CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES
RESPONSE TO REQUESTS FOR PROPOSAL
STATE DEMONSTRATIONS TO INTEGRATE CARE FOR DUAL ELIGIBLES

TO: Centers for Medicare & 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

FROM: Toby Douglas, Director, California Department of Health Care Services

Thank you for the opportunity to respond to the *Request for Proposals, State Demonstrations to Integrate Care for Dual Eligible Individuals*. Please contact Paul Miller, at 916-440-7534, or e-mail Paul.Miller@dhcs.ca.gov with any questions regarding the content of this proposal.

I. California's Proposed Approach to Integrating Care

A. Overview of California's Approach to Integrating Care: Dual eligible beneficiaries are the most chronically ill individuals within both Medicare and Medicaid, requiring a complex range of services from multiple providers. Despite the complexity of their needs, the vast majority of California's dual eligibles remain in the fragmented fee-for-service (FFS) delivery system. State legislation enacted in 2010 (Senate Bill 208) directed Medi-Cal, California's Medicaid program, has been directed by the California Legislature (Senate Bill 208) and the Governor's office to develop a program to provide more streamlined and effective care for California's dual eligibles. The legislative mandate directs the California Department of Health Care Services (DHCS) to initially implement integrated care pilots for full benefit dual eligibles in four counties. At least one of these pilot programs will be managed by a County Organized Health System (COHS) and at least one will be piloted within California's Two-Plan County Model. DHCS plans to implement these four pilots during 2012. During this time, DHCS will also explore integrated care options for rural areas of the state and implement pilots in these areas as rapidly as possible. All pilots will be closely monitored and evaluated to ensure quality and efficient service delivery. **DHCS plans to enroll up to 150,000 dual eligibles in integrated care in the next 24 months. By 2015, DHCS hopes to expand integrated care statewide based on successes and lessons learned in these pilots.**

B. Target Population: California will include all full benefit dual eligibles in the selected four geographic areas as directed by Senate Bill 208 passed in 2010. Full benefit dual eligibles receive Medi-Cal coverage for Medicare premiums, coinsurance, copayments, and deductibles, as well as additional services that are covered by Medi-Cal that Medicare does not cover.

C. Covered Benefits: The pilots will provide coverage for Medicare and Medi-Cal services through an integrated delivery system that includes all medical services, long-term supports and services (LTSS), and coordination with/or coverage for behavioral health services (to be finalized during the design process).

1) Individuals will receive Medicare services that are currently covered by Medicare Parts A, B, and D. They will also receive coverage for coinsurance, copayments, and deductibles for Medicare-covered services. Premiums for Medicare Part A and Part B (Medicaid beneficiaries do not have to pay premiums for Part D) that are currently paid by the state will continue to be paid directly by the state and will not be included in the integrated care program pilots.

2) Individuals will continue to be entitled to state plan benefits and services covered by Medi-Cal, including those services that Medicare does not cover.

3) The pilot programs will also include coverage of long-term supports and services. There may be some variation in the pilots depending on the readiness of the individual pilot areas and plans. The following will be considered for integration into the pilot programs[1]:

   - Institutional long-term care;
   - 1915(c) Home and Community-Based Services (HCBS) Waiver, including services provided by the Multipurpose Senior Services Program, Assisted Living Waiver, and the Nursing Facility/Acute Hospital Waiver;
   - Personal care services, adult day health care, home modifications, and meals; and
   - Paramedical/nursing services and physical, speech, and occupational therapies.

4) During the design phase, the pilots will also explore how to include Specialty Mental Health Waiver services, Developmentally Disabled Waiver services, and community behavioral health services. Inclusion of these services in the pilots will be determined through discussions with CMS and stakeholders.

D. Proposed Service Delivery System: In 2010, the California Legislature passed legislation authorizing DHCS to implement integrated care pilots. Senate Bill 208 added Section 14132.275 to the Welfare and Institutions Code. This section, in part, requires DHCS, not sooner than March 1, 2011, to:

- Identify health care models that may be included in proposed pilot projects;
- Develop a timeline and process for selecting, financing, monitoring, and evaluating these pilot projects; and
- Provide this timeline and process to the appropriate fiscal and policy committees of the Legislature.

This section also allows the Medi-Cal Director to enter into exclusive or nonexclusive contracts on a bid or negotiated basis, and allows the pilots to be implemented in phases. California's delivery system varies by county. The legislation specifies that the pilots include one COHS and one Two-Plan County Model. Through a Request for Information process early in 2011, DHCS will identify specific entities that are interested in participating as pilots and obtain high-level information about their proposed program models.

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[1] Adult Day Health Care and Multipurpose Senior Services Programs will be included if funding is appropriated for these services.

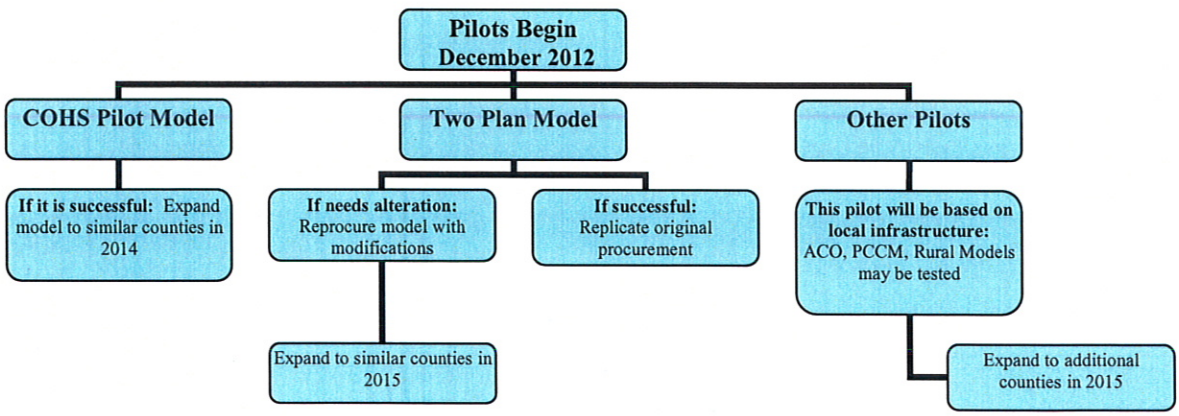
DHCS seeks CMS Demonstration funding to meet its state legislative mandate and develop four pilot projects that utilize at least two models of integrated care. All pilots will share common financing and streamlining principles, which will be developed during the design period. The design process, including stakeholder input, will dictate whether Medicare and Medicaid funding is combined at the state or health plan level. DHCS assumes, however, that blended funding for services will mean that contractors will not be required to report encounters separately. In addition, the program will utilize a single set of rules for grievances and appeals, marketing, enrollment, and member materials. The Technical Advisory Panel, including representatives of provider groups, advocacy organizations, and health plans, as well as DHCS cross-agency staff, has expressed a desire to hold the pilots to the highest standard when existing rules are in conflict, e.g., for benefit determination and member rights.

Initially, these models will cover four geographic regions, with at least one region operated by a COHS and one region that includes a Two-Plan County Model. The state will also explore other integrated care options for dual eligibles, such as in the state's rural areas. Following are specific details for each of these pilots:

- In the two plan region(s), the state will contract with health plans to provide a combined Medicare and Medicaid benefit package of fully integrated medical services, LTSS, and behavioral health services (as determined through a comprehensive stakeholder engagement process similar to the process held in 2010, see pg. 7 for details).
- In the COHS region(s), the state will contract with the COHS to provide a full benefit package of fully integrated medical services, LTSS, and behavioral health services (as determined through the stakeholder process).
- In addition, the state is open to other models of integration that can be developed within the necessary timeframe. For example, DHCS staff and stakeholders have also discussed: (1) directly contracting with Accountable Care Organizations (ACO) to provide integrated services; (2) developing a primary care case management model (PCCM) of enhanced fee-for-service payments; and/or (3) developing a shared savings program across Medicare and Medi-Cal.

DHCS will begin implementation of integrated care pilot programs for dual eligibles in four California counties in 2012. DHCS' goal is that all dual eligibles in California will have the option to enroll in a fully integrated system of care by 2015. (See Figure 1 below.)

Figure 1: **Pathway to Statewide Integration**



Problem Statement: Managed care plans provide a coordinated system of care for a number of Medi-Cal beneficiaries. However, only an estimated 175,000 of California's 1.1 million dual eligibles are in managed delivery systems such as PACE (Program of All-inclusive Care for the Elderly), Two-Plan Model plans, or COHS, leaving 926,000 beneficiaries -- over 80 percent -- in fragmented fee-for-service (FFS). Other than PACE, these other systems still only offer partially managed services. There is a critical need for new organized systems of care that provide beneficiaries with more tailored and supportive benefits in the setting of their choice.

The problem of fragmented care for a population in clear need of coordinated services has been exacerbated by the growing budget deficit in California. The state and federal governments invest almost $21 billion annually in caring for California's dual eligibles. In 2007, the state spent $3.2 billion on LTSS for dual eligibles, representing 75 percent of the total Medi-Cal LTSS expenditures. A significant opportunity exists to achieve federal and state savings through better coordination of benefits, coordination of care, and streamlined financial incentives. Fully integrated services and funding will allow beneficiaries to receive the services they need to live in the community and to avoid costly hospital and emergency department visits. Integration of services will improve utilization, beneficiary satisfaction, and health outcomes by ensuring the right services are delivered to the right people at the right time.

Who will Benefit from this Pilot and Why? As of January 2011, there are 1,099,199 dual eligibles in California: 770,042 are aged 65 and up; 326,822 are between 22-64 years of age. The COHS in both San Mateo and Orange County (CalOptima) have expressed strong interest in operating dual eligible pilots. DHCS estimates that over 83,000 dual eligibles in these two counties will be eligible for the pilot. DHCS is not yet certain of the other two counties that will be involved in the pilot; however, on average, a two-plan county in California has 33,000 dual eligibles (excluding Los Angeles). **In short, DHCS plans to enroll up to 150,000 dual eligibles in its pilots in the next 24 months, leading to statewide availability of integrated care by 2015.**

The stakeholder engagement process held in 2010 identified a core set of "achievable principles" for integrated care that are critical for program success. These include:

- Providing a streamlined continuum of care that is easy for beneficiaries and caregivers to navigate;
- Ensuring high standards of quality of care;
- Helping beneficiaries return to their homes after an acute episode of care;
- Preserving beneficiary choice of care providers;
- Preventing admissions to nursing facilities and providing robust and coordinated home- and community-based services (HCBS);
- Increasing access to primary care;
- Providing financial support to mental health professionals to participate on care teams and provide caregiver training;
- Blending Parts A and B funding with Medi-Cal dollars to expand flexibility in coverage;
- Blending home and community based funding with Medicaid acute and long-term care institutional funding to align incentives to help people stay out of institutions;

- Using one set of rules for appeals, marketing, quality measures, and reporting; and
- Creating a rapid cycle monitoring and learning process so that integrated care models can be developed, improved, replicated, and scaled as efficiently as possible.

Dual eligibles in the targeted areas will benefit from a delivery system that meets the above principles for integrated care.

Medi-Cal's Previous Experience: California has the largest enrollment of duals in Special Needs Plans among the fifty states, at 215,758, mainly in COHS and Two-Plan counties. SNPs are able to integrate services at the plan level; however, they are not able to integrate funding or home and community-based services. Therefore, the extent of integration in SNPs often falls short. California does, however, have experience with programs that offer true integration, including the nation's first PACE program. PACE is a comprehensive model of care that integrates Medicare and Medi-Cal financing to provide all needed preventive, primary, acute and long-term care services for older adults who are determined eligible for nursing home level of care. PACE began in California as a waiver demonstration project in the 1980s and was established as a permanent Medicare provider and a voluntary option under Medicaid as part of the Balanced Budget Act of 1997. California has five PACE programs, serving a largely dual-eligible population. In counties implementing pilot projects where PACE is available, individuals meeting the eligibility requirements for PACE will be able to select this option.

California is also the site of the nation's largest Social HMO demonstration that began in 1985 and continued through 2007. This program included a fully integrated contract with the state for dually eligible beneficiaries in Los Angeles, Riverside, and San Bernardino counties. At the end of the demonstration, the state decided to continue the program in these three counties. The program allows voluntary enrollment for all duals over the age of 65. State and federal funding provides for all Medi-Cal and Medicare preventive, primary, acute, and long-term care services. Members who meet California nursing facility level of care criteria are eligible for additional home and community-based services coordinated with a care management program. Independent research has shown this model to reduce nursing home placement and significantly increase the likelihood that members who are placed in nursing homes following hospitalization will return to their own homes within 90 days.

In addition, over the past few years Medi-Cal leadership has expressed a further commitment to provide organized systems of care for vulnerable populations. The state is currently expanding managed care for seniors and persons with disabilities (SPD). The California Legislature enacted Assembly Bill X4 6 as a part of the 2009-2010 budget. The goal of this provision was to build a better, more comprehensive system of care for these vulnerable populations while simultaneously slowing the Medi-Cal expenditure growth rate. California obtained a §1115 waiver to restructure the organization and coordinate the delivery of care for these medically vulnerable, high-cost beneficiaries. Per CMS' request, however, the state did not include dual eligibles in this expansion.

II. Overview of State Capacity and Infrastructure

DHCS is well aware of the significant capacity that is required to develop and enroll dual eligible beneficiaries into a new program of integrated care. DHCS is currently implementing a new managed care program for the SPD population in many counties of the state. Based on this experience, DHCS understands the special needs of this population and the considerable effort and staff that must be dedicated to ensure the success of an integrated program model. The state is confident that the necessary staff will be devoted to this program.

Staff will form an internal work group, which will meet monthly or more often as necessary. The composition of this workgroup is below:

- Workgroup Lead: Paul Miller, Chief, Long-Term Care Division;
- Managed Care: Tanya Homman or designee;
- Eligibility: René Mollow or designee;
- Benefits, Waiver Analysis and Rates Division: Vickie Orlich or designee;
- Information Technology: Christopher Cruz or designee;
- In Home Supportive Services, Department of Social Services: Eileen Carroll or designee;
- Mental Health: Cliff Allenby or designee; and
- Alcohol and Drug Programs: Michael Cunningham or designee.

In addition, over the past year The SCAN Foundation and the California HealthCare Foundation have provided additional support through contracts with technical experts, and DHCS anticipates that this support will continue through the next two years. For example, the UCLA Center for Health Policy Research is separately funded for the evaluation of §1115 waiver programs.

DHCS also plans to use consultants/contractors for activities such as overall project management (through a contract with an individual with Medicare expertise); rate development (likely to be Mercer); Medicare and Medicaid data analysis including development of baseline data and program monitoring metrics (likely University of California – San Francisco); enrollment planning (Maximus); conducting focus groups for beneficiaries (University of California-Berkeley); and conducting stakeholder meetings (Pacific Health Consulting Group). Note that while subcontractors cannot be definitively named at this time, the likely participants have the necessary experience with Medi-Cal, and contracting would not take an inordinate amount of time. This is especially true of the University of California contract arrangement.

State staff responsibilities will include work plan development and procurement activities. Several of the following activities are being conducted for SPD enrollment, so DHCS has experience in these areas and the ability to deploy staff to such tasks when needed:

- Program Design (Benefit Design, Risk Assessment, Care Coordination Model Development, Program Alignment, Training on LTSS): DHCS, with the assistance of contracted project management staff, will finalize the program design components and evaluate contractors' ability to comprehensively assess and plan care for dual eligibles.
- Authority (CMS Approval, Rates, and Contract Language): DHCS will dedicate staff to working with CMS to gain necessary approval and develop contract language.

- Network Adequacy Assessment: DHCS will use the Medicare/Medi-Cal blended data set to compare beneficiary needs, including LTSS and behavioral health needs, to the proposed provider network.
- Plan Readiness and Facility Site Reviews: DHCS will conduct site visits and determine whether plans have established that appropriate providers have met access criteria.

III. Description of Current Analytic Capacity

DHCS does not have Medicare data at this time; however, it plans to obtain this data from CMS when it becomes available this spring. Once this data is available, DHCS will be well positioned to readily incorporate this data into its data analysis process, using internal and external analysis.

Internally, DHCS staff has experience matching Medi-Cal claims data, eligibility data, Medicare data, Office of Statewide Health Planning and Development (OSHPD) hospital inpatient discharge data, vital records death data, and long-term care assessment data. The linkage of Medi-Cal eligibility data to hospital discharge data has been particularly successful. A 2005 *Health Services Research* article by Bindman, et al., indicates that over 90 percent of hospital discharges recorded in the OSHPD files can be accurately linked to Medi-Cal beneficiaries in the Medi-Cal eligibility and claims files.[2] Using the Medi-Cal eligibility data ensures that Medi-Cal enrollees, including dual eligibles, are accurately identified in the OSHPD hospital discharge files. These matched data files have been used to study ambulatory care sensitive admission rates among Medi-Cal's managed care populations. This experience will contribute to establishing baseline performance measures and monitoring indicators once implementation has begun.

In addition, combined funding from DHCS and The SCAN Foundation supports relevant work at the California Medicaid Research Institute (CaMRI), which is a University of California multi-campus research program hosted at the University of California San Francisco (UCSF) and directed by Professor Andrew Bindman, MD. The first statewide Comprehensive Analysis of HCBS in California[3] is a 36-month project, including a review and analysis of:

- The published research on cost-effectiveness of HCBS;
- The utilization and cost information for Medi-Cal beneficiaries receiving HCBS; and
- The costs and utility of HCBS provided under Medi-Cal via waivers and the State Plan.

The research will inform HCBS-related policy by providing information on how HCBS prevents or delays institutionalization; reduces the use of emergency room services and hospital admissions; and improves or maintains a person's quality of life. In addition, this project will provide insights on the cost-effectiveness of HCBS programs and services and identify which of these are the most essential to consumers. The results of this work will contribute to the pilots by setting baselines and informing the design of monitoring and performance measurement.

IV. Summary of the Stakeholder Environment

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[2] A.B. Bindman, et al. "The Impact of Medicaid Managed Care on Hospitalizations for Ambulatory Care Sensitive Conditions." *Health Services Research,* Vol. 40, No. 1, February 2005, pp. 19-37.

[3] See project description at http://www.thescanfoundation.org/sites/default/files/CaMRI_Overview%20-%20FINAL_January%202010.pdf.

DHCS began gathering input from stakeholders on plans for dual eligible integration in April 2010. In a project funded by The SCAN Foundation, a series of in-depth interviews with stakeholders were conducted by the Center for Health Care Strategies (CHCS). These interviews, which were mainly conducted in person, gleaned the perspectives of advocacy organizations, provider associations, union officials, and health plans. Following the interview series, two public meetings were held to present the initial findings. These meetings included a high-level description of the benefits of integrated care and an opportunity for stakeholders to provide additional input. The two public meetings were well-attended by a broad spectrum of stakeholders. The input is summarized in a CHCS paper, *Options for Integrated Care for Duals in Medi-Cal: Themes from Interviews with Key Informants and Community Dialogues*.[4]

California initially planned to include dual eligibles in its 2010 §1115 waiver application to improve care for the SPD population. As part of the waiver application development, DHCS held three Technical Workgroups in April, May and June 2010 in Sacramento. These meetings sought to develop consensus on a model approach and framework for integrated care for dual eligibles. The outcome of these technical workgroups was input on the core elements to be included in California's integrated care models and a set of outstanding issues that must be addressed by DHCS prior to program development. During fall 2010, however, CMS recommended that California not include dual eligibles in its §1115 waiver. California therefore excluded this population from its waiver application. Integrated care, however, was and continues to be discussed during public §1115 waiver stakeholder meetings (as recently as December 2010).

DHCS has continued to prioritize stakeholder involvement in duals integration activities since the Technical Workgroup process ended in August 2010. The SCAN Foundation has supported ongoing development of the framework for integrated care programs by funding a smaller Technical Advisory Panel, which convened in October 2010. This group consists of representatives of provider groups, advocacy organizations, and health plans, as well as cross-agency staff from within DHCS.

The Technical Advisory Panel has reviewed and given feedback on this proposal, and will continue to meet to advise DHCS on the planning, procurement, implementation, and evaluation of its integrated care model. Going forward, the group will be expanded to include beneficiaries and representatives of physician, mental health, and disability rights organizations. In addition to continuing the regularly scheduled smaller Technical Advisory Panel meetings, the Technical Advisory Panel will hold a series of meetings, beginning in May 2011, that synchronize with specific activities in the timeline (see next section). Stakeholders and the general public will have the option to attend these meetings in-person or by teleconference. In addition, DHCS will hold public meetings in the four pilot counties.

Focus groups of beneficiaries are planned in each of the four counties chosen for pilots. An experienced subcontractor will be chosen, likely Health Research for Action at UC-Berkeley.[5]

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[4] M. Bella, A. Lind, and S. Somers. "Options for Integrated Care for Duals in Medi-Cal: Themes from Interviews with Key Informants and Community Dialogues," April 2010, accessed at http://www.chcs.org/publications3960/publications_show.htm?doc_id=1261128.

[5] Health Research for Action (HRA) is a center in UC Berkeley's School of Public Health. HRA has over 20 years of experience creating research-based tools, programs, and policies to promote healthy communities. Their researchers and health literacy experts specialize in engaging

V. Timeframe

The California Legislature has authorized integrated care pilots for dual eligibles. The legislation (Senate Bill 208) requires DHCS, not sooner than March 1, 2011, to provide an implementation timeline and process to the appropriate fiscal and policy committees of the legislature. Following is a draft timeline of activities proposed to date:

PROPOSED TIMELINE	
Timeframe	**Activity/Deliverables**
October – December 2010	• October 20: Held first Technical Advisory Panel meeting. • Developed Draft Framework of Duals Integration Pilots. • December 6: Held conference call with Technical Advisory Panel. • December 8: Held introductory meeting with stakeholders.
January – February 2011	• January 12: Held webinar. • January 20: Held Technical Advisory Panel meeting to gather further input from stakeholders. • Develop response to contract opportunity through Center for Medicare and Medicaid Innovation and share proposal with stakeholders. • February 1: Submit proposal to CMS.
March 2011	• Draft Request for Information (RFI) soliciting interest from counties/potential contractors. • March 11: Technical Advisory Panel meeting. • Develop work plan including finalization of program design and components (e.g. enrollment, marketing, appeals, grievances, federal authority, state regulations, claims processing, IT systems changes, quality metrics, program monitoring plan, rate setting, contracting, program rollout and launch, and communications).
April 2011	• Early April: Hold public stakeholder meeting to announce upcoming RFI, review project plan, and solicit feedback. • Mid April: Release RFI.
May – June 2011	• May 15: RFI responses due. • Revise framework based on RFI and stakeholder input. • Incorporate draft evaluation plan into framework document.
July – September 2011	• Provide targeted stakeholder outreach. • Finalize integrated care models. • Draft CMMI Demonstration Plan for CMS Approval. • September 1: Submit CMMI Demonstration Plan for CMS Approval.

end-users to create communication tools that are accessible, understandable and readable for diverse audiences, including those with limited literacy and limited English proficiency. They have worked with several state agencies, including the California Department of Health Care Services, using participatory research to create, revise and evaluate interventions for diverse audiences including seniors, persons with disabilities, new parents and managed care beneficiaries. They have experience with several non-English languages including Spanish, Cantonese, Mandarin, Vietnamese, American Sign Language and 10 other threshold languages common in California.

PROPOSED TIMELINE	
Timeframe	**Activity/Deliverables**
October 2011	• Draft and finalize Request for Proposals (RFP). • Develop a timeline and process for selecting, financing, monitoring, and evaluating pilots. • Mid-October: Identify health care models; provide a timeline and process to legislative committees. • Late-October: Hold 2nd open stakeholder meeting to announce RFP and gather stakeholder input. • October 31: Release RFP.
December 2011	• December 22: RFP responses due.
Jan. – Feb. 2012	• Evaluate RFP submissions.
March 2012	• Director announces pilot counties. • Following announcement, Third Open Stakeholder Meeting.
April – Nov. 2012	• Work closely with Mercer, selected pilots, CMS, and others to finalize pilot development.
Nov. - Dec. 2012	• Begin operating pilots.

VI. Budget and Use of Funds

The budget outlined below represents the DHCS' need for funding support for contracted work. As noted, resources needed for planning include actuarial services and data analysis, as well as building stakeholder support and gathering information directly from consumers.

CALIFORNIA CMMI APPLICATION BUDGET		
Need	**Planned Provider**	**Funding**
Overall Project Management	To be determined	$100,000
Actuarial Services	Likely to be Mercer	$325,000
Medicare Data Analysis: Includes Baseline Establishment and Program Monitoring metrics	To be determined, but likely the University of California.	$200,000
Travel: including state technical assistance meetings, consumer representative to Technical Advisory Panel, and for outreach to rural areas	State staff and consumer representative	$30,000
Three Stakeholder Meetings: including facility logistics and operator assisted phone lines	Likely to be the Pacific Health Consulting Group	$50,000
Enrollment Broker Planning	Likely to be Maximus	$50,000
Seed Grants to Plans/Counties for Education and Outreach	Up to $45,000 each in 4 counties for local development of pilots	$180,000
Focus Groups of Beneficiaries: 10 focus groups in 4 counties	To be determined, likely Health Research for Action	$65,000
TOTAL Request		**$1,000,000**

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:	California
ADDRESS:	California Department of Health Care Services 1501 Capitol Avenue, MS 0018 P. O. Box 997419 Sacramento, CA 95899-7419
CONTRACTOR POC / TELEPHONE NUMBER(S):	Paul Miller, Chief Long-Term Care Division (916) 440-7534; FAX (916)552-9139
DUNS (Data Universal Numbering System) #	796528263
TIN (Taxpayer Identification Number)	68-0317191
CAGE CODE #:	44AD8

SIGNATURE

Paul Miller 01-28-11

For CONTRACTOR Date
(Title)

(a) The offeror 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.

(b) The signature on the offer is considered to be a certification by the offeror under this provision.