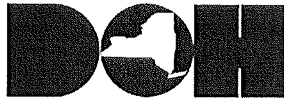

STATE OF NEW YORK
DEPARTMENT OF HEALTH
Corning Tower The Governor Nelson A. Rockefeller Empire State Plaza Albany, New York 12237

January 28, 2011

Mr. Charles Littleton
Center for Medicare and Medicaid Services (CMS)
CMS, OAGM, AGG, DSPSCG
Attn: RFP-CMS-2011-0009/ Charles Littleton
C2-21-15 Central Building
7500 Security Boulevard
Baltimore, Maryland 21244-1850

Dear Mr. Littleton:

Enclosed please find the New York State Medicaid Program's application for federal funding under the Integrating Care for Dual Eligible Individuals Initiative. The New York State Department of Health is the state Medicaid agency and, as such, will oversee the implementation of this very important planning process aimed at improving coordination of services for the dually eligible, reducing poor outcomes and increasing efficiency. Under Governor Cuomo's leadership, New York is currently undertaking a redesign of the state Medicaid Program and this funding opportunity dovetails perfectly with that endeavor.

We firmly believe that New York ranks "high" on the CMS Level of Readiness scale. New York has many years experience building managed care options for dually eligible Medicaid recipients and over the last several years has transitioned over 300,000 SSI-eligible Medicaid recipients, many with chronic conditions, mental health conditions and disabilities similar to those found in the dually eligible population. Our recently conducted satisfaction surveys of both the enrolled managed long term care and SSI-eligible populations find high levels of satisfaction with access to care, providers and the plans.

We are eager to begin the planning process and design innovative models to provide better care to dual eligibles and we look forward to partnering with our colleagues at the CMS Coordinated Health Care Office. Should you need any additional information regarding this application, please contact Joseph Anarella of my office at (518) 486-9012 or jpa02@health.state.ny.us.

Sincerely,

Jason A. Helgerson
Medicaid Director
Deputy Commissioner
Office of Health Insurance Programs

State Demonstrations to Integrate Care for Dual Eligibles: The New York State Department of Health Proposal

1) The State's proposed approach to integrating care.

Over the last fifteen years New York has developed four managed care programs for dual eligibles. Three focus on the management of long-term care services for a nursing home eligible population. The fourth model provides a limited service wrap and Medicare cost sharing for any dual eligible. It has been difficult to build enrollment in these programs and to expand their geographic reach however, in part because Medicaid and Medicare enrollment in the programs is voluntary. We propose to use the planning contract to develop options that would more fully integrate Medicare and Medicaid services for dual eligibles, including primary acute and long-term care services, in ways that would improve care for dual eligibles, and enable the state to better control and manage long-term care services including nursing home, personal care and other home and community based services.

Background: As of December 2009, there were over 709,430 dually eligible Medicare/Medicaid recipients in New York State (NYS), which is an increase of over 111,000 recipients since December, 2003. Many of New York's dual eligibles are vulnerable, disabled, frail adults with chronic medical conditions who are significantly functionally impaired and/or have complex mental health and long term care needs. Sixty-eight percent are over the age of 65 and represent 61% of the total costs. The needs of New York's dual population are very heterogeneous and the state has designed benefit packages that are designed to complement Medicare coverage. Fee-for service benefits included under the Medicaid program cover a wide range of services, including but not limited to: nursing home care, intermediate facility care for persons with developmental disabilities, home care, adult day health, personal care, durable medical equipment, non-emergency transportation, podiatry, dentistry, physical therapy, occupational therapy, audiology, nutrition and respiratory therapy.

New York's Medicaid expenditures for the duals have risen from $15.4 billion in 2003 to $18.1 billion in 2009 and currently represent 38% of the state's annual Medicaid expenditures. New York spends more than twice as much on duals as any other state and twice the national average per enrollee. These costs are driven by the richness of the Medicaid benefit package, and the relatively high costs of nursing home, personal and home care services. Per member per year (PMPY) expenditures appear relatively flat over the last six years at approximately $26,000, however, implementation of Medicare Part D coverage beginning in 2006, masks an increase in expenditures by removing prescription drugs from Medicaid costs. Skilled nursing facility care consistently consumes 30% of all Medicaid expenditures for duals each year, while other major categories of service, such as community and rehabilitation services and home health services have increased from 14% to 22% and from 3% to 6% respectively between 2003 and 2009. Personal care services and care for persons with developmental disabilities have consistently represented approximately 11% of the annual spending for duals.

New York has a long and successful history designing and implementing care options for the elderly and the disabled, including the dually eligible. The State has spent considerable time developing three coordinated managed long term care plan (MLTCP) models – the Program of All-Inclusive Care for the Elderly (PACE), Medicaid Advantage Plus (MAP) and partially-capitated plans. To date, the overwhelming majority of recipients enrolled in these programs are duals.

The table that follows describes each of the managed care program for duals developed by New York and its current enrollment. Medicaid enrollment in all of these programs is voluntary:

Program Type	Eligibility	Program Description	Enrollment as of December 2010
Program of All Inclusive Care for the Elderly	55 years of age or older, and reside in the Plan's service area. Dual Eligible, Medicare or Medicaid Only, or willingness to pay privately. Require Nursing Home level of care and upon enrollment need the long term care services of the plan for more than 120 days.	Full integration of Medicare and Medicaid capitation. Seamless coordination and provision of a Comprehensive Benefit package of all traditional Medicare and Medicaid services; including home care, custodial nursing home, and social/environmental supports. Center based. Care management using an Interdisciplinary Team approach, enables the plan to effectively manage care and all enrollee needs across all settings.	Upstate: 1,110 NYC: 2,303 STATEWIDE: 3,529 7 operational plans
Medicaid Advantage Plus	18 years of age or older, and reside in the Plan's service area. Dually Eligible, with Full Medicaid Coverage Enrolled in the Plan's Medicare Advantage Product Require Nursing Home level of care, and upon enrollment need the long term care services of the plan for more than 120 days.	Full integration of Medicare and Medicaid capitation and services. Care management of all primary, acute, behavioral and long term care services. Each enrollee has a care manager to assess, develop, implement and monitor a plan of care to meet all physical, social and environmental needs.	Upstate: 250 NYC: 913 STATEWIDE: 1,163 8 operational plans
LTC Partial Capitation Plans	18 years of age or older, and reside in the Plan's service area. Dual Eligibles or Non Duals. Require Nursing Home level of care, and upon enrollment need the long term care services of the plan for more than 120 days.	Benefit package includes Medicaid long term care, social/ environmental supports, non-emergent transportation, and some ancillary services. Each enrollee has a care manager to assess, develop, implement and monitor a plan of care that considers all physical, social and environmental needs; along with coordination of non-covered services.	Upstate: 1,946 NYC: 26,789 STATEWIDE: 28,735 14 operational plans

Program Type	Eligibility	Program Description	Enrollment as of December 2010
Medicaid Advantage	18 years of age or older Resides in the Plan's service area. Dually Eligible, with Full Medicaid Coverage Enrolled in the Plan's Medicare Advantage Product	Medicaid Advantage compliments the Medicare Advantage Product through payment of co-pays and deductibles. Medicaid covers limited home care and nursing home benefits and some ancillary services.	Upstate: 1,029 NYC: 4,841 STATEWIDE: 5,870 8 operational plans

All three models of MLTCP are responsible for assessing members and developing, implementing and monitoring a plan of care that meets the physical, social and environmental needs of the members. Members and caregivers have a single entity to which they can raise concerns and make requests. The plan is at risk financially and therefore has an incentive to implement a plan of care that meets the member's needs in the least restrictive setting to improve health or prevent further decline or acute illness. Members have shown a high degree of satisfaction with their MLTCPs. In a 2007 satisfaction survey conducted by the Department's external quality review organization, IPRO, 87% of respondents rated their MLTCP as "good" or "excellent" and 91% said they would recommend the MLTCP to others.

MLTCPs serve members with a high level of impairment. Department analysis of the severity of those receiving long term care services (using data items similar to those on the CMS developed Minimum Data set (MDS) and Outcome and Assessment Information Set (OASIS) and state-developed Semi Annual Assessment of Members (SAAM) assessment tools) found the MLTCPs serving a population that is less impaired than people in nursing homes but more impaired than those served by the Long Term Home Health Care Programs (LTHHCPs), New York's home and community-based services waiver program and Certified Home Health Agencies (CHHAs). As such the MLTCPs would be well able to serve the extended population of those eligibles currently in other programs.

New York has extensive experience in managing the comprehensive care needs for the chronically ill and the disabled. Since 2006 over 300,000 SSI-eligible Medicaid recipients have been mandatorily enrolled in Medicaid managed care plans, including persons with serious and persistent mental illness. In the fall of 2010, the state began the mandatory enrollment of persons with HIV, another group with multiple comorbid conditions and health care needs that may involve multiple providers and services.

Problem Statement: Many of the issues experienced by New York in attempting to care for duals are common to all states; coverage is divided between two different insurance programs and is confusing to consumers, especially those with high levels of impairment. Divided coverage can result in fragmented, poorly coordinated care, less than desirable outcomes and unnecessary expenditures. Providers have little or no incentive to communicate, care decisions are uncoordinated and nursing home placement is a more common option than home-based care.

An important issue for New York is the inability to obtain significant growth in its Medicaid Advantage and Medicaid Advantage Plus plans since enrollment in Medicare managed care is voluntary and many seniors and the disabled view managed care as a potential restriction on their benefits. Other states attempting to integrate care for dual eligibles through managed care plans face the same issues. To assist States in this regard, passive enrollment options should be considered to promote dual eligible enrollment in Medicare managed care plans that are integrated with MLTCPs, with appropriate education for duals about the implications of managed care enrollment, and an opportunity for them to opt out at any time.

In New York State, the service system supporting individuals with developmental disabilities has remained entirely outside managed care networks. Thus the clinical and medical experts who support individuals with developmental disabilities are paid through fee-for-service Medicaid, which keeps individuals with developmental disabilities from electing to enroll in programs designated to coordinate care.

The current lack of Medicare data is problematic for states such as New York as it complicates our understanding of dual recipients clinical and supportive service needs and puts states in the role of an uninformed payer. With only a small piece of the information on a dual recipient's medical services history the state is unlikely to be positioned to address many of the care coordination problems described above or understand the vast array of service needs this heterogeneous group of people has. While claims for wraparound services and Medicare cost sharing are billed to Medicaid, these claims do not always allow the state Medicaid program to glean the recipient's diagnosis, service history or ongoing clinical, social or rehabilitative needs. Opportunities to right-size the care and save money are missed.

Lastly, while the state is responsible for reimbursing wrap around services and long term care services for dual eligibles, the impact of those services on patient care in hospitals, emergency rooms and physician offices and patient use of prescription drugs is unknown due to lack of data. The State has developed models of care that focus on intensive case management and coordination of other supportive services, which are improve overall care of the individual. However, the potential savings in acute, emergency and outpatient benefits and prescription drugs accrue to the Medicare program at considerable cost to the Medicaid program. The ability to access Medicare data is critical to measurement of these savings.

New York is excited about this new opportunity to partner with CMS and intends to explore a full range of options recognizing that there may not be a "one size fits all" approach to improving care for all the dual eligibles. These options include the following:

NYS Assumes Full Risk - Similar to the approach being considered by some states, including Vermont, New York will explore the opportunities and financial risks of managing the delivery and financing of combined Medicare and Medicaid benefit package. This would require the state to integrate the delivery, management and administration of all Medicare benefits. This option would require significant planning and resources. Assuming full risk would allow the State Medicaid program to benefit directly from reductions in specialist visits, hospitalizations, and emergency room use that would result from providing case management and supportive services.

Promote Existing Managed Long Term Care Initiatives – To optimize the value of the integrated programs already developed, New York will explore various options for increasing enrollment. These options include but are not limited to the following:

- Mandate enrollment into Medicaid Advantage and Medicaid Advantage Plus for duals that are already enrolled in a Medicare managed care plan. State law currently allows for this option.

- Medicaid managed care plans should be allowed to passively enroll their members who become Medicare-eligible into their Medicare managed care product line with the ability to opt out. If a member has enrolled and received quality care in a Medicaid managed care plan and the same plan has a Medicare Advantage product, the member would benefit from continuity in care and would not have to change providers or seek different alternatives.

- Require duals age 21 and over and in need of community-based long term care services to enroll in a comprehensive and coordinated model of care.

- Require all Dual SNPs to develop and market a product that integrates Medicare and Medicaid services as a condition of entering into a contract with states as required by the ACA by the end of 2012.

Care Coordination for Nursing Home Residents - the State will work in collaboration with nursing homes and Medicare Special Needs Plans to enroll recipients residing in nursing homes in order to improve health care outcomes and reduce unnecessary hospitalizations. This would allow nurse practitioners to evaluate and treat patients before conditions progress to require acute levels of care. This coordination should reduce Medicare expenditures by reducing inpatient admissions, emergency transfers and readmissions.

"PACE without walls" - New York will explore options to the basic PACE model to build in additional flexibility and attract a larger group of dually eligible enrollees. This might include, for example, a less restrictive PACE model that would allow blending of Medicare and Medicaid benefits without the requirement of the current PACE service setting that allows dual beneficiaries to maintain access to existing providers within the community. Another option would be to allow disabled duals under the age of 55 to participate in a PACE model designed around their needs.

Gain Sharing Demonstration - Similar to the Section 646 dual demonstration that North Carolina is now implementing, New York would explore providing a care management function through Medicaid for duals without taking on full risk for the Medicare benefit package. Savings accruing as a result of decreases in inpatient, emergency room and other utilization would be shared between the state, providers and Medicare. Medicaid covered care management would thus be paid for - at least in part - through shared savings. This type of gain sharing is already authorized under current state law.

Managed Care for Persons with Developmental Disabilities - Develop and pilot specialized care coordination or managed care models that provides medical and long-term care services to

individuals with developmental disabilities who are Medicare-Medicaid eligible. The manager would receive capitated payments from both the Medicare program and Medicaid and be at-risk for the cost of all Medicare- and Medicaid-covered services for the enrolled population. The provider will coordinate the provision of each enrollee's health care needs to ensure that they are delivered in the most appropriate setting consistent with each enrollee's preferences, with an emphasis on the provision of primary and preventive care and services. Each enrollee will have a comprehensive plan of care and will receive care coordination and case management services appropriate to their unique needs and circumstances.

2) Overview of state capacity and infrastructure.
Oversight of the New York State Medicaid Program resides with the Department of Health. Within the Department are the Office of Health Insurance Programs (OHIP) and the Office of Long Term Care (OLTC), both of which administer programs that deliver needed care and services to the dually eligible. The OHIP administers all of the MLTCPs described above, including program design, licensure, certification and surveillance, rate setting and quality oversight. The OLTC has oversight responsibility for nursing homes and assisted living facilities, community-based waiver programs, the traumatic brain injury program, home and community-based services and other services. Staff from both offices routinely coordinates on matters related to Medicaid beneficiaries, developing new budget proposals and implementing new legislation. In addition to the Offices within the Department, there are several state agencies that serve large numbers of the dually eligible. The Office for People with Developmental Disabilities (OPWDD) provides care through its network of intermediate care facilities and waiver programs to over 40,000 duals. The Office of Mental Health (OMH) also provides care to thousands of dually eligible through its network of outpatient clinics across the state.

Since 1995, the Department of Health has been designing, developing and implementing managed care models for various populations including: low income women and children, non-dual SSI/disabled adults and children, low income adults (Family Health Plus) low income children with working parents (SCHIP), HIV special needs plans and Medicaid Advantage and managed long term care plans for the frail elderly and adult disabled population. Each new program takes into consideration the needs of the targeted membership and develops requirements that foster appropriate care such as: comprehensive provider networks, easy access to care and adequate financing and administrative infrastructure.

The Department has the infrastructure to immediately begin implementation of the planning contract once it is awarded. Staff within various Divisions of the Office of Health Insurance Programs (OHIP) will take on most of the responsibility for the planning process. This planning project will be administered by the Division of Managed Care (DMC) within OHIP. Within DMC, the Bureau of Continuing Care Initiatives will be assigned the responsibility to implement the workplan, participate in monthly conference calls with CMS, submit interim and final reports within agreed upon timeframes and coordinate planning work across Divisions. The Division of Quality and Evaluation (DQE) in OHIP will be responsible for all data analysis. We anticipate having Medicare data prior to the planning contract award announcement and will begin immediately linking to Medicaid recipient files to create a linked dataset. The OHIP administrative office will help expedite the execution of subcontracts.

With the availability of Medicare data the state will be better positioned to understand the diversity of diagnoses and range of services used by the dual population and can craft a demonstration that is responsive to their needs. As stated earlier, the Medicaid managed care plans in New York already have experience serving members with multiple chronic conditions, including over 385,000 with diagnosed behavioral health problems.

Key Department project staff includes:

Ms. Vallencia Lloyd, Director, Division of Managed Care will be responsible for the oversight of the planning contact and will be involved in all aspects of the planning process including stakeholder meetings, distilling recommendations for a demonstration and oversight of all planning related activities. She will direct all staff involved in the planning process. Ms. Lloyd has over 20 years experience overseeing the State's managed care products for publicly insured including financial, regulatory and licensure and certification related work.

Ms. Linda Gowdy, Director, Bureau of Continuing Care Initiatives, will be responsible for day to day administration of the contract with CMS. She will supervise the contract-funded program coordinator and program administrator and will manage of the work of all subcontractors funded under this project. Ms. Gowdy has over 25 years of professional experience working in the Department primarily on programs designed to support the health needs of the low income elderly.

Mr. Patrick Roohan, Director, Division of Quality and Evaluation (DQE) will be responsible for all analytic work related to this project. Mr. Roohan has over 25 years experience in conducting and overseeing health services research in the Department of Health. He and his staff will be responsible for receiving, housing, linking and protecting confidential Medicare data as well as overseeing analysis of the linked Medicaid/Medicare data file.

Ms. Mary Beth Conroy, Director, Financial Research and Analysis Unit, within DQE will be the lead analyst assigned to create a linked Medicaid and Medicare file for purposes of analysis. Ms. Conroy has over 20 years of experience in health services research and financial analysis and is the lead on risk adjustment payment methodologies for managed care and managed long term care. She will supervise the contract-funded Research Scientist II.

External Consultants:

The Department will procure several consultants to assist in the planning process for integrating care for duals. Proposed contractors for this project include:

Actuarial Support: A consultant firm experienced in working with New York State will be hired to assure the actuarial soundness of any proposed rates for an integrated model of care.

Analytic Support: A consulting firm with experience in working with dual data will be hired to respond to questions and support Department analysis of the linked data set.

Stakeholder Meetings: While Department staff and other state agency staff will be organizing and involved in gathering stakeholder input it is necessary to hire a consultant group who can develop interview tools, schedule meetings with key informants and organize larger forums including

scheduling and securing meeting space. The consultant will be responsible for development of a report synthesizing the recommendations that emanate from the stakeholder discussions.

3) Description of current analytic capability.

The Division of Quality and Evaluation, within the Office of Health Insurance Programs, has had the lead responsibility for evaluating the care provided to publicly insured individuals, in both fee-for-service and managed care delivery systems, for over fifteen years. The Division is charged with collecting and analyzing data from various sources and for assuring data integrity. Through the use of standardized, as well as NYS-specific measures, the Department has been able to monitor the cost, quality and utilization and describe successes and challenges in delivering care to populations at high risk of poor outcomes, describe the experiences of publicly insured individuals in various care settings (ambulatory, inpatient and long term care) and promote quality improvement across the delivery system. Specifically related to any analysis of the under-65 dual population, staff in the DQE has done a comprehensive evaluation of the cost, quality and utilization of the non-dual SSI population in both managed care and fee for service Medicaid using both claims and encounter data.

The Division is staffed with a team of clinicians, programmers and analysts and has a long and successful history of linking Medicaid data with data from other sources, such as Vital Records and hospital discharge data and then using the linked files for analysis. Examples of ongoing and successful linkages include: 1) linking Medicaid birth data with data from Vital Statistics birth files to monitor trends among low income women who give birth and, 2) linking hospital discharge data with Medicaid data and using software designed to identify potentially preventable hospitalizations and preventable readmissions. Results from matched data file analysis are then sent to health plans and providers for purposes of sharing information and promoting quality improvement. We would use an iterative process, similar to the ones we have used for other linking exercises for matching Medicare and Medicaid files to create a linked dataset. Division staff has also recently completed an analysis describing the differences in cost and utilization between persons enrolled in managed long term care plans and those in the fee for service long term home health care program. A draft report describing findings has been shared with managed long term care plans and providers and once the data has been refreshed will be publicly reported in 2011. The Division has also overseen the administration of satisfaction with care surveys including the dual population and validates encounter data submitted by managed long term care plans.

In the fall of 2010, Division staff engaged in discussions with CMS regarding the shared use of Medicare fee for service data for dually eligible Medicaid recipients who reside in New York. Since those calls we have completed the data sharing agreement and submitted it in early January. It is envisioned that 2006-2009 Medicare fee for service data should be available for use sometime within the first few months of 2011 and planning efforts are currently underway for housing the data, assigning analytic staff and reviewing the Medicare data reporting fields prior to undertaking a linking process. This data set will be used primarily for research purposes and for obtaining a better understanding of the health service needs of the population. In addition, CMS has indicated that pharmacy data could be provided in "real time," which would aid in helping plans identify early care management needs, risk stratifying the population and developing actuarially sound capitation rates. Medicaid eligibility, claims and encounter data will be used to link to the Medicare data.

Specifically, Medicare data is needed to understand the access, utilization and cost patterns for all categories of service for the dually enrolled population. DQE staff has been conducting these types of analyses for other populations, such as recipients with behavioral health conditions and non-dual SSI recipients, and will work to extend these analyses to the duals. Specific potential uses of integrated Medicaid and Medicare service utilization and expenditure data include, but are not limited to, the following:

- Extending an analysis previously conducted on the non-dual SSI population of expenditure patterns for duals by category of service to determine where greater efficiencies are possible;

- Use of predictive modeling to accurately reflect severity of illness and accurately identify high-risk enrollees. New York State uses 3M Clinical Risk Groups (CRGs) to assess the severity of illness of its Medicaid enrollees. CRGs are used currently for risk-adjusted payment for managed care enrollees, to determine thresholds for utilization review, and are used to stratify the Medicaid population for potential programs including care management and health homes. Medicare data will help the state to do a complete risk profile of the dually eligible population.

- Development of financial models for fully integrated care coordination (including Managed Long Term Care Program models);

- Enhanced person-centered care coordination through health homes;

- Development of shared savings models for dual eligible recipients with complex health and mental health needs residing in nursing facilities;

- Development of Pay for Performance Initiatives in conjunction with SAAM, HEDIS and HOS data;

- Pharmaceutical Analysis Using Part D Data (e.g., Psychiatric Drug Management);

- Avoiding Adverse Events such as emergency room use for low acuity patients.

Linked Medicare data will also be used to measure preventable inpatient events including preventable admissions (PQIs preventive quality indicators), potentially preventable readmissions (PPRs), and potentially preventable complications (PPCs). Well coordinated comprehensive primary care will help reduce these preventable events, and using these metrics will help improve quality and potentially reduce costs. The linked dataset would also help New York State evaluate the quality of care of the dually eligible population by having the ability to calculate national performance measures including select HEDIS measures.

4) Summary of Stakeholder Environment.

The Department has many avenues for obtaining feedback from advocates, industry representatives, trade associations, health plans, providers and other interested parties. Meetings are routinely scheduled to obtain input on new models of care, financing and issues related to care coordination and quality. Since the change in administration in January, the new Governor, Andrew Cuomo, has instructed the Medicaid Director, Mr. Jason Helgerson, to quickly mobilize a

Medicaid Redesign Team with representatives from across the health service industry in New York. The primary goal of this advisory body is to look for ways to right size the state's Medicaid program by reducing costs and improving quality. Representatives on the 25 member panel include home care and nursing home providers and it is likely that some of the recommendations from the Redesign team will impact the service delivery system for duals. We expect this concurrent planning process will be useful as we plan for our demonstration.

A portion of the funding made available through this contract opportunity will enable the Department to hire an experienced consultant to conduct formal stakeholder interviews with individuals and groups representing all interested parties. While the Department in conjunction with our agency partners in OMH and OPWDD will take the lead on obtaining stakeholder input, due to limited staff resources we will need the assistance of an organization familiar with New York Medicaid and issues related to dual integration.

Among those who would be considered as key partners in a demonstration design are: the New York State Health Plan Association, the Managed Long Term Care Coalition, the Healthcare Association of New York, the New York State Association of Homes and Services for the Aging and the Health Facilities Association. This information will assist the Department in formulating its Demonstration plan for managing the care of the dually eligible. The stakeholder information gathering will be key in identifying current and projected capacity within the existing system and in identifying areas where infrastructure needs further development and support.

5) Timeframe

The planning activities associated with this contract will begin upon notification of award. Contracting for vendors and hiring of state staff will begin immediately. Existing staff would assume responsibility for drafting requests for proposals and obtaining personnel waivers from our Budget Office. The Department does not anticipate any barriers that would prevent us from having a draft demonstration proposal to CMS within of twelve months from the notice of award and implementing a demonstration in 2012.

We do not anticipate any legislative authority being required to proceed with a planning process for the integration of services for duals. However, we could request a provision in the 2011/12 budget giving the Commissioner of Health the authority to seek a federal waiver to demonstrate innovative approaches for integrating care for dual eligibles and that allows New York to share in savings.

6) Budget and Use of Funds

See Attachment A. for the budget and corresponding justification.

Attachment A

6) Budget and Use of Funds

Personal Services	**Salary**
Program Coordinator, Health Prog. Admin. II, G-25	$92,974
Financial Analyst, Prog. Research Specialist,G-23	$83,954
Data Analyst, Research Scientist II, G-22	$79,819
Program Administrator, Health Prog. Admin, G -18	$65,190
Total	$321,937
Fringe Rate @ 48.43%	$155,914
Total Personnel	**$477,851**
Indirect @ 16.4%	$78,368
Personnel Services Subtotal	**$556,219**
Other than Personal Services	
Consultants	$400,000
Equipment	$6,000
Supplies	$8,000
Travel	$10,920
OTPS Subtotal	**$424,920**
Grand Total	**$981,139**

Budget Justification:

Personal Services: **$477,851**

Name, Position Title	Annual Salary	% Effort	# Months	Amount Requested
Vacant, Project Coordinator	$92,974	100%	12	$92,974

The Program Coordinator, (Health Program Administrator II) will be responsible for all aspects of managing the planning contract. The Coordinator will supervise the Program Administrator, be responsible for reports to CMS and will participate in monthly conference calls with representatives from the Coordinated Care office. The Program Coordinator will assist in the implementation of sub-awards and will monitor vendor deliverables. The Program Coordinator will organize and attend both internal meetings with program representatives from various DOH offices that serve duals as well as meetings with outside agencies such as the Office of Mental Health and the Office of Persons with Developmental Disabilities, advocates, industry representatives, among others.

Vacant, Financial Analyst	$83,894	100%	12	$83,954

The Financial Analyst (Program Research Specialist III) will be the lead analyst on the financial aspects of the demonstration. Responsibilities will include researching payment models for the dual eligible population, analyzing the financial impacts and developing recommendations for the

various models of care for the dual eligibles. This position will serve as the primary liaison with the actuarial consultant.

Vacant, Data Analyst	$79,819	100%	12	$79,819

The Data Analyst (Research Scientist II) will work closely with senior staff within the DQE and the data analytic consultant to cleanse and analyze the Medicare data and to conduct analysis on the linked Medicaid dataset. The RS II will work closely with senior staff in the Division to apply standardized measures of performance to assess services and outcomes for the dual eligibles.

Vacant, Program Administrator	$65,190	100%	12	$65,190

The Program Administrator, (Health Program Administrator) will be responsible for compiling information for reports, processing vouchers and overseeing the contracts of sub-awardees. The Program Administrator supports the Coordinator by investigating activities of other states and researching published literature for information on successful models of care.

Fringe **$155,914**
The fringe rate is 48.43%

Indirect **$78,368**
The NYSDOH has a federally negotiated rate of 16.4%

Other Than Personal Services: **$424,870**

Consultants: $400,000

a) Actuarial Support ($300,000): The services of an actuarial consultant will be needed to help the state in researching how other states have structured and financed their demonstrations and for developing actuarially sound rate proposals for several of the proposals outlined in Section 1. We anticipate needing approximately 750 hours of consulting time @ $400/hour.

b) Data Analytic Support ($50,000): The services of a consultant familiar with using linked Medicare and Medicaid data will be employed to assist the state in analyzing dual data and in identifying opportunities to reduce unnecessary utilization, increase efficiencies and measure and report on the quality of care.

c) Stakeholder Meetings ($50,000): A consultant experienced in working with states and with bringing diverse groups of stakeholders together will be hired to assist New York in gathering information on: successful service models for duals, health system capacity to test proposed innovations and addressing client needs among other topics. The successful applicant will conduct up to 20 individual structured interviews with key informants and several open forums with interested parties.

Equipment:
$6,000
Equipment needs for the four staff hired with Dual Planning contract funding.

	Quantity	Cost	Total
Phones	4	in-kind	in-kind
Desks	4	in-kind	in-kind
Chairs	4	in-kind	in-kind
Computers	4	$1,500	$6,000
Total			$6,000

Supplies: $8,000

Funds are requested for miscellaneous supplies. Printing supplies including paper and toner are needed. Other office supplies (pens, calculators, desk supplies) will also be required. Software licenses (Microsoft Office, SAS) will also be required.

Travel: $10,920

Travel will be required for staff to attend stakeholder meetings, planning meetings with providers and trade organizations in New York City and to attend a series of meetings on duals being sponsored by the Center for Health Care Strategies in or near D.C.

a) It is estimated that staff funded on the grant, as well as in-kind staff will attend up to five stakeholder meetings in NYC.

Round trip train ticket @ $76 x 3 staff =	$228
Parking@ $ 6 x 3 staff =	$18
Mileage @.50/mile =$10 x 3 staff =	$30
Meals@ $64/per diem x 3 staff =	$192
	$468
$468/ per meeting x 5 meetings =	$2,340

b) Travel funds are requested to send a team to Washington, DC for a series of five, two day meetings on dual integration hosted by the Center for Health Care Strategies and in collaboration with the CMS Coordinated Health Care Office.

Round trip airfare @ $500 x 2 staff =	$1,000
Hotel @ $200/ night x 2 staff =	$400
Airport parking @ $20/day x days x 2 staff =	$40
Mileage @ .50/mile x 20 miles x 2 staff =	$20
Meals @ $64/per diem x 2 days x 2 staff =	$256
	$1,716
$1706/per meeting x 5 meetings =	$8,580

STATE OF NEW YORK
DEPARTMENT OF HEALTH

Corning Tower The Governor Nelson A. Rockefeller Empire State Plaza Albany, New York 12237

January 25, 2011

Mr. Charles Littleton
Center for Medicare and Medicaid Services (CMS)
CMS, OAGM, AGG, DSPSCG
Attn: RFP-CMS-2011-0009/ Charles Littleton
C2-21-15 Central Building
7500 Security Boulevard
Baltimore, Maryland 21244-1850

Dear Mr. Littleton:

As part of our Dual Integration application we submit the following:

The New York State Department of Health certifies that, to the best of its knowledge and belief:

1) It has filed all Federal tax returns required during the three years preceding this certification;

2) It has not been convicted of a criminal offense under the Internal Revenue Code of 1986; and

3) It has not been notified of any unpaid Federal Tax assessment for which the liability remains unsatisfied, unless the assessment is the subject of an installment agreement or offer in compromise that has been approved by the Internal Revenue Service and is not in default, or the assessment is the subject of a non-frivolous administrative or judicial proceeding.

The signature on the offer is considered to be a certification by the New York State Department of Health under this provision.

Should you need any additional information, please contact Joseph Anarella at (518) 486-9012.

Sincerely,

Robert W. Reed
Deputy Commissioner for Administration

SECTION J - LIST OF ATTACHMENTS

J.1 ACCOUNTING CERTIFICATION

NOTE: This information should correspond to the information in the Central Contractor Registration (CCR.) Database

NAME of STATE:	New York
ADDRESS:	New York State Department of Health Corning Tower, Room 1315 Albany, NY 12237
CONTRACTOR POC / TELEPHONE NUMBER(S):	Robert Reed 518-474-8565
DUNS (Data Universal Numbering System) #	806781340
TIN (Taxpayer Identification Number)	146013200
CAGE CODE #:	3QSS3

SIGNATURE 1/28/11

Deputy Commissioner
for Administration

For CONTRACTOR (Title) Date