporting requirements schedule for school districts should be considered for this website.

FISCAL IMPACT OF THE RECOMMENDATION

Recommendation 1 would have no significant fiscal impact. The comprehensive schedule of school district reporting requirements could be completed with existing agency appropriations.

SUCCESSFUL PERFORMANCE AT ECONOMICALLY DISADVANTAGED SCHOOL DISTRICTS

In the past 10 years, the number of economically disadvantaged students entering Texas public schools has increased significantly. During this period, the number of these students increased at a rate more than double the increase of total student enrollment, and now compose over half of the state's total student enrollment. Analysis of school district data confirms a general perception that economically disadvantaged students are less likely to perform well in school than more affluent students.

Legislative Budget Board staff reviewed seven school districts in Texas during the 2007–08 school year with large percentages of economically disadvantaged students and that have performed well on academic criteria related to Texas Assessment of Knowledge and Skills performance and various college readiness indicators. The review identified characteristics of these school districts that may contribute to their success.

FACTS AND FINDINGS

Six themes were identified that represent similar policies, practices and general environment characterizing these districts. These districts:

- Establish a supportive infrastructure that shares responsibility throughout the leadership organization and supports staff.
- Implement a wide range of instructional programs representing innovative educational practices and responses to student demographics.
- Create a culture of high expectations that sets high academic expectations and encourages students to prepare for life beyond graduation.
- Use partnerships to support academic goals.
- Target resources to support academic expectations.
- Maximize the opportunities available from a small student enrollment to enhance service delivery.

DISCUSSION

To be identified as economically disadvantaged, public school students in Texas must be eligible for free or reduced-price lunches under the federal National School Lunch Program, be eligible for other types of public assistance such as Temporary Assistance to Needy Families, or be a member of a family whose income is at or below the official poverty line. For the 2008–09 school year, eligibility is an annual family income below $32,560 for a household of three or below $39,220 for a household of four.

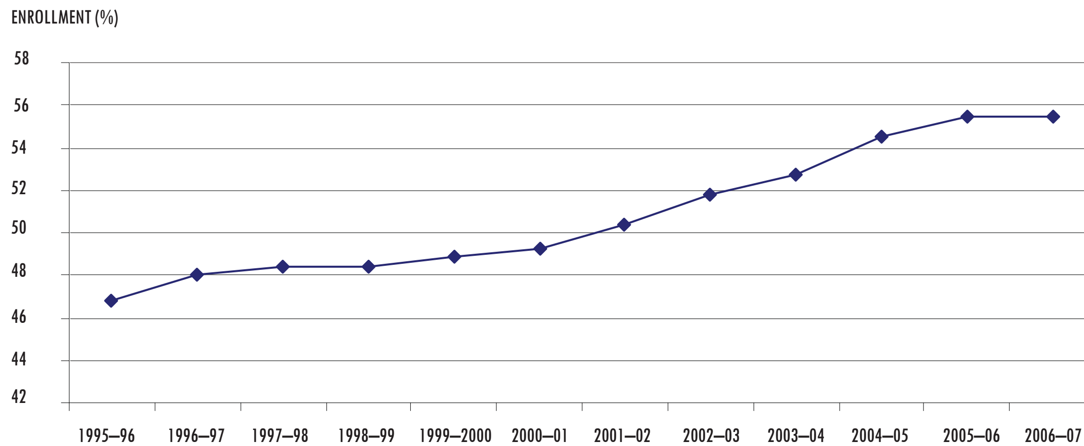
During the 2006–07 school year, there were approximately 2.5 million students identified as economically disadvantaged in Texas public schools, or 55 percent of Texas' total student enrollment. **Figure 439** shows how the enrollment of economically disadvantaged students in Texas, as a percentage of total student enrollment has increased from school years 1995–96 to 2006–07. During this period, Texas' economically disadvantaged student population increased 45 percent, an amount more than double the percentage increase in the state's total student enrollment.

The Texas Assessment of Knowledge and Skills (TAKS) is the state mandatory assessment instrument used to measure student performance on Texas education standards. The TAKS Met Standard is the percentage of a school district's students whose TAKS performance met the state designated score for any particular subject and grade level test. Of districts with a majority of economically disadvantaged students, 39 percent had 60 percent or less of its students perform below the standard. This is a sharp difference from districts with a majority of students performing at or above the standard where 92 percent have less than 60 percent economically disadvantaged students.

SCHOOL DISTRICT REVIEW

Legislative Budget Board staff reviewed seven school districts during the 2007–08 school year with large percentages of economically disadvantaged students and that have exhibited high student performance on academic criteria related to TAKS performance and various college readiness indicators. This review identified and assessed the ways that these districts educate their students, regardless of socioeconomic status.

FIGURE 439
ENROLLMENT OF ECONOMICALLY DISADVANTAGED STUDENTS TEXAS PUBLIC SCHOOLS
SCHOOL YEARS 1995–96 TO 2006–07



SOURCE: Texas Education Agency.

The districts selected for onsite work varied in both accountability rating and demographics. **Figure 440** shows a summary comparison of the districts selected for review by district accountability rating, student enrollment, and student demographics.

This review identified six broad themes. These themes pertain to multiple school district functions and manifest themselves differently from district to district.

THEME 1: ESTABLISHING A SUPPORTIVE INFRASTRUCTURE

Each of the seven districts reviewed have established a management structure that emphasizes a sharing of responsibility and collaboration throughout the district's organization structure to support the educational mission of the school district. This support can be peer-to-peer mentorship, staff autonomy, or programs designed to support staff recruitment and retention such as additional benefits or stipends.

In Pharr-San Juan-Alamo Independent School District (ISD), the district formed a team of seven elementary principals who serve as mentors to the other elementary principals in the district. Mentors are selected based on their campus' track record of consistently high academic performance. Mentors are assigned two or three team member principals who meet monthly with their cluster members and communicate with them on an ongoing basis. This assistance is provided in a non-threatening, non-evaluative manner with a relationship focused on instruction, student achievement, and intervention strategies.

The sharing of responsibility is also exhibited in Hidalgo ISD where it takes the form of campus principals designated as that campus' "Leader of Learning." These principals have the responsibility and autonomy to establish innovative programs or practices to stimulate academic success and maintain continuous improvement. Another example is from Friona ISD where teachers have a common planning period that they may use to work together and share ideas. This collaboration is further reinforced by an emphasis by school administrators that all staff are responsible for student discipline.

Coupled with shared leadership are district policies and programs that support staff and encourage staff retention. These types of support typically can be stipends supporting high need positions or additional staff benefits. For example, in Friona ISD staff have access to a childcare center for three and four year olds. This childcare is offered at a minimal cost of $3 per day or $15 per week for a full day enrollment and $1 per day for a four-year-old enrolled half a day. Children also receive breakfast and lunch free of charge.

THEME 2: IMPLEMENTING INNOVATIVE AND RELEVANT INSTRUCTIONAL POLICIES AND PROGRAMS

These districts have implemented a wide range of instructional programs that are both innovative educational practices and responses to characteristics of the district's student demographic makeup. These actions are a critical component of how these school districts use existing resources and seek out new opportunities to respond to the challenges of educating their students.

FIGURE 440
SUMMARY PROFILE OF SCHOOL DISTRICTS SELECTED FOR REVIEW
2006–07 SCHOOL YEAR

DEMOGRAPHIC ATTRIBUTE	PHARR-SAN JUAN-ALAMO	HIDALGO	FRIONA	O'DONNELL	MILFORD	BALMORHEA	AVINGER
District Accountability Rating	Academically Acceptable	Academically Acceptable	Academically Acceptable	Academically Acceptable	Academically Acceptable	Recognized	Recognized
Region	1	1	16	17	10	18	8
Enrollment	28,833	3,327	1,255	344	211	151	139
STUDENT ETHNIC COMPOSITION							
African American	0.2%	0.1%	0.7%	0.6%	27.0%	0.0%	18.0%
Hispanic	98.7%	99.7%	76.5%	59.9%	20.9%	92.7%	10.8%
White	1.0%	0.2%	22.3%	39.0%	52.1%	7.3%	69.8%
Other	0.2%	0.1%	0.5%	0.6%	0.0%	0.0%	1.4%
Economically Disadvantaged	90.0%	90.2%	76.3%	82.3%	75.8%	84.8%	64.7%
At-risk	75.9%	72.0%	48.5%	49.1%	45.0%	58.3%	40.3%
Limited English Proficient	41.4%	54.9%	22.0%	6.7%	5.2%	6.6%	0.0%

NOTE: Due to rounding of amounts in the Academic Excellence Indicator System report, totals may be slightly more or less than 100 percent.
SOURCE: Texas Education Agency.

Innovative practices in public education are an approach to academic challenges conducted through a variety of unique ways to meet needs. These practices can be system-wide or designed to meet the needs of a select group of students. For example, Hidalgo ISD has transitioned their single high school to an Early College High School. This provides all students access to a rigorous curriculum with the potential for graduates to leave the program with up to 60 hours of college credit. This change has repercussions that have extended down into the lower grade campuses. For example, the junior high campus is now required to begin preparing its students to take the Texas Higher Education Assessment by the eighth grade. Passing every component of this exam is necessary for a Hidalgo ISD student to take full advantage of the numerous college credit bearing courses available at the high school.

Balmorhea ISD requires its teachers to develop instructional timelines for each six-week period that specify performance indicators to be addressed, TAKS objectives, strategies, activities and resources the teacher will use, the type of assessment that will be administered and the time frame to complete these actions. Lesson plans are tied to this timeline. District leadership reviews these documents to ensure that teachers cover all TAKS objectives in a timely manner.

Pharr-San Juan-Alamo ISD has implemented an International Baccalaureate Primary Years Program at an elementary school. This program is an inquiry-based learning process to encourage development of information processing and problem-solving skills. The school also uses a Dual Language bilingual education model with the goal of having all students fluent in English and Spanish by the third grade.

These districts use their knowledge of student body characteristics to construct policies and programs to address student body characteristics that have natural educational barriers. Examples of these traits include high student mobility and limited English proficiency. To address this aspect of their student enrollment, both Hidalgo ISD and Pharr-San Juan-Alamo ISD established Dual Language bilingual education programs. This model provides language instruction in each language 50 percent of the time. Instructional delivery for each language is divided by subject area rather than by time.

Pharr-San Juan-Alamo ISD is addressing two characteristics of its student body. To address the frequent in-district mobility of their migrant students, the district has standardized its curriculum and timelines across all campuses. This standardization ensures that students who may switch campuses mid-semester receive no break in their instruction. To address dropouts, the district instituted a multi-part plan designed to account for and recover every student who left the district without graduating. This plan included campus community liaisons visiting ex-students, dropout recovery

walks and targeting students who failed the exit-level TAKS exam for immediate intervention into the district's College, Career and Technology Academy.

THEME 3: ESTABLISHING A CULTURE OF HIGH EXPECTATIONS

These districts created and maintain an environment of high expectations for students that is reinforced by district and campus administrators and supported throughout the organizational structure. This message takes a variety of forms, formal and informal. This culture is supported by the staff's commitment to hold every student accountable to an academic standard (a "no excuses" philosophy) and to intervene appropriately when necessary to sustain student academic success.

The most common procedural example of this among those districts profiled was through district use of student performance monitoring techniques, such as frequent student assessments and benchmarking, that evaluates student academic progress throughout the school year and can identify where each individual student is struggling. A variety of available interventions can address identified student academic deficiencies. Tutorials were the most common form of intervention used by the districts. Tutorial programs were offered both during and after school, and on weekends. Student participation in these tutorials ranged from voluntary to district policies requiring student attendance based on specific academic deficiencies. These sessions offer individualized instruction tailored to student need.

Another significant component of this culture is the emphasis all districts place on encouraging students to take steps that will prepare them for life after high school. The form of this emphasis varies from district to district. Examples include: elementary schools decorated with college paraphernalia; eighth grade students and parents provided information by guidance counselors detailing the benefits of taking a rigorous curriculum during high school that includes college-credit bearing courses; career exploration courses and interest profilers used to help students identify careers and vocational pathways that most fit their interests; and communication with parents and students on topics related to higher education such as financial aid and the college admissions process.

THEME 4: CREATING PARTNERSHIPS SUPPORTING ACADEMIC GOALS

School districts that successfully educate high economically disadvantaged populations are supported through a variety of partnerships with state and local entities. These can include city, county, and state governments, as well as higher education institutions, nongovernmental organizations and private businesses. The goals of these partnerships vary by school district, though all reviewed districts maintained a partnership with a local higher education institution, typically a community college, for purposes of offering state-required college-credit bearing courses.

For example, Pharr-San Juan-Alamo ISD has collaborated with Workforce Solutions (the local workforce development board) and South Texas College (a two-year higher education institution) to create the College, Career and Technology Academy. This unique program offers former students who failed the exit-level TAKS exam or are short a few courses and dropped out of school the opportunity to return and obtain their high school diploma, to gain college credit through dual enrollment courses and, upon graduating, to immediately transition into South Texas College to continue their education. Through the partnership with Workforce Solutions, students are provided a career inventory to gauge their professional interests and, through a partnership with South Texas College, students are provided access to dual enrollment courses, assistance with applying for college and completing the application form for federal financial aid.

Friona ISD offers another example of how partnerships can provide districts opportunities that strengthen instructional delivery. The district has incorporated service learning as a method of instruction at all grade levels. This teaching method combines academic classroom curriculum with meaningful service in the community. To support this work, this district collaborated with a variety of local, state and private entities. Partnerships have included:

- Parmer County Pioneer Heritage Museum: Renovation of the county museum coupled with a project to document the history of Parmer County. This project included an application to the Texas Historical Commission to document Friona ISD as the first school district to racially integrate African American students in Texas during the 1954–55 school year.
- Texas Historical Commission: Production of a video on the Texas Plains Trail to be used in museums in the

South Plains region. This video examines the history of the South Plains region and its unique geographic characteristics.

- Texas Tech University: Participation in a project studying playa lakes and their significance to the region's water supply. This project included fieldwork performed for and with the aid of university professors.

THEME 5: TARGETING RESOURCES TO BUTTRESS ACADEMIC GOALS

The reviewed districts prioritize resources based on identified needs recognized by district leadership. The most common example of this practice was the district's priority of obtaining and maintaining a high integration of technology into the school environment, which consisted of desktop computers, laptops, projectors, smart boards and digital cameras. Technology was integrated into all grade levels and was tailored to meet student needs and facilitate academic achievement. For O'Donnell ISD's junior high school, this meant participating in the Texas Education Agency's Technology Immersion Program. This program provides a laptop to each student in the campus that students are allowed to take home. Teachers incorporate technology use into their daily instructional delivery and include assignments that require the use of software. Students used the laptops for a variety of functions: as a study aid, to write papers, to create presentations, and to conduct Internet-based research.

Friona ISD and Balmorhea ISD offer another example of technology integration. Both districts use mobile labs and educational software coupled with widely used and available software to provide students with opportunities to work with commonly used programs such as Microsoft PowerPoint.

Another example of how districts prioritize resources to support academic goals is offering students college entrance exams such as the SAT or ACT or college-credit bearing exams such as Advanced Placement either free of charge or at a reduced cost. This practice was common to all districts reviewed.

THEME 6: MAXIMIZING THE OPPORTUNITIES OF DISTRICT SIZE

Districts with small student enrollments consider their size an asset and take advantage of the opportunity this trait offers.

These opportunities are realized in many ways, both formally and informally. District policies that take advantage of small staff and class sizes recognize the unique advantages such an opportunity offers. For example, in Avinger ISD, teachers in grades 7 to 12 are aligned with students throughout their high school experience by subject area, creating the opportunity to gain significant familiarity with each student's academic strengths and needs. In Milford ISD, student assignments are tailored to individual student interest. Informally, there are greater opportunities for staff camaraderie and collaboration and frequent individualized instruction in the classroom. In O'Donnell ISD elementary school teachers consult with lower grade teachers at the beginning of each year to learn about the academic strengths and weaknesses of each student. These teachers are then able to use this information to tailor their instruction to the needs of the students.

All reviewed districts with small student enrollments credited the close relationship between the school and community as a key factor in their district's success. For many of these districts, their staff grew up and eventually returned to work in the community of their birth, an experience that engenders a unique sense of ownership to the students, the district and the community.

ACCOUNTABILITY OF CONTRACTING PRACTICES IN PUBLIC SCHOOL DISTRICTS

Public school districts in Texas contract for services in educational, financial, and operational functions. Districts spent over $20 billion on contracted services from school years 2002–03 to 2006–07. During this period, contracted expenditures increased by 36.4 percent ($3.6 billion to $4.9 billion); whereas, total school district expenditures increased by only 24 percent ($38.3 billion to $47.6 billion).

Texas School Performance Reviews, conducted by Legislative Budget Board staff, have consistently identified concerns and recommendations related to contracting policies, procedures, and management in Texas school districts.

FACTS AND FINDINGS

- School districts are not held to the same requirements as state agencies for reporting contracted expenditures.
- The level of contracted expenditures in school districts could more than double in the next 10 years.
- Problems in school district contracting are documented in 12 years of Texas School Performance Review work.

DISCUSSION

Contracting for services is common to Texas state agencies, public colleges and universities, and independent school districts. For many agencies and school districts, contracting may result in decreased management functions. Nonetheless, contract oversight is a key principle to ensuring efficiency and effectiveness in service delivery. The *State of Texas Contract Management Guide*, 2006, established to provide recommendations to improve contract management process and procedures, identifies contract management as five interrelated components: planning, procurement, rate/price establishment, contract formation, and contract oversight. As indicated by the *Contract Management Guide*, a range of managerial tasks and functions are necessary for efficient and effective service delivery.

School districts contract for services in all functional areas. According to the American Schools and University's *7th Privatization/Contract Services Survey,* common services that school districts secure from private vendors include transportation, utilities, food service, grounds maintenance, and custodial service. Additionally, school districts contract services directly related to the teaching and learning process such as curriculum systems, professional development services, and tutoring. Service delivery contracting, which consists of allocating to vendors the responsibility of producing the service along with delegating management responsibilities, is most often used by school districts. While districts can transfer some monitoring functions to vendors, they must retain management responsibilities to monitor a vendor's performance and to evaluate the services/products received.

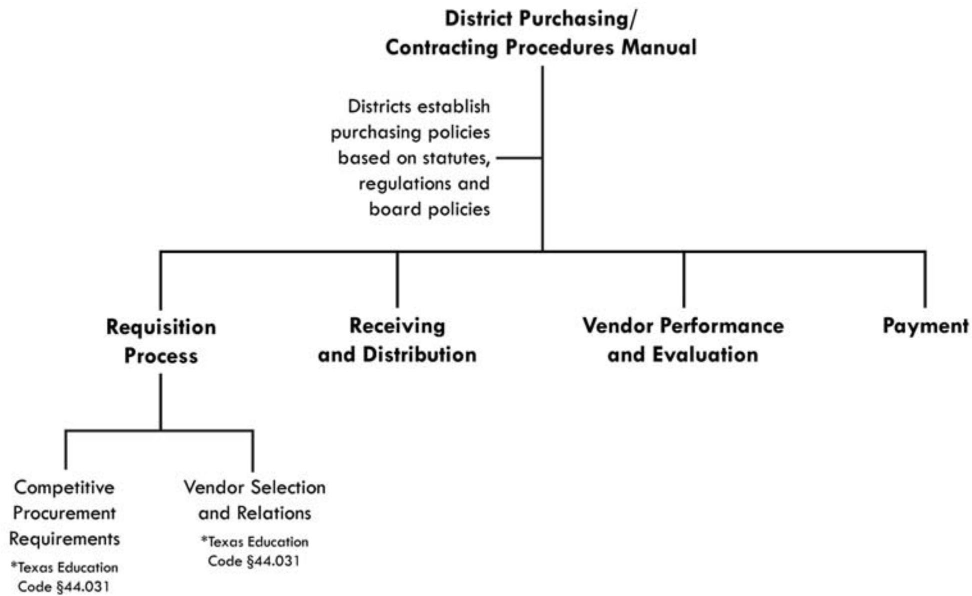
Figure 441 shows a suggested process for school district purchasing and contracting as outlined by the Texas Education Agency's (TEA) *Financial Accountability System Resource Guide*, (FASRG), 2008. The FASRG notes that "state law and Texas Attorney General Opinions establish the minimum requirements for school districts, and a district's governing board has broad discretion to establish stricter local policies." Statutes governing school district contracting are noted within the figure.

While school districts may contract for services with vendors independently, a majority of school districts participate in purchasing cooperatives when securing certain services. According to the Texas Association of School Business Officials (TASBO), most school districts participate in a purchasing cooperative. Cooperative purchasing, also referred to as interlocal cooperation contracting, involves districts participating with other districts or with government entities to acquire goods and services. Texas Government Code, Chapter 791 provides the guidelines for cooperative purchasing arrangements. Common purchasing agreements exist between districts and the Comptroller of Public Accounts, Regional Education Service Centers, cities, county departments of education, community college districts, and nonprofit corporations. TEA's FASRG identifies the potential advantages of purchasing cooperatives as being: cost savings on products or services, savings on administrative costs, and accessibility to more products and services.

REPORTING REQUIREMENTS FOR SCHOOL DISTRICTS

School districts are not subject to the same reporting requirements as state agencies. The Texas Government Code (Sections 2054.008, 2166.2551, 2254.006, and 2254.0301) details specific contract-related reporting requirements for

FIGURE 441
SCHOOL DISTRICT PURCHASING PROCESS



Source: Legislative Budget Board.

state agencies and institutions of higher education. It requires state agencies and institutions of higher education to report information regarding any professional service, construction or consulting contract that totals $14,000 or more, or a major information system contract that totals $100,000 or more to the Legislative Budget Board (LBB). These laws do not apply to school districts. Statutes governing school district contracting do not provide dollar thresholds for reporting or approval. Local school boards have discretion to establish more detailed policies.

School districts are required to report financial data through the Public Education Information Management System (PEIMS). The Texas Education Code, Section 44.007, requires school districts to report all financial data requested by TEA through PEIMS. PEIMS information is reported at an aggregate so the details regarding expenditures are not captured at the state level. For example, PEIMS classifies expenditures/ expenses for professional services rendered by personnel who are not on the payroll of the school district. Districts may classify these expenditures under any PEIMS functional area such as Instruction, Transportation, Plant Maintenance, and Data Processing. Although more detailed information regarding expenditures may be captured through the individual school districts' reporting systems, these details are not reflected in PEIMS.

Moreover, statutes governing school district contracting set minimum requirements for districts which allow for greater specificity through locally developed school board policies. The Texas Business and Commerce Code, Section 2.2201, requires school district contracts for the purchase of goods valued at more than $500 to be in writing. The Texas Education Code, Section 44.031 (a) and (b), further requires that all contracts, except contracts for the purchase of produce or vehicle fuel valued at $25,000 or more for each 12-month period, are to be made by the methods that provide the best value to the district. The law details several options for competitive procurement that are available to school districts, such as competitive bidding, competitive sealed proposals, requests for proposals (for services other than construction services), and interlocal contracts.

Statute also defines the role of local school boards regarding decisions related to district contracts. The Texas Local Government Code, Section 171.004(a), requires local public officials with a substantial interest in a business entity or real property to file affidavits stating the nature and extent of the interest before a vote or decision on any matter concerning the business entity or real property, and to abstain from voting on the matter. A substantial interest in a business entity and a substantial interest in real property are further defined by Texas Local Government Code, Section 171.002.

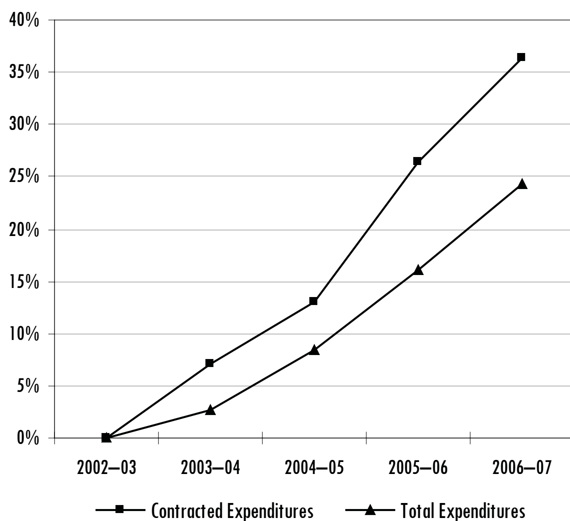
TRENDS IN SCHOOL DISTRICT CONTRACTING

Contracting has become a common expenditure and process in districts. In PEIMS, district expenditures are divided into

functions and objects which identify the purpose of the transaction or specific object purchased. LBB staff analysis of PEIMS data, from school years 2002–03 to 2006–07, shows that the level of contracted expenditures has increased in school districts across the state. Over the five–year period, contracted expenditures increased from 9.4 percent of school district expenses to 10.3 percent. While contracted expenditures represent a small percentage of overall expenditures, the growth in contracted expenditures from school years 2002–03 to 2006–07 represents an increase of $1.3 billion.

Figure 442 shows that from school years 2002–03 to 2006–07 the percentage growth of contracted expenditures in school districts outpaced the percentage growth of total expenditures. During this period, contracted expenditures increased at an average annual rate of approximately 9 percent per year. At this rate of growth, contracted expenditures will reach $7.5 billion in school year 2011–12, which would be twice the amount of contracted expenditures in school year 2002–03 ($3.6 billion).

FIGURE 442
PERCENTAGE OF CUMULATIVE GROWTH IN CONTRACTED AND OVERALL EXPENDITURES, FROM SCHOOL YEARS 2002–03 TO 2006–07



SOURCE: Legislative Budget Board.

Typically, smaller districts have a larger percentage of their expenditures contracted overall. Approximately two-thirds of the school districts in the state have 1,600 or fewer students, and are classified as small districts. **Figure 443** shows the level of contracted expenditures classified by the size of the district.

FIGURE 443
CONTRACTED EXPENDITURES BY SIZE OF DISTRICT, SCHOOL YEAR 2006–07

DISTRICT SIZE (STUDENTS)	NUMBER OF DISTRICTS	CONTRACTED EXPENDITURES (IN MILLIONS)	PERCENTAGE CONTRACTED OF TOTAL EXPENDITURES
Small 1,600 or less	666	$820.9	17.1%
Mid-Sized 1,601–4,999	199	$790.2	13.1%
Large 5,000 or more	166	$3,299.1	9.0%
State	1,031	$4,910.3	10.3%

NOTE: The preceding data represents all contracted expenditures reported into PEIMS, including intergovernmental charges and equity transfers.
SOURCE: Texas Education Agency.

The percentage of expenditures in a given functional area, such as Instruction, Transportation, and Food Service, varies based on the size of the district. Smaller districts often contract a larger percentage of expenditures in specific areas including Education Service Center Services, General Administration, and Facilities Acquisition and Maintenance. Larger districts contract a larger percentage of expenditures in the following categories: Utilities, Professional Services, and Miscellaneous.

Additionally, the overall increase in contracted expenditures is illustrated by examining individual school districts' reported expenditures. **Figure 444** shows the 10 school

FIGURE 444
TOP 10 CONTRACTED EXPENDITURES BY DISTRICT, SCHOOL YEAR 2006–07

DISTRICT NAME	CONTRACTED EXPENDITURES (IN MILLIONS)
Houston	$231.0
Austin	$194.1
Plano	$168.6
Dallas	$150.0
Highland Park	$83.7
Eanes	$66.9
Richardson	$58.7
Grapevine-Colleyville	$53.8
Northwest	$52.7
Lewisville	$52.0

NOTE: The preceding data represents all contracted expenditures reported into PEIMS, including intergovernmental charges and equity transfers.
SOURCE: Texas Education Agency.

districts with the largest total contracting expenditures in school year 2006–07.

Analysis of PEIMS data shows that several school districts spend a considerable percentage of their contracted services on Miscellaneous Contracted Services (MCS). According to PEIMS definitions, MCS refer to expenditures/expenses for services that are not specified elsewhere. **Figure 445** shows that in school year 2006–07, five school districts categorized over 50 percent of their total contracting expenditures as MCS. Given that PEIMS data is reported as an aggregate, school districts are not required to delineate these expenditures.

FIGURE 445
DISTRICTS THAT CATEGORIZED OVER 50 PERCENT TOTAL CONTRACTED EXPENDITURES AS MISCELLANEOUS, SCHOOL YEAR 2006–07

DISTRICT NAME	TOTAL CONTRACTING EXPENDITURES (IN MILLIONS)	MISCELLANEOUS CONTRACTING EXPENDITURES (IN MILLIONS)	MISCELLANEOUS AS PERCENTAGE OF TOTAL
Prairieland	$16.0	$12.0	75.0%
La Marque	$34.2	$22.8	66.8%
Ponder	$9.0	$5.9	66.3%
Damon	$1.2	$0.8	64.1%
Floresville	$19.6	$10.5	53.4%
State	$20,982.6	$2,150.9	10.3%

Note: The preceding data represents all contracted expenditures reported into PEIMS, including intergovernmental charges and equity transfers.
Source: Texas Education Agency.

SCHOOL DISTRICT CONTRACTING AS SEEN THROUGH 12 YEARS OF SCHOOL PERFORMANCE REVIEWS

Texas School Performance Reviews (TSPR), conducted by Legislative Budget Board staff, have made numerous recommendations concerning contracting policies and management in school districts. TSPR reports found that districts often do not have established mechanisms to monitor existing contracts or to provide an ongoing assessment of whether or not continuing to contract for service delivery is the best decision for the district. Numerous reviews have found that inadequately managed contracts often result from the lack of established district policies and staff trained in performance-based monitoring or contract management techniques. According to previous reviews, efficient operation of district contracts requires attention to oversight and management details related to vendor selection, desired outcomes, performance, and costs.

Following a 2006 federal criminal investigation of a small, rural school district, several school board members were indicted for accepting gifts in exchange for favorable, official votes and influence regarding district contracts. In 2007, three school board members along with the district superintendent of a large, rural district were also indicted for accepting money and gifts from various contractors doing, or seeking to do, business with the district. These gifts were in exchange for favorable, official votes and influence related to construction projects. In addition, news reports released during 2008 cited a large, metropolitan district for repeatedly awarding contracts worth millions of dollars to companies whose top executives held leadership positions within the district. TSPR reviewed these three districts prior to the indictments and news releases. Each of the reviews made recommendations focused on the development of contract management policy and training.

Upon analysis of TSPR reports from calendar years 1994 to 2006, the following categories represent the most common contracting recommendations that lead school districts to more efficient policies, procedures, and management:

- establish policies and procedures to manage and monitor district contracts;
- train key district personnel on effective contract development and management;
- evaluate the cost-effectiveness of contracting; and
- restrict contracts with business entities in which board members have a substantial interest.

ESTABLISH POLICIES AND PROCEDURES TO MANAGE AND MONITOR DISTRICT CONTRACTS

TSPR reports found that districts often lack specific policies or have undefined contracting standards and policies guiding procurement and contracting practices. Without formal policies and procedures governing contracting, districts are at risk of entering into contracts that are unfavorable to the district, of not receiving the services it has purchased, and of noncompliance with applicable statutes and laws. Additionally, past reviews have found that the lack of established contracting procedures results in undefined roles for district personnel in monitoring contract compliance, inadequately managed contracts, and often vague contractual policies.

TRAIN KEY DISTRICT PERSONNEL ON EFFECTIVE CONTRACT DEVELOPMENT AND MANAGEMENT

TSPR reports noted that district staff plays an important role in enforcing and monitoring district contracts. The Texas Association of School Business Officials developed a voluntary program of professional certification to provide recognized standards of professional competence for school business administrators, officials, and specialists for the state of Texas. While the Texas Education Code does not require training for district personnel in contract management, TSPR reports found that untrained personnel may contribute to inefficient management of district contracts. In addition, past reviews recommended that districts obtain training on contract management for all department heads and other school personnel who are responsible for managing contracts. Training for district personnel should cover all contract development and management functions that may be encountered by a project manager or department staff.

EVALUATE THE COST-EFFECTIVENESS OF CONTRACTING

Ensuring that the district is receiving value for the price paid should be part of a district's contract management policies and process. According to prior TSPR reports, evaluating elements of contract price include: (1) assessing the competitiveness of the contractor's fee; (2) determining whether the district should continue to outsource the service; (3) providing the contractor and board with a formal evaluation based on performance measures established for each contract; (4) documenting regular communication between the district and contractor; and (5) linking some or all of contractor fee increases to performance. Regular cost/benefit analyses of contracts are needed by school districts to evaluate whether there are goods or services that can be obtained from the private sector at a lower cost, higher quality, or both.

RESTRICT CONTRACTS WITH BUSINESS ENTITIES IN WHICH BOARD MEMBERS HAVE A SUBSTANTIAL INTEREST

The Seventy-first Legislature, Regular Session, 1989, amended Texas Local Government Code to require that local public officials with a substantial interest in a business entity or real property file an affidavit stating the nature and extent of the interest before a vote or decision on any matter concerning the business entity or real property. However, TSPR reports continued to note non-compliance with statute and public concern with school board members' actions regarding contract-related voting. Past reviews found that in several reviewed districts, board policy reflects the policy expressed in the Texas Local Government Code regarding substantial interest in a business entity. However, school board members do not always submit an affidavit prior to the board vote. In several instances, firms and vendors that were under consideration for district contracts were associated with sitting school board members. Further, TSPR reports noted that community members expressed concern about board members doing business with related entities and that these situations presented a conflict of interest.