

**SENATE COMMITTEE ON HEALTH AND
HUMAN SERVICES
SENATE COMMITTEE ON STATE AFFAIRS**



**JOINT INTERIM REPORT
TO THE
80TH LEGISLATURE**

December 2006

Please direct questions or comments to:

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Senate Committee on Health and Human Services

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THE SENATE OF TEXAS
COMMITTEE ON HEALTH AND HUMAN SERVICES

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December 1, 2006

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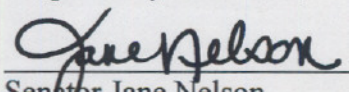
The Honorable David Dewhurst
Lieutenant Governor of Texas
P.O. Box 12068
Austin, Texas 78711

Dear Governor Dewhurst:

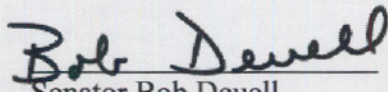
The Senate Committee on Health and Human Services submits this report in response to the joint interim charges you assigned to this Committee and the Senate Committee on State Affairs. The Committees held two public hearings to consider invited and public testimony from affected consumers, health and human service providers, and agency personnel regarding these three charges. This report includes a review of issues and makes recommendations related to the state's role in regulating pharmacy benefit managers, ways to reduce dependence on Medicaid for the provision of long term care, options for increasing the use of advance planning tools, innovative models of nursing facility services, and policies concerning forensic patients in state hospitals and community mental health organizations.

The Committee has carefully considered all of the testimony received on its charges in order to provide you with these recommendations. We appreciate the leadership and foresight you have displayed in asking this Committee to monitor and seek remedies to these key issues, and we trust that the recommendations offered in this report will serve to improve health care and human services in Texas.

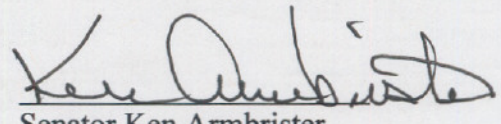
Respectfully submitted,



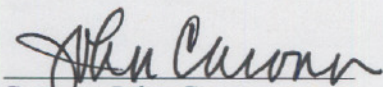
Senator Jane Nelson
Chair



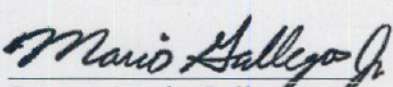
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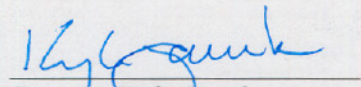
Senator Ken Armbrister



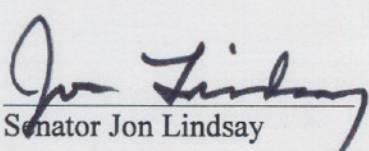
Senator John Carona



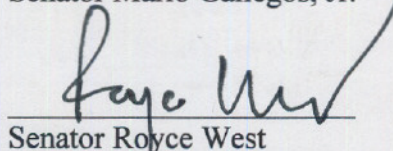
Senator Mario Gallegos, Jr.



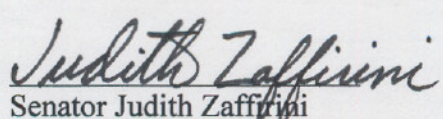
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December 1, 2006

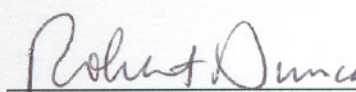
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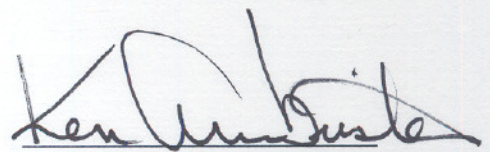
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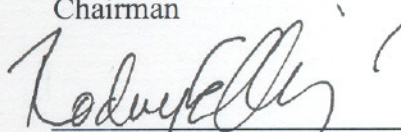
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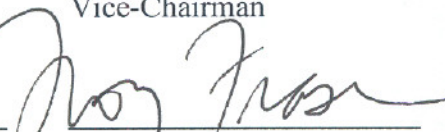
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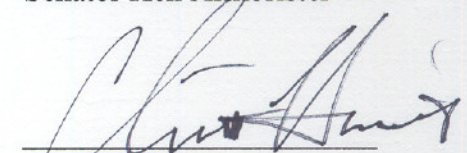

Senator Robert Duncan
Chairman

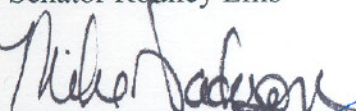

Senator Tommy Williams
Vice-Chairman

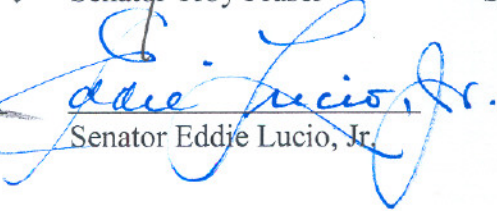

Senator Ken Armbrister


Senator Rodney Ellis


Senator Troy Fraser


Senator Chris Harris


Senator Mike Jackson


Senator Eddie Lucio, Jr.

ACKNOWLEDGMENTS

The Committees would like to thank the following for their contributions to this study:

Office of the Governor
Office of the Lieutenant Governor
Texas Health and Human Services Commission
Texas Department of State Health Services
Texas Department of Aging and Disability Services
Texas Correctional Office on Offenders with Medical or Mental Impairments
Texas Department of Criminal Justice
Texas Department of Insurance
Texas Employees Retirement System
Texas Teacher Retirement System
Texas State Board of Pharmacy
Office of the Attorney General
Texas Legislative Council
Texas Legislative Budget Board
Texas Senate Media Services
Texas Senate Research Center
Texas Senate Staff Services
Texas Senate Publications and Printing

This report was made possible by the leadership of the Committee members and the contribution of key Senate staff, including Porter Wilson, Lisa Kaufman, Jennifer Chambers, Jennifer Fagan, Deon Daugherty Allen, Anne Kimbol, Anna Libertino, Katherine Barksdale, Amy Herzog, Tiffany Arrington, Joe Dyer, Dave Nelson, and Steve Roddy. The Committee would also like to express its appreciation to the numerous other state, industry, provider and consumer representatives for their involvement in this process, especially those who presented testimony to the committee during its public hearings.

TABLE OF CONTENTS

JOINT CHARGE 1: PHARMACY BENEFIT MANAGERS.....	1
PHARMACY BENEFIT MANAGERS	1
REGULATORY STRUCTURE	13
RECOMMENDATIONS	17
JOINT CHARGE 2: LONG TERM CARE	19
REDUCING DEPENDENCE ON MEDICAID	19
ADVANCED PLANNING	28
NURSING FACILITY INNOVATION	33
RECOMMENDATIONS	41
JOINT CHARGE 3: FORENSIC PATIENTS IN STATE HOSPITALS AND COMMUNITY MENTAL HEALTH ORGANIZATIONS	45
BACKGROUND	45
PATIENTS IN STATE HOSPITALS	48
DECREASING DEMAND FOR INPATIENT FORENSIC BEDS	54
JAIL AND PRISON DIVERSION PROGRAMS	56
ALTERNATIVE TYPES OF COMPETENCY RESTORATION PROGRAMS	61
RECOMMENDATIONS	63
APPENDICES	68
APPENDIX A: LETTER FROM ANNE FUELBERG	68
APPENDIX B: CRIMINAL COMPETENCY FLOW CHART	71
APPENDIX C: RUSK DIVERSION PROJECT FLOW CHART	75

Joint Charge 1: Pharmacy Benefit Managers

Examine and make recommendations, if necessary, regarding the state's role in regulating pharmacy benefit managers in the interest of consumer protection. Examine alternative methods of dispensing maintenance drugs, including mail service and retail pharmacies, and provide an analysis of the state's role in protecting consumers.

Pharmacy Benefit Managers

Prescription medications help improve the quality of life for many Americans with approximately 154 million Americans taking prescription drugs on a regular basis.¹ As the demand for prescription drugs increases, expenditures on prescription drugs are also steadily raising to roughly 10 cents of every dollar spent on health care in the United States.² Many employers, Fortune 500 companies, labor unions, and state and local governments contract with pharmacy benefit managers (PBMs) to assist with managing drug spending and to increase the cost-effectiveness of the medications covered under their health plans.

PBMs originated in the 1960s as a claims processor for health plans. Since then, PBMs have evolved to become administrators for prescription drug benefit programs and offer services that include price discounts with pharmacies and pharmaceutical manufacturers, drug utilization review, drug formularies, mail-order pharmacies, and prescription drug

¹ National Conference of State Legislatures, Available: <http://www.ncsl.org/programs/health/drugdisc05.htm>. Accessed: October 20, 2006.

² Health Policy Alternatives, *Pharmacy Benefit Managers (PBMs): Tools for Managing Drug Benefit Costs, Quality, and Safety*, August 2003.

management groups within managed care organizations.³ Approximately 95 percent of all patients with drug coverage in the United States receive benefits through a PBM.⁴

The largest PBMs in the U.S. include Caremark Rx, Medco Health Solutions and Express Scripts. Each of these companies does business in Texas along with approximately 22 other PBMs.⁵

PBMs acquire clients typically through a competitive process whereby they respond to client requests for proposals (RFPs). Plan sponsors specify the types of services and coverage needed and choose from submitted proposals, weighing such things as price guarantees, dispensing fees, drug discounts, rebates, administrative fees, and available pharmacy networks. Once selected, the plan sponsor and the PBM typically enter into a fee for service contract that specifically articulates all the terms of the business agreement including any performance guarantees, contract oversight mechanisms, or auditing requirements.

Pharmacy Networks

PBMs are used to contain costs and provide quality management services.⁶ One of the primary ways PBMs accomplish this is through the establishment and maintenance of retail pharmacy networks used to dispense drugs prescribed by physicians. In most cases, enrollees have the option of filling their prescriptions at either a local retail or community

³ *Ibid.*

⁴ *National Conference of State Legislatures*, supra note 1.

⁵ Texas Department of Insurance, Testimony to the Senate Committee on Health and Human Services and Senate Committee on State Affairs (Austin, Tex, October 17, 2006).

⁶ *Health Policy Alternatives*, supra note 2.

pharmacy, or through a single mail-service pharmacy. In either case, pharmacies generate revenue through enrollee co-payments, PBM reimbursements that cover the prescription drug's ingredient cost, and dispensing fees.⁷ Pharmacies in small networks typically agree to lower fees with the expectation that a larger volume of business will be realized. To encourage the use of cheaper, generic drugs, PBMs often pay higher dispensing fees for generics in hope that pharmacies will encourage generic substitution.

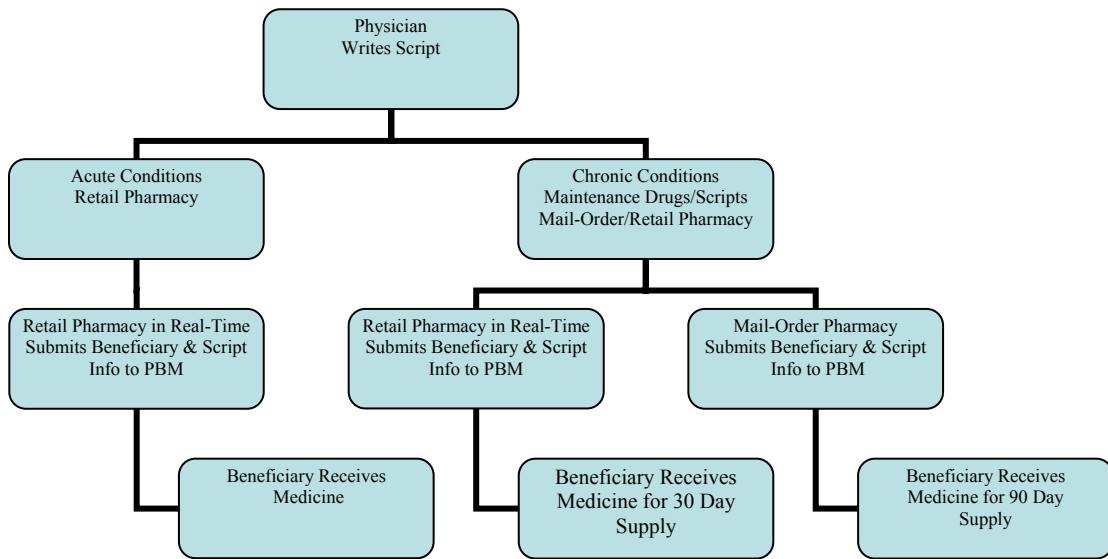
A mail order pharmacy is typically used to fill prescriptions for chronic conditions or illnesses that require maintenance drugs in which a 60 or 90 day supply may be dispensed for a reduced co-payment. Depending on contract provisions, maintenance drugs may be purchased through retail pharmacies but typically only a 30-day supply is allowed, and a surcharge or higher co-payment may be charged. These financial provisions encourage enrollees to utilize mail services and the provider is typically able to offer substantially reduced pricing to the PBM because of the economies of scale expected. In addition, since mail service pharmacies have a longer period of time to fill prescriptions, they are often more successful in other cost-reducing practices, such as contacting physicians to discuss possible lower cost alternatives.

Table 1 illustrates the flow in which a prescription is initiated and filled.⁸

⁷ *Federal Trade Commission Report*, supra note 5.

⁸ *Teacher Retirement System of Texas, 2006 Member Satisfaction Survey*, May 23, 3006.

Table 1



(Table 1) Adapted from the Teacher Retirement System's report.

Many PBMs own their own mail-order pharmacies and retail pharmacists have expressed concerns that a potential conflict of interest may exist when a PBM is allowed to operate as both a plan administrator and provider. Questions as to whether mail-order pharmacies are more cost-effective than retail pharmacies for maintenance prescriptions have also been offered.⁹ PBMs have countered these concerns by pointing out the decision to utilize pharmacy mail services is made by plan sponsors with full disclosure of ownership arrangements and any associated cost savings data. In addition, plan sponsors can require additional disclosure and pricing information prior to entering into an agreement to use mail service.

The Federal Trade Commission (FTC) submitted a report in August 2005 that assessed whether PBM-owned mail-order pharmacies maximize competition and provide lower

⁹ Texas Pharmacy Association, Testimony to the Senate Committee on Health and Human Services and Senate Committee on State Affairs (Austin, Tex, October 17, 2006).

prescription drug prices for its plan sponsor members. The study found evidence that in 2002 and 2003, PBM-owned pharmacies generally did not disadvantage plan sponsors. However, this finding was based on aggregate data and did not assess whether each plan sponsor received the best deal or if contractual obligations were filled by the PBM.¹⁰

Formularies

One of the other key tools used by PBMs to help manage cost is a drug formulary, which is a list of prescription drugs approved for coverage under an employer's pharmacy benefits plan. One of the main factors in determining what drugs are included on a formulary is clinical appropriateness. An independent panel of experts on the Pharmacy and Therapeutics (P&T) Committee reviews drugs available in each therapeutic class and determines which drugs are placed on the formulary list. This ongoing process requires the P&T to meet routinely to review the drugs available in each therapeutic class. Once a list of medications is established that assures the availability of a full range of appropriate therapies, the PBM enters into rebate negotiations with manufacturers.

Rebates

In addition to contracting with pharmacies to provide cost-effective dispensing services, PBMs also contract with drug manufacturers to provide a monetary rebate for each unit of a particular drug purchased by a plan enrollee. These rebates are generally negotiated on a drug-by-drug basis with the size of the rebate directly related to the expected volume of that drug that will be purchased. In some cases, rebates are paid on a flat, rebate-per-

¹⁰ *Federal Trade Commission Report*, supra note 5.

unit basis without consideration of the actual number of units purchased. In other cases, rebates may be scaled to take into account the volume of drugs ultimately purchased. Drug Manufacturers may also negotiate rebates with consideration of whether a particular drug is on a PBM's preferred drug list. Expectations of higher sales volume typically drive all these decisions. In all cases, rebate payments ultimately act to lower the net price of drugs purchased (either directly or indirectly) by the PBM.

The savings generated through rebates and other financial agreements are passed on to plan sponsors in a number of different ways. In some cases, the PBM will pass through to the client the entire rebate associated with drugs purchased. Other PBMs may calculate rebates into their negotiated price with clients. And in other cases, the PBM may negotiate separately with plan sponsors and the manufacturers and keep any spread between the two.

Concern does exist regarding rebates received by PBMs from drug manufacturers and whether the revenue generated compromises cost-effective patient care.¹¹ An example provided by the pharmacy community is "whether patients are diverted to formulary drugs for which the PBM makes more money rather than the drug that best fits medical needs...or is more appropriate for the patient." In addition, some claim rebates paid to PBMs create potential conflicts of interest between the PBM and plan sponsor. Scenarios where a PBM "steers" a doctor to prescribe a drug with a rebate arrangement more beneficial to the PBM than the plan sponsor are also of concern.

¹¹ Texas Pharmacy Association, supra note 9.

Concerns of PBM failure to accurately credit plan sponsors with all rebates earned have also been raised. These issues have driven many health care advocates and pharmacy interest groups to call for statutorily required fiduciary responsibility for all PBMs. The PBMs counter that fiduciary responsibility is not a concern for the vast majority of plan sponsors. Contract provisions authorizing independent audits to gauge compliance are common. In addition, many other safeguards are set forth in contract to ensure plan sponsor interests are protected. Ultimately, employers and plan sponsors are driven to closely monitor contract compliance to protect their own bottom-lines. In addition, a highly competitive PBM market allows employers who demand certain protections to effectively negotiate.

Therapeutic Substitution

Therapeutic interchange is the practice of replacing one prescribed medication with another therapeutically equivalent medication. Authorization from the prescribing physician is required prior to such an exchange.

Generic interchange occurs when a brand name product is prescribed, but the prescription is filled with a drug that is chemically identical although produced by another manufacturer. In many states, including Texas, doctor authorization is not required prior to generic interchange.

Many plan sponsors opt to require generic substitution as part of their prescription drug plan because of the significant cost savings associated with the use of generic

medications. In such cases, pharmacists must dispense the generic equivalent unless the physician has indicated on the prescription to "dispense as written."

While very little concern has been raised regarding generic substitution, therapeutic interchange is more closely scrutinized. Some have raised concerns regarding the appropriateness of this practice and have called for greater regulation because such substitutions are typically initiated for cost-saving rather than patient needs. The PBMs counter that patient interests are protected because prescribing physicians ultimately have the authority to determine the preferred course of treatment. They also claim therapeutic interchange offers additional cost savings opportunities to plan sponsors.

Prior Authorization

Another tool used by PBMs to help control cost is clinical prior authorization. Under this practice, pre-approval of a drug by the PBM's client is required prior to it being dispensed by the pharmacy. Generally used only for a small number of drugs, the main objective is to ensure appropriate yet cost effective drug therapies. Prior authorization is typically aimed at encouraging the pursuit of less expensive alternatives prior to moving a patient to more expensive courses of treatment.

While both therapeutic interchange and prior authorization offer cost savings tools to plan sponsors, some concerns regarding dispensing delays associated with these practices have been expressed. Because both practices require communication between the PBM, physicians, and pharmacies, dispensing delays are sometimes experienced by patients

forcing them to defer treatment. In addition, some physicians have complained of excessive requests from PBMs to initiate therapeutic interchanges.

Other Services

PBMs provide a variety of other services to plan sponsors in an effort to ensure appropriate, cost effective prescription drug utilization. Drug utilization review (DUR) allows a PBM to look at all the drugs prescribed and utilized by an individual patient. Such reviews serve two main functions. The most important is to allow the PBM to screen for possible adverse interactions between medications prescribed to a patient. If identified, pharmacists are notified immediately so that alternative drug therapies may be pursued. In addition, PBMs use DUR to examine trends in individual physician prescribing patterns. This information is generally used to detect broad patterns of inappropriate prescribing and utilization.

PBMs may also perform an auditing function aimed at ensuring accurate claims processing and detecting fraud. Auditing methodologies employed by some PBMs, however, have been criticized by many retail pharmacies. Extrapolation audits use a sampling of claims data to determine the accuracy with which providers have been reimbursed. If it is determined that insufficient or excessive payments have been made within the sampled claims, a mathematical inference is made to determine the total expected payment error for the entire volume of claims paid during the targeted timeframe. Payment to or by the pharmacy is made depending on the direction of the error.

Testimony provided by Medco, Caremark and Scott & White all indicated that they do not utilize extrapolation in their auditing practices.

Employee Retirement System

The Employees Retirement System (ERS) utilizes the services of Medco to manage the prescription drug benefits offered through their self-insured health plan. Selected through a competitive bid process, Medco provides a broad pharmacy network, mail service operations, claims administration, and other cost containment initiative selected by the agency. ERS' contract with Medco sets forth details regarding items such as pharmacy reimbursements, use of mail-order, price transparency, rebates, drug formularies, and compliance audits.

In a letter submitted to the committees on November 7, 2006 (Appendix A), ERS discusses how its contract with Medco addresses a number of the issues raised during the interim study process.

With regard to price spreads, the agency points out that reimbursement for pharmacies are based on a formula specified by ERS¹² and that Medco is required to bill ERS the exact amount that it pays a pharmacy. Compliance is verified by an annual independent audit.

¹² Employees Retirement System of Texas, *The Cost Containment Challenge: Controlling Costs and Preventing Fraud in the Texas Employees Group Benefits Program*, Fiscal Year 2005.

Under ERS' rebate agreement, the agency indicates it receives rebates from Medco based on "a contractually specified dollar amount for each brand name formulary drug dispensed." ERS notes that this methodology "allows for competition that can be objectively quantified, evaluated and audited." Compliance with these provisions is also verified by an annual independent audit.

Since 2003, ERS has utilized mail service as a mechanism for helping control costs. Originally designed to require all maintenance medication to be filled via mail service, ERS responded to objections from retail pharmacies and enrollees by modifying the plan to allow the purchase of maintenance drugs at retail pharmacies. To preserve the necessary savings associated with this change, a surcharge was added to all maintenance drugs dispensed through a retail pharmacy. In addition, enrollees were limited to 30 day supplies. The savings generated from this provision are projected at \$103 million for the 2008-2009 biennium.

ERS does not allow for therapeutic substitutions; however it does require generic interchange. The agency points out that when generics are used in place of multi-source brand drugs, their health plan experiences savings of 65 percent on average.

Finally, the agency points out that its 20 years of experience in dealing with PBMs coupled with advice from its consulting actuary provide sufficient expertise to ensure they are not disadvantaged when contracting with PBMs.

Teacher Retirement System (TRS)

The Teacher Retirement System (TRS) also uses a competitive bidding process to select the PBMs used by the two plans it oversees. TRS-Care, which services retired members, uses Caremark. TRS-ActiveCare, a program for active educators, uses Medco.¹³

TRS' contract with each provider sets out protections and provisions similar to those utilized by ERS. Specifically, TRS does not allow for any price spread between the amount the PBM pays the pharmacy and what the agency pays the PBM. Compliance with this requirement is verified via a biennial audit covering the previous two year period.

Rebate payments are also treated similarly. Both PBMs guarantee a flat rate rebate for each brand name formulary drug dispensed. However, under the TRS-ActiveCare contract the rebate rate is a guaranteed minimum and the program shares additionally in all pharmacy revenues derived by Medco from ActiveCare prescriptions.

Both TRS programs provide for mail order dispensing of maintenance medications and allow a reduced co-payments for 90-day supplies filled via mail. Each also allows retail dispensing of maintenance drugs although ActiveCare assesses a surcharge after the second refill. TRS-Care does not have a retail surcharge.

¹³ *Teacher Retirement System of Texas*, supra note 8.

Based on recent satisfaction surveys given to members of TRS-Care and TRS-ActiveCare, most members indicated their satisfaction with services received when filling prescriptions through mail order services. Approximately 88 percent of retired members disclosed that they were satisfied with prescription services and 92 percent were satisfied with the accuracy of their prescription. Eighty-six percent of active members disclosed that they were satisfied with prescription services, and 96 percent were satisfied with the accuracy of their prescription as delivered.¹⁴

Therapeutic substitution is not permitted in TRS-ActiveCare. However, TRS-Care currently participates in a Caremark program where prescribing physicians are asked to consider changing prescriptions when less expensive alternatives are available. Changes are only made with physician approval and patients may appeal for the originally prescribed drug, if desired. Participation in the program comes with guaranteed savings in relation to their administrative fees.

As with ERS, TRS feels it has more than sufficient expertise and resources to effectively negotiate and obtain the most favorable contracts for the state.

Regulatory Structure

PBMs are not regulated as insurance companies but rather as third-party administrators (TPAs). Typically, they do not sponsor benefit plans for an enrolled population but rather primarily perform certain financial services for carriers and employers. The Texas

¹⁴ *Ibid.*

Department of Insurance (TDI) is authorized under Chapter 4151, Texas Insurance Code, to license and regulate PBMs as administrators. These provisions are geared more toward basic financial practices and business controls as opposed to how PBMs conduct themselves in the marketplace.

Under state regulation, PBMs are required to obtain a certificate of authority from TDI and to maintain a fidelity bond to protect against an act of fraud or dishonesty by the PBM in exercising its powers and duties as an administrator. In addition, PBMs are allowed to provide services only under specific written agreements with clients. PBMs are also subject to laws prohibiting fraud, unfair and deceptive acts or practices, and unfair claims settlement practices.

Like with other TPAs, the Commissioner may audit PBMs to regulate compliance with the legal standards established in the Insurance Code. Such audits may include examination under oath and on-site inspections of written agreements, financial statements, or anything related to the "transaction of business by and the financial condition of the administrator."¹⁵

PBMs are also subject to areas of specific oversight. Chapters 843 and 1301, Texas Insurance Code, govern the operation of Health Maintenance Organizations and Preferred Provider Benefit Plans and also provide some regulatory authority over PBMs. Most notably are the sections related to the prompt payment of claims. The law imposes a more stringent standard for timely payment of pharmacy claims than for other medical

¹⁵ Texas Insurance Code, Section 4151.202 (b)

claims. Under these provisions, pharmacy claims must be paid not later than the 21st day after the date the claim is affirmatively adjudicated.¹⁶ All other health claims must be paid within 45 days.

TDI also regulates PBMs through laws that govern specific pharmacy benefit standards. Chapter 1369, Texas Insurance Code, governs benefits related to prescription drugs and devices and related services. This chapter addresses prescription drug coverage requirements and the regulation of formularies. This includes consumer notice requirements as to what drugs are on a formulary, how those drugs were chosen, as well as requirements for continuation of coverage when drugs fall off a formulary in the middle of a plan year. An appeals process for coverage denials is also set forth.

While the regulatory authority outlined above provides a broad range of tools to oversee the PBM industry, self-funded and government sponsored plans are generally exempted from state regulation. The Employee Retirement Income Security Act of 1974 (ERISA) is a federal law that sets minimum standards for most voluntarily established pension and health plans in private industry. ERISA preempts most state laws that seek to impose more stringent regulations or oversight of these types of plans. Government sponsored plans are generally exempt from state regulation. Only 25 percent of Texans are enrolled in health plans over which the state has great statutory and regulatory authority.

In addition to the authority granted to TDI to regulate PBMs, the Texas State Board of Pharmacy (TSBP) also has jurisdiction over some activities performed by PBMs. As

¹⁶ Texas Insurance Code, Sections 843.339 and 1301.104

discussed previously, many PBMs own and operate their own mail-order pharmacies. When operating in this capacity, regulatory authority falls primarily to the TSBP. The agency operates under various provisions of Texas law, primarily those contained under Subtitle J, Pharmacy and Pharmacist, Texas Occupations Code. The TSPB licenses all pharmacies operating in Texas (except those in federal facilities), and any out of state mail-order pharmacies that fill prescriptions and deliver them to Texas residents. As with all pharmacies operating in the state, PBMs that own and operate retail or mail-order pharmacies that fill prescriptions for Texans are encompassed by the regulatory powers granted to the TSBP.

Both TDI and the TSBP have authority to investigate complaints related to PBMs. Each agency deals with complaints falling under their regulatory jurisdiction and refers other claims to the appropriate regulatory entity. The agencies provide detailed information on-line about their complaint process, including an on-line complaint form. Toll-free numbers to call or fax in complaints are also available.

Complaints originating at TDI have remained fairly constant over the past couple of years, about 38 complaints per year. The majority of these have been related to claims processing such as denial of a claim, unsatisfactory settlement offers, or delays in claim handling. TDI resolves complaints almost exclusively without need for litigation.

Complaints initiated at the TSBP relating to PBMs make up only about 10 percent of the overall complaints fielded by that office. Dispensing errors, improper packaging,

confidentiality violations, and incorrect counseling are just a few of the concerns received by the agency. Probably the most serious complaint, unauthorized substitution, is rare and in almost all cases ultimately determined to be unfounded.

Neither TDI nor the TSBP have indicated a need for any expanded authority to better regulate the various aspects of the PBM industry.

Recommendations

- 1. ERS, TRS, The University of Texas System and Texas A&M University System should consider reviewing their PBM contracts to ensure sufficient provisions are included to guarantee the financial interests of the state are protected.**

Rationale: Authority to conduct independent compliance audits aimed at verifying contract performance, and other provisions seeking to ensure the PBM acts in the best financial interest of the state should be most carefully examined. PBMs receive rebates from drug manufacturers in a variety of ways and many in the pharmacy community contend that these negotiations should be disclosed.

- 2. The Legislature should consider legislation aimed at limiting unreasonable dispensing delays associated with cost containment practices such as drug interchange and prior authorization.**

Rationale: Delays in dispensing medications to individuals with conditions that require the medication remain in the bloodstream or must be taken during specific time intervals may result in serious harm. Providers and pharmacists contend that withholding medications due to cost

containment measures is not within the patient's best interest and does not offer consumer protection.

3. The legislature should consider legislation precluding the use of extrapolation in calculating payments owed by or to providers resulting from claims payment errors.

Rationale: Extrapolation is a method in which a sample of claims data is used to determine the accuracy of payments made to providers. Extrapolation methods may be used to identify general accuracy trends in claims processing but the pharmacist community contends that extrapolation unfairly draws conclusions based on an isolated sampling of data. These conclusions often translate into significant charge backs to the pharmacy long after the original adjudication of the claim. The pharmacist community contends that auditing practices should be fair and should protect against the possibility of an inadvertent error used as the basis for calculating payments owed.

Joint Charge 2: Long Term Care

Study how to reduce dependence on Medicaid for the provision of long term care by increasing the use of long-term care insurance and health savings accounts. Include a study of options for increasing the use of advanced planning tools, such as health care power of attorney and living wills, to ensure more effective decision-making regarding critical end-of-life and other health care decisions. Finally, study the feasibility of implementing innovative models of nursing facility services that encourage autonomy, choice and dignity of residents.

Reducing Dependence on Medicaid

Long Term Care Coverage Under Medicaid

Long term care, also known as long term services and supports, is funded largely by Medicaid. Medicaid funds over 40 percent of nursing home days in this country and is the nation's largest supplier of long term care (LTC) coverage.¹ The average cost of a year's care in a nursing home is \$74,000 nationally.² In 2002, only 10.2 percent of seniors had private LTC insurance,³ and a recent study found that while 57 percent of US residents are concerned about LTC costs, 70 percent of them have taken few or no actions

¹ John V. Jacobi, "Dangerous Times for Medicaid," *The Journal of Law, Medicine & Ethics*, Vol. 33, No. 4 (Boston, Mass., Winter 2005).

² Christopher J. Gearon, "Getting Stuck with the Tab," *Washington Post* (Feb. 21, 2006). Available: <http://www.washingtonpost.com/wp-dyn/content/article/2006/02/20/AR2006022000997.html>. Accessed: Feb. 21, 2006.

³ National Conference of State Legislatures, "Bracing for the Tsunami," *State Health Notes*, Vol. 27, Issue 463 (Denver, Co., March 20, 2006).

to address their concerns.⁴ Financial planners estimate that a 65-year-old couple retiring today would need \$200,000 to cover medical costs, not including long term care, dental care or over-the-counter medications; this number is likely to rise to closer to \$500,000 by the time the older baby boomers are retiring.⁵ Based on these numbers, it is easy to see how, as a nation, we have come to rely too heavily on Medicaid to pay for LTC and to see that many Americans fail to consider the costs of LTC when planning for retirement.

Deficit Reduction Act of 2005

The federal and state governments have struggled with the rising costs of Medicaid LTC coverage. The Deficit Reduction Act of 2005 (DRA) made several changes to Medicaid's LTC coverage in an attempt to limit these growing expenses.

The DRA made a number of changes to the asset portion of Medicaid eligibility. The DRA extended the look back period for asset transfers from three to five years,⁶ to make gifting of assets in order to spend-down for Medicaid eligibility more difficult. The penalty period – or time during which a person will not be considered eligible for Medicaid because due to asset transfers – for such transfers was also changed so that it now starts on the date of Medicaid eligibility, not the date of the transfer. Annuities must now be disclosed as assets and the state named the beneficiary of any annuities up to the

⁴ Kaiser Family Foundation, "Many Nursing Home Residents Hospitalized Because of Gaps in Medical Care," *Kaiser Daily Health Policy Report* (July 5, 2006). Available: http://www.kaisernetwork.org/daily_reports/print_report.cfm?DR_ID=38313. Accessed: July 5, 2006.

⁵ Maria M. Perotin, "Retiree health expenses could approach \$500,000," *Baltimore Sun*, (August 6, 2006). Available: <http://www.baltimoresun.com/news/health/balbz.ym.healthcare06aug06,0,1451255.story?coll=bal-health-headlines>. Accessed: August 8, 2006.

⁶ Christopher J. Gearson, *supra* note 2.

cost of Medicaid assistance. States are now required to consider all income of institutionalized spouses to meet the minimum monthly maintenance needs allowance for community spouses who appeal for an increased allowance; this is known as the income first rule. Additionally coverage is excluded for individuals with home equity in excess of \$500,000 (with a state option to raise to \$750,000) unless a spouse or disabled child is residing in the home. Recognizing the potential harshness of these rules, the DRA does permit hardship waivers if the imposition of an asset penalty or delay in Medicaid eligibility would threaten the health or life of the individual or would deprive the person of food, clothing, shelter or other necessities.⁷

The DRA also reversed a previous limit of LTC Partnership Programs.⁸ The Omnibus Reconciliation Act of 1993 had limited asset protection in a manner that precluded states from waiving estate recovery as part of an LTC Partnership Plan.⁹ The DRA lifted this moratorium but added several requirements for the programs; under the DRA, the programs have to adopt the National Association of Insurance Commissioners' model regulations and the Secretary of Health and Human Services must develop standards for making the policies portable across states.¹⁰

The DRA also included the Family Opportunity Act, which allows states to extend Medicaid buy-in coverage to children with disabilities with family income of up to 300

⁷ Jeffrey S. Crowley, *Medicaid Long-Term Services Reforms in the Deficit Reduction Act*, (April 2006). Available: <http://www.kff.org/medicaid/upload/7486.pdf>. Accessed: June 12, 2006.

⁸ The details of LTC Partnership Programs will be discussed further in the LTC Partnership Program section of this chapter.

⁹ University of Maryland Center on Aging, *OBRA 1993 Provisions Pertaining to the Partnership for Long-Term Care*. Available: <http://www.hhp.umd.edu/AGING/PLTC/obra.html>. Accessed: August 11, 2004.

¹⁰ Jeffrey S. Crowley, *supra* note 7.

percent of the Federal Poverty Level (FPL); those with higher incomes may also be offered this benefit but not through the use of any federal funds. The eligibility of this benefit is being phased in starting in 2007 for children up to age six, in 2008 for children under 12, and by 2009 for children up to age 19. Parents must participate in their employer-sponsored coverage if the employer covers at least 50 percent of the premium, and the states may charge income-related premiums and cost-sharing up to five percent of family income for those below 200 percent FPL, or 7.5 percent, for those between 200 and 300 percent FPL.¹¹ To implement this in Texas, the Health and Human Services Commission (HHSC) would need direction from the Legislature and a CMS-approved State Plan Amendment.¹²

Under the DRA, Cash and Counseling (C&C) Programs may now be formed by the states without approval of a Medicaid waiver.¹³ C&C Programs were originally 1115 waiver demonstration projects in New Jersey, Arkansas and Florida. Texas implemented its own C&C model later under House Bill 2292 (78R). Participating beneficiaries or designated advocates were given monthly cash allotments to hire personal assistants or purchase items required to promote the beneficiaries' independence. The states counseled beneficiaries on how to manage their budgets and how to comply with relevant laws regarding the employment of personal assistants. State counselors were assigned to oversee the use of the budgets and to ensure money was being spent in accordance with program rules. Beneficiaries under C&C Programs were found to receive more regular services and reported being more satisfied than those in traditional Medicaid; however for

¹¹ *Ibid.*

¹² Health and Human Services Commission, *Deficit Reduction Act Background*.

¹³ Jeffrey S. Crowley, *supra* note 7.

the first two years of the demonstration, C&C beneficiaries had higher costs than traditional Medicaid beneficiaries.¹⁴ The DRA removal of the waiver requirement could prompt a growth in states' use of C&C Programs, particularly as it does not require comparability or statewide implementation.¹⁵ It does require consumer protections and prohibits eligibility for individuals' exercising self-direction if they live in a home or property owned or controlled by service providers.¹⁶

The DRA also permits expansion of the Money Follows the Person (MFP) Program.¹⁷ Under the MFP Program, any Medicaid-eligible beneficiary who resided in a nursing facility, hospital or intermediate care facility for the mentally retarded for a predetermined period of time¹⁸ would be eligible to have their Medicaid money "follow" them to a home or community-based program.¹⁹ Competitive grants will be awarded to selected MFP demonstration programs to allow federal matching at the current Federal Medicaid Assistance Percentage (FMAP) rates plus half the difference between 100 and the FMAP;²⁰ for example, if a state's FMAP rate is 60 percent, under the demonstration the state would receive 80 percent match (60 percent plus 1/2 of 100-60). Texas currently has a MFP Program that is limited to nursing facility residents and does not have any minimum residential requirements. The Department of Aging and Disability Services is reviewing the DRA MFP requirements and the grant application process.²¹

¹⁴ Alliance for Health Reform, *Cash & Counseling Moves into the Mainstream*, (April 2006). Available: http://www.allhealth.org/recent/issue_briefs/Cash%20and%20Counseling.pdf. Accessed: June 21, 2006.

¹⁵ Jeffrey S. Crowley, *supra* note 7.

¹⁶ *Ibid.*

¹⁷ *Ibid.*

¹⁸ States have the discretion to choose a time period between six months and two years.

¹⁹ HHSC, *supra* note 12.

²⁰ Jeffrey S. Crowley, *supra* note 7.

²¹ HHSC, *supra* note 12.

Home and community based services (HCBS) are also expanded under the DRA through a new state option to provide all HCBS waiver services without needing a waiver for seniors and those with disabilities with incomes of up to 150 percent FPL.²² States are permitted to cap enrollment, maintain waiting lists and offer the option without statewide implementation.²³

Long Term Care Partnership Programs

LTC Partnership Programs are a means of encouraging state residents to purchase LTC insurance and not rely solely on Medicaid for LTC coverage. LTC Partnership Programs are public-private partnerships between the states and private insurance companies that offer some asset protection from Medicaid spend-down requirements in exchange for the purchase of a qualifying LTC policy. Prior to the implementation of the Omnibus Reconciliation Act of 1993, which limited the expansion of LTC Partnership Policies, only California, Connecticut, New York and Indiana had implemented LTC Partnerships. The California and Connecticut programs allowed dollar-for-dollar asset protection – for every dollar of private LTC coverage, a citizen could protect a dollar worth of assets. The New York program required purchase of a policy covering at least three years of nursing facility care and six years of HCBS in exchange for total asset protection. Indiana created a hybrid program – dollar-for-dollar coverage was allowed up to a certain amount or a citizen could obtain total protection through the purchase of qualified policies. Data from the programs demonstrated that people were most likely to purchase

²² Jeffrey S. Crowley, *supra* note 7.

²³ *Ibid.*

a higher level of coverage when offered complete asset protection. Most LTC Partnership Policies include inflation protection and are bought by individuals, not by groups. A majority of those buying such policies reported having assets worth more than \$350,000 and incomes of at least \$5,000 per month. The average premiums for 55 year-olds for Partnership Policies started at \$1,500 per year.²⁴

Reverse Mortgages

A reverse mortgage is a type of mortgage that allows a senior homeowner to convert home equity into cash.²⁵ Generally, no payments are due on the mortgage until the senior moves, dies or sells the home; at that time, the loan comes due in full, but the final payment may not exceed the selling price or value of the home.²⁶

Senate Joint Resolution 7 (79R) authorized the proposal of a constitutional amendment to allow reverse mortgages in Texas. The proposition provides that reverse mortgage documents must provide that the owner does not use a credit card or similar device to obtain an advance, that no transaction fees be charged after the time the extension of credit is established, and the lender or holder of the mortgage may not unilaterally amend the extension of credit.²⁷ Reverse mortgages in which more than one advance is made and the borrower follows all requirements of the mortgage documents must follow particular methods, generally either advances at regular intervals or advances at times and

²⁴ The Government Accountability Office, *Overview of the Long-Term Care Partnership Program*, Report No. GAO-05-1021R, (September 9, 2005). Available: <http://www.gao.gov/new.items/d051021r.pdf>. Accessed: June 8, 2006.

²⁵ Dream Town, *Mortgage Glossary*. Available: <http://www.dreamtown.com/mortgage/mortgage-terms.html>. Accessed: August 7, 2006.

²⁶ *Ibid.*

²⁷ Texas Senate. Senate Joint Resolution No. 7, 79th Legislature, 2005.

amounts specified by the borrower until the credit limit is reached.²⁸ The proposition passed by more than 59 percent of the vote.²⁹

Typical Texas reverse mortgage advances either consist of one lump sum in cash, equal monthly payments for as long as the borrower lives in the home, or equal monthly payments over time. At the time the borrower moves, sells the home or dies, the lender exercises the security interest in the house and forecloses on the property or the new owner or heirs can pay off the loan. Interest under a reverse mortgage generally begins with the first advance and is an adjustable rate with interest compounded monthly. Homeowners aged 62 or older are eligible so long as there are no other liens on the house. Reverse mortgage seekers are required to attend financial counseling before closing on the loan to ensure proper understanding of how a reverse mortgage works.³⁰

The advantage of a reverse mortgage is that it allows seniors to use the equity in their homes to pay for health care and other retirement expenses, thereby delaying the need for public assistance. Concerns about reverse mortgages focus on high closing costs and the impact of the reverse mortgage on the borrower's heirs.³¹

Educational Campaigns

²⁸ *Ibid.*

²⁹ Project Vote Smart, *Texas Ballot Measures 2005*. Available: http://www.vote-smart.org/election_ballot_measures_detail.php?ballot_id=M000001295. Accessed: August 7, 2006.

³⁰ Office of Consumer Credit Commissioner, *Moving Forward With a Reverse Mortgage?*. Available: <http://www.occc.state.tx.us/pages/consumer/education/ReverseMortgageArticle.pdf>. Accessed: August 7, 2006.

³¹ *Ibid.*

Another mechanism for increasing LTC planning and reducing dependence on Medicaid for LTC coverage is to improve the public's knowledge about LTC costs and coverage. A program in Milwaukee called "LTC: Let's Take Care" is focused on just that type of education. It is organized by Connecting Care Communities, a public-private partnership, to raise community awareness and encourage proper planning for LTC.³² An educational program like that in Milwaukee could be part of a LTC Partnership Program implementation or could be done independently in Texas.

Health Savings Accounts

Health care costs continue to rise, and health care consumers are often insulated from these costs until it is too late and they lose health insurance coverage. One method of continuing to provide coverage for consumers while ensuring that they are more cost-conscious is consumer driven health plans. The key tool in consumer driven health plans is the health savings account (HSA). Employers may place a certain amount of money into an HSA for each employee to be used to pay for routine medical care, and the employees are encouraged to deposit into the account as well. Any money not used by the end of the year remains in the account for potential use in later years. HSAs are coupled with high deductible health insurance plans that help cover any catastrophic costs. The idea is that since the consumer is directly paying the bills for doctor visits, prescription drugs and other healthcare expenses, she will become more aware of healthcare costs and more interested in obtaining only efficient and effective healthcare.

³² Bill Glauber, "Group puts new face on long-term care," *Milwaukee Journal Sentinel*, (March 27, 2006). Available: <http://www.jsonline.com/story/index.aspx?id=411172>. Accessed: March 29, 2006.

In 2005, one in five of the largest employers in the United States offered HSA plans, and state and local governments are beginning to offer such plans to their employees.³³

The theoretical benefits of HSA plans include ownership of an asset for consumers and financial certainty for employers. Employers find these plans favorable because they put a set amount in each account and catastrophic plan premiums vary at a lesser rate than more comprehensive plans. Disadvantages include the possibility of drastically increased out-of-pocket expenses for consumers and the potential for overly cost-conscious patients to decline necessary care as well as unnecessary care. Additionally, the lack of readily accessible price and quality data regarding health care treatments and providers means that even the most educated and driven consumer may not have sufficient information to make wise choices.³⁴

Although HSA plan enrollees may deduct money from their account for long term care costs and long term care insurance premiums,³⁵ the Committees are not aware of any proposals in other states focusing on the use of HSA plans to fund long term care. This may be due in part to the current limitation that HSA plan enrollees must be under the age of 65.³⁶

Advanced Planning

Texas Advanced Directives Act Coalition

³³ Penelope Lemov, "The Job of Patients," *Governing*, (March 2006).

³⁴ *Ibid.*

³⁵ The Federal Long Term Care Insurance Program, *Frequently Asked Questions: Tax Benefits*. Available: <http://www.ltcfeds.com/help/faq/taxes.html#6>. Accessed: September 29, 2006.

³⁶ Richard Cauchi, "Power to the Patient," *State Legislatures* (May 2006).

The Texas Advanced Directives Act Coalition (TADAC) was formed in 1994 to address end of life legal issues, particularly with respect to hospice patients being resuscitated by emergency medical personnel. The TADAC was formed to make legislative recommendations, which led to the Out-of-Hospital Do-Not-Resuscitate Act.³⁷

The TADAC met again in anticipation of the 1997 legislative session to review the then-existing end of life related Texas statutes; the related bill was vetoed by then-Governor Bush. Following the veto, the TADAC invited a member of the Governor's staff and the National and Texas Right to Life organizations to join the Coalition. With the input from these additional groups, the TADAC was able to make recommendations that led to the 1999 passage of the Texas Advanced Directives Act. Some changes were made to the Act in the 78th Regular Session, based largely on TADAC suggestions.³⁸

Texas Advanced Directives Act

The Texas Advanced Directives Act (TADA) creates the legal background for the creation and implementation of advanced directives in Texas. Health care providers are required to provide written notices to patients regarding advanced directives and have written policies regarding complying with directives,³⁹ and standards are established regarding the effects and enforceability of various directives.⁴⁰

³⁷ Texas House Public Health Committee, Testimony by Greg Hooser, Chairman, Texas Advanced Directives Coalition, (Austin, Tex., August 9, 2006).

³⁸ *Ibid.*

³⁹ Texas Health & Safety Code §166.004 (2006).

⁴⁰ Texas Health & Safety Code Chapter 166 (2006).

The main document referred to as an advanced directive is the Directive to Physicians and Family or Surrogates. This document, an example of which is contained in the TADA, explains to a patient's physicians and loved ones the types of treatment the patient wishes to receive and/or wishes not to receive in certain circumstances.⁴¹ Procedures are also established for making such decisions when the patient has not executed an advanced directive.⁴² Liability protections are established for physicians and health care facilities that comply with a patient's advanced directives, and penalties are discussed for the failure to follow the directive.⁴³ A separate procedure, including review by a hospital committee and proper notice to patients, is prescribed when a physician actively refuses to comply with a patient's advanced directive and when there are disagreements about the propriety of continued treatment.⁴⁴

Also under the TADA umbrella are Out-of-Hospital Do-Not-Resuscitate Orders (OOH DNR). An OOH DNR advises health care providers in an out-of-hospital setting to withhold cardiopulmonary resuscitation (CPR) and other specified life-sustaining treatment.⁴⁵ The form for this directive is established by rule and is contained on the Department of State Health Services (DSHS) website.⁴⁶ Specific related procedures and related liability limitations are established for the hospitals and physicians.⁴⁷

⁴¹ Texas Health & Safety Code §166.033 (2006).

⁴² Texas Health & Safety Code §166.039 (2006).

⁴³ Texas Health & Safety Code §§166.044-045 (2006).

⁴⁴ Texas Health & Safety Code §§166.046, 052 (2006).

⁴⁵ Texas Health & Safety Code §166.082 (2006).

⁴⁶ Department of State Health Services, *Standard Out-Of-Hospital Do-Not-Resuscitate Order*. Available: <http://www.tdh.state.tx.us/hcqs/ems/dnr.pdf>. Accessed: August 7, 2006.

⁴⁷ Texas Health & Safety Code Chapter 166, Subchapter C (2006).

Criteria and procedures for executing and implementing Medical Powers of Attorney are also included in the TADA.⁴⁸ A Medical Power of Attorney authorizes another individual to make medical decisions for the patient should the patient be unable to make decisions for herself. Unless limitations on the surrogate decision-maker's authority are included in the Medical Power of Attorney, the surrogate can make any decision that the patient could have made if she was competent to do so.⁴⁹ Examples of the information form regarding a Medical Power of Attorney and the Medical Power of Attorney form itself are contained within the TADA.⁵⁰

Department of State Health Services Information

The Department of State Health Services (DSHS) contains various advanced directives related information on its website. As part of the TADA, DSHS maintains a list of health care providers and referral groups that patients or their surrogates can use when seeking to transfer a patient to a facility willing to provide additional treatment.⁵¹

The DSHS Alzheimer's Page contains information on legal planning, including advanced directives and the process to complete such forms.⁵²

Additionally, the Texas Center for Infectious Disease has several related documents on the DSHS site, including an admission form that patients can fill out prior to hospital

⁴⁸ Texas Health & Safety Code Chapter 166, Subchapter D (2006).

⁴⁹ Texas Health & Safety Code §166.152 (2006).

⁵⁰ Texas Health & Safety Code §§166.163, 164 (2006).

⁵¹ Department of State Health Services, *Registry of Health Care Providers and Referral Groups*. Available: <http://www.dshs.state.tx.us/THCIC/Registry.shtm>. Accessed: August 7, 2006.

⁵² Department of State Health Services, *Legal Planning: Questions and Answers*. Available: <http://www.dshs.state.tx.us/alzheimers/legal.shtm>. Accessed: August 7, 2006.

admissions to inform the physicians and hospital of their wishes.⁵³ Also on the site is a form to acknowledge receipt of information about advanced directives.⁵⁴

Methods Being Used to Encourage Planning

While Texas has been one of the leaders in advanced directive laws, two states have policies that if applied in Texas could improve on the use of advanced directives.

Washington State has passed a law that authorizes the creation of a statewide living will databank.⁵⁵ Access will be available for physicians and emergency providers. Given the frequency of in-state travel and transfer of primary care providers with insurance changes, the likelihood of a person's advanced directive or living will making it with them to the hospital has decreased in the modern era. The availability of the documents through an electronic system could ensure that physicians and hospitals have access to advanced directives when and where they are needed.

Florida has created a unique advanced directives form which may appeal to a broader audience. The Five Wishes Document, created by the Florida Commission on Aging, focuses on a more holistic view of end of life care. It asks about the kind of treatment the patient wants or does not want, the comfort level the patient seeks, how the patient would like to be treated by others, what information should be shared with the patient's loved

⁵³ Texas Center for Infectious Disease, *Advanced Directive Admission Form and Checklist*. Available: <http://www.dshs.state.tx.us/tcid/Documents/Advance-Directive-Admission-Form-and-Checklist.pdf>. Accessed: August 7, 2006.

⁵⁴ Texas Center for Infectious Disease, *Acknowledgement Upon Admission*. Available: <http://www.dshs.state.tx.us/tcid/Documents/Acknowledge-upon-Admission.pdf>. Accessed: August 7, 2006.

⁵⁵ Karen Johnson, "Online Access to Living Wills Approved," *The Seattle Times*, (March 4, 2006). Available: http://www.seattletimes.nwsourc.com/html/health/2002843170_wills04.m.html. Accessed: March 6, 2006.

ones and which person should be authorized to make health care decisions for the patient when he is unable to make them for himself. The document is available online along with instructions on properly completing the document and ensuring necessary parties are aware of its existence.⁵⁶

Additionally, the Texas Partnership for End-Of-Life Care (TxPEC) has received a three year grant from the Aetna Foundation to implement the Respecting Choices® Program in Texas. The program focuses on ensuring that all adults are aware of their advanced planning options, that individuals are assisted in their advanced care planning and that all plans are clearly worded and will be available when needed.⁵⁷

Nursing Facility Innovation

Background

The term "nursing home" generally has negative connotations and conjures up images of a large and coldly institutional environment. While this is often not the case, many of us associate nursing homes as a sad and lonely place to be. In response to these negative stereotypes, the nursing facility industry has begun to develop innovative models that are more like home environments and less like institutions. The owners and administrators of these programs are seeking to improve the public's image of nursing homes as well as make them more inviting for the baby boomer generation, which is likely to be more service-demanding than previous generations.

⁵⁶ Aging with Dignity, *Five Wishes*. Available: <http://www.agingwithdignity.org/5wishes.pdf>. Accessed: August 7, 2006.

⁵⁷ Texas Senate Health and Human Services Committee, Correspondence with Suze Miller, Executive Director, Texas Partnership for End-of-Life Care (August 16, 2006).

One potential hindrance to the development of these new types of nursing facilities is concern about Texas laws and regulations regarding nursing facilities. The Department of Aging and Disability Services (DADS) has been working with providers to address their concerns and inform them about the interplay between innovations and facility regulation.⁵⁸

A review of several innovative nursing facility models follows. Given the diverse and mostly grassroots movements to rethink nursing facilities, this list is not comprehensive but serves as a sample of what is being done nationwide and here in Texas.

Senate Bill 52 from the 79th Legislative Session, authored by Senator Nelson and sponsored by Representative Hupp, created a competitive grant program for innovation in the providing services to aging and disabled populations.⁵⁹ The Department of Aging and Disability Services will be releasing two requests for proposals to implement SB 52, one focusing on best practice dissemination regarding innovative practices and one focused on a project created to test an innovative service idea.⁶⁰

Green House Project

Green Houses are the vision of Dr. William Thomas, a New York geriatrician who received his medical degree from Harvard. The project has been described as a

⁵⁸ Texas Health and Human Services Committee, Correspondence with Dr. Leslie L. Cortes of DADS, July 21, 2006.

⁵⁹ Texas Senate. Senate Bill 52, 79th Legislature, 2005.

⁶⁰ Correspondence with Julie Frank, Department of Aging and Disability Services (November 1, 2006).

"rethinking of the architecture, organization, staffing and philosophy of care normally associated with nursing homes." A Green House is a nursing facility designed to house seven to 10 people and to appear like a private home or apartment blending into the community. Each patient has his own bedroom and bathroom, and all residents share a central living area with an open kitchen, dining area and living room. Relatives and loved ones of residents as well as Green House staff are welcome to join residents at meal and activity times. The Green House is meant to be a resident's home for the remainder of his life, and eligibility to remain in the House is not dependent on the resident's medical condition.⁶¹

The Green House staff is based on a multidisciplinary support team of nurses, social workers, therapists, medical directors, nutritionists, and pharmacists.⁶² Staff members are often assigned to more than one Green House. The main hands-on staff members are known as shahbaz, which means "powerful falcon" in Farsi, and are certified nurse aides with additional training in cooking, first aid, listening and team building. The shahbaz manage the household with support for the rest of the clinical support team.⁶³

The first four Green Houses were opened in Tupelo, Mississippi in 2003.⁶⁴ The Tupelo pilot outcomes demonstrated high levels of satisfaction among staff and residents, fewer regulatory complaints than normal nursing facilities, lower decline in activities of daily

⁶¹ Andrea Daitz, *Developing Small Community Homes as Alternatives to Nursing Homes*, Robert Wood Johnson Foundation News Release (November 7, 2006). Available: http://www.ncbdc.org/documents/GH_RWFJ_PR11-05.pdf. Accessed: June 9, 2006.

⁶² *Ibid.*

⁶³ Beth Baker, "Small World," *AARP Bulletin*, (October 2005), p. 29.

⁶⁴ *Ibid.*

living, staff turnover of less than 10 percent, reduced prevalence of unexplained weight loss and of depression and no transfer-related back injuries to residents or staff.⁶⁵ Costs at the Green Houses were comparable to other nursing homes, and 90 percent of the Tupelo Green House residents were covered by Mississippi's Medicaid program.⁶⁶

Texas has a Green House community in San Angelo that is run by Baptist Memorial Ministries. It is a campus with 441 retirement residents and includes traditional nursing facility care, an Alzheimer's care center, hospital care, pharmacy services, and a full-time chaplain.⁶⁷

Eden Alternative

Dr. Thomas, the same geriatrician who invented the Green House Project, developed the Eden Alternative.⁶⁸ The idea was to help large nursing homes address issues with staff and residents by encouraging such activities as keeping pets, gardening and allowing staff to vote on certain administrative decisions.⁶⁹ The following are the 10 principles of the Eden Alternative:

- 1) The three plagues of loneliness, helplessness and boredom account for the bulk of suffering among our Elders.
- 2) An Elder-centered community commits to creating a Human Habitat where life revolves around close and continuing contact with plants,

⁶⁵ Andrea Daitz, *supra* note 61.

⁶⁶ Beth Baker, "Small World," *supra* note 63.

⁶⁷ The Green House Project, *San Angelo*. Available: <http://www.thegreenhouseproject.com/sanangeloT.html>. Accessed: February 14, 2006.

⁶⁸ William L. Hamilton, "The New Nursing Home, Emphasis on Home," *New York Times*, (April 23, 2005). Available: <http://www.globalaging.org/health/us/2005/emphasis.htm>. Accessed: June 9, 2006.

⁶⁹ *Ibid.*

animals and children. It is these relationships that provide the young and old alike with a pathway to a life worth living.

- 3) Loving companionship is the antidote to loneliness. Elders deserve easy access to human and animal companionship.
- 4) An Elder-centered community creates opportunity to give as well as receive care. This is an antidote to helplessness.
- 5) An Elder-centered community imbues daily life with variety and spontaneity by creating an environment in which unexpected and unpredictable interactions and happenings can take place. This is the antidote to boredom.
- 6) Meaningless activity corrodes the human spirit. The opportunity to do things that we find meaningful is essential to human health.
- 7) Medical treatment should be the servant of genuine human caring, never its master.
- 8) An Elder-centered community honors its Elders by de-emphasizing top-down bureaucratic authority, seeking instead to place the maximum possible decision-making authority into the hands of the Elders or into the hands of those closest to them.
- 9) Creating an Elder-centered community is a never-ending process. Human growth must never be separated from human life.
- 10) Wise leadership is the lifeblood of any struggle against the three plagues. For it, there can be no substitute.⁷⁰

⁷⁰ The Eden Alternative, *Eden 10 Principles*. Available: <http://www.edenalt.com/10.htm>. Accessed: August 8, 2006.

Research of Eden Alternative facilities have shown reduced medication use, reduced infection rates, and less employee absenteeism and turnover.⁷¹ A study of the Eden Alternative in Texas, based on two years of data, showed promise for increased satisfaction and quality of life for staff and residents alike.⁷²

Garrison Institute on Aging and Garrison Center

The Garrison Education and Care Center is a teaching nursing home which opened in the summer of 2002 on the campus of the Texas Tech University Health Sciences Center in Lubbock. The Garrison Center is researching the use of telemedicine in LTC, particularly applications for aging and Alzheimer's patients.⁷³ The Center provides care for 120 residents and focuses on researching and instituting best practices in nursing home care.⁷⁴

The Center works collaboratively with the Texas Tech Garrison Institute on Aging. The Garrison Institute contains research, education and clinical divisions as well as the Center for Advancement of Quality in Long-Term Care in order to conduct research on age-related diseases and conditions and educate health professional students on the unique

⁷¹ Susan Levine, "Creating an Eden for Seniors," *Washington Post* (November 21, 1997). Available: <http://www.washingtonpost.com/wp-srv/local/longterm/library/eden.htm>. Accessed: August 7, 2006.

⁷² Sandy Ransom, *Project Abstract, Eden Alternative: The Texas Project*, Texas Long Term Care Institute, Texas State University-San Marcos. Available: <http://ltc-institute.health.txstate.edu/Pub-Abstracts/EdenTX.htm>. Accessed: August 7, 2006.

⁷³ Texas Tech University Health Sciences Center, *Assisted Living*. Available: http://www.dads.state.tx.us/news_info/publications/legislative/Rider_35_COE2004.pdf. Accessed: August 7, 2006.

⁷⁴ Sears Methodist Retirement System, Inc. *The Mildred and Shirley L. Harrison Geriatric Education and Care Center*. Available: http://sears-methodist.com/ret_comm/mildred_shirley/index.htm. Accessed: October 24, 2006.

issues involved in treating long term care and elderly patients. Through its collaboration with the Garrison Center, the Garrison Institute is working to improve the lifestyle and health care of long term care patients while ensuring that the next generation of health professionals has sufficient education in geriatrics to effectively care for future nursing facility patients.⁷⁵

James L. West Alzheimer's Center

The James L. West Alzheimer's Center in Fort Worth focuses on Alzheimer's patients and their families. It is a no-restraint facility that acknowledges the need for care plans to focus not just on a patient's medical limitations but also their lifestyle preferences. The Center is known for its work with and inclusion of families in the care of its patients and in all treatment plans.⁷⁶

Patients' preferences and physical limitations are also considered in the facility design at the Center, which has special seating and low beds for those who are prone to falls and considers the possibility of long shadows disturbing patients when placing lights.⁷⁷ The Center also has full and half day adult day care programs for patients and families who do not choose the full residency program.⁷⁸ As with many innovative nursing facility models, the West Center focuses on the patient as a whole, not just as a medical case, and

⁷⁵ Texas Tech University Health Sciences Center, *Garrison Institute on Aging Vision & Mission*. Available: <http://www.ttuhscc.edu/centers/aging/vision.aspx>. Accessed: October 24, 2006.

⁷⁶ James L. West Alzheimer's Center. *Compassionate Care*. Available: <http://www.jameslwest.com/care.html>. Accessed: October 25, 2006.

⁷⁷ James L. West Alzheimer's Center. *Living Environment*. Available: <http://www.jameslwest.com/living.html>. Accessed: October 25, 2006.

⁷⁸ James L. West Alzheimer's Center. *Senior Adult Day Program*. Available: <http://www.jameslwest.com/program.html>. Accessed: October 25, 2006.

considers the needs and desires of its patients in the design of the facility and the programs it offers.

Pioneer Network

The Pioneer Network, like the Eden Alternative, focuses on changing the environment within existing nursing homes to promote a more community feeling. The Network's values and principles focus on acknowledging the individual resident, building relationships within the facility and promoting an environment to improve the physical, organizational and psycho/social/spiritual health of all involved.⁷⁹

The Network was developed by 33 LTC professionals in Rochester, New York in 1997 to address the need to transform nursing homes into more resident-friendly environments.⁸⁰

One suggestion of the Network is that key personnel and administrators of nursing facilities be admitted for 24 hours of care without receiving special attention, thereby giving them a better picture of life in the facility and potential areas in need of change.⁸¹

The main goal is to institute a cultural change that focuses more on the residents as individuals with individual needs and allows staff to form relationships with each other and with residents.⁸²

⁷⁹ Pioneer Network, *Toward a New Culture of Aging*. Available: http://www.pioneernetwork.net/documents/Toward_a_New_Culture_of_Aging.pdf. Accessed: August 7, 2006.

⁸⁰ Susan Misiorski, "Pioneering culture change: the Pioneer Network shares its approach to creating culture change in long-term care," *Look Smart*, (October 2003). Available: http://www.findarticles.com/p/articles/mi_m3830/is_10_52/ai_110267294/print. Accessed: August 7, 2006.

⁸¹ *Ibid.*

⁸² *Ibid.*

Erickson Communities

There are 17 Erickson Communities in 10 states, each offering a range of housing and health care options and providing on-site physicians and wellness centers.⁸³ Two Erickson Communities are in Texas – Eagle's Trace in Houston and Highland Springs in Dallas.⁸⁴ Eagle's Trace is a gated full-service community that attempts to create a small town feel.⁸⁵ Homes in Eagle's Trace come with a lifetime warranty and maintenance provided at no additional cost.⁸⁶ Buildings are connected by climate-controlled walkways, and a clubhouse provides many amenities.⁸⁷ An indoor Main Street provides access to banking, shopping, and doctors' offices.⁸⁸ A transportation service is provided to all residents.⁸⁹ Similar amenities are available at Highland Springs in the Metroplex.⁹⁰

Recommendations

1. Create a long term care partnership program in Texas.

Rationale: The promise of asset protection will help encourage the purchase of long term care insurance by those who might otherwise spend down to obtain Medicaid coverage. This

⁸³ Beth Baker, "An Abundance of Care," *Washington Post*, (April 18, 2006). Available: <http://www.washingtonpost.com/wp-dyn/content/article/2006/04/17/AR20060417-1275.html>. Accessed: April 19, 2006.

⁸⁴ Erickson Communities, *Erickson Retirement Communities in Texas*. Available: <http://www.ericksoncommunities.com/locations/Texas.asp>. Accessed: August 7, 2006.

⁸⁵ Erickson Communities, *Eagle's Trace*. Available: <http://www.ericksoncommunities.com/eth>. Accessed: August 8, 2006.

⁸⁶ *Ibid.*

⁸⁷ *Ibid.*

⁸⁸ Erickson Communities, *Eagle's Trace: The Small Town Atmosphere You Long For in the City You've Grown to Love*, <http://www.ericksoncommunities.com/eth/campus.asp>. Accessed: August 8, 2006.

⁸⁹ Erickson Communities, *Eagle's Trace: A Personal Staff is At Your Service*, <http://www.ericksoncommunities.com/eth/transportation.asp>. Accessed: August 8, 2006.

⁹⁰ Erickson Communities, *Highland Springs*, <http://www.ericksoncommunities.com/hsd>. Accessed: August 7, 2006.

will reduce improper reliance on Medicaid to replace personal responsibility and planning.

2. Create an electronic databank of advanced directives and medical powers of attorney.

Rationale: Given the frequency with which people travel and change primary care physicians, this would help ensure the availability of end-of-life planning tools at the time and place where relevant health care decisions are being made. Participation could be made voluntary.

3. Encourage use of end of life planning discussion tools at nursing homes.

Rationale: Ninety percent of people die in the course of a chronic illness, and 80 percent of those deaths occur in a medical facility. Ensuring that all nursing home patients, young and old, are aware of their options will increase the knowledge and completion of advanced planning documents for those most aware of their need for such planning.

4. Encourage employers to offer long term care insurance as part of their benefit packages.

Rationale: Only 354,085 people have private long term care insurance policies in Texas. Increasing this number is an important part of reducing dependence on Medicaid for long term care. In the health insurance market, groups are able to

negotiate lower rates for long term care insurance, thereby making it more affordable. Incentivizing employers to offer this to their employees would greatly increase access to group long term care insurance in Texas and should increase long term care insurance purchasing.

5. Institute the Physician Orders for Life-Sustaining Treatment (POLST) program in Texas.

Rationale: The POLST program is based on a form summary of a patient's end-of-life decisions to be filled out as part of a discussion between the patient and the patient's primary physician. The form will then be included in the patient's chart and will follow the patient as part of any discharge or transfer paperwork. This will ensure that information about the patient's decisions is available in a standard form, facilitating quick review and comprehension by health care providers as the patient moves locations.

6. Expand the current Department of Aging and Disabilities' Frequently Asked Questions document on advanced care planning to assisted living facilities.

Rationale: The Department worked with interested parties from throughout the state to develop its Frequently Asked Questions document on advanced care planning. This document provides an easy to read explanation of advanced

care planning and the documents involved. Providing this document to assisted living residents as well as nursing facility residents will ensure greater access to basic advanced care planning information.

7. Clarify that a medical agent may obtain access to the patient's medical records so long as the patient is under a physician's care.

Rationale: Current law allows medical agents access to the patient's medical records once the patient has been found incompetent. This does not address situations in which there is a dispute over the patient's competence and the agent needs the records to have them reviewed by another physician. It also neglects the potential need for a medical agent to review the records to discuss them with the patient and/or the patient's physician while the patient is still competent.

Joint Charge 3: Forensic Patients in State

Hospitals and Community Mental Health

Organizations

Study the current laws/policies relating to forensic patients in our state hospitals and community mental health organizations. Include analysis of and recommendations relating to pre- and post-trial forensic patients, competency laws and procedures, current treatment policies and guidelines, cost and placement considerations for creating specialty units for forensic patients, judicial discretion, and medical best practices.

Background

Statutory

An individual with a mental illness may be committed to a state hospital under two distinct processes: civil commitments or forensic commitments. A civil commitment, which is conducted by a county or probate court (depending upon the jurisdiction), requires the patient to have symptoms of mental illness that create a danger to themselves or others.¹ The treatment team at the state hospital determines when the patient is no longer an imminent risk to themselves or others and whether that person may be placed in a less restrictive environment.²

¹ Chapter 574, Health & Safety Code

² Section 571.004, Health & Safety Code

A forensic commitment, which is conducted by a state district court, involves a patient who has been charged with, or convicted of, a criminal offense. Forensic commitments fall under two categories: pre-adjudication or post-adjudication. Pre-adjudication means the case has not been legally resolved and the defendant is in need of an evaluation and/or treatment to restore that patient to a point where the person is deemed competent to stand trial.³ Post-adjudication means the defendant has already stood trial and was found not guilty by reason of insanity (NGRI).⁴ Under a forensic commitment, the treatment team makes a recommendation to the court regarding changes to commitment status or discharge. The court ultimately must approve those changes.

Funding

All beds at the state hospitals are funded through the legislative appropriations process and appear as a line-item in the Department of State Health Services (DSHS) biennial budget. Counties, through their local Mental Health and Mental Retardation Authorities (MHMRAs), are allocated a portion of these funds determined by the county's population -- under the State Hospital Allocation Methodology -- to pay for civil commitments and community-based programs. In contrast, forensic commitments are funded directly through the DSHS budget and are not subject to the MHMRAs' State Hospital Allocation Methodology.

³ A person is incompetent to stand trial if he or she does not have either a sufficient, present ability to consult with their lawyer with a reasonable degree of rational understanding or, a rational, as well as factual understanding of the proceedings against them. Chapter 46B, Code of Criminal Procedure

⁴ A defendant is found NGRI if he meets the following legal thresholds: (1) the prosecution has established beyond a reasonable doubt that the alleged conduct constituting the offense was committed; and (2) the defense has established by a preponderance of the evidence that the defendant was insane at the time of the alleged conduct. Chapter 46C, Code of Criminal Procedure

The Problem

State hospital capacity, for both civil and forensic patients, reached crisis levels in January 2005. Terrell State Hospital, which had a funded Average Daily Census (ADC) of 274 beds, reached an actual census of 330 on January 12, 2005 (56 patients over capacity). Furthermore, at any given time there are roughly 200 people waiting in Texas jails for transfer to state hospitals under forensic commitments.⁵ Overcrowding, as a result of excess demand for inpatient services, posed a risk to the health and safety of patients and staff. It also compromised the quality of care the state hospitals provide.⁶ Capacity pressure on the system may have led to premature discharge of civil commitment patients in order to accommodate the need for forensic beds.

In early 2005, as an attempt to address capacity, DSHS began to realign all of the state hospital patients. All 60 forensic patients at Terrell State Hospital (TSH) were transferred to either Kerrville State Hospital (Kerrville) or Big Spring State Hospital (Big Spring).⁷ The plan was for an increase in forensic services at Rusk State Hospital (Rusk) when Kerrville and Big Spring reached capacity.⁸ At the same time, the maximum security unit at North Texas State Hospital (Vernon) also added 20 more forensic beds.⁹

⁵ *supra.*, at note 10

⁶ *supra.*, at note 18

⁷ *supra.*, at note 10.

⁸ *supra.*, at note 18.

⁹ *Id.*

Shortly after the realignment, Governor Perry approved a request from DSHS for an additional \$13.4 million to fund 240 more beds.¹⁰ These funds were transferred from the department's FY 2007 appropriation to its FY 2006 budget.

Of the 240 beds appropriated, 194 are currently in use. The remaining 46 beds will not be available until DSHS hires 95 additional full time employees (FTEs) to staff those beds.¹¹ Ninety-six of the additional 240 beds were designated as forensic beds. All 96 of those beds are currently in use.¹² Current capacity in the state hospital system is 2,477 beds; of those, 1,622 are for patients in the hospital under civil commitments and 738 are under forensic commitments.¹³

Patients in State Hospitals

Within the Department of State Health Services system, there are 10 state hospitals that provide inpatient services for people with severe mental illnesses. They are located in Austin, Big Spring, El Paso, Harlingen, Kerrville, Rusk, San Antonio, Terrell, Vernon, Wichita Falls, and Waco.¹⁴ Five of the hospitals -- Big Spring State Hospital, Rusk State Hospital, Kerrville State Hospital, El Paso Psychiatric Center, and the Vernon campus of the North Texas State Hospital -- provide most of the forensic mental health services for the entire system.¹⁵ All of the remaining hospitals, with the exception of the Rio Grande

¹⁰ Letter to Albert Hawkins from Legislative Budget Board, February 14, 2006.

¹¹ DSHS anticipates filling these vacancies by end of August 2006.

¹² Texas Department of State Health Services, Status of State Mental Health Hospitals Capacity Expansion. August 2, 2006. Handout from Joe Vesowate, Kirk Cole, Chris Lopez of DSHS.

¹³ Id.

¹⁴ Texas Department of State Health Services, *State Mental Health Facilities and Commitments*. Online. Available: <http://www.dshs.state.tx.us/council/agendas/030305/4dii.pdf>. Accessed: July 11, 2006.

¹⁵ Texas Department of State Health Services, *Presentation to the Senate Committees on Health and*

State Center in Harlingen, have smaller forensic units. The Waco Center for Youth provides residential treatment for juveniles.¹⁶

All patients within the system may be transferred among hospitals based on various DSHS policies that include treatment plans, security issues and capacity.¹⁷ In addition, some of the state hospitals share resources to increase administrative efficiency.¹⁸ Below is the estimated average daily census for each of the hospitals:

FY 2006 Hospitals Estimated Average Daily Census

Facility	Civil Beds	Forensic Beds	TOTAL
Austin State Hospital (ASH)	283	24	307
Big Spring State Hospital (BSSH)	74	118	200
El Paso Psychiatric Center	58	16	74
Kerrville State Hospital (KSH)	18	184	202
North Texas State Hospital: Wichita Falls	241	24	265
North Texas State Hospital: Vernon campus	0	234	343
Rusk State Hospital (RSH)	245	90	335
Rio Grande State Center (RGSC)	55	0	55
San Antonio State Hospital (SASH)	278	24	302
Terrell State Hospital (TSH)	292	24	316
Waco Center for Youth (WCY)	78	0	78
System-All Facilities	1,622	738	2,477

From 2001 to 2005, the percentage of forensic patients in state hospitals has almost doubled from 16 percent to 30 percent (402 to 704 patients).¹⁹ As of June 26, 2006, the

Human Services and State Affairs, PowerPoint presentation, p. 2. (August 23, 2006.) (Copy on file with the respective committees).

¹⁶ Id.

¹⁷ supra., at note 5

¹⁸ Id.

¹⁹ Texas Department of State Health Services, *The Texas Approach to Transformation*, PowerPoint Presentation, Austin, Texas.

number of forensic patients with DSHS had increased to 752, or 30 percent of a total population of 2,477 patients.²⁰

Cause & Effect

No one reason exists for the increase in forensic beds in Texas. Rather, any one of the following factors may have contributed in whole, or in part, to the increase:

- passage of the Fair Defense Act,
- early identification of criminal offenders with mental illnesses,²¹
- lack of access to mental health services outside of the criminal justice system, and
- forensic commitments which typically last longer than civil commitments.²² These factors are discussed in more detail below.

Passage of the Fair Defense Act of 2001

In 2001, the 77th Texas Legislature passed the Fair Defense Act.²³ The law became effective in January 2002 requiring all defendants be appointed counsel within four days of arrest/detainment.²⁴ Prior to its passage, it was not uncommon for a defendant to remain in jail for weeks or even months without the appointment of a lawyer. Because lawyers are now appointed earlier in the process, legal issues, including those related to

²⁰ Texas Department of State Health Services, *Forensic Commitments as a Percent of Capacity*, Handout Presentation, Austin, Texas. (August 10, 2006).

²¹ Texas Department of Criminal Justice, *Texas Correctional Office on Offenders with Medical or Mental Impairments (TCOOMMI) Activities*. Available: <http://www.tdcj.state.tx.us/tcomi/tcomi-systemic.htm>. Accessed: August 7, 2006.

²² *Supra.*, at note 10.

²³ Section 1.051, Code of Criminal Procedure

²⁴ In rural areas, appointments must be made within six days. Code of Criminal Procedure, Section 1.051.

mental illness, are being raised more quickly and with more consistency, thus, potentially having an effect on the number of forensic beds.

Identifying Offenders with Mental Impairments

Early identification of persons with mental impairments is essential in providing the most appropriate handling and treatment of that individual. This statement is especially true in a criminal justice setting, where symptoms of one's mental illness may easily be exacerbated.²⁵ To identify which offenders have a diagnosis of a serious mental impairment, the 79th Legislature in 2005 compelled the sharing of information between DSHS and the jails. Under directive riders in the appropriations bill, jails are required to cross-reference with the Department of State Health Services' data system to determine whether a particular offender has ever accessed the public mental health system.²⁶ Once flagged as an individual with a history of mental illness, it is likely that legal issues related to a defendants' mental state -- including competency to stand trial -- will be raised. This cross-referencing practice may have contributed to the increased need for forensic beds.

²⁵ The very environment of a jail or prison -- crowded, noisy, lacking privacy, and often violent -- is a considerably difficult one for a person with a mental illness. The necessity for rules enforcing security, public safety and crowd control are not conducive to the needs of the mentally ill offender.

In addition to suffering from increased symptoms of their disease, inmates with mental illness are easily victimized by other inmates and "goaded into fights and rule-breaking." These kinds of behaviors and infractions can lead to extended sentences, and it follows that mentally-ill prisoners end up serving more time than other offenders with comparable crimes. One study found that inmates with mental illness spent an average of six and a half times longer in disciplinary units than their non-mentally ill counterparts.

Taken from: Dean H. Aufderheide and Patrick H. Brown, "Crisis in Corrections: The Mentally Ill in America's Prisons," *Corrections Today*, Vol. 67, No. 1 (February 2005), pp. 30-33; Jamie Fellner, "A Corrections Quandry: Mental Illness and Prison Rules," *Harvard Civil Rights-Civil Liberties Law Review*, Vol. 41, No. 2 (Summer 2006) p. 393.

²⁶ Section 614.013, Health and Safety Code.

Access to Mental Health Services in the Criminal Justice System

The 1960s phenomenon known as "deinstitutionalization" appears to have contributed directly to the increase of the mentally ill in the criminal justice system. States began to reduce and close their publicly-funded state hospitals at the same time that advocates were pushing for community-based care for people suffering from mental illness. This movement also converged with the first medications that successfully addressed the symptoms of some mental diseases. However, the federal government, along with virtually every state, did not achieve a proportional increase in funding for community-based or outpatient care. Without treatment, people who are suffering from serious mental illnesses, particularly those who are poor, homeless, and dealing with co-occurring substance abuse, may break the law. The result is sometimes referred to as trans-institutionalization, whereby people shift from the mental health system into communities with a lack of services, and subsequently into the criminal justice system when their condition deteriorates to a point of becoming a risk to themselves or other people. Many jails report frequently holding people with mental illness simply because there is no place else to take them.

Forensic Commitments Longer than Civil Commitments

The average length of stay for forensic patients is roughly triple that of civil commitments (80 days compared to 26 days), representing a greater demand on state hospital resources. In the third quarter of FY 2006, just five percent of forensic patients were discharged within 30 days of admission, while 49 percent were discharged within

31-90 days. Forty-six percent of forensic patients were released to the community after a stay longer than 90 days.

Competency Laws and Procedures

In 2001, the 77th Legislature authorized the creation of a 16-member taskforce to re-write the Texas criminal competency statute. The taskforce membership was a true cross-section of interested parties: psychiatrists and psychologists, defense counsel and prosecutors, judges, patient advocates, elected officials and relevant state agencies.²⁷

After studying the issue for two years, the members of the taskforce made recommendations to the 78th Legislature that resulted in the repeal of Section 46.02, Code of Criminal Procedure, and the codification of the new Chapter 46B, Code of Criminal Procedure.²⁸ In addition to ensuring consistency statewide, the legislation was designed to make the law user-friendly as well as more efficient. Procedural timeframes were shortened and the use of technology to realize cost savings was encouraged. A flowchart outlining the new criminal competency procedure is attached as Appendix B .

The Department of State Health Services asserts that the rise in forensic commitments to state hospitals is due to the statutory changes made during the 78th Legislative Session to criminal competency laws found in Chapter 46B, Code of Criminal Procedure. However, the changes to 46B, Code of Criminal Procedure, were not substantive in nature, but rather an attempt to streamline the statute to make its application more consistent

²⁷ The task force was created under S.B. 553 (77th Legislature). A copy can be found at <http://tlis/BillLookup/BillTextViewer.aspx?BillUrl=/tlisdocs/77R/billtext/html/SB00553F.htm>.

²⁸ The recommendations of the S.B. 553 task force can be found at: <http://www.tdcj.state.tx.us/publications/tcomi/publications-tcoommi-sb553-rprt-2002.htm>

statewide. For example, the actual hearing for determining competency was streamlined. Prior to the changes under Chapter 46B, a court was required to call a jury to rubberstamp a finding of incompetency in all cases, even in cases where all parties (defense and prosecution) believed that the defendant/patient was incompetent. Under the new law, the court can reach this same finding without having to call a jury pool when all the parties agree. Formal hearings with juries (when requested), are still required in cases where the parties do not agree. While it is true that the process has been streamlined (and more efficient for the courts), the outcome -- in terms of the number of those found incompetent -- is still the same. No conclusive evidence has been provided that shows the changes to the criminal competency statute caused the forensic bed population growth.

The department also contends that the changes to Chapter 46B change the law so that the court is the ultimate decision-maker when determining whether a patient is released from inpatient services. However, this is no different from the previous law.

Decreasing Demand for Inpatient Forensic Beds

Forensic commitment, which varies in duration as well as facility placement, is a costly option for both state and local governments. With few exceptions, the entire cost of a state hospital stay is subsidized by general revenue. County government assumes fiscal responsibility for the patients' transportation to and from the facility.

There is room in the Code of Criminal Procedure for innovation at the local level. Several communities have developed outpatient, community-based programs to ease demand for forensic beds at the state's 10 mental health facilities. The programs are diverse. Most initiatives can now document savings, in addition to providing more appropriate treatment, services, and outcomes for people who previously might have become more deeply involved in the criminal justice system. A number of these programs are discussed below.

Texas Correctional Office on Offenders with Medical and Mental Impairments (TCOOMMI) -- Mental Health Initiative

In 2001, the 77th Legislature appropriated \$16 million per year to the Texas Correctional Office on Offenders with Medical and Mental Impairments (TCOOMMI), a division of the Texas Department of Criminal Justice (TDCJ). Those funds called the "Mental Health Initiative" were targeted for jail diversion services and mental health treatment, as well as specialized supervision caseloads for adult offenders.²⁹ The goal of the new initiative was to reduce recidivism through the provision of targeted mental health services for offenders with serious mental illnesses.

TCOOMMI has received this funding to provide mental health services for offenders, both pre-trial and post-adjudicatory, from each legislature since 2001. TCOOMMI contracts with local MHMRAs, which are responsible for the mental health services in the counties. The MHMRAs then use the funds to provide direct mental health services

²⁹ Prior to 1991 (with the Mental Health Initiative), TCOOMMI received \$5 million (per year) in a direct appropriation and an additional \$1.4 million (per year) from TDCJ to provide this same service.

through a number of avenues. All TCOOMMI-funded programs must also draw down Medicaid funding for mental health services provided.

TCOOMMI-funded programs include jail diversion, outpatient restoration, specialized deputies trained in mental health, and specialized mental health probation/parole caseloads. The programs focus on keeping mentally ill persons out of jail or prison. The hope is that these programs ultimately minimize the contact between mentally ill patients and the criminal justice system. Examples of TCOOMMI-funded programs are discussed below.

Jail and Prison Diversion Programs

New START

In 1993, Harris County MHMRA established a comprehensive outpatient program, New START, for adult parolees, adult probationer/pretrial defendants, adults found not guilty by reason of insanity, and Texas Youth Commission parolees.³⁰ The mission of New START is to "assist the mentally impaired offender in avoiding unnecessary incarceration, as well as improve the quality of life in the community."³¹ New START staff assess each offender's social needs including housing, employment, drug and alcohol treatment, and medication compliance, and afterward provide them with extensive and customized services.

³⁰ Testimony by Ethel Perry, Director, Mental Health Mental Retardation Association of Harris County, to the Senate Committees on State Affairs and Health and Human Services, August 23, 2006, p. 2.

³¹ *Id.* at p. 15.

Eligibility for the program is restrictive, and New START can serve a maximum of 350 offenders. Offender participants must adhere to high expectations that include abstaining from drug and alcohol use, participating in daily rehabilitation groups for the first 90 days, submitting to random drug screens, complying with medications, and keeping all appointments with counselors and psychiatrists.³²

New START has been extremely successful and boasts a three-year program wide low recidivism rate of 10 percent.

Harris County Court Resource Jail Diversion

To decrease the demand for forensic commitments and jail space, Harris County MHMRA developed the Court Resource Jail Diversion program in August 2001. This initiative provides mental health experts inside the courtroom to help the court, defense counsel, and prosecution develop conditions of release for the defendant. Jurisdictions are able to use these resources as a less expensive alternative to a full-blown mental health court. The goals of this program are to:

- Identify and assess defendants during the pre-trial stage,
- Provide mental health information to the courts and attorneys,
- Inform defense attorneys about available treatment resources,
- Link all parties to appropriate services, and

³² Id. at p. 10.

- Track results and collect data for project evaluation on the needs of mentally ill female offenders with children.³³

Within two years, the project has expanded from six felony courts to 22, and from one misdemeanor court to all of them in Harris County.³⁴ In FY 2005, 3,151 offenders were seen face-to-face for services.

Midland and Ector Counties - Mental Health Deputies

Several communities in Texas have begun mental health deputy programs. These are law enforcement officials who are specially trained to deal with mentally ill individuals. The primary purpose of the deputies is to divert people with mental illness from jail into treatment. The program in Midland and Ector counties, which began in 2005, has diverted 24 percent of their calls related to mental illness treatment by improved assessment of the individual.³⁵ These deputies are funded through TCOOMMI.

Dallas County - Mental Health Courts

There are more than 100 mental health courts across the country for adult and juvenile offenders.³⁶ There are many variations in the design of these courts, but all exist to link participants to treatment instead of incarceration.³⁷ Moreover, the court focuses on providing ongoing supervision throughout treatment. Participation in mental health

³³ Id.

³⁴ Id. at p. 16.

³⁵ Stephanie Miller, "Mental Health Deputies a Great Addition, Authorities Say," *Midland Reporter-Telegram* (August 21, 2006).

³⁶ Ron Honberg and Darcy Gruttadaro, "Flawed Mental Health Policies and the Tragedy of Criminalization," *Corrections Today*, Vol. 67, No. 1 (February 2005), pp. 22-27.

³⁷ Id.

courts is voluntary for offenders, although most are limited to individuals charged with misdemeanors or nonviolent felonies.³⁸

"Achieving True Liberty and Success," a mental health court in Dallas, is an example of a "final stop before prison" program and is exclusively for felons who have been unsuccessful on probation. There are currently about 50 participants, and each must be a past or present client of the public mental health system.³⁹ All offenders are intensively monitored by Judge Susan Hawk and receive case management services along with their mental health and substance abuse treatment. Judge Hawk's mental health court is staffed with TCOOMMI-funded employees.

Crisis Intervention Teams (CIT) and Mobile Outreach Teams

Crisis Intervention Teams (CIT) is an increasingly popular model used by law enforcement agencies across the country. There are many different variations of CIT, but all involve giving specialized training (40 hours minimum) to 10 to 20 percent of all patrol officers within a department.⁴⁰ These officers, which can include mental health deputies, perform all patrol duties but respond immediately when there is a crisis situation involving a mentally ill person. Furthermore, CIT officers become knowledgeable about local resources for the mentally ill, and in turn become well known to mental health agencies and their staff.⁴¹

³⁸ Id.

³⁹ Testimony by Judge Susan Hawk, 291st Judicial District Court, to the Senate Committee on Health and Human Services, Austin, Texas, August 23, 2006.

⁴⁰ "Police Using New Approaches to Deal with the Mentally Ill," *Criminal Justice Newsletter* (June 15, 2006), p. 2.

⁴¹ Id.

In 2005, Williamson County created both a CIT and a Mobile Outreach Team to better serve the needs of law enforcement and county residents. The CIT consists of eight trained officers who deal exclusively with mental health calls throughout the county. They also collaborate with the justice system, county jail, hospitals, schools, and other non-profit agencies to facilitate jail diversion.⁴² The Mobile Outreach Team consists of two licensed professional health counselors that respond to non-violent mental health crises in Williamson County. Their main role is to link people in crisis to mental health, social service, or medical providers to prevent further interaction with law enforcement.⁴³ Both teams combined will save the county an anticipated \$1.53 million annually.⁴⁴

Mental Health Public Defender Office

Travis County, with a \$500,000 grant from the Texas Task Force on Indigent Defense, is developing the first stand-alone mental health public defender office in the state.⁴⁵ Scheduled to begin operating by mid-November 2006, the office will have two goals: reducing the cost of defending mentally ill indigents accused of crime; and stopping the "revolving door" of hospitals, criminal justice, schools, and other agencies through which people with mental illness often cycle.⁴⁶ Attorneys, social workers, and case workers work together to guide the offender through the court system, locate employment and housing, and monitor medication compliance.

⁴²Email from Kathy Grimes, Chairperson, Williamson County Mental Health Committee, "Williamson County Proposal for the State of Texas," to Katherine Barksdale, August 16, 2006.

⁴³ Id.

⁴⁴ Id.

⁴⁵ Mary Alice Robins, "Travis County Creates Mental Health Public Defender Office," *Texas Lawyer* (June 5, 2006), p. 1.

⁴⁶ Id.

Dallas and El Paso counties also have mental health public defenders within their public defender offices.⁴⁷ The Dallas County Outpatient Restoration Program, which helps defendants regain competency in order to stand trial, has already shown cost savings in addition to better care for the mentally-ill offenders.⁴⁸ Because meetings with mental health providers are court-ordered, there is better monitoring of the psychosocial needs and progress of the client, and the District Attorney is more confident about the offender's safe return into society.⁴⁹

Alternative Types of Competency Restoration Programs

Outpatient

Another way to reduce the number of forensic beds being used in state hospitals are programs that provide restoration services in alternative settings. One such service is to encourage outpatient restoration services. There is currently no statutory obstacle to using outpatient restoration. In fact, Section 17.032, Code of Criminal Procedure directs a magistrate to release a mentally ill offender on a personal recognizance bond if the defendant has not committed a violent offense. Participation in mental health services (including restoration) is required to be part of the defendant's conditions of release. Although legal, the existence of outpatient restoration is extremely limited because of a lack of resources at the local level.

⁴⁷ Id.

⁴⁸ Testimony by Beth Mitchell, Senior Attorney, Advocacy, Inc., to the Senate Committees on State Affairs and Health and Human Services, August 23, 2006.

⁴⁹ Id.

Inpatient -- Harris County Rusk Diversion Project

In November 2003, Harris County MHMRA, in conjunction with TCOOMMI, the Harris County sheriff and courts, initiated a community-based competency restoration project, the Rusk Diversion Program. The primary goal of the program was to identify defendants in the county jail who could potentially be restored to competency while at the jail, thus avoiding a lengthy and costly commitment to a state facility. As of August 21, 2006, 3,077 adult offenders had been referred to the program, and 2,331 had been diverted from a state hospital bed.⁵⁰ A more detailed overview of the project is included in Appendix

C. To accomplish this goal, the following objectives were identified as targets:

- Reduce the number of state hospital bed days utilized by Harris County,
- Provide a community-based pilot that was shorter in duration than a typical state hospital commitment,
- Reduce the overall transportation costs associated with transporting inmates to and from the state hospital, and
- Provide information to the courts about the psychiatric conditions of inmates to assist with release and detention decisions.

Although a cost-benefit analysis is not yet complete, several preliminary observations can be made:

- 419 of the 567 (74 percent) defendants referred from the court were diverted from state hospital commitments,

⁵⁰ Testimony by Rose Childs, Deputy Director, MHMRA of Harris County, to the Senate Committees on State Affairs and Health and Human Services, August 23, 2006.

- The average length of stay at the project was 21 days compared to the 112 days spent in the state hospital,⁵¹ permitting a speedier disposition of cases, and
- Harris County's transportation costs were significantly reduced.

Recommendations

1. Expand outpatient restoration programs and provide training to the judiciary.

Rationale: Jails and state hospitals are two very expensive interventions for mental illness. Incarceration also worsens symptoms of mental illness for many people. Funding outpatient restoration programs will save money and space used by state hospitals and will improve clinical outcomes for patients. Sections 17.032 and 46B.072, Code of Criminal Procedure, permits a court to release a non-violent offender on a personal recognizance bond if the defendant has a mental illness. By allowing these defendants to receive outpatient, community-based restoration treatment as part of their condition of release, they would be eligible for Medicaid coverage, allowing the state to draw down federal funds.

⁵¹ *Ibid.*

2. Reduce timeframe between a patient's restoration to competency and their return to court from 75 days to 50 days.

Rationale: Currently, a patient can remain in a state hospital for up to 75 days after the court and parties have been apprised that the patient has been restored to competency. The treatment teams believe that restoration can be accomplished in 50 days, thus allowing bed space to become available more frequently.

3. Prohibit the use of state hospital forensic beds for restoration of competency in misdemeanor cases. The MHMRAs shall ensure that these services will be provided; however, the State, through TCOOMMI, will pay for the medication costs.

Rationale: The limited number of forensic beds should be used for felons and violent offenders. Section 17.032 of the Code of Criminal Procedure already directs a magistrate to release a mentally ill offender on a personal recognizance bond if the defendant has not committed a violent offense. This provision will ensure that misdemeanor defendants are being served, but in a more appropriate and less expensive environment.

4. Clarify the maximum term of commitment under Chapter 46B of the Code of Criminal Procedure for misdemeanor defendants so they are

not in an inpatient competency restoration program longer than the maximum sentence would have been for their offense.

Rationale: Forensic patients are generally spending up to two years in state hospitals for offenses that would have had a six to 12 month jail or prison sentence.

5. Create a central registry of mental health professionals who meet the professional requirements for competency evaluations.

Rationale: The absence of a registry hinders the courts' and state hospitals' ability to track mental health professionals who meet all the legal qualifications.

6. Conduct medication hearings at the same time the court orders a patient committed.

Rationale: If a patient refuses medications, they cannot be medicated without going to court. This process can take up to two weeks, requires more resources, and the unmedicated patient can endanger hospital staff in the meantime.

7. Amend the Health and Safety Code to clarify that the costs of the medication-related hearings for forensic patients are to be borne by the county where the criminal proceedings were brought.

Rationale: Senate Bill 465 of the 79th Regular Session provided the authority for civil courts with probate jurisdiction to order forensic patients to take medications. It did not expressly allow these probate courts to charge the county of origin

for the medication hearings. This places a burden on probate courts located in counties with state hospitals. The use of this provision should be limited if the courts hold medication hearings simultaneous to the commitment hearing (recommendation above).

- 8. Amend Chapter 46B of the Code of Criminal Procedure to describe how the court is to re-assess the defendant's competency absent their being admitted to a state hospital and a final report being issued by the head of that facility.**

Rationale: 46B.071 and 46B.072 provide for competency restoration on an outpatient basis, but clarification is needed to determine how to assess a patient's competency on an outpatient basis without requiring their admission as an inpatient.

- 9. Amend certain provisions relating to procedures for 12 month commitments (Chapter 46B, Subchapter E of the Code of Criminal Procedure).**

Rationale: Clarification is needed regarding which procedures from the Mental Health Code and Persons with Mental Retardation Act apply to persons committed under the Code of Criminal Procedure, Chapter 46B.

- 10. Create more mental health courts; align these courts with jurisdictions with mental health public defender offices.**

Rationale: Mental health courts better address the needs of mentally ill offenders and promote greater understanding of mental illness among judges and attorneys.

11. Clarify the duty of the Sheriff to return all state hospital patients back to court.

Rationale: Current law only requires that the sheriff return patients whose commitments are set to expire back to court from the Maximum Security Unit (MSU) and not from other non-MSU state hospitals. This places a burden on the state hospitals to pay the costs if the sheriff declines to provide transportation.

APPENDICES

Appendix A: Letter from Anne Fuelberg



November 7, 2006

**EMPLOYEES
RETIREMENT
SYSTEM OF TEXAS**

ANN S. FUELBERG
EXECUTIVE DIRECTOR

DON GREEN
CHAIR

OWEN WHITWORTH
VICE-CHAIR

BILL CEVERHA

CAROLYN LEWIS GALLAGHER

YOLANDA GRIEGO

I. CRAIG HESTER

BOARD OF TRUSTEES

The Honorable Robert Duncan
Chair, Senate State Affairs Committee
State Capitol, Room # 3E.12
Austin, Texas 78701

Dear Senator Duncan:

Pursuant to your request, this letter will address some of the issues raised at the Senate State Affairs/Health and Human Services joint hearing on October 17, 2006 on the interim charge dealing with the regulation of Prescription Benefit Managers (PBMs).

The following issues were discussed at the hearing and are addressed below from the perspective of the Group Benefit Program (GBP) as administered by ERS:

- Therapeutic Substitution - This was considered several years ago by ERS and the decision was made to not permit therapeutic substitution since the process can raise questions regarding the objectivity of the PBM and runs the risk of interfering with the physician/patient relationship. Therapeutic substitution is not currently, nor has it ever been permitted in the GBP.
- Price Spread – In the GBP, there is no spread between the amount that the PBM pays the pharmacy and the amount ERS pays the PBM. Under the terms of the ERS contract with MEDCO Health Solutions, MEDCO pays the claim submitted by the retail pharmacy according to a reimbursement formula specified by ERS. ERS then pays MEDCO the exact amount that MEDCO has paid the pharmacy. Compliance is verified by an annual independent audit of MEDCO by an auditor retained by ERS.
- Prompt Payment of Claims – MEDCO pays claims submitted by retail pharmacies every 2 weeks. Generally, all claims are paid in less than 30 days.
- Rebates – ERS receives rebates from MEDCO based on a contractually specified dollar amount for each brand name formulary drug dispensed. ERS selected MEDCO through a competitive bidding process that considered all elements of cost associated with a PBM, including rebates. ERS requires rebates to be paid on the basis of each brand name formulary drug dispensed under the contract, a standard that allows for competition that can be objectively quantified, evaluated and easily audited. Compliance with the terms of the contract, including accurate payment of rebates, is confirmed through an annual independent audit by an auditor retained by ERS.

- Mail Service – In order to address budget concerns in the 2003 Legislative Session, ERS worked with both chambers of the legislature and was prepared to implement mandatory mail service for a 90 day supply of maintenance drugs in order to produce an expected \$79 million in savings for the FY 2004-2005 biennium.

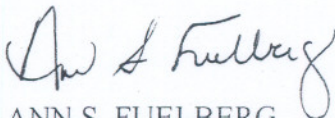
After receiving numerous objections from retail pharmacies, ERS modified its benefit design to allow participants to get a 30 day supply of maintenance drugs from retail pharmacies but required the participant to pay a surcharge in order to secure the savings that otherwise would have been achieved by requiring mandatory mail service for maintenance drugs. This benefit design is in place today. Mail service is projected to generate cost avoidance of \$103 million for the FY 2008 – 2009 biennium.

During FY 2006, approximately one-third of the GBP expenditure for maintenance drugs went to MEDCO and two-thirds went to retail pharmacies.

- Contracting Expertise – After contracting with various PBMs for almost 20 years, ERS is very confident that it has sufficient experience and expertise with its legal and program staff as well as from its consulting actuary to not be at a disadvantage when contracting with PBMs.
- Generic Drugs – Testimony was presented expressing concern about the efforts of PBMs to encourage the use of generic drugs. Encouraging the use of generics is a commonly accepted means of cost management in a prescription drug plan. In HealthSelect during FY06, the average cost of a day of therapy was \$0.85 when a generic was used as compared to \$1.40 (65% greater) when a multi-source brand drug was used. (A multi-source brand drug is one for which there is a generic equivalent available.) Generics save money for the plan and the members. Obviously, encouraging the use of generics is an important cost management strategy in HealthSelect.

Hopefully this information will be helpful to you and the members of State Affairs and Health and Human Services, as you deliberate on potential regulation of PBMs. If I can furnish any additional information, please let me know.

Sincerely,



ANN S. FUELBERG
Executive Director

cc: The Honorable Jane Nelson, Chair, Senate Health and Human Services Committee
Members, Senate Health and Human Services Committee
Members, Senate State Affairs Committee

Appendix B: Criminal Competency Flow Chart

Code of Criminal Procedure - Chapter 46B

Incompetency to Stand Trial

Flow Chart Key

Informational

Alternatives

Exits from 46B

A person is incompetent to stand trial if the person does not have:

- sufficient present ability to consult with the person's lawyer with a reasonable degree of rational understanding; or
- a rational as well as factual understanding of the proceedings against the person. **[46B.003(a)]**

Incompetency proceedings applicable to defendants ("D") charged with a felony or misdemeanor punishable by confinement **[46B.002]**

Competency issue raised by either party or the court on its own motion **[46B.004(a)]**

Court conducts informal inquiry **[46b.004(c)]**

Court may, at any time, **dismiss criminal charges against D** and transfer proceedings to civil court under 46B - Subchapter F **[46B.004(e), 46B.084(f)]**

No evidence of incompetency

Evidence of incompetency

Resume criminal proceedings

Court orders examination **[46B.005]**

- by qualified expert **[46B.021]**
- factors to be considered **[46B.024]**
- report due in 30 days **[46B.025, 46B.026]**

Competency hearing before judge or jury **[46B.005(c), 46B.051]** Defense must prove incompetency by a preponderance of the evidence **[46B.003(b)]**

No hearing required if no one requests a jury or opposes a finding of incompetency **[46B.005(c), 46B.054]** However, Court must still appoint expert to prepare report **[46B.021(b), 46B.074]**

Finding of competency

Court may **release D on bail** for outpatient treatment for the purposes of attaining competency **[46B.072]**

Initial Court Determination of Incompetency [46B.051 - 46B.055]

Commit* D to appropriate inpatient forensic facility for restoration of competency [46B.071, 46B.073]
Subchapter D "Restoration Commitment"

* Court personnel contact the State Hospital Forensic Clearinghouse at (940) 552-4061 for admission

If **D** charged w/ CCP Art. 17.032(a) offense, or indictment alleges 42.12 sec 3g(a)(2) affirmative finding, **D is committed*** to the DSHS Maximum-Security Unit (MSU) for up to 120 days, with one possible 60-day extension for the purpose of restoring **D** to competency **[46B.073(b)&(c), 46B.080(d), 46B.081]**

If **D is not charged with specified offense;** **D is committed*** to a non-MSU DSHS facility for up to 120 days with a possible 60-day extension for the purpose of restoring **D** to competency **[46B.073(b)&(d)]**

Competency procedures continued on next page

Treatment Responsibilities during Subchapter D “Restoration Commitment” [46B.077(a)]

- Develop individual treatment program for **D**
- Assess whether **D** will attain competency in the foreseeable future
- Report to the court and LMHA **D**’s progress toward competency

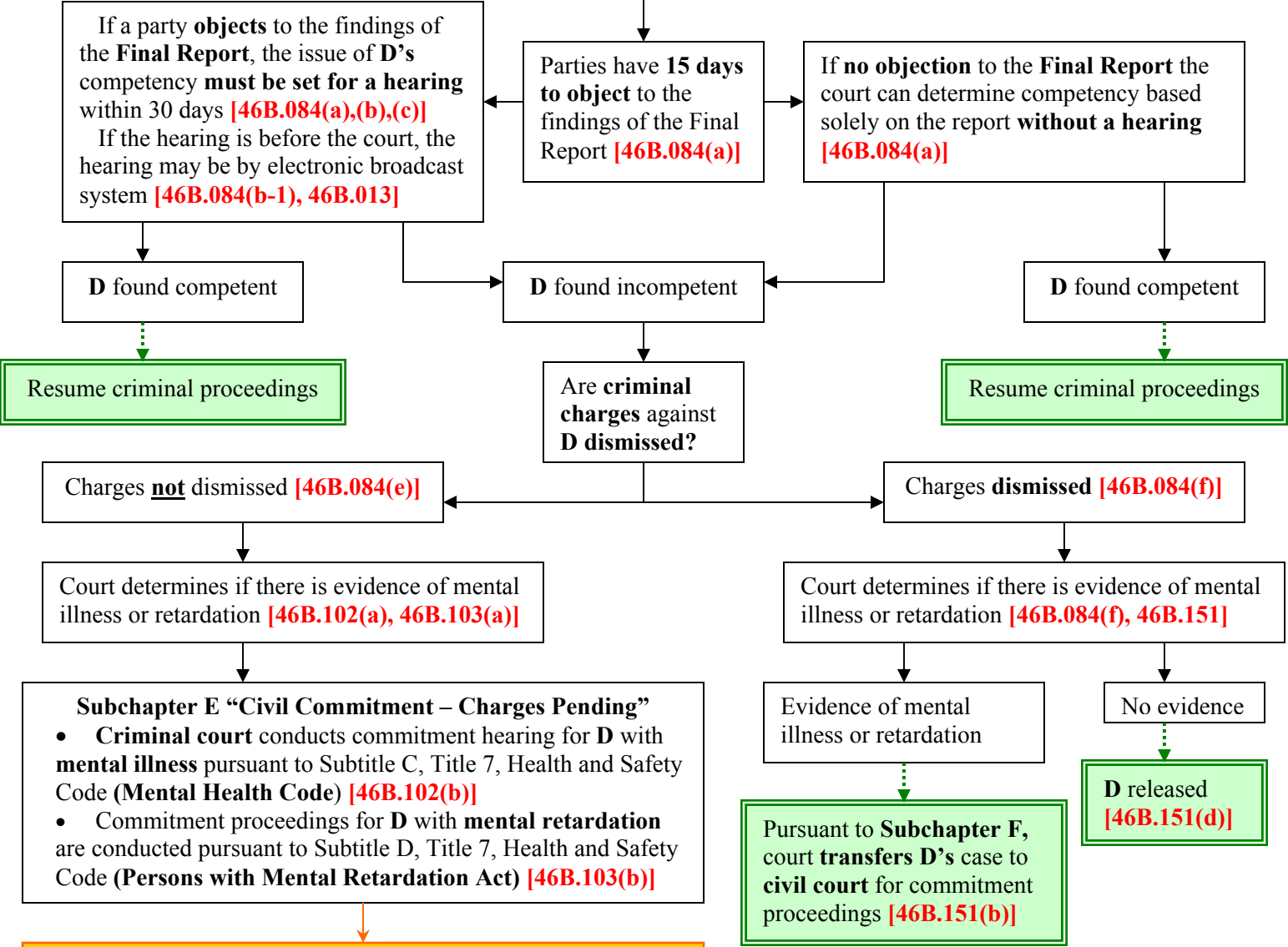
Head of Facility sends Notice to court when:

- **D** has attained competency [46B.080(b)]
- **D** won’t attain competency in foreseeable future [46B.080(b)]
- Term of commitment is set to expire* [46B.080(a)]

When giving notice the head of facility also files with committing court a **Final Report** stating reasons for **D**’s discharge and a list of types and dosages of medications **D** was on during treatment [46B.080(c)]

If the head of facility believes that **D** meets civil commitment criteria the facility will also supply court with Certificate of Medical Examination (“CME”) or affidavit supporting **D**’s mental retardation [46B.083(a)/(b)]

* Head of facility may request one **60-day extension** of commitment [46B.081]



Subchapter E commitment procedures continued on next page

(Cont'd from previous page)
Does **D** meet **Subchapter E – Commitment Procedures**?

CCP, 46B is silent.
According to
**Health and Safety
Code § 574.033, D
should be released.**

Yes

No

If **D (MH or MR) charged w/ CCP Art 17.032(a)** offense, or indictment alleges **42.12 sec 3g(a)(2)** affirmative finding, **D** is committed **initially** to the **DSHS Maximum-Security Unit (MSU) [46B.104]**

If **D is not charged with specified offense: D** is committed, for the continuing purpose of restoring **D** to competency to:
• **(MH) a non-MSU DSHS facility** for up to one year **[46B.106]**
• **(MR) D** is committed to **state school** under provisions of PMRA **[46B.106]**

Unless determined to be **manifestly dangerous** by **DSHS review board**, w/in 60 days **D** is transferred:
• **(MH) a non-MSU DSHS facility [46B.105(a)(1)]**
• **(MR) D** is committed to **state school** under provisions of PMRA **[46B.105(a)(2)]**
Facilities continue to pursue restoring **D** to competency

Redetermination of **D's** competency is available on the request of any party, the court, or the head of facility (DSHS or state school) **[46B.108-46B.110]**

Court may appoint Expert in accordance with Subchapter B **[46B.111]**

If both parties and court **agree** that **D** is **competent**, court shall find **D** restored to competency without a hearing **[46B.112]**

Court shall hold competency hearing if any party **disagrees** that **D** is **competent** (competency is presumed if head of facility submits opinion; presumption must be overcome at hearing by preponderance of the evidence) **[46B.113]**

Resume criminal proceedings

Finding of competency

Finding of incompetency

Court remands **D** back to treatment facility **[46B.117]**

The head of facility must notify the committing court if they determine that **D** on **Subchapter E commitment** should be **released**. This would include a release due to:
• **expiration of D's commitment** under the Mental Health Code; or
• facility determination that **D no longer meets commitment criteria** under Subtitle C or D, Title 7, Health and Safety Code (Mental Health Code/ Persons with Mental Retardation Act) **[46B.107(a)-(c)]**
The court may hold a hearing on these matters by means of an **electronic broadcast system [46B.107(d)(2), 46B.013]**
If the court determines **release is not appropriate**, the court shall enter an **order** directing **D** not be released **[46B.107(e)]**

Appendix C: Rusk Diversion Project Flow Chart

Harris County Jail – Rusk Diversion Project

