MEDICARE RIGHTS

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JOINT LEGISLATIVE PUBLIC HEARINGS ON
THE 2010-2011 EXECUTIVE BUDGET PROPOSAL
FEBRUARY 9, 2010

In response to New York's fiscal crisis, the Governor's budget saves State funds while preserving much of his "patient first" agenda. However, the proposed changes that significantly cut the Elderly Pharmaceutical Insurance Coverage (EPIC) program will place a heavy burden on people with Medicare. EPIC helps older New Yorkers access and pay for necessary prescription drugs. While the state is forced to confront financial hardship, it should not be forgotten that New York State residents are hurting as well. Eliminating EPIC protection will only exacerbate the burden on people with Medicare.

From our experience helping thousands of New Yorkers access needed prescriptions, the Medicare Rights Center is concerned about the effect this cut will have people with Medicare. We are a New York-based nonprofit, consumer service organization that works to ensure access to affordable health care for older adults and people with disabilities through counseling and advocacy, educational programs and public policy initiatives.

Instead of making general cuts to EPIC, the State should pursue alternative methods of savings through streamlining low-income programs and maximizing federal dollars. This saves State funds, and also ensures that vulnerable populations, such as those who have experienced drops in retirement income, remain protected.

Protect EPIC

When the Medicare Part D Prescription Drug benefit began in 2006, New York led the nation in ensuring that its older citizens had access to prescription drugs through EPIC. The proposed 2010-11 Executive Budget, however, removes this critical safety net by eliminating the EPIC wrap-around coverage for Medicare Part D beneficiaries. EPIC will no longer fill in gaps in Part D coverage for approximately 300,000 older New Yorkers with Medicare. EPIC wrap-around coverage of Part D should be maintained to protect these individuals.

Medicare Rights has not yet not yet received a briefing from EPIC or the Department of Health about how these changes will be implemented, and this testimony may be revised if a briefing is presented. However, from our experience working with thousands of New Yorkers with Medicare, we can anticipate that there will be two groups of Medicare beneficiaries who will suffer most harshly from this cut: individuals who cannot access coverage under Part D and individuals who face obstacles in the Medicare appeals process.

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Without EPIC protection, these individuals may not be able to access medically necessary prescriptions. Research demonstrates that if a person with Medicare is unable to afford a drug out of pocket, he or she will likely stop taking that drug.[1] These interruptions in treatments could cause dangerous health complications.

1. Gaps in Part D Coverage

Some EPIC enrollees who have relied on EPIC for coverage will find that they have no option for coverage under Medicare. This occurs when a prescription fails to meet the regulatory definition of "Part D drug."[2] This happened in the case of Ms. Q, a Medicare Rights' client:

> Ms. Q has been diagnosed with diabetes and a digestive disorder that causes frequent nausea and vomiting. After she tried several medications with no success, Ms. Q's doctor prescribed an antiemetic drug that is used to prevent nausea related to chemotherapy and/or in postoperative patients. This new drug has stabilized Ms. Q. and eliminated her need for frequent hospitalizations for dehydration and malnutrition.
>
> However, Ms. Q relies on EPIC to access this drug because Medicare Part D does not cover it. Regardless of doctor support and medical necessity, Part D prohibits coverage of "off-label" prescriptions, drugs used for indications not approved by the FDA, unless the prescribed use is supported in medical compendia specifically-cited in law. Because Ms. Q's medication is not FDA-approved for her specific diagnosis nor listed in the compendia, her Part D plan disregarded her doctor's statement that this drug is medically necessary and denied coverage for this "off-label" treatment. Unfortunately, there is no exception to this blanket prohibition. As a result, without EPIC, Ms. Q would not have coverage for this required drug.

Because Part D coverage is not always available, EPIC wrap around coverage must be maintained. If it is not, New Yorkers, like Ms. Q, will go without medically necessary – sometimes life-sustaining – medications.

2. Obstacles in the Medicare Appeals Process

The Governor's budget rightfully preserves EPIC's authority to represent enrollees in the Medicare Part D appeals process. This effort has proven to be largely successful. However, every year, Medicare Rights receives calls from thousands of people with Medicare who have tried to appeal without assistance, but have found the process to be too challenging. For instance, Part D plan representatives often provide false, inaccurate or incomplete information to enrollees seeking authorization of a prescription. Additionally, plans often fail to abide by relevant rules and regulations – making it difficult even for those who are aware of their rights to pursue appeals.

Because EPIC will no longer provide immediate access to prescriptions, more EPIC enrollees will bear the burden of fighting for their prescriptions. As a result, many EPIC enrollees are likely to go without needed prescriptions while in the appeals process - with or without EPIC representation. This happened in the case of Mr. M:

> Mr. M received a letter on January 31, 2008 from his Medicare Prescription Drug Plan that he would need to appeal for coverage of Provigil, which was prescribed for the depressive episodes of bipolar disorder, because it had a prior authorization requirement. Mr. M submitted the necessary documentation to overcome the prior authorization requirement including a coverage

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[1] "Medicare Part D 2010 Data Spotlight: The Coverage Gap", The Henry J. Kaiser Family Foundation, http://www.kff.org/medicare/upload/8008.pdf (November 2009).
[2] 42 C.F.R. § 423.100.

request with the written support of his psychiatrist. The plan never responded. Mr. M called the plan but was not able to get substantive information on the status of his appeal. Later, Mr. M's physician submitted an expedited appeal. The plan did not respond within the requisite 72 hours. Mr. M called once a week for several weeks, was transferred from one department to another, and never received a definitive answer as to the outcome of appeal. Mr. M was only able to access a favorable decision after requesting assistance from Medicare Rights.

As a result of bureaucratic delays, many people like Mr. M, face interruptions in care. Currently, EPIC acts as a failsafe allowing people to access medications while navigating the appeals system. EPIC should continue pursuing Medicare appeals on behalf of its enrollees, but without EPIC wrap around coverage, many will still go without needed prescriptions while fighting for Part D coverage.

Alternative Savings Achievable Through the Medicare Savings Programs

To achieve alternative savings for the State, the Medicare Rights Center suggests that the State maximize enrollment in the Medicare Savings Programs (MSPs). MSPs help pay the health costs of Medicare beneficiaries with low incomes. Most importantly, enrollment in an MSP automatically qualifies the recipient for the federally funded Extra Help program to assist with Part D costs, thereby reducing state costs in the EPIC program. The State may achieve additional savings by creating greater efficiency in the EPIC and MSP enrollment process through online applications.

1. Automatic MSP Enrollment & Recertification Through the EPIC Program

EPIC, as a State Pharmaceutical Assistance Program (SPAP) and authorized representative pursuant to the Medicare Modernization Act of 2003, may automatically enroll and recertify individuals into MSPs; however, it does not currently do so. If EPIC were to enroll eligible individuals in MSPs, this could dramatically increase the number of New Yorkers enrolled in these programs. As a result, these individuals would automatically be enrolled in Extra Help, maximizing federal dollars and saving EPIC funds. This would achieve savings for EPIC without requiring an across the board cut that would substantially reduce benefits.

2. Modernization of Application Systems for EPIC and MSP

The State has made great strides in simplifying enrollments in MSPs over the past two years. Wile New York serves as a model for other states, simple improvements to the enrollment process for both EPIC and MSPs must be made to further save State funds.

Currently, both EPIC and MSP applications cannot be submitted over the internet. Allowing online submission would create efficiency and savings. Both the federal government and other states have realized the benefits of allowing online applications for programs. For example, the SPAP of Pennsylvania, PACE, uses an online portal to enroll their new members. Similarly, the federal Extra Help application is available online through the Social Security Administration. In addition Florida and Maryland have an online application process for MSPs.

Electronic submissions would not require EPIC or Medicaid offices responsible for MSP enrollment to manually enter data. Additionally, electronic data transfer would prevent human errors from occurring during data entry that create roadblocks in processing applications. In Medicare Rights' experience, we frequently spend hours working with State staff to sort out complications arising from these errors.

Additionally, the State could use existing data to automatically recertify individuals already enrolled in MSPs. People with MSPs must re-certify for the programs every year; however, people enrolled in MSPs usually have incomes that do not dramatically change from year to year. Automatic recertification of these individuals would save administrative costs in addition to providing continuous access to these vital programs. The State

could potentially reduce man hours, mailings, and other resources necessary to do recertification outreach under the current system.

Online applications and automatic recertifications would allow eligible individuals quicker access to EPIC and MSPs, prevent bureaucratic disentitlements, streamline enrollment efforts, and potentially decrease costs in administrative overhead.

NEW YORK STATE CONSUMER COALITION ON PART D

Don't End Safety Net "Wrap-around" Coverage in the EPIC and Medicaid Programs for Drugs Not Covered by Medicare Part D Plans

The Governor proposes cutting back on the safety net "wrap around" drug coverage currently offered by both Medicaid and EPIC, when elderly and disabled beneficiaries are unable to access medically necessary drugs through their Medicare Part D plans. Both of these wrap around programs, now much smaller in scale than they were during the initial roll-out of Medicare Part D in 2006, continue to provide critical protection for the most vulnerable of the medically needy and should not be eliminated.

Part D plans continue to deny medically necessary prescription drugs that they should be covering, and consumers cannot navigate the complex appeal system alone.

- ✓ **Just one year ago, CMS sanctioned two national Part D plans (both operating in NYS), for recurrent, pervasive contract violations.** According to the *Wall Street Journal*, thousands of seniors enrolled in one of the sanctioned plans "found they couldn't fill or renew prescriptions for drugs to treat chronic heart failure, seizures, asthma and other medications," because of systemic computer problems which the plan failed to address.[i] The other sanctioned plan, Wellcare, improperly denied prescription drug access to hundreds, if not thousands, of beneficiaries during January 2009, according to CMS. 800 of the 2500 complaints CMS received involved "immediate need" cases – people out of their medications. Wellcare was also cited for substantial violations in their processing of Part D-related appeals.

  While CMS did eventually intervene and issue formal sanctions, preventing the plans from enrolling any new members until the violations were corrected, substantial harm had already occurred. Here in New York, Medicaid and EPIC provided a prescription safety net to Wellcare and Wellpoint enrollees caught in this mess.

- ✓ The reversal rate of Part D plan denials shows that **plans frequently deny medically necessary prescriptions that should have been approved in the first place.** Maximus, the Part D Independent Review Entity, reversed the plans' decisions in 53% of the cases that reach the reconsideration appeal stage (the third level of appeal), and in 59% of the cases involving a plan's utilization management requirements. Off-formulary exception requests are granted by Maximus 48% of the time.[ii] **This means that plans are improperly denying coverage more than half the time** for cases reaching the reconsideration appeal stage. EPIC's own success rate at winning first level appeals is more illuminating still. Out of more than 2,500 appeals filed since the program's inception in October 2008, EPIC has won 1,900 of them, or fully 75%.[iii]

The Elderly Pharmaceutical Insurance Coverage (EPIC) Wrap-Around

State law wisely prevents Medicare Part D plans from shifting costs to the State when EPIC pays for a Part D drug through the "wrap." The Legislature wisely authorized EPIC to file appeals of denials by Part D plans on behalf of EPIC enrollees. Since the Part D Maximization Project began in October 2008, EPIC has successfully pursued over 1,900 "first level" appeals. and it has recovered $7,300,000 for the State in winning more than 65% of the appeals filed against Part D plans (note 3). The State should add resources for EPIC to pursue appeals beyond the initial level, and recover funds expended when Part D plans incorrectly refuse to cover drugs. EPIC should also be expanded to cover people with disabilities under age 65, especially those in the 2-year waiting period for Medicare.

The Governor has justified ending the EPIC wrap under the rationale that EPIC is covering drugs when "clinically effective, lower cost alternatives" are typically on a plan's Part D formulary. However, EPIC only provides wrap coverage after the Part D plan has denied coverage and the person's physician has deemed the drug to be medically necessary.

The Medicaid Wrap-Around

The Executive budget proposes to eliminate the limited wrap-around benefit for Medicaid beneficiaries who also have Medicare Part D. New York currently provides Medicaid wrap-around coverage for only four classes of vital medications:

- ✓ atypical anti-psychotics for treatment of psychiatric conditions like schizophrenia, acute mania and psychotic agitation,
- ✓ anti-depressants,
- ✓ anti-retrovirals for the treatment of HIV/AIDS, and
- ✓ anti-rejection medications for recipients of organ and tissue transplants)

DOH has indicated that the Medicaid wrap affects very few beneficiaries (1% or less). To ensure that Part D plans are held accountable, and to minimize the State's costs, the State should make necessary systems changes to ensure that Medicaid is the payer of last resort. These changes would allow the Medicaid program to track Part D plan denials and establish the reasons for them. It would also ensure that Medicaid, as is the procedure with all other third-party payers including Medicare Parts A & B, must be billed only *after* the third-party payer denies payment. In addition, the Medicaid program should act on beneficiaries' behalf in the same manner as the EPIC program and recover the costs to the program by appealing incorrect denials by Part D plans. Even if relatively few beneficiaries need to utilize the Medicaid wrap, the potential harm to those beneficiaries is too great if we remove the wrap altogether.

NEW YORK STATE CONSUMER COALITION ON PART D

Steering Committee

- Center for Independence of the Disabled of New York (CIDNY)
- Empire Justice Center
- Legal Aid Society, NYC
- Medicare Rights Center
- New York Legal Assistance Group
- Selfhelp Community Services, Inc

On behalf of Coalition members

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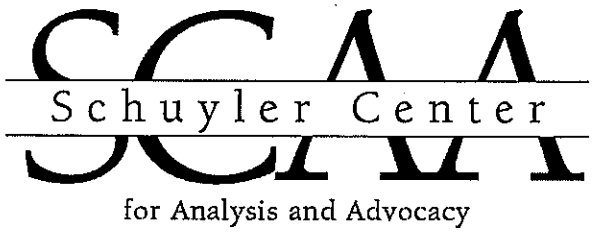
[i] "Wellpoint penalized for botching drug benefits," *Wall Street Journal*, January 14, 2009.

[ii] "Fact Sheet: Part D Reconsideration Appeals Data – 2007." (Most recent data available from 2007) Avalable at: http://www.cms.hhs.gov/MedPrescriptDrugApplGriev/07_Reconsiderations.asp

[iii] Report by Mike Brennan, NYS Dep't of Health, to the Medicare Savings Coalition, December 3, 2009.

Testimony Submitted to the Joint Fiscal Committees on the SFY 2010-11 *Executive Budget* Health/Medicaid Hearing February 9, 2010

Karen Schimke, President/CEO
Schuyler Center for Analysis and Advocacy



Shaping New York State public policy
for people in need since 1872

Testimony Submitted to the Joint Fiscal Committees
on the SFY 2010-11 *Executive Budget*
Health/Medicaid Hearing
February 9, 2010

Karen Schimke, President/CEO
Schuyler Center for Analysis and Advocacy

The Schuyler Center for Analysis and Advocacy (SCAA) is a statewide, human services advocacy organization. Since our founding in 1872, SCAA has advocated to improve health and human services for New Yorkers with an emphasis on the most vulnerable populations. We are also the convener of the New York Children's Action Network (New York CAN).

In a difficult budget year, difficult choices have to be made. We believe that Governor Paterson and Commissioner Daines stuck to their commitments to improve the health status of New Yorkers by continuing to promote primary care and making investments in public health. In addition, the Center on Budget and Policy Priorities indicates that twenty-nine states have reduced services in public insurance programs during this recession and others are expected to do so this year. Despite this trend, the *Executive Budget* continues New York's commitment to vulnerable populations who rely on programs such as Medicaid and Child Health Plus.

We have some specific comments on portions of the *Executive Budget* as it pertains to health:

Sugar Sweetened Beverage Tax

Of all the proposals in the *Executive Budget* this year, the one that seems to have generated the most press is the tax on sugary soft drinks and juices. ***Both SCAA and New York CAN support this tax because we believe that it will have the desired effect of reducing the consumption of these beverages which have been linked repeatedly to obesity and dental disease.***

Obesity is linked to higher rates of any preventable illnesses such as diabetes, heart disease, cancer, asthma and hypertension. High sugary soft drink consumption increases the risk of diabetes by 83% in women according to a study in the Journal of the American Medical Association. And a study from Harvard Medical School determined that each additional 12 ounce sugary soft drink consumed per day increases the odds of a child becoming obese by 60%. Not only do these illnesses increase health care costs – including the costs of Medicaid, Child Health Plus and Family Health Plus – they take a terrible personal toll on individuals and families as well as decrease productivity and the ability to work.

If the sugary soft drink tax helps to achieve an overall 5% reduction in consumption, that would result in an average of 4,100 calories saved per year per person, or about 1.2 pounds. According to public health professionals, this reduction, along with other measures to educate the public and encourage physical activity, would go a long way in helping slow down the obesity epidemic.

In addition to obesity, sugary soft drinks are also one of the leading contributors to dental disease. Dental caries (tooth decay) is the single most common chronic childhood disease—5 times more common than asthma and 7 times more common than hay fever.[1] There is a known positive association between carbonated soft drinks and dental diseases.[2] In fact, carbonated soft drinks have a ten-fold higher erosive potential as compared to juices. Children who frequently drink acidic, sugar-rich soft drinks, are at a higher risk of developing cavities (caries).[3]

In New York State, as of 2006, 54% of children have had dental disease and one-third of 6-8 year olds have untreated dental caries. More children in low socioeconomic groups and racial minorities have dental disease. New York State spent approximately thirty million in Medicaid funding in 2006 on caries-related services (restoration, endodontics and extractions) for children less than 20 years old.

A significant portion of the revenue generated from this tax must be used for public health efforts – combating obesity and improving oral health.

For public health reasons the Legislature should pass the tax on sugary soft drinks. ***A significant portion of the revenue generated from this tax must be used for public health efforts – combating obesity and improving oral health. If not, New York will once again lose an opportunity for funding a significant increase in public health.***

Tobacco Tax

SCAA and New York CAN also support the increase in the tobacco tax. This tax has the benefit of improving the long-term health of today's children while raising additional revenue for health programs.

Repeated studies and decades of information tell us that raising the price of cigarettes keeps children from picking up the smoking habit. The Campaign for Tobacco-Free Kids estimates that the proposed increase of $1.00 would be expected to prevent more than 100,000 children from becoming smokers and cause more than 50,000 adult smokers to quit. This is a win-win for New York.

Program Consolidation

The *Executive Budget* proposes to consolidate a number of programs and funding streams in the Department of Health. While consolidating funding streams can promote efficiency and provide additional flexibility in program areas, care must be taken that necessary functions and services continue to be provided.

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[1] U.S. Department of Health and Human Services, *Oral Health in America: A Report of the Surgeon General*, Department of Health and Human Services, National Institutes of Health, Editor. 2000: MD.

[2] Lim, S, Sohn W, et.al, Cariogenicity of Soft Drinks, Milk and Fruit Children: A Longitudinal Study Juice in Low-Income African-American *J Am Dent Assoc* 2008;139;959-967

[3] Jensdottir T, et al Immediate erosive potential of Cola drinks and orange juices. J Dent Res 2006 85(3):226-230.

Consolidated funding streams in the budget do reflect some reductions in overall spending in these areas, such as cancer programs. ***But, if these consolidations reduced the need for more extensive cuts and the Department can still provide necessary services to New Yorkers, such efforts should be allowed to move forward.*** There must be careful oversight of these areas to ensure that programs goals continue to be met.

Adult Homes

SCAA has been a strong advocate for the needs of adult home residents with psychiatric disabilities. This population was ignored for years by public policy and the agencies charged with protecting them. Through the efforts of organizations like the New York State Coalition for Adult Home Reform (NYSCAHR) and the efforts of legal and lay advocates, the voices of adult home residents are starting to be heard here in Albany.

Fully Fund Lay Advocacy

The most important advocate for adult home residents is the Coalition for Institutionalized and Aged Disabled (CIAD). This small organization works day to day with residents directly in adult homes. Every day, CIAD:

- Informs residents of their rights and empowers them to use those rights.
- Strengthens resident councils and brings residents together to learn from each other.
- Mediates between adult home residents and adult home management.
- Works with adult home residents on individual concerns/complaints.

For many years the Legislature has recognized the accomplishments of CIAD by funding them with a small amount of money. ***We ask that this funding be restored so that residents can continue to have an advocate in their corner.***

The State Response to Adult Home Lawsuit is Inadequate

As the result of a long-standing lawsuit against New York State, the District Court ruled in September that about 4,300 people with mental illness living in New York City adult homes were not getting adequate care. The judge said that current conditions are a violation of the Americans with Disabilities Act and the Rehabilitation Act, which mandates that residents live in the least restrictive setting possible.

The state issued a plan in November indicating how they would remedy the situation although it has not yet been approved by the court. Under the plan, the state would provide community housing and supports for only 1,000 adult home residents over a 6 year period rather than 4,300 residents over a 4 year period as recommended by the judge. The housing and other elements of the plan (educating residents about housing options, performing evaluations of eligibility) are contingent on state budgets that include funding.

The *Executive Budget* includes $1 million to begin assessments of impacted Adult Home residents and funding to start the process of developing 200 community beds in 2011-2012.

Advocates and adult home residents believe very strongly that the state's response is "woefully inadequate." We believe that New York currently spends enough to support the residents in the

adult homes in the community. Millions has been poured into facilities that were never designed to house and appropriately serve this population. We must stop paying for inappropriate settings that even the court agrees also violate residents' rights. The current system does not spend the taxpayer's money wisely. ***New York must immediately fund the necessary services to move adult home residents out of these homes and into the community.***

QUIP and EnAble Funding

The *Executive Budget* proposed consolidation of the QUIP and EnAble programs. Together, these two programs fund initiatives to improve the quality of life in adult homes. The proposal alters the way funding is directed and the purposes for which funds can be spent.

In this difficult budget year advocates understand the needs to consolidate programs and seek efficiencies. We are still studying the impact of these proposed changes. It is critical that the rights of residents be protected and that residents continue to have a voice in how these funds are spent. After all, these are their homes.

If we believe that the proposal warrants additional protections for residents we will let you know and provide you with appropriate language changes.

Medicaid Simplification

We are always in favor is simplifying the application and enrollment for public insurance programs. The *Executive Budget* contains several initiatives that will cut the red tape for applicants and for program administrators. New York should move forward with:

- Attestation of interest with verification.
- Attestation of residency and income for long-term care.
- Transitional Medicaid under ARRA.

The Department of Health should also be given the authority to move forward with *Express Lane* eligibility as authorized in the federal Child Health Insurance Program Reauthorization Act (CHIPRA). *Express Lane* authorizes Medicaid and SCHIP agencies to borrow specific eligibility findings from other public need-based programs (i.e. food stamps) rather than having to re-gather and re-analyze data according to their own rules. There will be a lot of specifics to work out with federal authorities over the next months so it makes sense to give the Department of Health the authority to start that process as quickly as possible.

As always, SCAA is available to speak to you about any of these proposals. Thank you for your time and consideration.

Nelson Eusebio

Chairman of New Yorkers Against Unfair Taxes and
Executive Director of the National Supermarket Association
Offers Public Testimony in Support of Honest, Fair, and Responsible Economic/Health Policy,
and in ***Opposition to the Sugar Beverage Tax***

Submitted on February 9, 2010

Thank you for the opportunity to again express my strong opposition to the proposed sugar beverage tax, and ***to issue a renewed call for honest, fair and responsible*** economic and health policies that reflect the will of New Yorkers; aid them in their struggle to persevere during these tough economic times; and respect the freedom they enjoy to pursue their own healthy choices.

I am Nelson Eusebio, the Executive Director of the National Supermarket Association. And because of the persistent threat that food and beverage taxes have posed to our businesses, our communities, and our great state of New York, I have been compelled to add to my list of titles and responsibilities: "Chairman of New Yorkers Against Unfair Taxes," ***a coalition of concerned New Yorkers – hard working individuals, struggling families, and already burdened small businesses – opposed to any tax increases on juice drinks and soda.***

Since Governor Paterson's first tax assault on juice drinks and soda, New Yorkers Against Unfair Taxes has been busy. It is important work, and it is an honor to speak on behalf of such a vital New York business sector.

New Yorkers Against Unfair Taxes has a simple, declarative mission...to prevent the enactment of unfair and misdirected beverage tax increases that could cost our state over thousands of jobs.

We all agree. ***New Yorkers are already among the highest taxed citizens in the nation.*** *We can't tolerate a regressive tax* that disproportionately targets middle and lower income New Yorkers. ***Albany has gotten themselves into a serious mess with the budget and we cannot afford to bail them out!***

We issued the call to all New Yorkers to join us in opposing a tax, which would have had a devastating affect on jobs and families in the state.

And in just one month, the response was overwhelming. Grassroots took hold and multiplied. So, too, our membership list of small, family-owned and operated businesses...AND thousands of citizens from every region in the state.

We made quite a ruckus. ***And as is supposed to happen in a properly functioning democracy, Albany listened. <u>And acted.</u>***

And so, ***just 11 months ago***, the Governor and the legislative leadership called a press conference to declare the proposed 18 percent tax hike abandoned, and to offer a renewed pledge to "alleviate the burden" on hard-working New Yorkers.

Just 11 months ago, Governor Paterson, Speaker Silver, and Majority Leader Smith acknowledged that the soda tax had "disturbed" and "frustrated a lot of New Yorkers." And again, they were right to do so.

Just 11 months ago, we thanked the Governor for his decision to pull the devastating soda tax from his budget, and we thanked him for his commitment to hardworking New Yorkers, who, in his own words, "need relief."

For the citizens of New York, it was a short-lived victory...***Just 11 months ago.***

Perhaps you can imagine our frustration, dismay, and confusion when we learned at the beginning of this week that sodas and sports drinks are the focus of yet another – but even more onerous – predatory tax...from the same governor, and for the very same underlying reason as last year: ***to balance a poorly managed and recession-pummeled state budget.***

The Governor may exhibit little faith in our collective memory, but the people of New York could not tolerate anymore taxes ***just 11 months ago.*** So, what, exactly, has changed in the intervening period?

Not the economic climate, that's for sure. It's still quite fragile. Our businesses continue to hang in the balance, and we remain among the highest taxed people in the country.

And in few places is the hardship felt more strongly than in our industry. It has always been this way; the exorbitant cost of doing business in New York has already taken a major toll on the state's small supermarkets and neighborhood bodegas, with more than 2,300 bodegas closing over the past four years representing a loss of more than 8,500 jobs.

The facts are established, and the data is incontrovertible. But if you are looking to stimulate the senses with some real-world confirmation, just stroll through most any neighborhood in

one of the five boroughs later today, and you will see iron gates where once stood thriving storefronts.

In addition to the bodegas, more than one-third of our city's supermarket owners have had to close their doors in the past five years.

We represent 400 independent supermarket owners of the tri-state area. And our office is the nerve center of the supermarket industry. We're constantly getting phone calls, faxes, and e-mails from our membership. Telling us just how tough it is to make it in New York. Right now, never mind with these new taxes.

Doing business in New York every year gets tougher and tougher. As a result, we have a lot of stores leaving the city, leaving the state, moving down to North Carolina, South Carolina, Georgia, Florida. Up and down the length of the I95 corridor, you will find a lot of stores run by ***former*** New Yorkers.

It's tragic. And it's unsustainable; our state cannot afford to lose even one more job right now.

When does it end???

So, shouldn't we be encouraging a business-friendly climate?

Shouldn't we be promoting the success of small and family-owned businesses, and neighborhood commerce in general?

And shouldn't we be devising ways to ease the burden of those businessmen and businesswomen who run these establishments to all of our benefit?

Isn't it the job of government – especially during times of acute economic crisis – to remove obstacles, and facilitate fruitful business?

I'd think so. My members certainly think so, and so do the many New Yorkers with whom we come in contact daily.

Honestly, where is the relief that we are well within our rights as taxpayers to expect?

Levying a new tax on a severely crippled industry is just not going to cut it. The result is certain and predictable: additional lost revenue, higher operating expenses, vanished jobs, FAILURE.

And these are just some of the reasons why New Yorkers this week have overwhelmingly rejected both the concept and the name, Sugar Beverage Tax, and have opted instead for a bit of "truth in advertising", swiftly labeling it the ***Stifle Business Tax.***

This entire tax scheme will have a trickle-down effect that I can't believe the governor has soberly contemplated.

A tax on beerages is a regressive tax, burdening lower-income consumers disproportionately more than others. In fact, Bureau of Labor Statistics data demonstrates that half of a tax imposed on nonalcoholic beverages would be paid by households earning less than $70,000 per year. The burden of a beverage tax on the lowest income households is ***six times higher*** than for the highest income households.

So, why would it be fair to force our lowest income households – my lowest income customers – to carry the brunt of New York's budget deficit?

WE APPRECIATE YOUR TIME, AND DO HOPE YOU'RE LISTENING

11 months ago in Albany, at the Governor's press conference announcing the scrapping of the original soda tax, Majority Leader Smith declared, "New Yorkers have input in the process, and we are listening." Our inclusion here today seems to put the truth to that statement.

Please continue to listen, as most New Yorkers are united in their opposition to additional unfair taxes.

Many thanks for your time.

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Testimony Before The Joint Budget Committee
February 9, 2010

Mr. Chairman and distinguished members of the Committee, thank you for the opportunity to present testimony for your consideration as you react to Governor Patterson's budget proposal. This year, more than any other year, your deliberations are guided by the overwhelming budget deficit which the State faces. As you consider which cuts to make and which revenue actions to take to right the ship of state, yet maintain the vital services which you provide, it is essential that you consider not just the numbers but the faces of the people you will impact by your actions.

Albeit, it is difficult to put a face on these numbers when it comes to proprietary long term nursing facilities. We appreciate the intense pressure you are under to close the deficit. What I have learned more than anything during my consideration of these issues is that I should not have been looking at facilities or buildings, but rather at the communities that they make up. These communities have already been hurt by the prolonged recession at the family level. If their care is compromised at the nursing home, they simply may not be able to receive the care they need.

Historical perspective:

New York State has historically supported the long term care (LTC) industry. The long term care industry takes care of the elderly, infirm, medically dependant residents in our state. This support is accomplished mostly through reimbursements for operating and capital expenses through the "**Medicaid**" system.

For some time, the state's financial support has really been at maintenance levels as opposed to investing in the growth of this essential industry. Last year, however, the legislature, in conjunction with the federal government, approved legislation to finally **add** monies to the "LTC" system.

This was done for the following reasons;

1) Improve the quality of care;
2) Add $210,000,000 for needy facilities in order to ensure a higher, uniform standard of care;
3) Allow the good running facilities to continue to operate on a high level by a "hold harmless" provision.

Yet, there have been a series of successive cuts which have seriously jeopardized the ability of these homes to continue to operate.

Essential to the provision of long term care is the ability to see long term resource allocation. Up and down funding plays havoc with a system that is sometimes as fragile as the residents it provides care for. Several factors have led to uncertainty and danger to this industry.

Recently, the state has been forced by yawning budget deficits to reopen the annual budget mid-year. This has resulted in the adoption of a "mini-budget". These "mini budgets" shrink the budget cycle and make a longer term impact analysis much more difficult. Lost in these mini budget cycles is the fact that the long term care industry has already "given at the office". Multiple cuts and programmatic changes effect the Medicaid reimbursement at a time when Medicaid is already a losing proposition for the homes. The truth be told, proprietary nursing homes lose money on Medicaid and make a profit only on Medicare and private pay patients. Now that Washington is considering reducing back Medicare expenditures, nursing homes can truly be facing the loss of operational funds to keep their doors open at current staffing levels. Perhaps, it might be asked whether the current staffing levels are necessary. I am here to tell you that they are. Reduced staffing means not only the jeopardizing of care for the most vulnerable in our society, it also means the loss of jobs as well as the loss of federal matching funds. Given the fact that this industry has already given its share, it is time to look at the real cost drivers of health care.

A part of the problem is that budget analysts tend to look at Medicaid expenditures as a lump sum, when it is not. In the past few years, the number of facilities has not risen. Nor has the staffing level. In fact it has been reduced. What has gone up? Enrollment and utilization. Increased enrollment was the logical and predicted result. This fact has been acknowledged by the Governor. But the irony is that increased enrollment calls for increase capacity, not less. Yet, the proposed budget continues to cut.

As all of you know, utilization has been a difficult challenge for our health care system. It is hard to predict, and even harder to manage. One thing the state should do much more of, and which I am glad to see has received some attention in the budget, is a systems, as well as a

case by case review of service level, particularly in sectors which operate with less oversight that institutionalized care, such as home care. But while we have created the Office of the Medicaid Inspector General for fraud we have not focused enough on determining whether the level of service first provided to the patient is actually appropriate anymore. DOH needs to focus on the adoption of a streamlined, focused, accurate case intensive review. Such a system still eludes us. Hence the Governor's proposal to create a statutory cap on rate appeals. This is like adding insult to injury. First the rate is wrong, and now only a certain number of appeals can be taken. Instead of this approach, why don't we get it right in the first place.

As serious as the Governor's proposal is, the recent Medicaid rates provide an *ironic* outcome

In an acknowledgement of the need to create a new base year for the costs associated with providing long term care, you passed a law to rebase all nursing homes throughout New York State. The implementation of this rebasing legislative policy by the Department of Health through Medicaid rates, however, is actually contrary to the legislature's intent and stated goals. The recently proposed rates;

1) Contrary to the promises made in the previous year's law, homes which had already rebased, were supposed to be held harmless. They were not. As a result, these rates have resulted in devastating cuts to a large portion of downstate homes.
2) As a result, homes will be forced to cut their labor force.
3) Operators will no longer reinvest in infrastructure and new technology, thus eliminating the opportunity for cost reductions through efficiency.
4) This rate scheme actually rewards inefficient facilities and penalizes efficient ones.
5) Creates true dangers to life and safety in resident care.

In addition, these new rates include changes in the law which are being applied retroactively. While many of the Association's member facilities are contemplating litigation, this problem can be fixed by your decision to only implement any rate changes to the rates going forward.

The Budget

The 2010/2011 budget proposal continues to hammer the "LTC" industry with further Medicaid cuts to the system. Should the new rate structure be implemented as is, or the proposed budget cuts be allowed to pass, it will destroy the fabric of the downstate nursing homes. There will be some homes that will be forced to close their doors and force residents back to hospitals.

The proposed budget yet again takes away the promised trend factor.

It increases the tax, called an "assessment" by one percent taking another projected $67 million out of the system.

Needed Relief

Even in such economic times there are better more equitable means for the state to accomplish its goals;

1) Continue the flow of federal dollars by enacting the trend factor;
2) Don't add to the devastation of downstate facilities by trying to collect retroactively the new rates and hold harmless homes that had already received a new baseline year;
3) Economically feasible to the state;
4) Place back in the rate the '08 '09 '10 trend factors (don't leave potential revenues behind);
5) Take instead non reimbursable assessment;
6) Have department of health reevaluate the new rate system for its inequities The state must study the effect of these rates prior to their going into effect. Support Leader Sampson's call for a suspension of the proposed rates and an immediate review by the legislature;
7) Establish a regional pricing system as soon as possible;
8) Reject the Governor's proposed assessment;
9) Reject the plan to cap rate appeals.

These actions will ensure the stability and quality of care for some eighteen thousand residents of Greater New York homes. If the state continues to cut and tax these facilities, however, then we know what will happen. Homes will close. And if homes close, you know what we will see: more hospital-based acute care, more substandard care at the homes which remain open, and for those residents sent back to fend for themselves in their neighborhoods, no care at all.

The Association stands ready to provide any information or to react to any ideas which you would consider.

Respectfully Submitted,

Michael Balboni
Executive Director

New York State Area Health Education Center System

NYS Area
Health Education
Center System

TESTIMONY
to the
Joint Legislative Public Hearing on
2010-2011 Executive Budget Proposal

Health/Medicaid
February 9, 2010

Thank you for the opportunity to present testimony on behalf of the New York State Area Health Education Center (AHEC) System, a community-based health workforce development initiative with a mission "to enhance access to quality health care and improve health care outcomes by addressing health workforce needs of medically disadvantaged communities and populations through partnerships between the institutions that train health professionals and the communities that need them most." We respectfully request that the $2.5 million in the Governor's budget for the New York State AHEC System be preserved in the FY 2010-11 State Budget.

> *"I had a wonderful opportunity to complete what ended up being three rotations... Emergency Medicine, Pediatrics and Family Medicine. I have seriously considered practicing in a rural community when I graduate, but up until this time had never had an opportunity.... ...AHEC allowed me to have that rural experience. I was able to share my time...with other [health professions] students.... We shared experiences of our rotations and discussed how our specialties can work hand-in-hand to provide quality patient care."*
>
> Health professions student regarding AHEC community-based training

> *"I am learning a great deal not just about healthcare disparities, but also, in a broader sense, about the social, political, and economic inequalities that play an integral role in the health outcomes of the underserved. The fact that I am on the ground witnessing this every day, as opposed to reading about it in a book, makes this experience all the more valuable."*
>
> Health professions student regarding AHEC summer externship

These quotes are from two AHEC program students. Last year, the New York State AHEC System achieved record levels of outreach, training over 40,000 students throughout the state.

The New York State AHEC System Pipeline Makes All of New York State a Campus

New York State AHEC System Accomplishments Since 2000:

CONNECTING STUDENTS TO CAREERS

- *Nearly* **124,000** *young people have learned about health careers through classroom and real-life settings*

CONNECTING PROFESSIONALS TO COMMUNITIES

- *Over* **21,000** *medical, nursing, and other health professions students have been provided with over* **2 million hours** *of community-based training*
- *These students, under community-based teacher supervision, provided care to more than* **930,000** *patients*

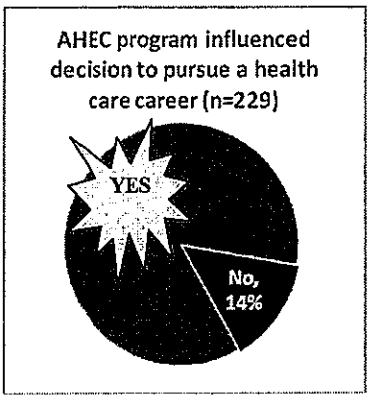
CONNECTING COMMUNITIES TO BETTER HEALTH

- *Over* **73,000** *health professionals have enhanced their clinical skills through AHEC's continuing education and re-training programs*

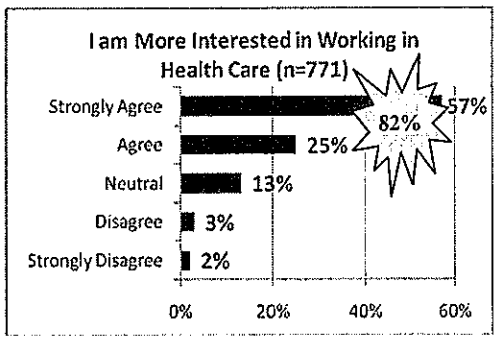
New York State AHEC System strategies:
Through nine centers, located in urban and rural areas throughout the state, the New York State AHEC System develops clinical training opportunities for future health professionals in underserved areas; recruits faculty committed to working with them; encourages young people, especially from underrepresented and disadvantaged backgrounds, to pursue health careers; and provides continuing education and professional support to practitioners, develops career ladders, and promotes workforce re-entry programs.

New York State AHEC System community-based strategies cultivate a more diverse health care workforce, assure that each community has enough practitioners in the right categories, particularly in primary care, and improve access to quality health care for all New Yorkers. New York State AHEC System strategies keep skills and talents in our state, promoting economic recovery and sustainability while improving the health and well-being of all New Yorkers.

New York State AHEC System Outcomes:



While the numbers are impressive, each of our nine AHECs across New York State has success stories. Students from every region are already working as nurses, therapists, social workers and doctors in underserved communities. Students who are either planning to or are already pursuing a health care career indicate that their participation in an AHEC program influenced that decision. Adults whose jobs have been eliminated, or who need new skills to keep pace with advancing technologies, or are simply seeking a new career, have benefited from AHEC programs also.



New York State AHEC System strategies keep skills and talents in our state, contributing to the health of the economy while improving the health and well-being of all New Yorkers. The New York State AHEC System is "Connecting students to careers, professionals to communities, and communities to better health."

New York State AHEC System activities represent both economic and health workforce development strategies:
Community-based AHECs are positioned as effective liaisons and facilitators to build partnerships between the health workforce supply side (secondary and post-secondary schools) and demand side (health care employers and communities). AHEC's goal is to train health care workers who live in underserved communities to provide care in underserved communities. They have insight to improve the health of New Yorkers while also contributing to the economic health of urban and rural communities in the State.

New York State AHEC System's capacity to help New York State address health care reform:
The New York State AHEC System's multifaceted recruitment, training and retention strategies are solutions to current health workforce shortages and New York State Department of Labor forecasts that health care sector jobs will grow at rates more than twice that of all other occupations.

New York State AHEC System recruitment programs increase the number of students from under-represented and disadvantaged backgrounds who enter health careers. Research shows these students are more likely to choose primary care and practice in their community of origin or similar communities.

New York State AHEC System strategies focus on development of a primary care workforce, which is essential to reducing health care costs, improving health outcomes, and retaining a safety net.

New York State AHEC System leverages funding to address state's workforce needs:
The State of New York's longstanding partnership in the New York State AHEC System's work is a fiscally sound investment in the State of New York's present and future.

In this economic environment, the New York State AHEC System provides results that impact not only the health of New Yorkers but the economy of New York. The $17.7 million state investment to the New York State AHEC System since 2000 has leveraged $24.8 million in federal funding and $24.2 million in local community and private foundation funding.

As citizens, we understand that New York State is in crisis. As stewards of public funds, we also understand that AHEC's community-based programs are a sound investment and result in the sons and daughters of New Yorkers becoming health professionals on staff at hospitals, clinics and private practices providing care to residents throughout the state while improving the employment rate in these critical fields. We respectfully request that the $2.5 million to the New York State AHEC System in the Governor's budget (the same allocation as last year) be preserved in the FY 2010-11 State Budget. Federal funds are only available to the New York State AHEC System if they are leveraged with matching state and community funds. Last year, the State's investment bought an $8.4 million workforce development initiative that results in better jobs and better health care for New Yorkers. This expansion of New York's investment is possible because the nine AHECs in New York successfully compete for federal and local community and private foundation grants and contracts that enhance training and job opportunities in New York.

State funding is essential to the success of the New York State AHEC System to continue the planned scope of work of our nine community based centers with a statewide capacity to address New York's health workforce needs in New York's medically underserved rural and urban communities.

Respectfully submitted,

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Hospice & Palliative Care Association of New York State

Testimony

Joint Legislative Public Hearings
2010-2011 Executive Budget Proposal
Health / Medicaid

February 9, 2010

Thank you for the opportunity to comment on the State Fiscal Year 2010-11 Health/Medicaid Budget. I am Kathy McMahon, President and CEO of the Hospice and Palliative Care Association of New York State.

Background

The Association represents the state's certified hospice providers and palliative care providers, as well as individuals and organizations concerned with care for patients at the end of life. Hospice serves patients at the end of life and provides pain and symptom management, addresses social, emotional and spiritual needs and provides care and support to the bereaved. Hospice services are provided in the home, nursing home, and inpatient facilities. Hospice:

- Embraces all patients coping with advanced illnesses
- Focuses on comfort rather than cure
- Emphasizes quality of life
- Promotes personal choice and individual dignity
- Respects the traditions and wishes of the patient and the patient's family
- Most often provides care in the patient's home, but when necessary, also provides care in the nursing home and inpatient setting
- Utilizes current treatments and medications
- Addresses physical, social, emotional, and spiritual needs
- Provides care and support to the bereaved

Palliative Care, as defined by the World Health Organization, seeks to address not only physical pain, but also emotional, social and spiritual pain to achieve the best possible

need, while being cost effective. Hospice is one of Medicare's most cost-effective programs. According to an independent study conducted at Duke University, hospice saves Medicare an average of $2,300 per patient, or nearly $2 billion a year. A recently published study by Aetna found that "Liberalization of hospice benefits that permits continued curative treatment and removes limits on hospice benefits is a strategy that is financially feasible for health plan sponsors, insurers, and Medicare." Data from the 2008 Dartmouth-Atlas study, "Tracking the Care of Patients with Severe Chronic Illness" demonstrates "...more resources and more care (and more spending) are not necessarily better."

Speaking on behalf of the patients and families served by New York's hospice and palliative care providers, I ask that you not allow these very vulnerable people to "fall through the cracks" as New York reforms its Medicaid program. I urge you to integrate Hospice and palliative care into New York Connects, the Community Living Program Grant, and Medical Home pilot projects.

Hospice and Long Term Care

Hospice in the Nursing Home

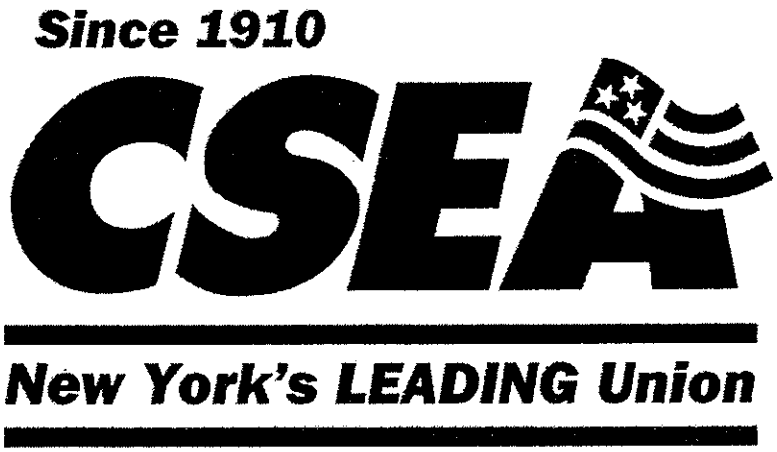
By providing incentives for nursing homes to make hospice care available through contracts with their local hospices, the State could realize considerable Medicaid savings. A study conducted by Brown University supported the role of hospice in nursing homes, concluding that hospice patients:

- Are less likely to be hospitalized in the last 30 days of life; and
- Received superior pain assessments.

According to federal rules, Medicaid pays hospice 95% of what it compensates nursing homes for room and board, saving 5%. Hospice, in turn, must pay the nursing facility. Medicaid is the primary payer for care in nursing homes, and this expenditure is the largest portion of the state's Medicaid budget. For nursing facility hospice eligibles who are not using their hospice benefit, Medicaid would pay 100% of the room and board charges to the nursing facility. Encouraging appropriate use of hospice in nursing homes would save Medicaid significant dollars.

Hospice and the Long Term Home Health Care Program (LTHHC)

Currently patients on the LTHHC program are denied access to Hospice services, while residents in a nursing facility are afforded access to their hospice benefit. LTHHC patients



Testimony on 2010-11 Executive Budget Proposal – Health & Medicaid

New York State Senate Finance Committee
Chair, Senator Carl Kruger

&

New York State Assembly Ways and Means Committee
Chair, Assemblyman Herman D. Farrell, Jr.

Tuesday, February 9, 2010
Legislative Office Building
Albany, NY

Testimony Submitted by
Fran Turner

Thank you for allowing us to submit testimony for today's hearing regarding the Governor's proposed cuts to our public health care system. As you know, CSEA represents 300,000 employees statewide including thousands of direct care employees in public and private hospitals and nursing homes throughout the state who provide daily care to the ill and fragile. Besides representing employees, CSEA also represents working families in this state who rely on these health care services for their family.

Years of budget cuts experienced by public nursing homes and hospitals have forced severe cutbacks, closures and privatization of services. Governor Paterson's proposed budget continues the misguided path of past executives by proposing devastating cuts and increased assessments and fees on health care facilities. We have no doubt that these proposed actions will drive more facilities to either shut their doors or cut critical patient care.

The current state of the economy has caused New Yorkers to lose not only their incomes but their health insurance as well. Although our federal and state governments have tried mitigating this problem through the expansion and extension of programs such as COBRA it has unfortunately not helped everyone. We have seen a sharp increase in the number of people seeking routine care in public hospitals while at the same time hospitals are seeing a decrease in their level of state funding. This recession has proven that our public safety net hospitals and nursing homes are a critical crutch in our health care delivery system and must be funded at an adequate level.

CSEA was dismayed to see the elimination of the trend factor for nursing homes and hospitals. This cut will cause severe hardships for public facilities at a time when they are struggling on a daily basis. This cut, projected to total $106 million for hospitals

and $112 million for nursing homes, will make a bad situation worse. Facilities will have to layoff frontline staff or cut the level of care patients receive. Neither of these options is acceptable or safe. In addition to the elimination of the trend factor, the Governor adds insult to injury by increasing assessments on hospitals and nursing homes.

Besides monetary cuts and assessments, the Governor makes several proposals that would drastically alter the state's long-term care structure. CSEA recognizes that changes in the state's nursing home system is inevitable however it is critical that before one nursing home is closed or downsized we must ensure that there are other options available for long-term care in the community. What we need is a definitive plan of investments for building a new, modern long-term care system that will ensure access and affordability for all New Yorkers instead of the piecemeal approach that we take now.

Governor Paterson's "County long-term care financing demonstration program" would allow up to five counties to reduce their county nursing home bed capacity or close a county nursing home and dedicate the savings to community based long-term care alternatives. These alternatives include the expansion of adult day services, senior housing, caregiver support services, assisted living programs, as well as subsidies to non-public nursing homes and assisted living programs.

County nursing homes are many times the homes of last resort for individuals who do not have the resources to live in a private nursing home or are too ill to be in an assisted living facility or at home. We have severe concerns that while a county is encouraged to downsize or eliminate a public nursing home they will do so without knowing the true demand for services and will overestimate the capacity of alternative care in the community. This will undoubtedly leave those most vulnerable without the

care they will require. Further, with the coming spike in the elderly through the retirement and aging of the baby-boomers we do not feel that this is the time to play a game of Russian roulette with our public nursing homes.

The Governor's plan assumes that a county can eliminate its nursing home and still have enough capacity through alternative care to carry this load. This is a recipe for disaster. Many times, especially in more rural areas of the state, public nursing homes are the only form of long-term care available. Further, while Governor Paterson believes that we must promote alternative forms of care he then proceeds to propose cuts in funding for them in this budget. We urge you to proceed with care on this issue.

Please be assured that we are not ignorant to the condition of our state's economy and the choices that must be made to balance our state's budget. However, we urge you to exercise caution. The decisions you make regarding nursing home capacity will affect not only individuals' currently in nursing homes but future generations. Once a public facility closes the chance of them reopening are slim to none. Let us not rush into a new policy without first examining all of the facts.

Testimony

for the

Legislative Budget Hearing
2010-2011 Executive Budget
Tuesday, February 9, 2010
Hearing Room B, LOB

Respectfully Submitted by:

Craig M. Burridge, M.S., CAE
Executive Director
Pharmacists Society of the State of New York

I want to thank the chairs and committee members for this opportunity to provide testimony on behalf of the Pharmacists Society of the State of New York.

The Pharmacists Society has represented New York State's pharmacists and the patient's they serve for over 131 years and we hope to continue that tradition for many more years to come. We feel strongly that our pharmacists have performed their duties as health care providers and patient advocates in the honored tradition of this society and their profession despite the many challenges they have faced over the past several years.

Pharmacy's Own Financial Crisis – The Hidden Cut is Biggest Cut of All!

Each year we come before the Legislature and the Executive and share ideas that have saved or could have saved tens of millions of dollars in the Medicaid and EPIC programs. Nevertheless, in all but one of the past fifteen years, the Executive has proposed drastic cuts in pharmacy reimbursement. You, the Legislature, have restored millions of dollars in cuts that were proposed. In 2008, we suffered the largest cut in NY Medicaid history resulting in a 30% reduction in pharmacy's gross margins for more than 5 million people or 1 in 4 patients. We understand the state's critical fiscal situation and will continue to work with you to help keep down prescription drug prices but our pharmacy network has reached the point of imploding.

The deepest cut to date, one that never had Legislative approval or showed up in this state budget as a cut has been quietly booked as a $48.7 million "state share" savings in the Executive Budget with an additional $2 mil. in EPIC savings. This cut was the direct result the First Databank federal lawsuit. A lawsuit, in which pharmacy was not a party, has resulted in an effective additional 55% reduction in

pharmacy's gross margin. (see attachment at the end of this testimony showing the gross margin loss). With the federal match ($69.3 mil. enhanced FMP), the additional losses to pharmacy's bottom line is a staggering $118 million and that only includes Medicaid reimbursement losses and not losses from the EPIC, ADAP, Child and Family Health Plus programs that all use the same reimbursement formula.

These are unsustainable losses for community pharmacies, in particular our independents who make up nearly half of this state's pharmacy network. Over 320 independent pharmacies have closed in the past two years and that number will accelerate over the coming months if the reimbursement formula is not fixed.

The Medicaid program continues to gamble and blindly assumes that New Yorkers will continue to have a nearby pharmacy where they will have immediate access to medications they need and access to the pharmacist they know and trust. With the closure of those 320 pharmacies and more than 8,500 pharmacy staff layoffs, pharmacy has come to a crossroads of "barely surviving" or taking the option of just "throwing in the towel" and calling it a day. The job losses in pharmacy belie their actual economic impact on communities. Most pharmacies fill their positions with local individuals living in the community the pharmacy serves. They are well paying jobs. Just 18 months ago, New York had a severe pharmacist shortage as measured by job openings. The job openings severity chart runs from 1.0 to 5.0 with 5.0 being the most severe (University of Minnesota). New York was at 4.8 and in certain areas of the state the pharmacist shortage was worse than the nursing shortage. Today, New York sits at 3.2, reflecting unemployment for pharmacists (lower than 3.5). Our pharmacy school graduates have few if any offers for positions in New York, and many have no choice but to leave the state.

Indications from our wholesalers are that the independent pharmacies – their customers – are slipping deeper and deeper into a financial abyss. Approximately 40% of independents in the NYC-Metropolitan area have fallen 30 days or more behind in paying their wholesalers, and in increasing numbers they are between 90 and 180 days behind. I can assure you, those pharmacies are working off of mainly bare shelves. At the end of December, an independent pharmacy in Brooklyn had to close his doors simply because he could no longer pay his bills. Another independent sold his pharmacy because he could no longer bear to get up each morning, go to his computer to see what checks cleared into his pharmacy account so he could pay his wholesaler that day to restock his shelves. That scenario is being played out week after week across the state.

Access to Certain Medications is Becoming an Issue:

Some branded medications are very expensive to carry in inventory. If it costs a pharmacy $500 to put a bottle of 100 tablets on the shelf, the pharmacy owner may decide not to stock every dosage level of the medication (i.e. Seroquel). Many high-cost drugs are once a day anti-psychotics and anti-depressants. Every bottle in the inventory can be viewed as a financial risk. The owner gambles that 100 tablets will be dispensed before the expiration date on the container. When that happens, the pharmacy eats the loss. One 30-day prescription at a particular dosage level may be critical for one patient, but if the medication at that dosage is uncommon, it is likely that the product will not be available when the prescription is presented at the pharmacy counter. This is the financial risk that pharmacies take every day. It is a risk they no longer can afford to take, a risk not recognized by Medicaid.

It is now Medicaid policy in New York to reimburse pharmacies at or below the drug acquisition cost plus the dispensing fee of $3.50, but no more than 80% of the time the pharmacy's fee is $0.50 because most beneficiaries do not pay the co-pay amount of $3.00 for a brand-drug prescription. (The state automatically subtracts the $3.00 co-pay.) So, going forward, patients and prescribers will have fewer medication options and fewer pharmacies participating in Medicaid, EPIC, ADAP, and Child and Family Health Plus programs unless immediate changes are made to the pharmacy reimbursement formula. Furthermore, New York is compelled to change its reimbursement formula because as early as year's end the benchmark Average Wholesale Price (AWP) will no longer be published, a consequence of the settlement in the federal case against First Data Bank.

Medicaid Officials Believe There is No Access Problem

Without so much as offering a single study or survey, we are told that Medicaid officials are not aware of any loss of access to prescription drugs. But the magnitude of pharmacy reimbursement losses since July 1, 2008 should prompt very careful analysis of the access issue. The September 26, 2009 drop in the value of AWP published prices represents an annualized loss of $120 million from New York's pharmacy sector, combined with more than $100 million dollars cut from pharmacies in 2008, represents more than $220 million that comes not from the cost of the drug, but directly from the operating revenue of the state's pharmacies. When we provide specific instances of access problems, they are dismissed as anecdotal. We are asked to conduct surveys. In fact, we have conducted very expensive Cost of Dispensing Surveys in the past, as has the National Community Pharmacy Association. Those study results were dismissed as "biased". Why would we undertake another survey? Where do Medicaid recipients take their complaints? It appears there is no toll free number to call. If a Medicaid

beneficiary calls DOH, the call goes to the main number in Albany. If you are a recently diagnosed mentally-ill homeless person who has a fist full of prescriptions you can't get filled, what do you do? Who do you call? Do you even know who to call? Harlem hospital has 25,000 psychiatric outpatients, many of them enrolled in Medicaid. How many of their ER patients are there because of an access to prescriptions issue? Does Medicaid collect this data? Have hospital costs gone up in the past couple of months? To simply say there is "no access issue" without any empirical evidence is misleading, possibly costly, and potentially dangerous to patients who rely on state-funded programs for their healthcare including prescription medications.

Increasing Co-pays in the Executive Budget

The Executive Budget calls for increasing co-pays to the Family Health Plus "Buy-in" program to $5 (generics) and $15 (brands). My question is: Will these co-pays be mandatory? You will recall that Family Health Plus comes under Medicaid rules, and under those rules, service must be provided whether or not the co-payment is made. Given today's marginal pharmacy reimbursement in Medicaid, Family Health Plus and Child Health Plus, an uncollectable co-payment of $5 or $15 becomes in effect a very significant provider cut. On a $100 brand prescription, if the pharmacy does not collect the $15 co-pay, the state will pay the pharmacy $13-$14 less then the acquisition cost of the drug. The $5 co-pay on a generic prescription is equally problematic. Furthermore, as an operational matter, we question how the state plans to differentiate between categories of FHP enrollees. We respectfully request that the proposed co-pays be made mandatory or that the proposal be withdrawn.

Moving from an AWP-minus based reimbursement to a WAC-Plus formula

Representatives of the Pharmacists Society met with Medicaid officials several years ago to discuss changing the pharmacy reimbursement formula from Average Wholesale Price (AWP) minus a percentage to Wholesale Acquisition Cost (WAC) Plus a percentage. At the time, the change-over would have been budget neutral, and, more importantly, it would have made pharmacy reimbursement policy more transparent. We provided information that showed the conversion equivalent, but our initiative went unanswered. If New York had made the formula conversion back then, we would not be in the dire situation we are in today. The several states that implemented the change to WAC-based pharmacy reimbursement years ago were not affected at all by the First Data Bank settlement that dropped the value of AWP so precipitously, because WAC is a truer, more transparent and reliable reference price. While pharmacy reimbursement policies in New York place pharmacies in jeopardy of closing, pharmacies in every other state are paid a higher product cost allowance and higher dispensing fees. Many have no co-payments.

We once again call upon the legislature in the strongest terms to reject the proposed additional hidden cut to pharmacies participating in Medicaid, EPIC, ADAP, Child Health Plus and Family Health Plus programs by changing the Medicaid formula from an AWP minus 16.25% to WAC plus 4.68%.

Further, we ask that you seriously consider adjusting our 16-year old dispensing fee to $7.25 (retail) and $8.00 for pharmacies that provide the specialized unit-of-use packaging that is required by nursing homes and other residential care settings. This fee is consistent with the fees paid in other states that have product cost allowances as low as they are in New York. (See A1118 Destito/S3901 Addabbo.)

Pharmacists and Pharmacies Expand Access to Immunizations, Saving Millions of Healthcare Dollars

Pharmacists offer a unique opportunity for a modest investment that could bring significant returns in healthcare quality and cost-containment. Immunization provides an excellent example. The statute allowing certified pharmacists to immunize adults with flu and pneumococcal vaccine became law in 2008, regulations followed in the fall of 2008, and in 2009, just one year from authorization, more than 2,000 pharmacists have completed the rigorous training process and over 1,500 have are certified as immunizers by the NYS Board of Pharmacy. Preliminary results estimate that between 600,000-700,000 seasonal flu vaccines were administered by pharmacists in 2009 and over 400,000 H1N1 vaccines will have been administered by the end of this month. Although pharmacies were the last to receive the H1N1 vaccine, the convenience factors – evening hours, weekends and no appointments needed – meant that many more New Yorkers will have had access to immunizations. It is also important to note that this expanded access to prevention means millions of dollars in Medicaid cost savings because of fewer ER visits and fewer hospitalizations.

New York's Medicaid program generates more than $1.2 billion in rebate dollars

Every prescription filled under the Medicaid program generates rebate dollars under provisions of the federal budget enacted in 1990 (OBRA '90). The federal rebate methodology is a mechanism that guarantees the state access to the 'best price' at which any prescription product is sold in the commercial market. These OBRA '90 rebates in SFY 07-08 brought in $1.127 billion; in SFY 08-09, $1.240 billion. And it is estimated they will bring in $1.314 billion in SFY 09-10. The state's share of those rebates is 25% with the counties getting the other 25% to

offset their Medicaid liability to the state. The state's Preferred Drug Program drives still deeper discounts from the "best price." The PDL supplemental rebates accounted for: $137.6 million in SFY 07-08; $165.3 million in SFY 08-09 and it is estimated to bring in $186.2 million by the end of SFY 09-10. These supplemental rebates are ***not shared*** with the federal government, and they will grow exponentially as more and more drug categories are added to the list of Preferred Drugs. Combined, the supplemental rebates and the OBRA '90 rebates reduce the net cost of prescriptions in Medicaid, EPIC, Child Health Plus and Family Health Plus by approximately 37%. Given this extraordinary revenue stream into the General Revenue Account that reduces the state's cost for prescription drugs to well below market prices, we find it wholly unnecessary and detrimental to the Medicaid program generally that the state's pharmacy providers are continually targeted with reimbursement cuts that bring them to the brink of financial collapse. No other component in the federal or state Medicaid program drives hundreds of millions of dollars into the state's coffers as does pharmacy year after year.

It is also important to note that a percentage of the Medicaid budget, prescription drug costs – reduced by the rebate dollars – is consistently falling. In SFY 2007-08 state's share of spending on the pharmacy benefit was 2.4% of total Medicaid spending, and in SFY 2008-09 it dropped from 2.3% according to the CMS 37 Reports. We estimate that actual drug cost will continue to go down because rebates will increase through 2012 then, as more brand-name/innovator drugs lose their patents in 2011 and 2012, overall drug costs will drop as generics are only 22% of total drug costs. Some of the most expensive drugs in the Medicaid program today will have A-rated generics in place very soon. The state's Medicaid program has cut generic reimbursement to the bone at a time it should consider the

cost-benefit of any incentives to increase the use of generics and, as an added benefit, strengthen the viability of pharmacies that provide jobs and pay taxes.

Independent pharmacies are holding out hope that the Legislature will intervene. So many have already given up, yet even those numbers belie the real crisis that awaits if the budget process doesn't yield favorable results.

Social Security Administration Medicare Part D Asset Rule Changes Could Save New York Millions in EPIC Wrap Around Coverage for Prescription Drugs

Starting this year, approximately 3 to 4 million more seniors will be eligible for Low-Income Subsidies (LIS) due to program changes made by the Social Security Administration with regard to "asset" definitions. Seniors who apply now for LIS help will no longer have to include "life insurance" values or the extra help they receive to pay rent, utilities, etc. We estimate that between 180,000 - 240,000 New York Part D enrollees may now be eligible for LIS assistance if they apply after January 1, 2010.

The state may be the beneficiary of these changes as well. Of the 28,000 EPIC primary enrollees, thousands may be newly eligible for the LIS assistance. As they qualify for LIS, the federal government takes on greater responsibility for their Part D premiums and drug coverage, and EPIC no longer pays their lower Part D co-payments or their drug costs in the 'donut hole.'

Additionally, EPIC has transitioned 11,000 enrollees into Medicare Advantage programs in January, thereby saving the program approximately $11 million (based on an average drug spend of $1,000 per enrollee, per year). This transition saves the beneficiaries over $100.00 per month on their Part B coverage which is

included with the MA-PD plan. We commend the EPIC staff for so diligently looking out for our seniors and making sure that they get the best coverage for the best price.

Medicare Part D Contract Changes Means Big Savings for New Yorkers

Starting with the 2010 Medicare Part D (prescription drug programs), Pharmacy Benefit Managers (PBM) will no longer be able to hide hundreds of millions of dollars in generic drug "spreads" that have pushed seniors prematurely into the coverage gap or what is referred to as the "donut hole". It was the Pharmacists Society of the State of New York that uncovered the pricing "spreads" on generics, a PBM-enrichment scheme that was well hidden from pharmacies, the federal government, the plans and seniors. PSSNY met with CMS officials and pressed for regulatory changes at the federal level in Part D programs. I personally worked with seniors who hit the 'donut hole'. I have seen their 'explanation of benefit' reports. I have seen evidence that Medicare Part D PBMs forced seniors to pay far more in out of pocket prescription costs than the same PBM paid the pharmacy. I have seen a "spread" as high as nearly $800 a month. Here in the Capital District one PBM charged $400 for the same generic prescription it paid the pharmacy just $12. The pharmacy's cash price was $16. What happened to the patient? The patient saved hundreds of dollars a month by paying the cash price to the pharmacy instead of using her Part D card for the remaining 6 months of the year. Because of the change in Medicare Part D regulations that went into effect January 1, 2010, I estimate that approximately 60,000 New York Medicare Part D enrollees will not hit the donut hole or hit it much later in the year and will reap the benefits of PSSNY's advocacy for regulatory change at the federal level. When the remaining 14,000 EPIC enrollees, who can enroll in a Part D program, they and the state will save millions. This society will continue to monitor the Part D plan's charges for

generics submitted by their PBMs. Any "spreads" we detect will be passed on to the sponsoring Part D plan and the Office of the Inspector General at CMS.

Transparency for Prescription Benefit Managers – Much needed reform and Significant Cost-Savings for Businesses and Individuals

What surprises me the most is the audacity of the PBMs to keep the Part D plans and most any other prescription drug plan in the country totally in the dark as to what they pay the pharmacy for a drug. Think about it. How would you feel if you bought a new car and the dealer showed you that you saved 50% over suggested retail only to find out that your neighbor bought the same exact car for 35% less? We call upon the Legislature to pass tough PBM Transparency legislation (A2008 Gottfried/S3930 Duane) to make sure that prescription drug plans have all the information they need to make an informed decision on what the "real price" of a drug is. It is not what the PBM says it is. ***The cost of any prescription drug plan should be going down by 2% a year, taking into account the drug price and increases in utilization.*** If it is not going down by 2%, then that plan, the payers and the enrollees are getting ripped-off! It's that simple.

The State of New York, its municipalities, school districts and the tax payers will save hundreds of millions of dollars annually by shinning the light of "transparency" on all PBMs doing business in this state. PBM's will argue that transparency will increase prescription drug costs. We say, "Prove It!" We have the documentation that demonstrates clearly that PBMs are hiding hundreds of millions of dollars in revenue because they pay pharmacies far less than they are charging the unions, the states and any other purchaser of prescription drugs. Their excessive profits have made them the darlings of Wall Street but their dollars come at the expense of the business, consumers and state and local governments.

Mandatory Mail Order Prescription Plans – Not Cheaper!

PBMs tout mandatory mail order prescription plans as being "cheaper" then retail pharmacy. Mail order "appears" to be less expensive because the PBMs control all of the data and are loath to share what they have. First of all, PBMs collect rebates from the manufacturers. Although they may share some rebate revenues with their clients, rebates also work to their advantage with their mail-order pharmacy subsidiaries. For consumers, PBM's make rules such as co-payment amounts, 'preferred' drugs, quantity limits, or higher co-payments for using local pharmacies. For independent pharmacies, PBM's control which pharmacies are in the network, how much they will be paid and when, how much medication can be dispensed, whether a 90-day supply of a 'maintenance' medication can be obtained locally, when 'mail order' is mandatory, etc. Because PBM's have a financial interest in their mail order pharmacies, they frequently discriminate against local pharmacies and co-payment policies and other rules. PBMs consider much of their data to be 'proprietary', allowing them to bill health plans, unions or other self-insurers more for generic drugs than what they paid to the local pharmacies in their network. It is common for PBM's to pay the pharmacy under one formula and bill the plans under another more costly formula. I have provided some examples of how this works at the end of my written testimony. (It involves "reference pricing" for generics which has NOTHING to do with what the pharmacy is paid. It applies only what PBMs bill the plan.) Patients who pay a percentage of the drug cost as their co-pay, are getting ripped off every time they fill their prescriptions. Out-of-pocket prescription drug co-pays have skyrocketed over the past 10 years, shadowing the ever increasing profits of the Big Three PBMs. I have also included a chart developed by a truly transparent PBM showing the **per day of therapy cost savings** if retail pharmacies were allowed to fill 90-day supplies of maintenance medications over mail order. Community pharmacy is **$0.53 per day less expense**

then mail order. Now, $0.53 per day savings doesn't sound like a lot of money but in the 9-month comparison of mail order to community pharmacy, those 950,000 prescriptions totaled more than $41 million in savings. One large NY-based union (360,000 covered lives) saved over $50 million in its first year out of its mandatory mail order program and back to community pharmacy under a newer 'transparent' prescription benefit model. The plan absorbed an 8% drug cost increase and 2% increase in utilization that same year which made their actual savings more than $70 million. Overall, the union experienced a **2% NET** reduction in prescription costs over the previous year of mandatory mail order. This same union expects to save $210 million over the next three years. (see slides at end of testimony.) Transparency saves money. Mandatory mail order programs are expensive. Access to local pharmacies are a cost-effective alternative to mail order, and access to a local pharmacist both enhances compliance and drives value to the healthcare dollar.

Mail order only prescription drug plans cost this state thousands of jobs and millions in tax revenue based on income and spending. Mail order prescription drug plans account for 28% of all drug expenditures or $83 billion in 2009. For NYS, total drug expenditures were $17.76 billion (6% of national total) with $4.98 billion of that total going to out-of-state mail order pharmacies. New York sends hundreds of millions in tax payer dollars out of the state every year for tax payer-supported prescription drug plans. **(Total U.S. Drug expenditure for 2009 = $296 billion NYS = 6% of that total or $17.76 billion.)**

Pharmacists working with municipal unions have saved unions tens of millions of dollars every year. We call upon the Legislature to pass PBM Transparency as a way to save New York taxpayers and employers over **$1.365 billion annually,** an

amount calculated from the savings on "spreads" on generics. **(Avg. estimated overcharges on generics is 35%. Generic drug dollars equals 22% of the total drug spend. $17.76 bil. X 22% = $3.90 billion X 35% = $1.365 billion in savings)**

In conclusion, we ask the Legislature:

1.) Change the pharmacy reimbursement formula to WAC + 4.68%;

2.) Increase dispensing fee in Medicaid, Child Health Plus and Family Health Plus to $7.25/$8.00 for special packaging for residential care;

3.) Adopt PBM Transparency as the means to save NYS businesses, consumers and taxpayers over $1.3 billion annually in drug costs;

4.) Consider the financial havoc being wrought on NYS-based businesses as it relates to mandatory mail order programs.

Once again, thank you for allowing us this opportunity to testify today. We'll address any questions that you may have at this time.

Supporting Materials

For the

Pharmacists Society of the State of New York, Inc.

2010-2011

Budget Hearing Testimony

February 9, 2010

Example A: Pre-Sept. 26th Medicaid Reimbursement (same drug):

$100.00	AWP Published Price Pre-Sept. 26th.
$ 78.00	Pharmacy Purchase Price with a 22% discount (That's the highest %)
$ 22.00	"Spread" for pharmacy on acquisition cost of drug
$ 16.25	NYS Medicaid AWP - 16.25 % discount off AWP (in statute)
$ 5.75	Gross Margin for pharmacy on drug acquisition cost
$ 3.50	Medicaid Dispensing fee (Not paid 80% of the time)
$ 9.25	"gross margin" for that transaction. It's **$6.25** if the dispensing is not paid.

Example A: Post-Sept. 26th Medicaid Reimbursement (same drug):

$ 95.00	New AWP Published Price (using 120 basis point markup)
$ 78.00	Pharmacy's drug acquisition cost with a 22% discount
$ 17.00	"Spread" for pharmacy on acquisition cost of drug
$ 15.43	NYS Medicaid AWP-16.25% discount off AWP (has a roll-back equivalent of AWP-20.25%)
$ 1.57	Gross Margin for pharmacy on drug acquisition cost
$ 3.50	Medicaid dispensing fee (if paid by recipient)
$ 5.07*	"gross margin" for that transaction. It's **$2.07** if the dispensing fee is not paid.

*** This equals a 55% reduction in a pharmacy's gross margin.**

Example B: Pre-Sept. 26th Medicaid Reimbursement Using an Avg. Brand Drug Cost

$177.00	AWP Brand Drug Published Price Pre-Sept. 26th.
$138.06	Pharmacy Purchase Price at 22% off AWP
$ 38.94	"spread" for pharmacy acquisition cost of drug
$ 28.76	AWP-16.25% - NYS Medicaid reimbursement discount
$ 10.18	Pharmacy's "gross margin" on drug acquisition
$ 3.50	Medicaid dispensing fee (paid less then 20% of the time)
$ 13.68	Pharmacy's "gross margin" if co-pay paid

Example B: Post-Sept. 26th Medicaid Reimbursement Using Avg. Brand Drug Cost

$168.15	New AWP Published Price Post Sept. 26th Court Agreement
$138.06	Pharmacy Purchase Price with a 22% discount
$ 30.09	"spread" for pharmacy acquisition cost of drug
$ 27.32	AWP-16.25% 0 NYS Medicaid Discount
$ 2.77	Pharmacy's "gross margin" on drug acquisition cost
$ 3.50	Medicaid dispensing fee
$ 6.77	Pharmacy's "gross margin" if co-pay paid

**** Avg. per Rx loss from uncollected co-pays equals $1.75 for every Medicaid Rx dispensed.**

Example:
Community Pharmacy Generic

Drug "A" AWP $80.00/100 tablets

Pharmacy Cost $0.08

Pharmacy MAC $0.12

Payment Formula MAC + $2.00 =

Client Rate AWP – 50%

Pharmacy Paid on 100 Tablets

$0.12 x 100 = $12.00

MAC + $2.00 = $14.00

Client Pays

AWP – 50% =

$80.00 – 50% = $40.00 + $2.00
or $42.00

PBM Makes a Spread of:

$42.00 – $14.00 = <u>$28.00</u>

Example:
Community Pharmacy Brand

Retail Pharmacy Rate

AWP $100.00/100 tablets

AWP – 14% + $2.00 =

$100.00 - $14.00 + $2.00 = $88.00

Client Rate

AWP $100.00/100 tablets

AWP – 12% + $2.50 =

$100.00 - $12.00 + $2.50 = $90.50

$2.50 Spread + Rebate Money

Case Studies in Transparency
Case Study #1 – Before Transparency

- Large Labor Fund (360,000 lives) in NYC with active and retirees throughout the nation, but mostly within the NYC Metropolitan area
- Had a "traditional" (margin-based) PBM pricing arrangement
- Key Benefit Features:
  - Had mandatory mail order with 2x co-pays (fixed-co-pays)
  - Had mandatory generics with co-pay penalties
- Fund was experiencing a trend of a 15%-20% annual increase (approx. $20-$25 million)

Case Study #1
Post Switch to Transparent PBM

- Switched to a fully transparent and auditable PBM in 2006 and did not alter their current benefit
  - Removed Mandatory Mail Order
  - Implemented new 90-day at Retail

- First year in new program, union experienced a net -2% savings despite an 8% increase in drug prices and a 2% increase in member utilization.
- Savings estimated to be $50 mil.
  - Accounts for a previous 15%-20% trending annual cost increases

Innoviant®
Prescription Benefits Administrator

	Average Day Supply	Total Claim Volume	Total Days of Therapy	Total Claim Dollars	Cost Per Day of Therapy	Generic Utilization
Mail Order	89	540,370	48,092,930	$95,367,736.07	**$1.98**	48.4%
Retail 90-Day Supply	90	411,169	37,005,210	$53,654,772.07	**$1.45**	57.5%
Retail 30-Day Supply	24	5,419,450	130,066,800	$322,113,150.81	**$2.48**	59.9%

Based upon Innoviant Book of Business data
January 1 – September 30, 2007
Total cost/claim, including member and plan pay

Fact Sheet
PBMs and Mail Order

Background
Pharmacy benefit managers (PBMs) are the largely unregulated drug middlemen that administer the prescription drug benefit portion of health insurance plans for private companies, unions, and governments.

Each of the giant PBMs owns a mail order drug company and attempts to drive its customers away from community pharmacy and into the mail order firm it owns. PBMs argue that this saves consumers and plan sponsors money when, in fact, their motivation is higher profits. As the facts below illustrate, patients overwhelmingly prefer filling their prescriptions at a local pharmacy and it is community pharmacy, not mail order, which saves patients and payers money.

The National Community Pharmacists Association strongly opposes efforts by the PBMs to commoditize the prescription benefit and eliminate the important face-to-face relationship between patients and their local community pharmacist by coercing patients into mail order delivery of their prescription medications.

Given the choice, patients prefer their local pharmacy over mail order.

- Given equal copays and days supply, 83% of consumers prefer filling a prescription at their community pharmacy over mail order.[1]
- 72% of consumers oppose mandatory mail order.[1]
- Almost half (46%) of consumers disagree that mail order is more convenient.[1]
- Half of all consumers feel they would be more likely to make mistakes taking medications obtained through mail order.[1]
- 71% of consumers indicated they would be concerned about not having the advice and personal attention of their local community pharmacist if they had to obtain medications through mail order.[1]
- In a May 24, 2004, press release, Mark B. McClellan, MD, PhD, administrator of the Centers for Medicare & Medicaid Services said, "Four out of five seniors and people with disabilities prefer to buy their drugs from their neighborhood pharmacies, where they can get face-to-face advice and quick access to their medicines from a pharmacist who knows them."
- A *Consumer Reports* survey recommends the use of independent pharmacies, saying "independents are usually far more attuned to your personal needs and total health picture."[2]
- Congress, which represents the interests of the American people, rejected mandatory mail order provisions for the Medicare Modernization Act of 2003.

(more)

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Consumers, payers, and the government pay more and get less when it comes to mail order.

- Based on the top 10 brand drugs and top 10 generic drugs, mail order costs the plan sponsor more than using community pharmacies.[3]
- Mail order dispenses cost-saving generic drugs only 30% of the time, while community pharmacies dispense generics at least 46% of the time.[4]

PBMs have a financial incentive to push patients to mail order.

- PBMs make an average $3.50 for every mail order prescription they fill compared to $1.40 for a prescription filled at their community pharmacy network.[5]

PBMs steer consumers to their own wholly owned mail order facilities by preventing competitors from being able to effectively compete.

- PBMs usually prevent patients from receiving more than a 30-day supply at the pharmacy, while incentivizing 90-day supplies by their own wholly owned mail order firm.
- Community pharmacies are forced into take-it-or-leave-it contracts with the PBMs because they are not legally able to negotiate contracts as a group with PBMs.

PBMs have an incentive to dispense more expensive brand name drugs over cost-saving generics.

- PBMs earn revenues from their own mail order operations and two general sources: administrative fees—including spread pricing—paid by managed care clients and rebates, discounts, and other monies that pharmaceutical manufacturers pay to PBMs to favor the manufacturers' drugs.[5]
- Rebates are typically paid for single-source branded drugs, but not for most generic drugs. PBMs usually retain a portion, and in some cases all, of the rebate dollars that they collect from branded manufacturers, giving PBMs an incentive to sell more single-source branded drugs, even when cheaper and therapeutically similar or identical drugs are available.[5]
- The giant PBM Medco Health Solutions received more than $3 billion in rebates in 2004 and kept 44% of the rebates instead of passing them along to their clients. The company also received nearly $180 million in "service" revenues from pharmaceutical manufacturers, which also were not shared with their clients.[3]
- 38% of Medco Health Solutions revenue comes from its own mail order operations.[3]
- PBMs with mail order houses profit by repackaging prescription drugs and selling the repackaged goods at higher per unit AWP (average wholesale price) than the manufacturer originally charged. A study found 15 instances when a branded drug was repackaged and sold at a higher per unit price, sometimes by as much as 176%.[5]
- PBM-owned mail order facilities switch to higher-priced drugs more frequently than nonaffiliated mail order facilities.[5]

(more)

Pharmacy Benefit Manager Licensure and Solvency Protection Act

Section 1. Title.

This Act shall be known and cited as the Pharmacy Benefit Manager Licensure and Solvency Protection Act.

Section 2. Purpose and Intent.

The purpose of this Act is to establish standards and criteria for the regulation, solvency and licensing of Pharmacy Benefit Managers. This Act is designed to promote, preserve, and protect the public health, safety, and welfare by and through effective regulation, solvency requirements and licensing of Pharmacy Benefit Managers.

Section 3. Definitions.

For purposes of this Act:

A. "Board of Pharmacy" or "Board" means the State Board of Pharmacy.

B. "Commissioner" means the Commissioner of Insurance.

C. "Covered Entity" means a nonprofit hospital or medical service organization, insurer, health coverage plan or health maintenance organization, a health program administered by the department or the State in the capacity of provider of health coverage; or an employer, labor union or other group of persons organized in the State that provides health coverage to covered individuals who are employed or reside in the State. "Covered entity" does not include a health plan that provides coverage only for accidental injury, specified disease, hospital indemnity, Medicare supplement, disability income, long-term care or other limited benefit health insurance policies and contracts.

D. "Covered Person" means a member, participant, enrollee, contract holder or policy holder or beneficiary of a covered entity who is provided health coverage by the covered entity. "Covered individual" includes a dependent or other person provided health coverage through a policy, contract or plan for a covered individual.

E. "Department" means Department of Insurance.

F. "Health Benefit Plan" means a policy, contract, certificate or agreement offered or issued by a health carrier to provide, deliver, arrange for, pay for or reimburse any of the cost of health care services including prescription drug benefits.

G. "Maintenance drug" means a drug prescribed by a practitioner who is licensed to prescribe drugs and used to treat a medical condition for a period greater than 30 days.

H. "Multi-source drug" means a drug that is stocked and is available from three or more suppliers.

I. "Pharmacist" means any individual properly licensed as a pharmacist by the Board.

J. "Pharmacist Services" includes drug therapy and other patient care services provided by a licensed pharmacist intended to achieve outcomes related to the cure or prevention of a disease, elimination or reduction of a patient's symptoms, or arresting or slowing of a disease process as defined in the Rules of the Board. *DRAFTING NOTE: Use "the practice of pharmacy" definition in the state code.*

K. "Pharmacy" means any appropriately licensed place within this state where drugs are dispensed and pharmacist services are provided. *DRAFTING NOTE: Use the definition of "pharmacy" in the state code.*

L. "Pharmacy Benefits Management" means the administration or management of prescription drug benefits provided by a covered entity for the benefit of covered individuals.

M. "Pharmacy Benefits Manager" or "PBM" means a person, business or other entity that performs pharmacy benefits management. The term includes a person or entity acting for a PBM in a contractual or employment relationship in the performance of pharmacy benefits management for a covered entity.

N. "Usual and Customary Price" means the price the pharmacist would have charged a cash paying (not a patient where reimbursement rates are set by a contract) patient for the same services on the same date inclusive of any discounts applicable.

Section 4. Applicability and Scope.

This Act shall apply to a PBM that provides claims processing services, other prescription drug or device services, or both to covered persons who are residents of this state.

Section 5. Certificate of Authority to act as a PBM.

A. No person or organization shall act or operate as a PBM in this state without a valid certificate of authority issued by the Department. The failure of any person to hold such a certificate while acting as a PBM shall subject such person to a fine of not less than $5,000 or more than $10,000 for each violation.

B. Each person seeking a certificate of authority to act as a PBM shall file with the Department an application for a certificate of authority upon a form to be furnished by the Department, which application shall include or attach the following:

(1) All basic organizational documents of the PBM, such as the articles of incorporation, articles of association, bylaws, partnership agreement, trade name certificate, trust agreement, shareholder agreement and other applicable documents and all amendments to those documents.

(2) The names, addresses, official positions and professional qualifications of the individuals who are responsible for the conduct of the affairs of the PBM, including all members of the board of directors, board of trustees, executive committee, other governing board or committee, the principal officers in the case of a corporation, the partners or members in the case of a partnership or association and any other person who exercises control or influence over the affairs of the PBM.

(3) A Certificate of Compliance issued by the State Board of Pharmacy indicating that the PBM's plan of operation is consistent with the Pharmacy Practice Act and any regulations promulgated thereunder.

(4) Annual statements or reports for the 3 most recent years, or such other information as the Department may require in order to review the current financial condition of the applicant.

(5) If the applicant is not currently acting as a PBM, a statement of the amounts and sources of funds available for organization expenses and the proposed arrangements for reimbursement and compensation of incorporators or other principals.

(6) The name and address of the agent for service of process in the state.

(7) A detailed description of the claims processing services, pharmacy services, insurance services, other prescription drug or device services, audit procedures for network pharmacies or other administrative services to be provided.

(8) All incentive arrangements or programs such as rebates, discounts, disbursements, or any other similar financial program or arrangement relating to income or consideration received or negotiated, directly or indirectly, with any pharmaceutical company, that relates to prescription drug or device services, including at a minimum information on the formula or other method for calculation and amount of the incentive arrangements, rebates or other disbursements, the identity of the associated drug or device and the dates and amounts of such disbursements.

(9) Such other information as the Commissioner may require.

(10) A filing fee of $5,000.

C. The applicant shall make available for inspection by the Department copies of all contracts with insurers, pharmaceutical manufacturer or other persons utilizing the services of the PBM for pharmacy benefit management services. Certain contracts are subject to prior approval as provided in Section 10.

D. The Department shall not issue a certificate of authority if it determines that the PBM or any principal thereof is not competent, trustworthy, financially responsible, or of good personal and business reputation or has had an insurance license or pharmacy license denied for cause by any state

E. A PBM shall maintain a fidelity bond equal to at least 10 percent of the amount of the funds handled or managed annually by the PBM. However, the Department may require an amount in excess of $500,000 but not more than 10 percent of the amount of the funds handled or managed annually by the PBM. A copy shall be provided to the Department.

Section 6. Certificate of Compliance issued by Board of Pharmacy.

A. Each PBM seeking to become licensed in the state must submit its plan of operation for review in a format to be furnished by the Board of Pharmacy.

B. The Board will review the submission in order to determine if it complies with the Pharmacy Practice Act. The Board shall promulgate rules and regulations concerning, but not limited to, the format required, the filing fee, the requirements for re-certification and any other information

that it may require to complete its review. The fees collected shall be used solely for the purpose of regulating PBMs.

C. If the PBM's filing meets with Board approval, it shall be issued a Certificate of Compliance. Subsequent material changes in the plan of operation must be filed with the Board.

Section 7. Disclosure of ownership or affiliation and certain agreements.

A. Each PBM shall disclose to the Department any ownership interest or affiliation of any kind with: any insurance company responsible for providing benefits directly or through reinsurance to any plan for which the PBM provides services; or any parent companies, subsidiaries and other entities or businesses relative to the provision of pharmacy services, other prescription drug or device services or a pharmaceutical manufacturer.

B. The PBM must notify the Department in writing within five (5) calendar days of any material change in its ownership.

C. Every PBM shall disclose the following agreements:

1. Any agreement with a pharmaceutical manufacturer to favor the manufacturer's products over a competitor's products or to place the manufacturer's drug on the PBM's preferred list or formulary, or to switch the drug prescribed by the patient's health care provider with a drug agreed to by the PBM and the manufacturer;

2. Any agreement with a pharmaceutical manufacturer to share manufacturer rebates and discounts with the PBM or to pay money or other economic benefits to the PBM,

3. Any agreement or practice to bill the health plan for prescription drugs at a cost higher than the PBM pays the pharmacy,

4. Any agreement to share revenue with a mail order or internet pharmacy company and

5. Any agreement to sell prescription drug data including data concerning the prescribing practices of the health care providers in the state.

Section 8. Maintenance of records; access; confidentiality; financial examination.

A. Every PBM shall maintain for the duration of the written agreement and for 2 years thereafter books and records of all transactions between the PBM, insurers, covered persons, pharmacists and pharmacies.

B. The Department shall have access to books and records maintained by the PBM for the purposes of examination, audit and inspection. The information contained in such books and records is confidential. However, the Department may use such information in any proceeding instituted against the PBM or insurer.

C. The Commissioner shall conduct periodic financial examinations of every PBM in this state to ensure an appropriate level of regulatory oversight. The PBM shall pay the cost of the examination which shall be deposited in a special fund to provide all expenses for the regulation, supervision and examination of all entities subject to regulation under this Act.

Section 9. Annual statement and filing fee required.

A. Each authorized PBM shall file with the Department an annual statement on or before March 1st.The statement shall be in such form and contain such matters as the Department prescribes and include the filing fee established by the Department. It must include the total number of persons subject to management by the PBM during the year, number of persons terminated during the year, the number of persons covered at the end of the year and the dollar value of claims processed.

B. The statement shall disclose all incentive arrangements or programs such as rebates, discounts, disbursements, or any other similar financial program or arrangement relating to income or consideration received or negotiated, directly or indirectly, with any pharmaceutical company, that relates to prescription drug or device services, including at a minimum information on the formula or other method for calculation and amount of the incentive arrangements, rebates or other disbursements, the identity of the associated drug or device and the dates and amounts of such disbursements.

Section 10. Contracts; Agreements must be Approved; Prohibited Provisions.

A. No person may act as a PBM without a written agreement between such person and the PBM.

B. A PBM shall not require a pharmacist/pharmacy to participate in one contract in order to participate in another contract. The PBM shall not exclude an otherwise qualified pharmacist/pharmacy from participation in a particular network solely because the pharmacist/pharmacy declined to participate in another plan or network managed by the PBM.

C. The PBM must file a copy with the Department of all contracts/agreements with pharmacies for approval not less than thirty (30) days before the execution of the contract/agreement. The Department shall consult with the Board on the criteria prior to promulgation. The contract shall be deemed approved unless the Department disapproves it within thirty (30) days after it is filed.

D. The written agreement between the insurer and the PBM shall not provide that the pharmacist/pharmacy is responsible for the actions of the insurer or the PBM.

E. All agreements shall provide that when the PBM receives payment for the services of the pharmacist/pharmacy that the PBM shall act as a fiduciary of the pharmacy/pharmacist who provided the services. The PBM shall distribute said funds in accordance with the time frames provided in this Act.

Section 11. Disclosures to Covered Person and Authorization for Substitutions.

A. When the services of a PBM are utilized, the PBM must provide a written notice approved by the insurer to covered persons advising them of the identity of, and relationship between, the PBM, the insured and the covered person.

B. The notice must contain a statement advising the covered person that the PBM is regulated by the Department and has the right to file a complaint, appeal or grievance with the Department concerning the PBM. The notice shall include the toll-free telephone number, mailing address and electronic mail address of the Department.

C. The notice must be written in plain English, using terms that will be generally understood by the prudent layperson and a copy must be provided to the Department and each pharmacist/pharmacy participating in the network.

D. When a PBM requests a substitute prescription for a prescribed drug to a covered individual the following provisions apply:

(1) The PBM may substitute a lower-priced generic and therapeutically equivalent drug for a higher-priced prescribed drug.
(2) With regard to substitutions in which the substitute drug costs more than the prescribed drug, the substitution must be made for medical reasons that benefit the covered individual. If a substitution is being made under this subparagraph, the PBM shall obtain the approval of the prescribing health professional or that person's authorized representative after disclosing to the covered individual the cost of both drugs and any benefit or payment directly or indirectly accruing to the PBM as a result of the substitution and any potential effects on a patient's health and safety including side effects.
(3) The PBM shall transfer in full to the covered entity any benefit or payment received in any form by the PBM as a result of a prescription drug substitution under subparagraph (1) or (2).

Section 12. PBM Responsibilities to the Covered Entity.

A. A PBM shall provide to a covered entity all financial and utilization information requested by the covered entity relating to the provision of benefits to covered individuals through that covered entity and all financial and utilization information relating to services to that covered entity. A PBM providing information under this section may designate that material as confidential. Information designated as confidential by a PBM and provided to a covered entity under this section may not be disclosed by the covered entity to any person without the consent to the PBM, except that disclosure may be made when authorized by a court.

B. A PBM shall disclose to the covered entity all financial terms and arrangements for remuneration of any kind that apply between the PBM and any prescription drug manufacturer or labeler, including, without limitation, rebates, formulary management and drug-switch (substitution) programs, educational support, claims processing and pharmacy network fees that are charged from retail pharmacies and data sales fees.

C. A PBM shall disclose to the covered entity whether there is a difference between the price paid to retail pharmacy and the amount billed to the covered entity for said purchase.

D. The covered entity may audit the PBM's books and records related to the rebates or other information provided in sections A through C.

E. A PBM shall perform its duties exercising good faith and fair dealing toward the covered entity.

Section 13. PBM Responsibilities to Pharmacist/Pharmacy.

A. A pharmacist/pharmacy may not be terminated or penalized by a PBM solely because of filing a complaint, grievance or appeal as permitted under this Act.

B. A pharmacist/pharmacy may not be terminated or penalized because it expresses disagreement with the PBM's decision to deny or limit benefits to a Covered Person or because

the pharmacist/pharmacy assists such Covered Person to seek reconsideration of the PBM's decision or because the pharmacist/pharmacy discusses alternative medications.

C. Prior to the terminating a pharmacy from the network, the PBM must give the pharmacy/pharmacist a written explanation of the reason for the termination at least 30 days prior to the termination date unless the termination is based on the (i) loss of the pharmacy's license to practice pharmacy or cancellation of professional liability insurance or (ii) conviction of fraud.

D. Termination of a contract between a PBM and a pharmacy or pharmacist, or termination of a pharmacy or pharmacist from a PBM's provider network shall not release the PBM from the obligation to make any payment due to the pharmacy or pharmacist for pharmacist services rendered.

Section 14. Medication Reimbursement Costs; Use of Index Required.

PBMs shall use a current and nationally recognized benchmark to base the reimbursement paid to network pharmacies for medications and products. The reimbursement must be determined as follows:

A. For brand (single source) products the Average Wholesale Price (AWP) as listed in First Data Bank (Hearst publications) or Facts & Comparisons (formerly Medispan) correct and current on the date of service provided shall be used as an index.

B. For generic drug (multi-source) products, Maximum Allowable Cost (MAC) shall be established by referencing First Data Bank/Facts & Comparisons Baseline Price (BLP). Only products that are compliant with pharmacy laws as equivalent and generically interchangeable with a Federal FDA Orange Book rating of "A-B" will be reimbursed from a MAC price methodology. If a multi-source product has no BLP price, then it shall be treated as a single source branded drug for the purpose of determining reimbursement.

Section 15. Timely Payments to Pharmacists/Pharmacies; Audits.

A. If a PBM processes claims via electronic review then it shall electronically transmit payment within seven calendar days of said claims transmission to the pharmacist/pharmacy. Specific time limits for the PBM to pay the pharmacist for all other services rendered must be set forth in the Agreement.

B. Within 24 hours of a price increase notification by a manufacturer or supplier, the PBM must adjust its payments to the pharmacist/pharmacy consistent with the price increase.

C. Claims paid by the PBM shall not be retroactively denied or adjusted after seven days from adjudication of such claims except as provided in paragraph D below. In no case shall acknowledgement of eligibility be retroactively reversed.

D. The PBM may retroactively deny or adjust in the event (i) the original claim was submitted fraudulently; (ii) the original claim payment was incorrect because the provider was already paid for services rendered, or (iii) the services were not rendered by the pharmacist/pharmacy.

E. The PBM may not require extrapolation audits as a condition of participating in the contract, network or program.

F. The PBM shall not recoup any monies that it believes are due as a result of the audit by setoff until the pharmacist/pharmacy has the opportunity to review the PBM's findings and concurs with the results. If the parties cannot agree then the audit shall be subject to review by the Board.

Section 16. PBM Prohibited Practices.

A. A PBM shall not intervene in the delivery or transmission of prescriptions from the prescriber to the pharmacist or pharmacy for the purpose of: influencing the prescriber's choice of therapy; influencing the patient's choice of pharmacist or pharmacy; or altering the prescription information, including but not limited to, switching the prescribed drug without the express authorization of the prescriber.

B. No agreement shall mandate that a pharmacist/pharmacy change a covered person's prescription unless the prescribing physician and the covered person authorize the pharmacist to make the change.

C. The insurer and the PBM may not discriminate with respect to participation in the network or reimbursement as to any pharmacist/pharmacy that is acting within the scope of his or her license or certification.

D. The PBM may not transfer a health benefit plan to another payment network unless it receives written authorization from the insurer.

E. No PBM may discriminate when contracting with pharmacies on the basis of co-payments or days of supply. A contract shall apply the same coinsurance, co-payment and deductible to covered drug prescriptions filled by any pharmacy, including a mail order pharmacy or pharmacist who participates in the network.

F. No PBM may discriminate when advertising which pharmacies are participating pharmacies. Any list of participating pharmacies shall be complete and all inclusive.

G. No PBM may mandate basic record keeping by any pharmacist or pharmacy that is more stringent than required by state or federal laws or regulations.

Section 17. Complaint Process.

A. The Department and the Board shall each adopt procedures for formal investigation of complaints concerning the failure of a pharmacy benefits manager to comply with this Act.

B. The Department shall refer a complaint received under this Act to the Board if the complaint involves a professional or patient health or safety issue.

C. The Board shall refer a complaint received under this chapter to the Department if the complaint involves a business or financial issue.

Section 18. Adjustment or settlement of claims; compensation of PBM.

Compensation to a PBM for any claims that the PBM adjusts or settles on behalf of an insurer shall in no way be contingent on claims experience. This section does not prohibit the compensation of a PBM based on total number of claims paid or processed.

Section 19. Regulations.

The Commissioner and the Board may promulgate regulations to carry out the provisions of this Act. The regulations may include the following: definition of terms, use of prescribed forms, reporting requirements, prohibited practices and enforcement procedures. The regulations shall be subject to review in accordance with general rules of administrative rulemaking and review of regulations.

Section 20. Applicability of other laws and regulations. (*DRAFTING NOTE*: Use existing code sections to define the enforcement process including, grounds for license revocation, fines, suspension and reinstatement. If the State has an unfair trade practices act and/or a privacy/confidentiality act then this Act should be subject to those provisions. If not then this Act must include prohibitions against discrimination, false and misleading advertising and protections for privacy/confidentiality of covered person information.)

Section 21. Separability.

If any provision of this Act, or the application of the provision to any person or circumstance shall be held invalid, the remainder of the Act, and the application of the provision to persons or circumstances other than those to which it is held invalid, shall not be affected.

Section 22. Effective Date.

This Act shall be effective (insert date). In order to continue to do business in this state, a PBM must obtain a Certificate of Authority from the Department within ninety (90) days after the effective date of this Act.

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Though we understand the challenges faced by the state in these difficult economic times, these are also the times when people are without jobs, have lost or are on the verge of losing their homes, and must turn to essential human services to feed and clothe their families, pay for heat, medicine and other needs.

This written testimony will address the Governor's budget proposals for the Department of Health AIDS Institute, State Office for the Aging and the Medicaid program, with emphasis on programs that will particularly impact the elderly and individuals living with HIV/AIDS.

I. Department of Health AIDS Institute

FPWA is pleased to know that the Governor has kept his promise by allocating adequate funds back to the AIDS Drug Assistance Program, which was removed in FY 2009-10. However, FPWA is deeply concerned about the consolidation of the AIDS Institute budget from roughly 60 budget lines to 5 large categories. We believe this action will severely undermine state agency transparency, thus making it difficult for legislators, as well as the general public, to learn about the budget allocations. It also eliminates statutory protections for safety providers including those funded by Community Development Initiatives/Multi Service Agency lines and the Community Service Provider lines. This adds incredible uncertainty to service providers to leverage private and government funds in a difficult economic environment.

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If this proposal is adopted, it will set an unprecedented example that the AIDS Institute will no longer be required to disclose budget allocations for each program. Instead, only the lump sum of each of the five large categories will be listed on the budget document. **FPWA urges the Legislature to oppose the AIDS Institute budget consolidation and instead continue to maintain separate budget line allocations for each program to preserve transparency.**

FPWA is also concerned about the Governor's proposal to eliminate Medicaid Part D wrap-around coverage which would impact approximately 11,000 HIV positive individuals in New York State who are dually eligible for both Medicaid and Medicare. The current Medicaid Part D wrap-around coverage pays for four specific categories of drugs including atypical anti-psychotics, anti-depressants, anti-retrovirals used to treat HIV/AIDS, and anti-rejection drugs used by organ and tissue transplant recipients. Currently, prior authorization for these prescription drugs is exempted to ensure unrestricted access for these particularly vulnerable people who rely on them.

The elimination of wrap-around coverage means that those who are dual eligible would be limited to their Part D plan's formulary and subject to utilization requirements. Typically, clients will not know which prescription drug is not covered by the formulary of their medical plans until they are told by the technician at the pharmacy. Similarly, clients may not know prior authorization is required until Part D denies their coverage. Unless their doctor intervenes immediately to help them through the utilization process, clients may leave the pharmacy <u>without</u> the medication they need. Although FPWA understands that the state is not required by law to provide coverage for these medications, the elimination of this coverage would disrupt and compromise the continuity of care of approximately 11,000 HIV positive individuals in New York State who are dually eligible for both Medicaid and Medicare. FPWA strongly recommends that New York State continue supporting Medicaid Part D wrap-around coverage.

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II. State Office for the Aging (SOFA)

FPWA appreciates that the Governor has proposed $245,000 for the enriched social adult day services demonstration project. Persons who are 85 years or older are the fastest growing portion of the older adult population in New York State. We believe it is critical for social adult day agency personnel to be able to provide an array of enriched services to seniors who attend their programs including assistance with toileting, mobility, transferring and eating, medication dispensing by an R.N., case management, and restorative and maintenance therapies. FPWA believes cost-effective and affordable services, such as enriched social adult day care, is essential to meeting the future needs of this expanding human services target population, and is pleased to know of the Governor's continuing support to this initiative.

FPWA is also pleased that the $2 million allocation for geriatric mental health programs has been maintained in the Governor's Executive Budget. The $2 million was previously allocated to establish demonstration programs under the Geriatric Mental Health Act. Funding is being utilized for the creation of state of the art demonstration programs to provide innovative geriatric mental health services, as well as education and training programs, for primary care physicians in the identification and treatment of depression among older adults. Due to the dramatic increase in the older adult population, we urge the legislature to support the continued funding of $2 million to provide these innovative geriatric mental health services to older adults.

A number of national and local research findings have shown that investing in community-based programs and services would result in significant cost savings by keeping people healthy and in their homes for as long as possible, helping to avoid more expensive premature nursing home placement. Taking into consideration the increasing demand and projected increased need for elderly programs, FPWA urges the Governor and his administration to think of creative ways to preserve funding for important support services and community-based resources for seniors. Particularly, FPWA asks the Governor and the Legislature to consider restoring funds for the following programs:

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Strongly support restoration of the full $1.9 million for vehicle operating expenses for senior service providers

The Governor's Executive Budget includes funding in the amount of $921,000, down from $1.9 million in the 2008-09 budget, for vehicle operating expenses for senior service providers. In addition to meal delivery to homebound seniors, these vehicles transport the elderly to important services and activities including senior centers, adult day services, medical appointments and food shopping. Operating expenses include costs for insurance, maintenance, and fuel. Due to the continually increasing costs for insurance and vehicle maintenance, a funding restoration is critical. FPWA requests that the amount of funding for this program be restored to $1.9 million.

Support $1 million in funding for Social Model Adult Day Services (SADS) Programs

The budget includes funding in the amount of $872,000, down from $1.2 million in the 2008-09 adopted state budget for social model adult day service programs. Due to the current and projected increased need for these programs, an allocation of $1 million is greatly needed to help meet the demand. SADS programs are designed to provide a variety of long term care services to older New Yorkers with functional impairments in a congregate setting and according to an individualized service plan. Social adult day services are a cost effective way to care for frail elders and enable them to live in their homes and communities, averting premature nursing home placement.

Restore trend factors for Certified Home Health Care Agencies (CHHA), Long Term Home Health Care programs (LTHHCP), personal care providers and nursing homes.

The Governor's Executive Budget Proposal calls for the elimination of trend factors for home care, LTHHCP, personal care program providers and nursing homes. FPWA is concerned about the impact these recommended trend factor eliminations will have on program providers and the seniors who need to access these critical services. For example, the current LTHHCP rate of reimbursement to social adult day care programs is currently far

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less than the actual cost of services. The highest rate of reimbursement to one program is $45 per day when the actual cost for a social adult day care day is at least $70. With the projected growth of the elderly in the coming years, sufficient financial resources need to be in place for the continued provision of home care and long term home health care services for the seniors. An investment in these community based services needs to be made as nursing home placement is a much more expensive option.

Rescind the proposal to increase the gross receipts tax on home care revenue from 0.35 percent to 0.70 percent.

We are concerned that the Executive Budget proposes increasing the assessment on home and personal care providers from 0.35 to 0.70 percent. This increased assessment will place financial burdens on home care providers of service who are also facing further potential funding reductions with the proposed trend factor elimination. With the projected growth of the elderly population throughout the coming years, agencies need sufficient financial resources in place to meet the future demand for service.

Support the SSI Supplemental state benefit

We are pleased the Governor has proposed passing through any federal cost-of-living adjustment (COLA) to all SSI recipients. Currently SSI recipients must survive on a benefit which is about $140 per month below the poverty level. In addition, New York State needs to institute an increase in the SSI benefit level for the elderly, disabled and visually impaired target populations and continue to ensure the federal COLA gets passed through each year to recipients.

Support restorations for an array of Community Based Programs

With the projected growth of the elderly population throughout future years, it is gratifying to see continued support for these critical initiatives, but many of the programs are still slated for reductions in the Governor's proposed Executive Budget. These programs provide

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important services to the elderly who wish to remain in the comfort of their own homes and in the community for as long as possible, averting premature institutionalization.

We request that the Governor and Legislature restore funding for the following programs as these community based options are vital, and in many instances provide more appropriate care and are less expensive than institutional care.

List of community-based programs	***Proposed in Executive Budget***	***Amount Requested***
Community Services for the Elderly Grant program	$15.3 M	$16.3 M
Naturally Occurring Retirement Communities (NORCs)	$2.02 M	$2.02 M
Neighborhood NORCs	$2.02 M	$2.02 M
Respite	$656,000	$672,000
Expanded In-Home Services for the Elderly Program (EISEP)	$46 M	$48 M
Social Model Adult Day Services	$872,000	$1 M
Caregiver Resource Centers	$353,000	$353,000
Regional Caregivers Centers for Excellence	$230,000	$230,000
COLA for EISEP, CSE, and SNAP providers	$14.7 M	$14.7 M
Supplemental Nutrition Assistance Program (SNAP)	$21.4 M	$23.4 M
Congregate Services Initiative (CSI)	Eliminated	$806,000

Thank you for the opportunity to submit this written testimony.

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Phone: (212) 777-4800 / Fax: (212) 414-1328 / www.fpwa.org

important services to the elderly who wish to remain in the comfort of their own homes and in the community for as long as possible, averting premature institutionalization.

We request that the Governor and Legislature restore funding for the following programs as these community based options are vital, and in many instances provide more appropriate care and are less expensive than institutional care.

List of community-based programs	***Proposed in Executive Budget***	***Amount Requested***
Community Services for the Elderly Grant program	$15.3 M	$16.3 M
Naturally Occurring Retirement Communities (NORCs)	$2.02 M	$2.02 M
Neighborhood NORCs	$2.02 M	$2.02 M
Respite	$656,000	$672,000
Expanded In-Home Services for the Elderly Program (EISEP)	$46 M	$48 M
Social Model Adult Day Services	$872,000	$1 M
Caregiver Resource Centers	$353,000	$353,000
Regional Caregivers Centers for Excellence	$230,000	$230,000
COLA for EISEP, CSE, and SNAP providers	$14.7 M	$14.7 M
Supplemental Nutrition Assistance Program (SNAP)	$21.4 M	$23.4 M
Congregate Services Initiative (CSI)	Eliminated	$806,000

Thank you for the opportunity to submit this written testimony.

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TESTIMONY OF

THE COALITION OF NEW YORK STATE

PUBLIC HEALTH PLANS

ON THE GOVERNOR'S PROPOSED FY 2010-2011 HEALTH AND MEDICAID BUDGETS

SUBMITTED BY MAURA BLUESTONE, CHAIR OF THE COALITION

TO THE

SENATE AND ASSEMBLY COMMITTEES ON

HEALTH, MEDICAID AND THE AGING

FEBRUARY 8, 2010

Introduction

Thank you for the opportunity to provide testimony on behalf of the Coalition of New York State Public Health Plans (PHP Coalition) regarding the Governor's proposed Medicaid and Health Budgets for the State Fiscal Year commencing April 1, 2010. My name is Maura Bluestone, and I am testifying in my role as Chair of the Coalition. Established in 1995, the Coalition of New York State Public Health Plans is an important voice for New York's non-profit, publicly-focused health plans and the low-income people we serve. Over the last decade, Coalition plans have grown to serve the majority of children and adults accessing their public insurance coverage through health plans. Coalition plans offer decades of experience in delivering high quality services to members that often experience significant barriers to health care. Our plans consistently receive high marks in quality of care and member satisfaction. The Coalition currently represents nine plans serving over 2.3 million, or over two-thirds of, children and adults enrolled in New York's Medicaid managed care, Family Health Plus, and Child Health Plus programs. All Coalition plans are sponsored by or affiliated with public and not-for-profit hospitals, community health centers and physicians.[1]

Protecting Health Coverage for New York's Medicaid Beneficiaries

The PHP Coalition recognizes the challenging fiscal and economic conditions facing New York State. With the economic downturn continuing to drain state revenues, a multi-billion dollar budget shortfall, and increasing enrollment and costs in Medicaid and other programs, the Governor and Legislature face tough choices in fashioning a budget that is equitable, affordable and sufficient to meet New York's most pressing needs. Assuring that a strong and stable healthcare safety net is in place is critical for the growing number of vulnerable individuals that

[1] A complete list of Coalition plans is included in the appendix.

rely on it. Over the past several years, our plans have been asked to do more with less. In the face of shrinking resources, we have been committed to delivering high quality health care to New York's neediest; however, we cannot continue to make Medicaid managed care work if we are stretched any further.

In 2009, few PHP Coalition plans reported small margins while some reported losses. For 2010, most plans are already projecting no margins or losses. Enrollment is growing, and inpatient and outpatient expenses are on the rise. In keeping with the Medicaid reimbursement reforms proposed by the Governor and enacted by the Legislature over the past two years, plans are driving more dollars per member to primary, preventive and outpatient care. However, plans are not realizing a decrease in inpatient expenses as had been projected with statewide reforms to Medicaid in-patient reimbursement. As a result, public health plans are under more financial pressure than ever. For this reason, our message to the Legislature and the Governor as Budget negotiations continue is simple and urgent: ***plans cannot sustain any additional increases to our expenses or cuts to our revenue and remain financially stable.*** Any action the Legislature takes to increase Medicaid fee-for-service reimbursement – specifically a restoration of the trend factor to providers – must be matched by a commensurate increase in health plan rates. The two are inextricably linked.

New York's Medicaid managed care program is arguably the most successful in the country and certainly has delivered on its promise to New York State. We are covering more low-income New Yorkers than ever, containing Medicaid costs, and delivering high quality care to increasingly complex populations. These gains cannot continue when we cut health plans to the bone year after year. The very infrastructure on which you rely to curtail Medicaid costs and

deliver access to quality health care for children, families, people with disabilities, New Yorkers who suffer from mental illness, and those with HIV/AIDS will crumble if the Legislature and Administration directly or indirectly cut health plan premiums.

Simplifying and Streamlining Access to Public Health Insurance Coverage

With Federal reform at risk, it is more important than ever that the Legislature stand firm in support of past and proposed streamlining initiatives that make quality coverage accessible for New York's low-income families and position New York as one of the models of coverage in the country. We applaud the Governor and the Legislature for continuing efforts to simplify and streamline the complicated process of enrolling in and maintaining public health insurance coverage. But many low-income New Yorkers still experience challenges in enrolling in and maintaining coverage in these programs because of bureaucratic hurdles and rules. We urge the Legislature to continue their streamlining efforts by supporting:

- *Authority for Express Lane Eligibility and other Simplifications to Promote Access to Care:* The Governor seeks authority to implement "Express Lane Eligibility," a new Federal option allowing the State to rely on eligibility information that is already verified and on record with other public benefit programs (e.g., TANF, Food Stamps and the National School Lunch Program) to help expedite children's enrollment and renewal for public insurance. Research suggests that significant numbers of low-income children could be connected to health coverage through this policy. Across the nation, 96 percent of children receiving free lunches have incomes that qualify them for Medicaid or Children's Health Insurance Program coverage under current program rules. More than 70 percent of uninsured, low-income children live in families who participate in Food

Stamps, the National School Lunch Program, or the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) – programs that require eligibility data that could easily be used to enroll these same children in public health insurance coverage.[2] The Governor also proposes other simplifications for low-income children and families that would allow for verification of information required for public insurance coverage through available State and Federal systems, and attestation to modest interest income amounts.

- *Simplifying Access to Transitional Medicaid Coverage*: Through new options authorized under the Federal American Recovery and Reinvestment Act, the Governor proposes to simplify eligibility requirements for transitional medical assistance, time-limited Medicaid coverage available to low-income families transitioning from welfare to work (and who would otherwise become ineligible for Medicaid coverage). This proposal helps to promote access to health coverage for working families who are just getting on their feet.

The Governor also proposes to modify the co-payments for the Family Health Plus Employer Buy-In, which is a positive first step toward making the program more accessible to employers and their employees. The PHP Coalition looks forward to working with the Legislature and the Governor to enact additional reforms so that more New Yorkers will have access to this coverage option.

Promoting a Healthy Lifestyle for All New Yorkers

Health plans that serve the Medicaid, Family Health Plus, and Child Health Plus programs not only reduce costs to the State by coordinating the care of our enrollees, but we provide access to high quality services and encourage healthy lifestyles. In order to provide

[2] Dorn, Stan. "Express Lane Eligibility and Beyond: How Automated Enrollment Can Help Eligible Children Receive Medicaid and CHIP." *A Joint Report Issued by The Urban Institute, the National Academy for State Health Policy, and The Robert Wood Johnson Foundation*, April 2009.

these services, plans and providers must be adequately reimbursed. The Governor's proposals to implement taxes on sugary drinks and cigarettes generate essential revenues dedicated to our health care system allowing plans and our provider partners to continue providing critical services to New York's most vulnerable residents. At the same time, these taxes are tools to promote important public health goals of reducing obesity and smoking-related illnesses in our state.

- *Implementing a Tax on Beverage Syrups and Soft Drinks.* Currently, one in four New Yorkers is considered obese while an astonishing 35 percent are overweight. A recent study published in the *New England Journal of Medicine* showed that a one cent tax per ounce of soda and other sugary drinks could stem the United States' obesity epidemic.[3] Other studies continue to link consumption of beverages sweetened with sucrose (regular sugar), high-fructose corn syrup or fruit-juice concentrates to obesity, diabetes and heart disease, not to mention dental decay. The Governor proposes a new one penny per ounce excise tax on sugared beverages and soft drinks that is expected to raise $450 million in FY 2010-11 and $970 million in subsequent fiscal years. Implementation of a tax would also help deter people from buying non-nutritious sweet drinks, thereby helping New Yorkers lose weight and reduce their health risks.
- *Increasing the Tax on Cigarettes.* The Governor also proposes a $1 per pack increase in taxes on cigarettes which brings the tax to $3.75 per pack. This proposal is expected to raise $200 million in the upcoming fiscal year. Similar to the soda tax, an increase in the tax on cigarettes will have a direct impact on the consumption on

[3] Brownell, K.D., et al. The public health and economic benefits of taxing sugar-sweetened beverages. *New England Journal of Medicine*. 2009 Oct 15;361(16):1599-605.

cigarettes. Studies show that when states implement a tax, demand for cigarettes decline. Other studies show smoking declines prompted by a cigarette tax increase will likely reduce a state's public and private smoking-related costs and improve public health.

Conclusion

Thank you for the opportunity to provide testimony on these critical issues. The Coalition and its members look forward to continuing our work with the Senate, Assembly, and the Governor to improve the quality and accessibility of the State's public health insurance programs.

MEMBERS OF THE COALITION OF NEW YORK STATE PUBLIC HEALTH PLANS

HEALTH PLAN	AFFILIATED ORGANIZATIONS	SERVICE AREA
Affinity Health Plan	*Primary care provider organizations with representation on the Board of Directors:* Morris Heights Health Center, Charles B. Wang Health Center, Urban Health Plan, Brownsville Multi-Service Center, Community Health Care Network	New York City and Nassau, Orange, Suffolk, Rockland and Westchester Counties
Fidelis Care New York (The New York State Catholic Health Plan)	Diocesan Bishops of the State and Ecclesiastical Province of New York and Catholic healthcare providers	New York City and 45 other counties[1]
Healthfirst PHSP	Hospitals in all counties in which the plan operates[2]	New York City and Nassau and Suffolk Counties
Health Plus PHSP	Lutheran Medical Center	New York City and Nassau County
Hudson Health Plan	Open Door Family Medical Centers, Hudson River Community Health	Dutchess, Orange, Rockland, Sullivan, Ulster and Westchester Counties
MetroPlus Health Plan	New York City Health and Hospitals Corporation	Bronx, Kings, New York and Queens Counties
The Monroe Plan for Medical Care[3]	The Monroe Plan for Medical Care is an independent, not-for-profit managed care organization that has a contract with Excellus BlueCross BlueShield to manage their Medicaid, Family Health Plus, andChild Health Plus products	Broome, Chemung, Chenango, Livingston, Monroe, Ontario, Orleans, Schuyler, Seneca, Steuben, Tioga, Wayne, and Yates Counties
Neighborhood Health Providers	Brookdale Hospital and Medical Center, Jamaica Hospital Medical Center	New York City and Suffolk County
Total Care (Syracuse PHSP)	Syracuse Community Health Center	Cortland, Onondaga, Oswego, and Tompkins Counties

[1] New York City and Albany, Broome, Cattaraugus, Cayuga, Chautauqua, Chenango, Clinton, Columbia, Cortland, Delaware, Dutchess, Erie, Essex, Franklin, Fulton, Genesee, Greene, Hamilton, Herkimer, Livingston, Madison, Monroe, Montgomery, Nassau, Niagara, Oneida, Onondaga, Orange, Orleans, Ostego, Oswego, Putnam, Rensselaer, Rockland, Saratoga, Schenectady, Schoharie, Suffolk, Sullivan, Tompkins, Ulster, Warren, Washington, Wayne, and Westchester Counties.

[2] Beth Israel Medical Center, Bronx-Lebanon Hospital Center, Brooklyn Hospital Center, Elmhurst Hospital Center, Interfaith Medical Center, Jamaica Hospital Medical Center, Kingsbrook Jewish Medical Center, Lenox Hill Hospital, Long Island Jewish Medical Center, Maimonides Medical Center, Montefiore Medical Center, Mount

Sinai Hospital, Nassau University Medical Center, New York City Health and Hospitals Corporation, New York Downtown Hospital, North Shore University Hospital, NYU Langone Medical Center, Staten Island University Hospital, St. Barnabas Hospital, St. John's Episcopal Hospital, St. Luke's-Roosevelt Hospital Center, Stony Brook University Hospital, SUNY Downstate Medical Center

[3] The Monroe Plan is an independent not-for-profit managed care organization that has an exclusive contract with Excellus Blue Cross Blue Shield, Rochester division of Lifetime Health Care, Inc. to manage Blue Choice Option, HMOBlue Option, Child Health Plus and Family Health Plus.

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NEW YORK STATE CONSUMER COALITION ON PART D

Don't End Safety Net "Wrap-around" Coverage in the EPIC and Medicaid Programs for Drugs Not Covered by Medicare Part D Plans

The Governor proposes cutting back on the safety net "wrap around" drug coverage currently offered by both Medicaid and EPIC, when elderly and disabled beneficiaries are unable to access medically necessary drugs through their Medicare Part D plans. Both of these wrap around programs, now much smaller in scale than they were during the initial roll-out of Medicare Part D in 2006, continue to provide critical protection for the most vulnerable of the medically needy and should not be eliminated.

Part D plans continue to deny medically necessary prescription drugs that they should be covering, and consumers cannot navigate the complex appeal system alone.

- ✓ **Just one year ago, CMS sanctioned two national Part D plans (both operating in NYS), for recurrent, pervasive contract violations.** According to the *Wall Street Journal*, thousands of seniors enrolled in one of the sanctioned plans "found they couldn't fill or renew prescriptions for drugs to treat chronic heart failure, seizures, asthma and other medications," because of systemic computer problems which the plan failed to address.[i] The other sanctioned plan, Wellcare, improperly denied prescription drug access to hundreds, if not thousands, of beneficiaries during January 2009, according to CMS. 800 of the 2500 complaints CMS received involved "immediate need" cases – people out of their medications. Wellcare was also cited for substantial violations in their processing of Part D-related appeals.

  While CMS did eventually intervene and issue formal sanctions, preventing the plans from enrolling any new members until the violations were corrected, substantial harm had already occurred. Here in New York, Medicaid and EPIC provided a prescription safety net to Wellcare and Wellpoint enrollees caught in this mess.

- ✓ The reversal rate of Part D plan denials shows that **plans frequently deny medically necessary prescriptions that should have been approved in the first place.** Maximus, the Part D Independent Review Entity, reversed the plans' decisions in 53% of the cases that reach the reconsideration appeal stage (the third level of appeal), and in 59% of the cases involving a plan's utilization management requirements. Off-formulary exception requests are granted by Maximus 48% of the time.[ii] **This means that plans are improperly denying coverage more than half the time** for cases reaching the reconsideration appeal stage. EPIC's own success rate at winning first level appeals is more illuminating still. Out of more than 2,500 appeals filed since the program's inception in October 2008, EPIC has won 1,900 of them, or fully 75%.[iii]

The Elderly Pharmaceutical Insurance Coverage (EPIC) Wrap-Around

State law wisely prevents Medicare Part D plans from shifting costs to the State when EPIC pays for a Part D drug through the "wrap." The Legislature wisely authorized EPIC to file appeals of denials by Part D plans on behalf of EPIC enrollees. Since the Part D Maximization Project began in October 2008, EPIC has successfully pursued over 1,900 "first level" appeals. and it has recovered $7,300,000 for the State in winning more than 65% of the appeals filed against Part D plans (note 3). The State should add resources for EPIC to pursue appeals beyond the initial level, and recover funds expended when Part D plans incorrectly refuse to cover drugs. EPIC should also be expanded to cover people with disabilities under age 65, especially those in the 2-year waiting period for Medicare.

The Governor has justified ending the EPIC wrap under the rationale that EPIC is covering drugs when "clinically effective, lower cost alternatives" are typically on a plan's Part D formulary. However, EPIC only provides wrap coverage after the Part D plan has denied coverage and the person's physician has deemed the drug to be medically necessary.

The Medicaid Wrap-Around

The Executive budget proposes to eliminate the limited wrap-around benefit for Medicaid beneficiaries who also have Medicare Part D. New York currently provides Medicaid wrap-around coverage for only four classes of vital medications:

- ✓ atypical anti-psychotics for treatment of psychiatric conditions like schizophrenia, acute mania and psychotic agitation,
- ✓ anti-depressants,
- ✓ anti-retrovirals for the treatment of HIV/AIDS, and
- ✓ anti-rejection medications for recipients of organ and tissue transplants)

DOH has indicated that the Medicaid wrap affects very few beneficiaries (1% or less). To ensure that Part D plans are held accountable, and to minimize the State's costs, the State should make necessary systems changes to ensure that Medicaid is the payer of last resort. These changes would allow the Medicaid program to track Part D plan denials and establish the reasons for them. It would also ensure that Medicaid, as is the procedure with all other third-party payers including Medicare Parts A & B, must be billed only *after* the third-party payer denies payment. In addition, the Medicaid program should act on beneficiaries' behalf in the same manner as the EPIC program and recover the costs to the program by appealing incorrect denials by Part D plans. Even if relatively few beneficiaries need to utilize the Medicaid wrap, the potential harm to those beneficiaries is too great if we remove the wrap altogether.

NEW YORK STATE CONSUMER COALITION ON PART D

Steering Committee

- Center for Independence of the Disabled of New York (CIDNY)
- Empire Justice Center
- Legal Aid Society, NYC
- Medicare Rights Center
- New York Legal Assistance Group
- Selfhelp Community Services, Inc

On behalf of Coalition members

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David Silva, Selfhelp Community Services, Inc, dsilva@selfhelp.net 212.971.7695

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[i] "Wellpoint penalized for botching drug benefits," *Wall Street Journal*, January 14, 2009.

[ii] "Fact Sheet: Part D Reconsideration Appeals Data – 2007." (Most recent data available from 2007) Avalable at: http://www.cms.hhs.gov/MedPrescriptDrugApplGriev/07_Reconsiderations.asp

[iii] Report by Mike Brennan, NYS Dep't of Health, to the Medicare Savings Coalition, December 3, 2009.

STATEMENT OF THE
AD HOC STATEWIDE COALITION OPPOSING
CAP ON MEDICAID PERSONAL CARE and
CONSUMER DIRECTED PERSONAL ASSISTANCE PROGRAM (CDPAP) SERVICES

ADAPT - NYS
Alzheimer's Association, New York City Chapter
Alzheimer's and Aging Resource Center of Brooklyn
Bronx Independent Living Services
Brooklyn Center for Independence of the Disabled
Catskill Center for Independence *serving Delaware, Otsego, Schoharie, and Chenango Counties*
Center for Disability Rights, *Rochester*
Center for Independence of the Disabled in New York (CIDNY)
Cerebral Palsy Associations of NYS
Cerebral Palsy of the North Country - *St. Lawrence, Franklin, & Jefferson Counties*
The Children's Aid Society
CLC Foundation, Inc., Trustee For The CLC Pooled Trusts I&II
Consumer Directed Choices, Inc.
Consumer Directed Personal Assistance Association of New York State, Inc
Disability Advocates, Inc. (*serving Albany, Clinton, Columbia, Dutchess, Essex, Franklin, Fulton, Greene, Hamilton, Montgomery, Rensselaer, Saratoga, Schenectady, Schoharie, St. Lawrence, Ulster, Warren and Washington counties*)
Disabled in Action of Greater Syracuse Inc.
DOROT, Inc.
Empire Justice Center (*all NYS outside of NYC*)
Enable, *Syracuse*
F.E.G.S Health and Human Services System
Options/CDPAS, Newburgh -- *Dutchess, Orange, Sullivan & Ulster Counties*
JASA/Queens Legal Services for the Elderly
The Legal Aid Society, New York City
Legal Services for the Elderly and Disabled, *Buffalo*
Lenox Hill Neighborhood House
Main Street Legal Services, Inc., CUNY School of Law
Medicaid Matters NY
Metropolitan Council on Jewish Poverty
MFY Legal Services, Inc.
Morningside Retirement and Health Services (MRHS)
National Center for Law and Economic Justice
New Yorkers for Accessible Health Coverage
New York Legal Assistance Group, New York City
Regional Center for Independent Living, *Rochester*
Resource Center for Independent Living, *Utica*
Self-Advocacy Association of New York State, Inc.
Selfhelp Community Services, Inc.
United Jewish Organization of Williamsburg
United Spinal Association
UJA-Federation New York
Westchester Disabled on the Move, Inc.
Westchester Jewish Community Services

Individuals:
Leslie Salzman & Toby Golick, Cardozo Bet Tzedek Legal Services (for identification purposes only)
Nina Keilin, Esq.

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Chris Hilderbrandt, childerbrant@rochestercdr.org 585.546.7510

REJECT 12-HOUR CAP ON PERSONAL CARE & CDPAP

Governor Paterson's 2010-11 Executive Budget will undermine the successful Consumer-Directed Personal Assistance Program (CDPAP), which has saved money for the State and is just now reaching more people upstate, relieving a dire staffing shortage. The proposal will require seniors and people with disabilities who need more than 12 hours of Medicaid personal care or CDPAP per day to switch to a costlier, less available home care program. The alternate programs cannot serve these 4,980 people, who -- due to quadriplegia, Parkinson's, stroke, multiple sclerosis, Alzheimer's disease, and other severe impairments -- have the most extensive disabilities of the 80,000 people receiving personal care or CDPAP services. Data show that in areas of the state where personal care is less available, use of nursing homes increases greatly. The cap will reduce access to home care for the most disabled, and increase placement in nursing homes.

1. Give last year's Long Term Care Assessment Centers a chance. DOH is working hard to begin implementation of the pilot program under which private contractors will take over the county's home care assessment role in Brooklyn, Ulster and Orange counties. That pilot will explore any concerns about counties authorizing services that may be unnecessary. Give that a chance to work before slashing vital home care services to 5000 needy people.

2. Reject the harshest cuts slated for the Consumer Directed Personal Assistance Program (CDPAP), which saves money by replacing costly nurses with lower paid aides. The biggest growth in this program has been upstate and in rural counties, where it serves as a vital safety valve because of the severe aide and nursing shortage.

3. The alternative programs cannot meet the needs of vulnerable seniors and people with disabilities who need 24-hour personal care or CDPAP services.

- **Certified home health agencies (CHHAs)** primarily provide post-acute short-term rehabilitation care, and will not serve individuals who lack skilled needs.

- The **long term home health care or Lombardi program (LTHHCP)**, and **Managed long term care programs (MLTC),** have funding mechanisms that limit the number of hours available. Frail elderly or disabled individuals "cap out" of these programs as their needs grow, and they transfer to personal care or CDPAP. **LTHHCP** has a hard individual cost cap which generally limits care to 8 hours per day. **MLTC** plans receive a capitation rate, which, even if increased, will not be sufficient to absorb the cost of 5000 high-need individuals. MLTC plans will become insolvent, and frail people will not receive services.

- The **nursing home transition and diversion waiver (NHTD)** has been riddled with implementation problems such that only 23 people are enrolled in NYC in its third year of implementation. The waiver has only 5000 slots - badly needed by 22,000 people eager to leave nursing homes. An influx of high-hour individuals threatens the aggregate cost cap in this waiver.

4. The cuts will cause unnecessary nursing home placement of people who can and do live in the community, violating *Olmstead* and the Americans with Disabilities Act.

THE FACES OF PEOPLE WHO NEED 24-HOUR CARE

Chris Layo, age 25, lives in Norfolk, near Massena, in St. Lawrence County. He has had 24 hour (three 8-hour shifts) of CDPAP care for 6 years because of Duchenne muscular dystrophy, which affects 1 in 3,000 males. The disease has slowly progressed since age 3 to confine him now to a power wheelchair. Other than using a mouse on his voice-activated computer, he needs a person for everything - to feed him, use a hoyer lift to lift him in and out of his wheelchair, administer medications, etc. At night, his aide must assist with his ventilator, turn and position him, etc. He has lived independently for six years -- with his excellent care, he has avoided pressure sores to which he is extremely vulnerable. He likes the autonomy he has with hiring and training his own CDPAP aides, and the fact that his aides, not wearing uniforms, blend in when they assist him at SUNY Pottsdam, where he is pursuing a double major in communications and creative writing. The Medicaid 2009 rate for his CDPAP provider is only $15.50/hour, to be cut to just over $12 per hour in 2010. Compare the Medicaid private duty nursing rate for LPNs - 2006 rate was $24.72/hour.

Mrs. G, age 80, has advanced Parkinson's disease and lives alone in senior housing in Queens. It is unsafe for her to attempt ambulation unassisted, even with a walker and wheelchair. Before split-shift (two 12-hour shifts) personal care services were approved in April, 2009, she fell several times. Once while moving from her bed to the bathroom, she fell and hit her eye on the doorknob, leaving a bruise. Another time, she was moving from her walker to the wheelchair, fell, and scraped herself on the arm of the chair. The aide helps her out of bed to use the commode when she wakes up 3 - 5 times a night, often in an agitated state because of a sleep disorder related to Parkinson's. She tries to get up and walk on her own at night, which is unsafe, so the home attendant must be awake and vigilant. Her doctor prescribed sleep medications to decrease her need for assistance at night. Seroquel made her even more lethargic and exacerbated her difficulty moving around from Parkinson's. Ambien caused agitation and made her sleep all day. Her conditions are degenerative, but stable. An on-site social worker in her apartment building, a daughter living nearby, and her physician, manage her care. More case management will not reduce her need for round-the-clock care.

Mrs. R, an 86-year-old Panamanian widow living in the Flatbush area of Brooklyn, is at risk of falls and fracture from severe rheumatoid arthritis, especially in her knees, causing an unsteady gait and poor balance. When she gets up from a chair or her bed, she must rock back and forth a few times to gain momentum, and can easily lose her balance, even with a cane. She suffers from dementia, which, along with poor vision, compounds the risks of falling because she tries to walk unassisted frequently day and night. Before she received 24-hour (2 x 12) home care, she fell several times. A social worker and her son, together with her doctor, manage her care from the personal care program. Additional care management will not reduce her need for 24-hour care.

MORE ON WHY THE PERSONAL CARE/CDPAP CAN SHOULD BE REJECTED

Governor Paterson's 2010-11 Executive Budget would require seniors and people with disabilities who need more than 12 hours of Medicaid personal care or Consumer-Directed Personal Assistance Program (CDPAP) aide services per day, on average, to switch to a different home care program.[1] The alternate programs may be appealing on paper but cannot serve these 4,980 people, who -- due to quadriplegia, Parkinson's, stroke, multiple sclerosis, Alzheimer's disease, and other severe impairments -- have the most extensive disabilities of the 80,000 people now receiving personal care or CDPAP services.

1. Give last year's Long Term Care Assessment Centers a chance. Last year's state budget law authorized a pilot program that will establish Long Term Care Assessment Centers. In Brooklyn, Ulster and Orange counties, a yet unnamed private contractor will take over the local district function of authorizing personal care, CDPAP and other home care services.[2] The law mandated the new centers to begin operations for new applicants after January 1, 2010, but that implementation has been delayed while the Department extended its deadline to respond to its Request for Proposals beyond October 15, 2009.[3] We acknowledge a concern about whether improper or unnecessary services are being authorized in New York City or anywhere else. These new Assessment Centers -- along with appropriate investigation by OMIG and other investigative entities -- will reveal any such patterns. These processes should be given a chance before cutting hours of service across the board, harming thousands of vulnerable people.

2. Consumer Directed Personal Assistance Program (CDPAP) Saves Money. At least 20 percent of the 4,986 people affected by the cap are in the CDPAP program, which just last year the Legislature wisely expanded. SSL 365-f(2). CDPAP saves because Medicaid pays the low hourly personal care rate to an aide, who is specially authorized by the Nurse Practice Act[4] to perform tasks that would otherwise would require a nurse at much higher cost. Thousands of individuals with quadriplegia and other impairments live independently at home with the help of a CDPAP aide, who can suction tracheostomies, manage ventilators, administer insulin, etc. Moreover, the CDPAP agency rates are lower than other personal care agencies, since the consumer or his or her family does scheduling, training, and supervision of aides.

- **CDPAP is a safety valve in rural counties and upstate, where the aide and nursing shortage is critical.** In 2008, 75% of all CDPAP consumers lived outside of New York City. Out of all personal care cases outside of New

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[1] DOH has stated that people receiving 24-hour "live-in" services will not be affected by this proposal, since Medicaid pays for only 12 hours of service for this schedule. This should be clarified.

[2] N. Y. Soc. Serv. L. 367-w(5).

[3] The Request for Proposals and a Question & Answer document are posted at http://www.health.state.ny.us/funding/rfp/0907070849/.

[4] Public Health L. § 3622, subd. 10, Education Law § 6908, subd. 1(iii); NYS DOH GIS 08 LTC-005 (9/9/08), amending DOH 06 OMM/LCM-1 (Q & A on CDPAP).

York City, 30% receive care through CDPAP, compared to only 11 percent in NYC.[5]

- **Despite the critical role played by CDPAP, the proposed restriction on CDPAP is harsher than on traditional personal care.** Because of the word "such" in section 13-a of the Article VII bill, a CDPAP consumer who needs more than 12 hours of aide services must switch *from* CDPAP altogether to a certified home health agency, a long term home health care program, or an AIDS home care program. None of these alternate programs offer an option to provide consumer-directed services, thus cutting access to this cost-saving program. In contrast, those receiving traditional personal care may keep more than 12 hours per day if they receive any services from a CHHA, such as a visiting nurse. This disparity makes no sense.

3. The alternative programs cannot meet the needs of vulnerable seniors and people with disabilities who need 24-hour personal care or CDPAP services. The proposal wrongly assumes that with extra care management, the functional needs for extensive daily assistance will be reduced. Even with the best medical and nursing care management, a relatively small number --just 6 percent -- of people needing personal care have such extensive functional limitations that they need help night and day -- to go to the bathroom, to change an adult diaper, to turn over in bed, to drink or eat. Without this help, they will get pressure sores, they will fall and sustain fractures, or will simply have to be institutionalized. These alternatives will cost more money -- or won't work:

- Many **certified home health agencies (CHHAs)**, designed for short-term acute post-rehabilitation care, will not accept patients who lack any "skilled nursing" need, who need only assistance with the Activities of Daily Living (ADL) such as mobility and toileting. At a minimum, if the proposal were to go forward, NY Social Services Law 365-a(2)(d) must be amended to clarify that a "skilled" need is not a prerequisite for Medicaid payment for CHHA services.[6] Nursing visits are among the most costly rates in home care, and, with no skilled need, Medicare will not pay for these visits, leaving Medicaid to foot the bill. The proposed episodic payment methodology will deter CHHAs from serving high-need consumers.

- The **long term home health care program (LTHHCP)**, also known as the **Lombardi** program, and **Managed long term care programs (MLTC)**, have funding

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[5] NYS Dep't of Health, *Interim Report - Home Health Care Reimbursement Workgroup*, Appendix B, Table 2, 2-A (December 2009) Source: NYS DOH OHIP Datamart (based on claims paid thru 10/2009) (http://www.nyhealth.gov/facilities/long_term_care/reimbursement/docs/hcrw_interim_report.pdf) (data extrapolated from tables; for calculations contact vbogart@selfhelp.net)

[6] In a recent letter concerning the Missouri Medicaid program, CMS stated, "...[Y]ou indicate that Missouri is requiring participants to be... receiving skilled nursing or therapy service in order to receive Medicaid home health services. We agree that these are not requirements included under [federal] Medicaid regulations...." Letter from Cindy Mann, Director, CMS Center for Medicaid & State Operations to Joel Ferber, Legal Services of Eastern Missouri (Nov. 4, 2009) (on file with Selfhelp Community Services, Inc.; *see also* Gene Coffey, *To be or not to be Homebound: The Limits of States' Discretion in Medicaid's Coverage for Home Health Services,* National Senior Citizens Law Center, December 2009, <http://tinyurl.com/MedicaidCHHA-NSCLC>

mechanisms that in different ways limit the number of hours available. Frail elderly or disabled individuals "cap out" of these programs as their needs grow, and they transfer to personal care or CDPAP. Thus the rapid growth in MLTC enrollment since 2003 (143.8% increase from 2003 to 29,967 persons statewide in 2008)[7] explains the increase in hours authorized for personal care recipients, despite the decreased enrollment in personal care,[8] since they transfer from MLTC to personal care to get more hours. The same is true with LTHHCP.

- ✓ **LTHHCP,** while beneficial for thousands of seniors and people with disabilities, cannot meet the needs of those who need more than 8 hours of aide service per day because of the *individual cost cap* that applies to this home and community-based waiver program. No CDPAP services are available.

- ✓ **Managed long term care programs (MLTC)** are financed by capitated payments to managed care organizations, unlike personal care and CDPAP which are paid on a fee-for-service basis for hours approved by the local district. Advocates have observed that the capitated payment creates an inherent conflict between providing necessary quality care and worrying about the bottom line. This conflict creates an incentive for MLTC plans to avoid enrolling individuals with greater medical needs and to deny expensive services though they are needed. At least one MLTC provider has indicated that an influx of high-hour consumers will threaten their financial solvency under their capitation rates. While the proposal would increase these capitation rates, the increase is not likely to be sufficient to accommodate 5000 new high-hour consumers, and the incentive to deny high hours of care remains.

- **The nursing home transition and diversion waiver** has had tremendous barriers in implementation, with *only 23 people enrolled* in New York City in its third year of implementation. Problems include bureaucratic delays and extensive barriers to enrolling providers for each of the 17 services encompassed by the waiver, duplicative approval systems for provider and consumer enrollment at the local and state level, lack of standardized training programs and procedures, and redundant and cumbersome paperwork.

  - There is a cap of only 5,000 people in the NHTD waiver as currently approved by CMS, so even if the bureaucratic barriers suddenly lifted, it could not absorb everyone who would likely be moved out of personal care and CDPAP by the current budget proposal.

  - Taking up the limited slots with people already living in the community with home care would prevent some of the estimated 22,000 people now hoping to be discharged *from* nursing homes to enroll in the waiver.

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[7] NYS Dep't of Health , *Interim Report - Home Health Care Reimbursement Workgroup, supra, n 4* at Appendix 1 Table 2. Note that though these figures are statewide, 89% of MLTC recipients are in New York City, which explains increase in higher-hour personal care cases in New York City.

[8] 2010-11 Executive Budget Briefing Book, http://publications.budget.state.ny.us/eBudget1011/fy1011littlebook/HealthCare.html "From 2003 through 2007, personal care spending increased by 27 percent, while the number of people served declined by 6.3 percent."

- An influx of so many high-need individuals would exceed the aggregate cost cap required by federal law. The Governor's proposal to supplement the waiver with state funds negates cost savings, and may not be approved by CMS.

- The **AIDS Home Care program** will be accessible only to those few individuals who have an HIV/AIDS diagnosis.

4. Potential Violations of the Americans with Disabilities Act -- The proposal may *appear* to require a benign, innocuous change in home care administration from one program to another. In reality, the alternative programs are not designed to serve people with extensive 24-hour needs, and will not or cannot provide sufficient hours of service to this small but extremely vulnerable population. As a result, the shift will inevitably result in placement in nursing homes in violation of the U.S. Supreme Court's 1999 *Olmstead* ruling, which holds that the *Americans with Disabilities Act* (ADA) requires that services be offered in "the most integrating setting" appropriate to a person's needs.

A 12-hour cap will reduce access to Medicaid home care, which is known to increase nursing home placement -- as shown by the higher nursing home use outside of New York City, since home care is less available.

- In New York City, only **8.4%** of all Disabled, Aged, and Blind Medicaid recipients **are in nursing homes** in an average month, while 10.8% receive personal care or CDPAP. *24.1 % of all Medicaid dollars spent for this population in NYC was spent on nursing home care.* (See references on following page)

- Outside of New York City, **14.7%** of all Disabled, Aged, and Blind Medicaid recipients **are in nursing homes** in an average month, while only 4.6% receive personal care or CDPAP. *32.3 % of all Medicaid dollars spent for this population outside of NYC was spent on nursing home care.*

The proposed 12-hour cap resembles the "fiscal assessment" laws enacted in the early 1990's, which were challenged in *Sanon v. Wing*.[9] The New York State Supreme Court remanded the case to the State to:

> "... address the requirements of the Americans with Disabilities Act .... Unless [the State] can demonstrate that accommodating Medicaid recipients who otherwise qualify for 24-hour home care would result in a fundamental alteration in the Medicaid program, [the State] must provide services in 'the most integrated setting appropriate to the needs of' petitioners. 28 CFR 35.130(d)."

Because the "fiscal assessment" law expired under a sunset clause, the State never conducted this ADA analysis. The 12-hour cap will revive these same ADA claims for people with extensive needs.

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[9] 2000 N.Y. Misc. LEXIS 139, Index No. 403296/98 and 402855/98 (Sup. Ct. N. Y. Co., Moskowitz, J.) (N.Y.L.J. Mar. 3, 2000 p. 27 col. 2)

Medicaid Expenditures & Average No. Beneficiaries per Month for Long Term Care Services in NYS CY 2008

	SERVICE CATEGORY	EXPENDITURES			Average Monthly Medicaid Beneficiaries		
		TOTAL MEDICAID EXPENDITURES	Expenditures for Disabled, Aged, Blind (DAB)[1]	% of DAB Expenditures spent on this service	All beneficiaries NYS	Disabled, Aged, Blind Ben'ies	% DAB Benie's receiving this service
New York State	GRAND TOTAL	38,245,731,355	24,692,116,330		3,454,266	814,723	
	SKILLED NURSING FACILITY	6,756,281,795	6,636,423,176	26.9%	89,957	88,967	11%
	ICF DD	570,057,174	552,857,445	2.4%	3,633	3,586	0.4%
	PERSONAL CARE	2,519,380,027	2,484,651,648	8.8%	73,118	72,156	8.9%
	HOME HEALTH SERVICES	1,433,601,260	1,391,061,812	5.0%	79,093	73,208	9.0%
	WAIVERED SERVICES	3,176,254,279	3,132,724,718	13.3%	56,990	55,811	6.9%
	ASSISTED LIVING PROGRAM	79,865,592	79,841,740	0.3%	2,735	2,754	0.34%
New York City	GRAND TOTAL	24,511,379,233	14,953,986,731		2,367,857	488,602	
	SKILLED NURSING FACILITY	3,580,759,022	3,493,974,258	24.1%	41,673	40,892	8.4%
	ICF DD	263,320,410	249,230,999	1.8%	1,670	1,625	0.3%
	PERSONAL CARE	2,041,613,064	2,016,073,598	11.7%	53,433	52,724	10.8%
	HOME HEALTH SERVICES	1,242,937,837	1,207,971,030	7.3%	53,282	51,429	10.5%
	WAIVERED SERVICES	912,434,014	894,890,921	6.5%	19,598	19,051	3.9%
	ASSISTED LIVING PROGRAM	43,432,904	43,416,833	0.2%	1,327	1,332	0.27%
Rest of State	GRAND TOTAL	13,734,352,122	9,738,129,599		1,086,409	326,121	
	SKILLED NURSING FACILITY	3,175,522,773	3,142,448,918	32.3%	48,285	48,075	14.7%
	ICF DD	306,736,764	303,626,446	3.2%	1,964	1,961	0.6%
	PERSONAL CARE	477,766,964	468,578,049	4.6%	19,684	19,432	6.0%
	HOME HEALTH SERVICES	190,663,423	183,090,782	1.8%	25,811	21,779	6.7%
	WAIVERED SERVICES	2,263,820,265	2,237,833,797	23.2%	37,392	36,760	11.3%
	ASSISTED LIVING PROGRAM	36,432,688	36,424,907	0.3%	1,408	1,422	0.44%

Data from Medicaid Quarterly Reports of Beneficiaries, Expenditures, and Units of Service by Category of Service by Aid Category by Region, at http://www.health.state.ny.us/nysdoh/medstat/quarterly/aid/quarterly.htm. CY 2008 data from http://www.health.state.ny.us/nysdoh/medstat/quarterly/aid/2008/cy/docs/2008_cy_aid.xls

Valerie Bogart, Selfhelp Community Services, Inc., vbogart @selfhelp.net . For **AD HOC STATEWIDE COALITION OPPOSING CAP ON PERSONAL CARE and CONSUMER DIRECTED PERSONAL ASSISTANCE PROGRAM (CDPAP) SERVICES**

[1] Disabled, Aged, Blind (DAB) figures for Expenditures and Average monthly Medicaid beneficiaries represent the total of four categories of beneficiaries from the online DOH Excel document: above (1) SSI Aged, (2) SSI Disabled, (3) Medicaid Only Aged, (4) Medicaid Only Disabled

Greater use of PERSONAL CARE in NYC must be looked at in the context of all Long Term Care services. Limiting home care services causes increased placement in nursing homes.

1. Of the 326,121 Disabled, Aged, and Blind Medicaid recipients living **outside of NYC**--
   - 14.7 percent are in nursing homes,
   - 6.0 percent receive personal care, including Consumer-Directed Personal Assistance (CDPAP)
   - 6.7 percent receive home health care on an average monthly basis

2. Of the $9.7 billion spent on Medicaid for Disabled, Aged, and Blind Medicaid recipients living **outside NYC -**
   - 32.3 percent was spent on nursing home care,
   - 4.6 percent was spent on personal care, including CDPAP,
   - 1.8 percent was spent on home health care

3. Of the 488,602 Disabled, Aged, and Blind Medicaid recipients living **in NYC** --
   - 8.4 percent are in nursing homes,
   - 10.8 percent receive personal care, including Consumer-Directed Personal Assistance (CDPAP)
   - 10.5 percent receive home health care on an average monthly basis

4. Of the $14.9 billion spent on Medicaid for Disabled, Aged, and Blind Medicaid recipients living **in NYC --**
   - 24.1 percent was spent on nursing home care,
   - 11.7 percent was spent on personal care, including CDPAP,
   - 7.3 percent was spent on home health care

5. 50% more Disabled, blind, and aged people living in NYC receive Medicaid than the rest of the state.
   - That 50% more Medicaid Dollars are spent on Long Term Care in NYC than in the rest of the State is consistent with its higher Medicaid population of disabled, blind and aged.
   - **That NYC spends more of its LTC dollars on home care rather than nursing home care should be encouraged, not punished. Medicaid dollars ARE spent upstate - but in nursing homes, not at home.**

6. **CDPAP growth has been critical for Upstate to catch up in offering home care as an alternative.** From CY 03 to CY 08, Medicaid expenditures for CDPAP Upstate grew 117.6%, and for non-CDPAP only 5.9%. Number of CDPAP enrollees grew upstate 68% in same period, while non-CDPAP personal care *decreased* 11.4%.[1] A cap on CDPAP hours will cut off access to CDPAP, and to care in the community outside of a nursing home.

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[1] NYS Dep't of Health , *Interim Report - Home Health Care Reimbursement Workgroup*, Appendix B (December 2009) Source: NYS DOH OHIP Datamart http://www.nyhealth.gov/facilities/long_term_care/reimbursement/docs/hcrw_interim_report.pdf

MICHAEL J. DI SCIPIO
86 JONES DRIVE
SCHENECTADY, NY 12309

To: New York State Senate Finance Committee Members
and
New York State Assembly Ways and Means Committee Members

Good afternoon Senators and Assembly persons, my name is Michael Di Scipio and I am a former Albany County Sheriff's Department Corrections Officer currently residing in the Town of Colonie.

I want to thank you for giving me the opportunity to speak before you today about Governor Paterson's executive budget 2010-2011 which proposes to terminate the Spinal Cord Injury Research Board and phase out the Spinal Cord Injury Research Program.

On July 3, 1999, I had a tragic diving accident leaving me paralyzed from the chest down. Since, my life has drastically changed as well as my children's, my loved ones, and my communities. Each and every day is a struggle where I need twenty-four hour care, seven days a week, three-hundred sixty-five days a year. The daily struggles that we go through each and every day I would not wish upon any human being. That is why I have become an advocate and supporter for research in finding a cure for this devastating injury.

The New York State Spinal Cord Injury Research Board / Research Program was signed into law on July 14, 1998 by Governor George Pataki, its mission is to fund cutting edge cure directed research in New York State such as that of distinguished researcher Dr. Sally Temple. Through the hard work and dedication of Paul Richter, Christopher Reeve, Terry O'Neill, and so many others plus the sponsorship by Senator Vincent Leibell and Assemblyman Ed Griffith made this program a reality. This program raises approximately $8.5 million per year through surcharges imposed on motorists that are convicted of moving traffic violations and ***not tax dollars***. It does not contribute towards New York State's budget deficit in any way, shape or form, it is a self sustaining program. This program is so successful that it attracts world renowned researchers and their staffing to New York State.

I believe this funding can ultimately lead to a cure getting tens of thousands of New Yorkers who suffer from paralysis out of our wheelchairs to lead a normal, productive life again.

New York State needs to remain in the forefront and not fall behind with this kind of research that is why this program is so important. I am urging you today ***not to support*** Governor Paterson's budget proposals for terminating / phasing out of the Spinal Cord Injury Research Board / Research Program that will ultimately help lead to the cure we are desperately seeking.

I again thank you for this opportunity to speak here today and know that you will do the right thing.

Respectfully submitted,

/S/ Michael J. Di Scipio

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Schenectady, NY 12309
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CURE – NOT CARE •

SPINAL CORD SOCIETY

An International Society for cure research and treatment of spinal cord injury and related problems

Paul Richter, NYS Chapter Coordinator
24 Davis Avenue • Albany, NY 12203 • (518) 458-2141

To: NYS Senate Finance Committee Members and
NYS Assembly Ways and Means Committee Members
Public Hearing, Hearing Room B
Legislative Office Building, Albany, NY
From: Paul Richter
Subject: Governor Paterson's 2010-11 Executive Budget proposals to terminate the Spinal Cord Injury Research Board (SCIRB) and to phase out the Spinal Cord Injury Research Program (SCIRP)
Date: February 9, 2010

It is an honor to appear before this distinguished committee today.

My name is Paul Richter, currently residing in Albany, NY. I am the NYS Chapter Coordinator of the Spinal Cord Society, an unpaid member of the NYS Spinal Cord Injury Research Board and a former New York State Police Zone Sergeant retired on disability as a result of being shot three times while on duty during a traffic stop. I am here today to urge you **NOT TO SUPPORT** Governor Paterson's 2010-11 Executive Budget proposals to terminate the Spinal Cord Injury Research Board (SCIRB) and to phase out the Spinal Cord Injury Research Program (SCIRP).

I am accompanied today by:

- Mr. Michael DiScipio, a former Albany County corrections officer who is paralyzed from the neck down as the result of a back yard swimming pool accident almost ten years ago.
- Mr. Terry O'Neill, Esq., Director of the Constantine Institute and former counsel to former Assemblyman Ed Griffith who sponsored the SCIRP program.
- Dr. Allen Carl, M.D., surgeon, Professor of Orthopedics and Pediatrics, Albany Medical College, Albany
- Lorne Mendell, Ph.D., an M.I.T. graduate, a distinguished Professor of Neurobiology and Behavior at the State University of New York at Stony Brook, NY, and currently the chairman of the Spinal Cord Injury Research Board (SCIRB).

The shooting incident took place on September 30,1973, at about 2AM in Lake Placid, NY, one of the .22 caliber bullets damaged my spinal cord in the neck/shoulder area causing me to fall to the ground paralyzed from the neck down. The two perpetrators fled the scene and were eventually captured. With good fortune, excellent medical treatment, rehab at Sunnyview Hospital and support from my family, friends and the State Police I regained enough function thankfully to ambulate with a leg brace and cane. I had to retire from the State Police, and begin living a new and different life with my wife and six young children. Because of the life altering changes, not only personal but for our loved ones caused by spinal cord injury (sci) paralysis, and being blessed to have regained so much body function, I began to advocate for a cure of this devastating injury caused paralysis. That was 37 years ago.

In 1998 I had an idea to create a state spinal cord injury research program that would be focused on finding a cure and funded by a surcharge imposed on motorists convicted of moving traffic violations. It is the disregard of these moving traffic laws by auto/motorcycle operators that cause the majority of the spinal cord injuries in NYS. I contacted Mr. O'Neill, staff person of Assemblyman Griffith and Mr. Bob Farley, staff person of Senator Vincent Leibell to present my idea for their consideration and sponsorship. The spinal cord injury community in NYS were so pleased to learn that these two forward looking legislators agreed to sponsor the "Spinal Cord Injury Research Board" and the resulting research program. A ground swell of citizen political activity across NYS resulted in the unanimous passage of this legislation in both houses in record time, less that 6 months from date of introduction until it was signed into law on July 14, 1998 at the NYU Medical Center by then Governor George Pataki (NYS Chapter 338, Laws of 1998, as amended by Chapter 612, Laws of 1999). Present at the bill signing was Christopher Reeve, and New York City police officer Steven McDonald, also a gunshot victim and confined to a wheelchair.

At the same time, a special revenue fund was established for these surcharge funds, known as the "Spinal Cord Injury Research Trust Fund":

§ 5. Article VI of the state finance law is amended by adding a new section 99-f to read as follows:

§ 99-f. Spinal cord injury research trust fund.

1. There is hereby established in the joint custody of the state comptroller and the commissioner of taxation and finance a special revenue fund to be known as the "spinal cord injury research trust fund."
2. The fund shall consist of all monies appropriated for its purpose, all monies required by this section or any other provision of law to be paid into or credited to such fund, and monies in an amount not to exceed eight million five hundred thousand dollars collected by the mandatory surcharges imposed pursuant to subdivision one of section eighteen hundred nine of the vehicle and traffic law. Nothing contained herein shall prevent the department of health from receiving grants, gifts or bequests for the purposes of the fund as defined in this section and depositing them into the fund according to law.
3. Monies of the fund, when allocated, shall be available for administrative costs of the spinal cord injury research board established pursuant to title four of article two of the public health law and for funding spinal cord injury research projects administered by such board.
4. Monies shall be payable from the fund on the audit and warrant of the state comptroller on vouchers approved and certified by the commissioner of health.

§ 6. This act shall take effect January 1, 1999.

It is my opinion as well as many of our supporters that the mission of the Board and research program to find a cure for spinal cord injury paralysis remains incomplete and leads to greater medical costs associated with these injuries. The Legislature clearly intended to fund this program $8.5M per year based on surcharges from convictions of moving traffic violations. I can assure you that the level of convictions has not precipitously dropped as such infractions occur in the millions within the state annually.

The following only scratches the surface of the many accomplishments achieved by these programs since enacted ten years ago:

- **approved funding for more than $54 million in research awards in NYS--which many recipients have leveraged to bring into NYS many more millions from NIH and private foundations.**
- **the fund has earned over $5.5 million in interest.**
- **created hundreds of good jobs in the medical research field, thereby encouraging new post grads to enter the field of sci research.**
- **creating the Spinal Cord Injury Center of Research Excellence (CORE), which is made up of researchers and support staff at eleven institutions across the state, from New York City to Buffalo.**
- **this program is a high tech job magnet - local institutes are now able to attract excellent spinal cord researchers from other states who want to move here to take advantage of this NYS funding opportunity.**
- **lest we forget that this program provides ""HOPE"" for those paralyzed by a spinal cord injury.**

Christopher Reeve's prediction "that those suffering from sci and I will stand up from our wheelchairs and walk away from them forever" did not come true in time for our great champion, but I still believe in his great dream. When that happens, New York will have been part of that tremendous effort—if we act now to prevent bureaucratic short-sightedness from killing it.

The trust fund revenues from surcharges currently supports the salaries, benefits, travel and supplies for four (4) full time state employees who are assigned to handle administrative duties of this program, it costs New York State TAXPAYERS NOTHING. The SCRIB and SCRIP are long term investments to find a cure for spinal cord injury paralysis thus reducing the taxpayer cost for care on average of $300,000 per year, multiply that by 100 patients = $30,000,000 per year. There are many thousands of such disabled people across the State of New York.

I know that my friend Christopher Reeve would join me in asking you to please, DO NOT SUPPORT the governor's proposals to terminate this one of a kind NYS Spinal Cord Injury Research Board and phase out the Spinal Cord Injury Research Program.

Respectfully submitted,

Paul Richter

Paul Richter

From: bjb08@health.state.ny.us
To: lome.mendell@sunysb.edu, alcsar@nycap.rr.com, bsk0909@aol.com, prichter05@aol.com, davisandtrotta@taconic.net, wolpaw@wadsworth.org, brookemellison@gmail.com, dfaber@aecom.yu.edu, gary_paige@urmc.rochester.edu, jason_huang@urmc.rochester.edu, astein3@nshs.edu, meg2008@columbia.edu
CC: ldr01@health.state.ny.us, mlr06@health.state.ny.us, tka03@health.state.ny.us, met03@health.state.ny.us
Sent: 1/21/2010 4:55:43 P.M. Eastern Standard Time
Subj: Governor's Budget Proposal - Impact on SCIRB

Hello -

The Commissioner of Health has asked that we notify you that the Governor's Executive Budget for 2010-2011 proposes the elimination of the Spinal Cord Injury Research Board, effective April 1, 2010. As a cost-saving measure, it is one of several programs that are proposed to be eliminated or consolidated.

As we currently understand it, the proposal is to phase out the program. Thus, the budget proposes the reappropriation of unspent funds from past years to support executed contracts.

While the official role of the board would be eliminated under the Governor's proposed budget, the Department certainly expects to continue to reach out to you for input as we close out the program. Due to the close proximity of the April 9 meeting to the start of the new fiscal year, please continue to hold the date for the April 9 meeting. We will advise you as soon as possible regarding our ability to convene.

Thank you for your continued support.

In service,
Bonnie

Bonnie Jo Brautigam
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518-486-2191 (fax)

Davis & Trotta

From: <Prichter05@aol.com>
To: <davisandtrotta@taconic.net>
Sent: Monday, February 08, 2010 12:38 PM
Subject: Reduce or Eliminate Public Health Programs.

need
40 copies to go with my cover letter
10 copies , one for copy i will read from, 9 for media

i have 2 more items to send--then i will call you in about one hr about how i would like these stapled together in what order   thks

PLEASE UNDER LINE OR HIGHLIGHT BELOW IN FIRST BULLET PARA>>>while contracts for spinal cord research ($6.7 million) would be phased out.
///below for sumission/////////

Public Health and Aging Programs

The Department of Health and the State Office for the Aging administer a number of programs that support New York's public health and senior care systems. The budget achieves savings by reforming the Elderly Pharmaceutical Insurance Coverage (EPIC) program, the Early Intervention (EI) program, and the General Public Health Work (GPHW) program; consolidating various public health programs; reducing spending on programs less central to agency core mission programs; and other operational and administrative efficiencies. These actions would save $104.2 million in 2010-11 and $187.3 million in 2011-12.

- **Reduce or Eliminate Public Health Programs.** Spending on Infertility ($1.5 million – including $1.3 million in HCRA savings) and Red Cross emergency preparedness ($0.9 million) would be reduced by 50 percent; while contracts for spinal cord research ($6.7 million) *** would be phased out. Funding for the following programs that are less essential to DOH's core mission would be eliminated: Eating Disorders ($1.7 million); Maternal and Early Childhood Foundation ($0.9 million); Arthritis Foundation ($0.2 million); Interim Lead Safe Housing ($0.1 million); Translational Neurological Research ($0.1 million); and various education and outreach programs ($2.0 million). *(2010-11 Savings: $14.2 million; 2011-12 Savings: $21.5 million)*
- **Reduce Spending for Senior Services.** Spending would be eliminated for the Patients' Rights and Advocacy Hotline Project ($0.1 million) and Congregate Services Initiative ($0.6 million). *(2010-11 Savings: $0.7 million; 2011-12 Savings: $0.7 million)*
- **Additional Agency Reductions.** The Executive Budget recommends an additional $29.6 million reduction to the operations of the Department of Health, and $0.3 million for the State Office for the Aging. The agencies would manage these reductions through a broad range of savings actions, including: strict limits on staffing; energy conservation; purchases of vehicles, supplies, equipment, and contracts for technology and other services; and the development of shared services. *(2010-11 Savings: $29.9 million; 2011- 12 Savings: $22.3 million)*

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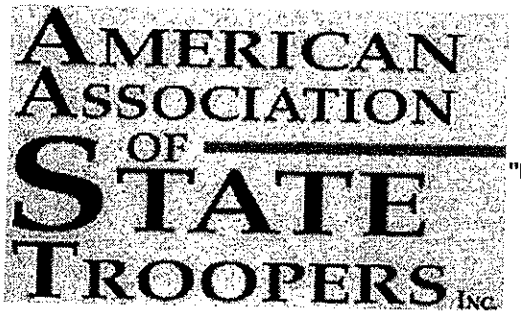
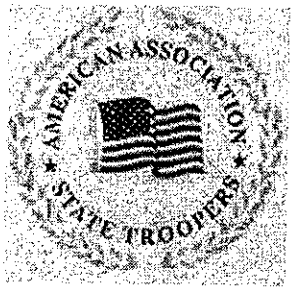


"Providing benefits and services to America's state troopers since 1989"



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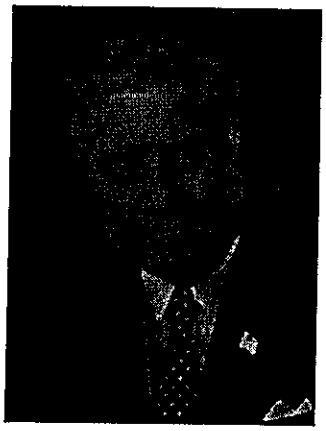
Retired New York trooper pioneers spinal cord injury research

Near fatal gunshot wound left him paralyzed



Retired New York Trooper and AAST Member Paul Richter

On a late-night traffic check in Lake Placid on September 30, 1973, Paul Richter was working as a New York State Police trooper when he was shot in the neck with a .22 caliber gun, leaving him paralyzed from the neck down. He has since dedicated much of his life to spinal cord injury research.

On July 14, 1998, a bill was passed realizing Richter's initiative to establish a spinal cord injury research fund. With its broad grassroots support, including a mass letter-writing campaign across the state, the bill passed unanimously in a brief nine months, becoming the first law of its kind in the nation. Major legislation typically takes three to seven years to get passed.

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Richter literally could have walked away from the devastation of spinal cord injury after regaining the ability to walk with a cane. Today he considers himself lucky.

"I couldn't turn my back on other spinal cord injury victims who aren't as fortunate as me to regain the ability to move and walk," Richter said. "My injury and extensive rehabilitation were for a reason. I can now use my situation to help find a cure."

Christopher Reeve, pictured right with Richter, was among those who helped get the bill passed to establish a spinal cord injury research fund in New York state.

Friends and connections, eventually including the late actor Christopher Reeve, paralyzed after a fall from a horse, provided invaluable support along the way to help get the bill passed, a law which provides $8.5 million a year for spinal cord injury research. The bill passed with no lobbyists – grassroots only.

In 1977 Richter joined the Spinal Cord Society, whose function is to raise money to fund research to find a cure for spinal cord injury paralysis. He is now the New York state chapter coordinator of the group, which is comprised solely of volunteers. Richter also serves on the New York State Spinal Cord Injury Research board and takes a keen interest in the research efforts that his bill makes possible, including the Center of Research Excellence.

7

Research money is dispensed in the form of grants, requests which are submitted to a review board administered through the New York State Department of Health.

Richter has been recognized many times for his work. On June 3 the Burke Rehabilitation Hospital and Burke Medical Research Institute in White Plains, N.Y., honored Richter as the research recipient of the Burke Award, the highest honor bestowed by Burke and its board of directors. The award is presented to an individual or group for strength in overcoming a disability for the development of science and research regarding disability, and for contributions made to the development of rehabilitation.

Thank you, Paul Richter, for your clear vision and unyielding efforts in this life-changing field.

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Common food dye may hold promise in treating spinal cord injury

A common food additive that gives M&Ms and Gatorade their blue tint may offer promise for preventing the additional -- and serious -- secondary damage that immediately follows a traumatic injury to the spinal cord. In an article published online today in the Proceedings of the National Academy of Sciences, researchers report that the compound Brilliant Blue G (BBG) stops the cascade of molecular events that cause secondary damage to the spinal cord in the hours following a spinal cord injury, an injury known to expand the injured area in the spinal cord and permanently worsen the paralysis for patients.

This research builds on landmark laboratory

findings first reported five years ago by researchers at the University of Rochester Medical Center. In the August 2004 cover story of Nature Medicine, scientists detailed how ATP, the vital energy source that keeps our body's cells alive, quickly pours into the area surrounding a spinal cord injury shortly after it occurs, and paradoxically kills off what are otherwise healthy and uninjured cells.

This surprising discovery marked a milestone in establishing how secondary injury occurs in spinal cord patients. It also laid out a potential way to stop secondary spinal injury, by using oxidized ATP, a compound known to block ATP's effects. Rats with damaged spinal cords who received an injection of oxidized ATP were shown to recover much of their limb function, to the point of being able to walk again, ambulating effectively if not gracefully.

Now, scientists detail the clearing of yet another hurdle in moving this research closer from bench to bedside by successfully identifying a compound that could be administered systemically to achieve the same benefit. Previously, the team needed to inject a compound directly into the injured spinal cord area to achieve its results.

"While we achieved great results when oxidized ATP was injected directly into the spinal cord, this method would not be practical for use with spinal cord-injured patients," said lead researcher Maiken Nedergaard, M.D., D.M.Sc., professor of Neurosurgery and director of the Center for Translational Neuromedicine at the University of Rochester Medical Center. "First, no one wants to put a needle into a spinal cord that has just been severely injured, so we knew we needed to find another way to quickly deliver an agent that would stop ATP from killing healthy motor neurons. Second, the compound we initially used, oxidized ATP, cannot be injected into the bloodstream because of its dangerous side effects."

Nedergaard cautions that while this body of work offers a promising new way of treating spinal cord injury, it is still years away from possible application in patients. In addition, any potential treatments would only be helpful to people who have just suffered a spinal cord injury, not for patients whose injury is more than a day old. Just as clot-busting agents can help patients who have had a stroke or heart attack who get to an emergency room within a few hours, so a compound that could stem the damage from ATP might help patients who have had a spinal cord injury and are treated immediately.

Too Much of a Good Thing

While ATP is usually considered to be helpful to our bodies – after all, it's the main source of energy for all of our body's cells ? Nedergaard was the first to uncover its darker side in the spinal cord. Immediately after a spinal cord injury occurs, ATP surges to the damaged area, at levels hundreds of times higher than normal. It is this glut of ATP that over-stimulates neurons and causes them to die from metabolic stress.

Neurons in the spinal cord are so susceptible to ATP because of a molecule known as "the death receptor." Scientists know that the receptor ? called P2X7 ? plays a role in regulating the deaths of immune cells such as macrophages, but in 2004, Nedergaard's team discovered that P2X7 also is carried in abundance by neurons in the spinal cord. P2X7 allows ATP to latch onto motor neurons and send them the flood of signals that cause their deaths, worsening the spinal cord injury and resulting paralysis.

So the team set its sights on finding a compound that not only would prevent ATP from attaching to P2X7, but could be delivered intravenously. In a fluke, Nedergaard discovered that BBG, a known P2X7R antagonist, is both structurally and functionally equivalent to the commonly used FD&C blue dye No. 1. Approved by the Food and Drug Administration as a food additive in 1982, more than 1 million pounds of this dye are consumed yearly in the U.S.; each day, the average American ingests 16 mgs. of FD&C blue dye No. 1.

"Because BBG is so similar to this commonly used blue food dye, we felt that if it had the same potency in stopping the secondary injury as oxidized ATP, but with none of its side effects, then it might be great potential treatment for cord injury," Nedergaard said.

The team was not disappointed. An intravenous injection of BBG proved to significantly reduce secondary injury in spinal cord-injured rats, who improved to the point of being able to walk, though with a limp. Rats that had not received the BBG solution never regained the ability to walk. There was one side effect: Rats who were injected

with BBG temporarily had a blue tinge to their skin.

Nedergaard's long-time collaborator on this and other projects, chair of the University of Rochester Department of Neurology Steven Goldman, M.D., Ph.D., adds, "We have no effective treatment now for patients who have an acute spinal cord injury. Our hope is that this work will lead to a practical, safe agent that can be given to patients shortly after injury, for the purpose of decreasing the secondary damage that we have to otherwise expect."

Nedergaard and Goldman believe that further laboratory testing will be needed to test the safety of BBG and related agents before human clinical trials could begin. Nonetheless, the investigators are optimistic that with sufficient study, strategies like this could yield new treatments for acute spinal cord injuries within the next several years.

Other authors from the University of Rochester Medical Center include Weiguo Peng, Maria L. Cotrina, Xiaoning Han, Hongmei Yu, Lane Bekar, Livnat Blum, Takahiro Takano, and Guo-Feng Tia.

*** The research was supported by the New York State Spinal Cord Injury program, the Miriam and Sheldon Adelson Medical Research Foundation, and grants from the National Institutes of Health.

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Same blue dye in M&Ms linked to reducing spine injury

- Story Highlights
- Researchers find way to reduce secondary damage caused by spinal injuries
- Compound BBG is similar to blue food dye used in sweets, sports drinks
- Only side effect of intravenous injection was that it turned test rats blue
- Researchers are planning to apply to the FDA for permission for human tests

(CNN) -- The same blue food dye found in M&Ms and Gatorade could be used to reduce damage caused by spine injuries, offering a better chance of recovery, according to new research.

Researchers at the University of Rochester Medical Center found that when they injected the compound Brilliant Blue G (BBG) into rats suffering spinal cord injuries, the rodents were able to walk again, albeit with a limp.

The only side effect was that the treated mice temporarily turned blue.

The results of the study, published in the "Proceedings of the National Academy of Sciences," build on research conducted by the same center five years ago.

In August 2004, scientists revealed how Adenosine triphosphate, which is known as ATP and described as the "energy currency of life," surges to the spinal cord soon after injury occurs.

Researchers found that the sudden influx of ATP killed off healthy cells, making the initial injury far worse. But when they injected oxidized ATP into the injury, it was found to block the effect of ATP, allowing the injured rats to recover and walk again.

"While we achieved great results when oxidized ATP was injected directly into the spinal cord, this method would not be practical for use with spinal cord-injured patients," said lead researcher Maiken Nedergaard, professor of Neurosurgery and director of the Center for Translational Neuromedicine at the University of Rochester Medical Center.

"First, no one wants to put a needle into a spinal cord that has just been severely injured, so we knew we needed to find another way to quickly deliver an agent that would stop ATP from killing healthy motor neurons. Second, the compound we initially used, oxidized ATP, cannot be injected into the bloodstream because of its dangerous side effects."

Back in 2004, Nedergaard's team discovered that the spinal cord was rich in a molecule called P2X7, which is also known as "the death receptor" for its ability to allow ATP to latch onto motor neurons and send the signals which eventually kill them.

Nedergaard knew that BBG could thwart the function of P2X7, and its similarity to a blue food dye approved by the Food and Drug Administration (FDA) in 1982 gave her the confidence to test it intravenously.

It worked. The rats given BBG immediately after their injury could walk again with a limp. Those that didn't receive a dose never regained their mobility.

Nedergaard told CNN that there is currently no standard treatment for patients with spinal injury when they reach the hospital emergency room.

"Right now we only treat 15 percent of the patients we receive with steroids and many hospitals question if that even works for that 15 percent; it's a very moderate benefit to only a subset of patients. So right now 85 percent of patients are untreated," she said.

Nedergaard said the research team isn't claiming that BBG can cure spinal injuries, instead that it offers a potential improvement in

patients' condition.

"Even a moderate improvement in functional performance of the patient is a big, big event for these patients," she said. "They can control their bladder. If they can just take small steps instead of sitting in a wheelchair all the time, it's a tremendous benefit for these patients," she added.

The dose must be administered immediately after the injury, before additional tissue dies as a result of the initial injury.

Researchers are currently pulling together an application to be lodged with the FDA to stage the first clinical trials of BBG on human patients.

"Our hope is that this work will lead to a practical, safe agent that can be given to patients shortly after injury, for the purpose of decreasing the secondary damage that we have to otherwise expect," said Steven Goldman, Chair of the University of Rochester Department of Neurology.

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