Failure to Enforce Title IX?

April 22, 2014

By
Allie Grasgreen

NO MU MENTION

A complaint filed last week with the U.S. Department of Justice alleges that more than 120 California institutions are failing to provide sufficient athletic opportunities for women – and that the government office in charge of enforcing Title IX of the Education Amendments of 1972 isn’t doing anything about it.

The initial mass complaint against 121 public and private California colleges and universities of varying size and athletic competitiveness, filed with the U.S. Education Department Office for Civil Rights’ regional San Francisco post, alleged that the programs were failing to address gender disparities in sports participation and opportunities.

OCR uses a three-prong test to determine whether a college is in compliance with Title IX; a college is in compliance if it meets any one of the three requirements. OCR agreed that the California colleges failed to meet the “proportionality” and “history and continuing practice” prongs, which would show that the ratio of male to female participation equals the gender ratio of the student body, or that the programs have a history of expanding sports programs for the underrepresented sex. But OCR said the complainant’s evidence that the colleges didn’t pass the third test – which shows that even if one sex is underrepresented, their “interests and abilities” are being “fully and effectively accommodated” – was insufficient in detail. Thus, OCR said, it wasn’t necessarily clear a violation was occurring.
The complainant responded with data showing that at least 10 institutions that failed to meet parts one and two of the test had also cut women’s teams in recent years, which OCR has previously said demonstrates an unmet interest. But OCR in this case said that the evidence – news articles discussing the cuts that were published between 2004 and 2012 – were not “current” enough to adequately support the allegations of noncompliance. The complaint was dismissed.

The complaint – which now includes allegations that OCR “has deliberately refused to investigate these postsecondary institutions despite irrefutable evidence of Title IX violations by these recipient institutions, effectively aiding and abetting the continued discrimination and violation of the civil rights of women attending these colleges and universities” – is now filed at the Department of Justice. Both versions were filed by Mark Rossmiller, a parent in Vancouver, Wash. who has been critical of OCR's Title IX enforcement.

Erin Buzuvis, a law professor at Western New England University and author of the Title IX blog, has criticized OCR’s “quick dismissal of so-called mass complaints” before, she wrote on her blog.

“I understand that it may be technically infeasible for the agency to open 121 investigations simultaneously, but requiring detailed information about the presence of unmet interest puts too high a burden on the complainant,” Buzuvis wrote. Any college that is relying on prong three should be able to draw up evidence of their compliance easily enough, she said, so why not just go directly to the colleges and cut out the complainant middleman? “The institutions that don’t reply, or that can’t produce some evidence that they’re actively engaging in efforts to comply with prong three – open an investigation against those schools,” she said. “The alternative is that you’re siding with the people who aren’t complying with prong three – or any of the prongs.”

The regional and national OCR offices declined to comment.

This is not the first college-level mass complaint, Buzuvis said in an interview, but most have been filed (and dismissed for lack of evidence of failure to meet prong three) at the high school level. Yet as these cases have emerged in the past few years, OCR has been reluctant to take them up, even while agreeing to open investigations at individual colleges.
in the same context.

“They’re being singled out because they’re filing them in bulk and creating a logistical
infeasibility that OCR has been dealing with – in not necessarily a principled way,” Buzuvis
said of the mass complaints. This one takes it even further, she said, because the
complainant provided additional (and in Buzuvis’s opinion, sufficient) data at OCR’s request,
but the complaint was still dropped.

Buzuvis said that at the very least, she’d have investigated the 10 campuses for which the
complainant provided additional data. But given that so many campuses are included in
these complaints, should the bar for opening an investigation be higher?

“I guess I don’t understand why. Because it’s just as likely that those individual schools are
violating Title IX,” Buzuvis said. “The fact that other schools are in the same boat doesn’t
produce a principled reason to not look at the individual schools that might be violating Title
IX.”

But the DOJ complaint points to a larger problem with OCR than just its handling of mass
complaints, said Nancy Hogshead-Makar, senior director of advocacy at the Women’s Sports
Foundation. She compared OCR’s procedures to those of the agencies that regulate
occupational health and environmental protection.

"If you see dumping going on, you shouldn’t need to be the one who gets sick in order to be
able to get the EPA to respond, right?” she said. “You’re making mass complaints
impossible.... You’re asking an 18- to 22-year-old to be responsible for suing their school to
bring about Title IX compliance. When you think about achieving the true promise of Title
IX, which is real gender equity that everybody can see and appreciate, their current
strategy is ineffective.”

Hogshead-Makar recently testified in Congress that that ineffectiveness is also costing
taxpayer money. An ongoing – even worsening – nationwide issue cannot really be solved
through a “Whac-a-Mole” strategy that assumes individual investigations stemming from
individual complaints will identify and solve all of the problems, she said.

The Women’s Sports Foundation has found that at the high school level, regardless of school
type and location, girls get about three-fifths of whatever athletic opportunities boys are
getting, and researchers believe that figure is roughly the same at the college level, even as women are growing as a share of college undergraduates nationally. More sports are being added for both men and women – but for the former more so than the latter.

In 2012-13, women accounted for 43 percent of participants in National Collegiate Athletic Association sports. In Division I, they received $885,380,783 in athletic aid, compared to $1,023,495,966 for men.

Some of the colleges cited in the DOJ complaint have startling gender disparities and yet cut multiple women’s sports between 2007-13. They include El Camino College, which eliminated “several” sports and a 2013 participation disparity of 37.17 percentage points, according to the complaint, and Moor Park College, which cut golf and has an 18.55 percent disparity. Pepperdine University cut swimming and diving, but has just a 2.81 percent disparity.

Colleges may counter that they cut sports precisely because there was no demand, but generally speaking, when it comes to college sports, demand is always greater than supply: In high school, about half of students play sports, Hogshead-Makar said; only about 2 percent of them go on to play on college teams.

“An equestrian team in Alaska,” Buzuvis said when asked whether cutting women’s sports, which OCR has historically seen as counterproductive or in violation of Title IX, is ever in response to lack of demand. “There might be lack of interest in that.”

April 21, 2014

**State and Local Money for Higher Education Increased Slightly in 2013**

By Eric Kelderman

**NO MU MENTION**
The latest report on state financing of higher education shows a glimmer of good news for public colleges. But it’s also a reminder of how much has changed for public higher education since the start of the recession, in 2008.

State and local dollars for higher education increased by 0.7 percent from the 2012 to the 2013 fiscal years, according to the State Higher Education Executive Officers. At the same time, enrollment at the nation’s public colleges dropped by 2.4 percent, according to the association’s "State Higher Education Finance" report.

Net tuition—gross tuition minus state and institutional financial aid—increased by 3.5 percent from 2012 to 2013, according to the report, "suggesting that tuition does not increase only in response to state funding cuts" but also because of inflation and the need to increase salaries after years of pay freezes.

The increasing state and local appropriations are a sign of the slowly recovering economy, but the larger picture for higher education remains mixed.

Educational revenues, per full-time student, are still more than 6 percent less than they were in 2008, the report says.

The national figures mask the much deeper financial problems for public higher education in many individual states since 2008 as a result of a combination of enrollment increases and state budget cuts. Educational appropriations per full-time student have fallen more than 50 percent in New Hampshire and more than 40 percent in both Florida and Louisiana. More than 20 other states have seen declines exceeding 25 percent in appropriations per full-time student.

Only four states increased tax dollars for public higher education from 2008 to 2013: Alaska, Illinois, North Dakota, and Wyoming. Illinois also did so, but most of the increase in that state resulted from its efforts to shore up its public pensions, the report notes.
Jefferson City — Missouri lawmakers have only a few weeks to decide whether to expand a college scholarship for top students in an effort to employ them in the state after graduation.
The Senate budget-writing panel is scheduled this week to consider funding for a new forgivable loan component in the Bright Flight program. The House included $7 million in loan funding in its budget plan earlier this year, and passed a measure to authorize the loan-forgiveness program last week.

Lawmakers have until May 9 to pass the budget for the fiscal year that starts in July. In order to enact the loan forgiveness program, the money would need to be included in the budget and lawmakers also would have to pass a separate bill authorizing the program before their session ends May 16.

Bright Flight scholarships are awarded to students who attend participating Missouri schools based on ACT or SAT scores; those who score in the top 3 percent now receive $2,500 per year. About 1,600 freshmen were given Bright Flight scholarships in 2013.

Under the pending legislation, those students also could receive a forgivable loan that could be worth about $5,000 if they attend one of Missouri's public four-year universities. Each year a student works in Missouri after school would count toward one year of loan forgiveness, and leaving Missouri before the loan is repaid would require it to be paid back with interest. The loan amount could not exceed the cost of tuition and other fees, but the academic scholarship would not count in that calculation.

Gov. Jay Nixon called for money to fund the forgivable loan component in his budget recommendation. He and other supporters say it will help entice top students to get jobs in Missouri after graduating college.

"We're losing our highest assets. A lot of very sharp kids are leaving the state," said Rep. Mike Thomson, R-Maryville, who's sponsoring the House legislation.

The plan has run into opposition on the Senate floor because of its projected cost. Legislative staff estimates it could reach $22 million annually once the loan forgiveness program is fully implemented.

It will take four years to realize the total cost because students currently receiving the scholarship would only eligible for the loan forgiveness after graduating. The cost analysis is based on the assumption that half of the students qualifying for a Bright Flight scholarship will take advantage of the loan at the maximum amount offered.
Opponents of expanding the program said it is possible more students would take advantage and that the state could face larger costs if schools raise tuition and fees.

But new attendance standards laid out in the legislation could also reduce the number of recipients eligible for the loan. Under the bill, students would need to complete 24 credit hours during their first year and 30 credit hours each following year to remain eligible for the scholarship.

State education officials project that 10 percent of Bright Flight scholars take five years to graduate, which could reduce loan forgiveness eligibility if those students don’t meet the annual credit hour requirements.

In Health Care, Lessons for Obama on Rating Colleges

By Kelly Field

It was the early 1980s, and the nation’s health-care system was in crisis. Costs were soaring, and hospitals and other providers were being blamed for the increase. Policy makers were questioning the quality of the nation’s health care, and the medical profession had lost some of its political clout.

In an effort to rein in costs and improve outcomes, the federal government began compiling data on hospitals’ mortality rates and sharing them with contractors that were reviewing the medical necessity and quality of care provided to Medicare beneficiaries.

In 1986, a New York Times reporter filed a Freedom of Information Act request seeking those data, and the government reluctantly released them. The report identified hospitals with higher and lower patient-mortality rates and summarized each institution’s overall performance.
By the early 1990s, the annual report had become a 55-volume publication. But the reports had also become a political and professional embarrassment, criticized by industry executives and scholars alike for their statistical shortcomings. After just eight years, the first federal rating of hospitals was abandoned. Washington didn’t rejoin the ratings game for five years, when the Centers for Medicare and Medicaid Services began publishing Nursing Home Compare, the first of its six health-care comparison sites.

Fast forward 15 years, and the nation’s colleges are in crisis. Costs are skyrocketing, and lawmakers are blaming the colleges. Policy makers are raising doubts about the quality of the nation’s higher-education system, and President Obama is crafting a controversial ratings system that aims to capture the value of a college degree. For Darrell G. Kirch, president of the Association of American Medical Colleges, there’s a sense of "massive déjà vu."

"You have these two very important public goods, and we all want them to be of the best quality," he says.

But rating large institutions isn’t easy, and Dr. Kirch and academic researchers who have studied the health-care ratings say the administration should be mindful of the pitfalls. Here are the top five lessons they say the Education Department can learn from the experiences of the Centers for Medicare and Medicaid Services, or CMS.

1. What You Measure Matters

These days, CMS offers six health-care-comparison websites, covering hospitals, doctors, home health-care services, dialysis facilities, and health plans. Much of the data they provide are pulled from claims that providers submit to the federal government for Medicare reimbursement, or are culled from existing databases. The website Nursing Home Compare, for example, draws from the agency’s health-inspections database and its "minimum data set," which includes assessments of the health of all residents at federally supported nursing homes.

While the reliance on existing data alleviates the collection burden for providers, it has some drawbacks. Claims provide only limited information on patient conditions, making it harder to adjust the ratings for risk. Quality measures are often self-reported, and they represent only a fraction of the conditions and outcomes that matter to prospective patients.

In part, that’s because in health care, as in education, not all outcomes are easily measured, says Helen Burstin, senior vice president for performance measures at the National Quality Forum, a
nonprofit group that convenes panels to evaluate health-care measures for use by states, the federal government, and private organizations. To capture the intangibles, the sector is increasingly turning to "patient-reported outcomes," the industry equivalent of alumni-satisfaction surveys, Dr. Burstin says.

"Sometimes we look at things that are quantitative because they’re easier to measure," she says. "But they may not measure what really matters."

At the same time, there's often a tension between "waiting for what’s perfect and starting to measure something," she says. Those trade-offs sometimes lead to disagreements between scientists and patients on the forum’s panels over whether to endorse a measure, she says.

Even so, there are fewer gaps in federal health-care data than in federal education data, says Dana B. Mukamel, a professor of medicine at the University of California at Irvine, who testified at the Education Department’s recent ratings forum. She was surprised to learn, at the forum, that federal law prohibits the department from creating a "unit-record" database to track individual students. "This is really going to frustrate the objectives of quality reporting," she warns. "Hopefully cooler heads will prevail."

2. Risk Adjustment Isn’t Easy—but It Is Essential

Most health-care comparisons adjust for risk, weighing patient-related factors when evaluating providers. The amount of adjustment varies by site, but the majority account only for the severity of illness and coexisting conditions, not for patient demographics.

That approach is consistent with the policies of the National Quality Forum, which advises against adjusting for demographic disparities. The concern is that doing so could hide differences in outcomes and make weaker providers complacent. Instead, the forum recommends that outcomes be "stratified," or calculated separately by sociodemographic factors, such as income, race, and education level.

But some patients, providers, and policy makers say the current protocol is unfair to hospitals that serve disadvantaged patients, and that it will exacerbate disparities in care. They warn that
cutting funds to poorly rated "safety net" providers will leave them with fewer resources to treat disadvantaged patients or force the providers to abandon their mission altogether. That warning resonates among colleges that serve disadvantaged students.

Responding to those concerns, the National Quality Forum issued a draft report last month recommending that measures that are "influenced by factors other than the quality of care provided" be adjusted to account for sociodemographic factors when used for accountability purposes.

The change was driven by two new federal accountability measures that penalize providers with high rates of readmission and high levels of spending per Medicare beneficiary. In general, hospitals that serve large numbers of disadvantaged patients tend to perform worse on both measures.

The question, says Andrew M. Ryan, an associate professor of health-care policy and research at Cornell University, is: "Is it the hospital’s fault?"

As an alternative, Mr. Ryan suggests grouping like providers together, then distributing awards and penalties within the peer group. That approach has been endorsed by MedPac, an independent agency that advises Congress on Medicare issues. Mr. Obama has promised to take a similar approach to his college ratings.

The challenge for both health care and higher education will be deciding who is assigned to each group, Mr. Ryan says.

"There’s no way you can come up with a grouping that will satisfy everyone," he says.

3. There Are Trade-offs Between Simplicity and Completeness

When Nursing Home Compare debuted, in 1998, it compared facilities using a series of discrete measures. A decade later, in an effort to make the website more user-friendly, the Centers for Medicare and Medicaid Services added a five-star rating system.

In the five years since the star system took effect, the proportion of facilities receiving four or five stars has risen, suggesting that nursing homes are responding to the ratings. Patients say they
prefer the new system, and there’s some evidence that they are more likely to use it to pick a
nursing home, says Rachel Werner, an associate professor of medicine at the University of
Pennsylvania who is studying the shift.

The problem with star ratings and other "composite" scores, researchers say, is that quality is
multidimensional, and the dimensions don’t often correlate, or "scale." So a nursing home that
excels in dealing with depression may be less effective in treating pressure sores, just as a
university may have high graduation rates but poor job-placement rates. Composite scores mask
strengths and weaknesses in given areas in favor of a global, "big picture" assessment. The result
is simpler, but also less nuanced.

"The main drawback is that you lose a lot of detail," says Dr. Werner. "If a consumer is looking
for a nursing home that is good at one thing, it’s much harder to find that information."

Another drawback of composite scores is that they rely on the value judgments of experts.
Nursing Home Compare, for example, places the greatest weight on hospital inspections, adding
or subtracting a single star each if the staffing and quality ratings are very high or very low. The
index includes only half of the quality measures the site reports, and it averages outcomes across
long-term and acute-care facilities.

Ms. Mukamel says the solution lies in customized ratings, in which patients (or prospective
students) can assign their own weights to the measures, based on personal preferences. She is
now testing that idea in a randomized control trial at Irvine’s hospital.

4. Ratings Work—in Intended and Unintended Ways

The goal of all ratings systems, regardless of the sector, is to motivate providers to improve and
to help consumers make informed decisions.

In health care, there is some evidence that ratings have guided at least some patients to higher-rated providers. Dr. Werner found, for example, that higher-risk patients were more likely to choose high-quality nursing homes after consulting Nursing Home Compare. And Ms. Mukamel found that patients seeking a cardiac surgeon were half as likely to rely on "implicit measures" of
quality, such as cost and experience, after New York State began publishing its surgeons’
mortality rates.

But Ms. Mukamel says there is just as much evidence that ratings don’t work, and Dr. Werner
says Hospital Compare, which provides comprehensive quality data on hospitals, is "rarely used
by consumers, as far as we can tell." Dr. Kirch says that when he asked 100 college presidents at
the American Council on Education annual meeting last month if any of them had used Hospital
Compare to choose a facility, only one hand went up.

He says that despite the popularity of ratings in general, most patients still turn to "trusted
sources," such as their primary-care physicians, for help with health-care decisions. He worries
that the multitude of ratings has confused patients and created "more noise than signal" for the
providers themselves.

When it comes to quality improvement, however, it may not really matter if consumers are using
the ratings or not. If providers believe that consumers are paying attention, they will respond,
"functionally or dysfunctionally," says David L. Weimer, a professor of political economy at the
University of Wisconsin at Madison. His research, and others’, has found evidence of both
positive and negative outcomes, with some providers improving their care and others simply
shifting resources around.

In the case of Nursing Home Compare, some facilities appear to be "teaching to the test,"
moving money and resources from unmeasured areas to measured ones. There’s less evidence
that providers are engaging in "cream skimming," dropping riskier patients, though some studies
suggest that is happening with other rating systems.

Mr. Weimer urges the Education Department to consider ways it can maximize the "functional"
responses its rating system elicits, while mitigating the "dysfunctional" ones.

"You have to anticipate how this can be gamed," he says.
5. Pay for Performance Doesn’t Pay (at Least Not Yet)

The most controversial piece of President Obama’s college-ratings plan is his proposal to tie a portion of student aid to the ratings. Under his plan, which Congress must approve, students attending higher-rated institutions could obtain larger Pell Grants and more-affordable loans.

The federal government has been testing the idea of performance-based pay in health care for several years, offering Medicare bonuses to high-performing providers. Results from the early experiments have been mixed, with some studies suggesting that the money changed provider behavior and others suggesting that it didn’t.

But it was not until Congress passed the president’s Affordable Care Act, in 2010, that performance-based pay went mainstream, says Mr. Ryan, of Cornell. Under the sweeping health-care-reform law, all Medicare payments to hospitals and physicians will eventually depend, in part, on metrics of quality and efficiency.

Conceptually, the idea of paying performers on the basis of value, rather than volume, is compelling, Mr. Ryan says. But research shows it’s very hard to get right. If the reward or penalty is token, providers may not respond. But make it too big, and it could send struggling providers into a death spiral.

In response to this concern, lawmakers structured the hospital payment system to reward both high performance and improvement. Under the system, some hospitals gain money, and some lose it.

So far, the incentives don’t seem to be having much of an effect. Mr. Ryan studied the program in its first year and found that hospitals focusing on poorer patients did indeed get smaller bonuses, as feared. But because the incentives were small, he concluded that they were unlikely to deepen disparities in the short term. However, he worries that as the incentives grow larger, the quality of care could deteriorate at some hospitals.

Mr. Ryan suggests that the government revise its payment criteria to give greater weight to improvement over achievement. He acknowledges that will be "a tough task."
Policy makers, he says, still don’t know how best to structure performance-based pay systems. So they rely on trial and error, "gradually developing an evidence base" as they go.

"We’re rolling out these national programs without a clear idea that this is the best way to do it," he says.

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**How a Health-Care Rating System Might Translate**

The federal government is no newcomer to the ratings game; its Centers for Medicare and Medicaid Services has been rating health-care providers online for more than 15 years. Nursing Home Compare, the oldest of its six sites, assigns facilities one to five stars based on three separate measures. Here’s what the model might look like if it were applied to higher education.

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<tr>
<th>Nursing-home measures</th>
<th>Higher-education equivalent</th>
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<tr>
<td><strong>Health-inspections rating</strong>: based on the three most recent annual inspections, and on inspections prompted by complaints in the past three years. Greater emphasis given to recent inspections.</td>
<td><strong>Compliance rating</strong>: based on the findings of federal program reviews, accreditor visits, and state and federal audits and investigations.</td>
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<tr>
<td><strong>Quality-measures rating</strong>: combines values on nine quality measures, such as the percentage of long-stay residents experiencing falls, urinary-tract infections, pressure ulcers, and pain.</td>
<td><strong>Quality-measures rating</strong>: based on retention and graduation rates and job-placement rates; or, negatively constructed, on dropout and unemployment rates.</td>
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<tr>
<td><strong>Staffing rating</strong>: based on nurse/patient ratios and total hours of care per day.</td>
<td><strong>Staffing rating</strong>: based on student/faculty ratios and staffing levels.</td>
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