
**Report to
The Vermont Legislature**

**Report on
Rate Setting; Medicaid**

In accordance with Act 54, Sec. 27. PROVIDER RATE SETTING; MEDICAID

(a) The Department of Disabilities, Aging, and Independent Living and the Division of Rate Setting in the Agency of Human Services shall review current reimbursement rates for providers of enhanced residential care, assistive community care, and other long-term home- and community-based care services and shall consider ways to:

(1) ensure that rates are reviewed regularly and are sustainable, reasonable, and adequately reflect economic conditions, new home- and community-based services rules, and health system reforms;

(2) encourage providers to accept residents without regard to their source of payment.

(b) On or before January 15, 2016, the Department and the Agency shall provide their findings and recommendations to the House Committee on Human Services and the Senate Committees on Health and Welfare and on Finance.

Submitted to: **Representative Ann Pugh, Chair,
House Committee on Human Services**

**Senator Claire Ayer, Chair,
Senate Committee on Health and Welfare**

**Senator Tim Ashe, Chair
Senate Committee on Finance**

CC: **Hal Cohen, Secretary
Agency of Human Services**

Submitted by: **Monica Caserta Hutt, Commissioner
Department of Disabilities, Aging and Independent Living**

Prepared by: **Megan Tierney-Ward, Director
Adult Services Division**

Report Date: January 15, ~~2015~~**2016**



**AGENCY OF HUMAN SERVICES
Department of Disabilities, Aging and Independent Living**

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I. Executive Summary

Vermont is very fortunate to have a diverse long-term services and supports system for people to receive care in the setting that they choose: home, residential care and nursing facility. However, what makes the system diverse also makes it complex when discussing the many ways in which services are delivered, managed and paid for.

In an effort to be targeted, this report focuses on the way Medicaid rates are managed for residential care services (Enhanced Residential Care and Assistive Community Care services) and home and community-based services reimbursed under the Choices for Care long-term care Medicaid program. What this report does not include are the other long-term services and supports (a.k.a. “Specialized Services”) funded through the Global Commitment to Health waiver, including Traumatic Brain Injury, Developmental Disabilities, Community Rehab and Treatment, Children’s Personal Care services and other State Plan Medicaid services.

Currently, two offices within the Agency of Human Services manage specific rates for certain Medicaid services. The Department of Vermont Health Access manages rate-setting for Medicaid outpatient, inpatient and professional fee services, in addition to Federally Qualified Health Center and Rural Health Clinics. The Vermont Division of Rate Setting (DRS) manages a complex system of accounting for setting Medicaid rates for licensed Nursing Facilities and Private Non-Medical Institutions (PNMI) for children. However, a comparable system does not exist for Vermont’s long-term services and supports system, including residential care and home and community-based services.

This report describes:

1. ways that Vermont currently manages Medicaid rates
2. ways to ensure Medicaid rates for residential care and home-based services are:
 - a. reviewed regularly,
 - b. sustainable,
 - c. reasonable, and
 - d. adequately reflect economic conditions, new home- and community-based services rules, and health system reforms
3. ways to encourage providers to accept people without regard to their source of payment; and
4. recommendations on next steps

Sources of input for this report include:

- Provider stakeholder input
- Department of Disabilities, Aging and Independent Services (DAIL)
- Division of Rate-Setting (DRS)
- Department of Vermont Health Access Medicaid Reimbursement Unit
- Agency on Human Services Medicaid Policy Staff
- Agency of Administration, Health Care Reform

II. Current System

The Department of Disabilities, Aging and Independent Living (DAIL) manages the long-term services and supports for elders and adults with physical disabilities through the state's Global Commitment to Health, Choices for Care program. Choices for Care pays for services in a variety of settings for people who are Medicaid eligible under long-term care rules and meet nursing home level of care (High/Highest clinical eligibility). Settings include home-based, Adult Family Care, Enhanced Residential Care and Nursing Facility. Choices for Care also provides limited funding for "Moderate Needs" homemaker and adult day services to people who have a lower level of need. Vermont's Medicaid State Plan covers services in residential care (Assistive Community Care Service's) and Adult Day (Day Health Rehab) for people who are financially eligible for Vermont Medicaid benefits. As with all Medicaid services, the budget stems from a combination of State General Funds (44.97%) and matched federal funds (55.03%).

Medicaid State Plan Health Benefits

For context it is important to understand that the Department for Vermont Health Access (DVHA) Medicaid Reimbursement Unit currently oversees rate setting, pricing, provider payment and reimbursement methodologies for Vermont State Plan Medicaid benefits for outpatient, inpatient and professional fee services. The unit works to support equitable, transparent and predictable payment policy in order to ensure efficient and appropriate use of Medicaid resources. Because long-term services and supports have historically been de-coupled from traditional Medicaid State Plan health benefits, they are not currently managed under the same rate setting system at DVHA.

The DVHA Payment Reform Team supports the Vermont Health Care Innovation Project (VHCIP) which is jointly managed by DVHA and the Green Mountain Care Board. The goal is to create an integrated system of value-based provider payment, care coordination and care management and electronic medical records.

For the past several months, DVHA has been working closely with the Visiting Nurse Association of Vermont on the development of a new prospective payment model for their Medicaid State Plan home health services. The target implementation date for the new payment model is July 1, 2016. However, this new payment model does not include any long-term services supports administered through the Global Commitment to Health waiver, including Choices for Care.

Nursing Facility Rates

The Division of Rate-Setting currently manages Medicaid rates for licensed nursing facilities and children's Private Non-Medical Institutions (PNMI). The rate-setting methods are complex and are established in regulation. Nursing facility services are the only Choices for Care service that currently follow a formal rate-setting methodology.

As described in regulation, Medicaid payment rates for licensed nursing facilities are set on a quarterly basis in advance of the actual provision of services. A daily rate is set for each facility based on the historic allowable costs of that facility. The costs are divided into certain designated cost categories, some of which are subject to limits. The basis for reimbursement within the Nursing Care cost category is a resident classification system that groups residents into classes according to their assessed conditions and the resources required to care for them. The costs in some categories

are adjusted to reflect economic trends and conditions, and the payment rate for each facility is based on the daily costs for each category.

One way nursing facility rates are unique is that they include the cost of room and board. However, the Medicaid rules require that after a certain period of time, the person pay a monthly “patient share” or portion of the cost of care, depending on the person’s income. As of October 2015, Medicaid nursing facility rates range from \$157 per day to \$263 per day, with an average of \$219 per day. In October 2006, the rates ranged from \$112 per day to \$240 per day. This is a 33% increase from 2006 when the average rate was \$165 per day.

Nursing facilities receive reimbursement from Medicare, Medicaid, private insurance as well as private pay. Nursing facilities are not required by regulation to accept everyone who applies to their facility.

Residential Care Home Rates

There are currently two provider types that are licensed by the State and participate in Medicaid reimbursement; Level III Residential Care Homes (RCH) and Assisted Living Residences (ALR). Both RCH and ALR providers are licensed by the Division of Licensing and Protection (DLP) and offer a shared living environment in which three or more people reside with 24/7 staff, nursing overview, medication management and limited personal care. Of the 123 licensed RCH and ALR, 96 (78%) are enrolled Medicaid providers.

There are currently two sources of Medicaid payment for participating homes:

1. Assistive Community Care Services (ACCS) and
2. Choices for Care Enhanced Residential Care (ERC).

ACCS is a State Plan Medicaid benefit that pays a daily rate for people eligible for Vermont Medicaid and living in licensed RCH or ALR. Only 32 (29%) of RCH and zero ALR accept people on ACCS only reimbursement. Rates are managed by the Division of Vermont Health Access (DVHA). Providers that are authorized by DLP to offer ACCS are considered a Private Non-Medical Institution (PNMI). ACCS rates are typically based on the State’s available budget with stakeholder input. Currently, ACCS pays \$37.25 per day. This is a 12% change from 2006 when the rate was \$33.25 per day.

ERC is a three-tiered daily payment for people with a higher level of care who reside in a licensed RCH or ALR. Eligible participants meet the Choices for Care financial and clinical eligibility standards (high/highest). The tier is based on the person’s assessed level of need; the higher the care needs, the higher the reimbursement. A slightly higher rate (five dollars per day more) is given to Assisted Living Residences (ALR) based on the regulatory requirements for additional personal space, safety standards and “aging in place” standards of care. ERC rates are based on the State’s available budget with input from stakeholders. Currently, ERC pays between \$50.20 per day and \$69.44 per day. This is a 7% change from 2006 when the rates ranged from \$47 per day to \$65 per day.

In licensed RCH and ALR, the person always pays for their own room and board as defined by the DAIL Room & Board Standards. Providers who accept people under ERC also receive an ACCS payment in addition to the ERC tier payment. The ERC tier payment is intended to pay for the additional services needed to care for a person with higher needs.

RCH and ALR providers are not required to accept Medicaid payment for people they serve. People living in a private-pay only home may be forced to move once they have spent down to Medicaid eligibility.

Service	2006 Daily Rate	2015 Daily Rate	% Change
Assistive Community Care Services (ACCS)	\$33.25	\$37.25	12%
ERC Tier 1 Level III Residential Care Home	\$47.00	\$50.20	7%
ERC Tier 2 Level III Residential Care Home	\$53.50	\$57.15	7%
ERC Tier 3 Level III Residential Care Home	\$60.00	\$64.09	7%
ERC Tier 1 Assisted Living Residence	\$52.00	\$55.54	7%
ERC Tier 2 Assisted Living Residence	\$58.50	\$62.48	7%
ERC Tier 3 Assisted Living Residence	\$65.00	\$69.44	7%

NOTE: Since the above rates are set based on the amount appropriated by the State's Legislature through the budget process and do not reflect a standardized rate-setting method, there is no sound way to determine if changes in rates over time have been "reasonable".

Home and Community-Based Services Rates

Most Choices for Care home and community-based services are an hourly fee-for-service rate model and are set based on available State funds and stakeholder input. Some important variables exist between services.

- All self-directed services Medicaid rates include the employee's hourly wage which is set through a Collective Bargaining Agreement plus the employer's share of FICA and amounts for workers compensation and unemployment insurance.
- ARIS Solutions provides Financial Management Services (FMS) for self-directed services in which the rate is set through a contract negotiation process with the Agency of Human Services.
- Adult Day services are center-based and include one meal per day. Transportation to the center is not included in the rate and is provided through local Medicaid transportation providers or the individual/family.
- Adult Family Care is a new shared-living model that is contracted through an Authorized Agency (AA). People pay their own room and board based on the DAIL room and board standards. Since the AA is either a Designated Agency (DA), Special Services Agency (SSA) or Traumatic Brain Injury (TBI) provider, they serve multiple populations and may receive more than one source of Medicaid payment from other long-term services and supports programs within those agencies.
- Home-based case management is provided by Area Agencies on Aging (AAA) and Designated Home Health Agencies (HHA). The person chooses which agency to work with. There are significant differences between the AAA and HHA cost centers and revenue sources. For example, AAAs receive a limited amount of federal Older American's Act funding, however they do not participate in Medicare or other insurance funding sources as Home Health Agencies do. Both agencies are vulnerable to uncontrollable and unpredictable changes in their other sources of revenue.

Service	2006 Hourly Rate	2015 Hourly Rate	% Change
Case management	\$65.00	\$69.40	7%
Flex Choices Consultant	\$65.00	\$69.40	7%
Home Health Personal Care	\$25.00	\$27.70	11%
Home Health Respite/Companion	\$20.00	\$22.12	11%
Home Health Homemaker	\$18.00	\$19.88	10%
Self-Directed Personal Care	\$11.32	\$12.80	13%
Self-Directed Respite/Companion	\$9.64	\$12.24	27%
Adult Day	\$12.00	\$15.43	29%

NOTE: Since the above rates are set based on the amount appropriated by the State's Legislature through the budget process and do not reflect a standardized rate-setting method, there is no sound way to determine if changes in rates over time have been "reasonable".

III. Stakeholder Feedback

The topic of Medicaid rates is clearly important to Vermont's valuable providers of residential care and home and community-based services. Stakeholders are very interested in demonstrating the need for a fair and predictable Medicaid rate that allows providers to hire the right amount of quality staff, and grow services as the demand increases with Vermont's aging population. This section summarizes the stakeholder input solicited by DAIL and can be found in full in Attachment C of this document.

DAIL solicited input from the following stakeholders:

- Adult Day directors
- Area Agencies on Aging directors
- DAIL Advisory Board
- Home Health Agency directors
- Residential Care Home and Assisted Living administrators
- State Long-Term Care Ombudsman
- VT Center for Independent Living
- VT Healthcare Association

Input was received from:

- American Health Care Software Enterprises, Inc. & American Financial Services, LLC
- CarePartners Adult Day
- Ethan Allan Residence
- Vermont Associations of Area Agencies on Aging (V4A)
- Vermont Healthcare Association
- VNA's of Vermont

Residential Care Homes (RCH and ALR) Stakeholder Input

Ethan Allan Residence provides care to 39 elders, both private pay and Medicaid. They feel that currently, the Medicaid rate is “woefully inadequate” and does not come close to covering the cost of providing care. They also feel the people who pay privately are “subsidizing” the cost of providing services to people with Medicaid. Some key points include:

- Many residential care homes will not accept Medicaid because the rate is too low
- The low Medicaid rate makes it hard to cover building maintenance such as replacing a boiler or appliances.
- Private pay care homes are currently allowed to evict people when they run out of money.

The Vermont Healthcare Association (VHCA) agrees that the Medicaid rates for residential care have been historically low and require attention. While the VHCA, in consultation with their financial analyst, does not recommend an intensive cost reporting and rate setting process similar to the nursing facility process, they believe there should be a rate-setting method that includes the following:

1. The system should be cost based, reflecting the major components of providing care such as nursing and other salaries, payroll taxes, benefits, property costs, etc.
2. The costs should be calculated to set a baseline in year one
3. Census information should be used to generate the cost per day for direct care in the base year,
4. Providers would complete an easy to use fillable form
5. An inflationary increase should be provided annually.

Area Agencies on Aging Stakeholder Input

The Vermont Association for Area Agencies on Aging (V4A) represents Vermont’s five Area Agencies on Aging who serve Vermonters 60 years and older, as well as those who receive their case management services through the Choices for Care program. The V4A attests that the Medicaid rates for home and community-based services, and the methods used to calculate them, are not reasonable, sustainable, nor adequately reflect economic conditions and the changing health care system. A copy of their input is attached. Some key points include:

- Vermont’s population is rapidly aging with 23 Vermonters turning 65 every day
- Vermont is the second oldest state in the nation
- Vermont’s seniors are at high risk of chronic disease, hospitalization and are the most frequent users of the healthcare system
- The number of seniors being served by the V4A has increased 35% between 2005 and 2014.
- The Older American’s Act funding has decreased or remained stagnant for almost a decade
- 90% of seniors would prefer to receive services in their own home instead of a facility
- Home-based services are typically less expensive than facility-based care
- The V4A is not able to continue to meet their goals at the current reimbursement levels

Home Health Agencies Stakeholder Input

The VNA’s of Vermont (VNAVt) represents Vermont’s non-profit, designated home health agencies who provide Choices for Care case management, personal care, respite and companion services, in addition to a wide variety of insurance-based acute care services for people of all ages. The VNAVt

clearly support a rate method that is reviewed regularly, sustainable, and cost-based. A full copy of their input is attached. Some key points include:

- Medicaid payments for all home care services including CFC do not cover the cost of doing business as a designated, Medicare approved home health agency.
- Agency losses have increased steadily over the past decade, losing about \$7.4 million a year providing Medicaid services.
- Agencies often make up losses through community donations, which is not sustainable.
- The VNAVt believes home care costs and rates should be reviewed annually and adjustments made based on the costs reported.
- Agencies need annual inflationary increases otherwise the gap between payments and costs will continue to widen.
- Designated home health agencies provide care to everyone who qualifies regardless of income or the location of their homes.
- Agencies desire more flexibility in determining how services are provided.

Adult Day Stakeholder Input

Input from one adult day provider suggests that the cost of providing adult day services has increased as the needs of the people they serve become more complex requiring a higher level of nursing oversight. This provider calculated actual costs for SFY15 at \$17.47 per hour compared to the Medicaid rate of \$15.43 per hour. Some other key points include:

- Recommend that rates be reviewed every year or two.
- The cost of providing Adult Day services exceeds the current Medicaid rate.
- Adult day providers are small, free-standing organizations that are unable to assume the financial risk of a capitated system.

IV. Ways to Consider Managing Rates

There are several ways to consider managing Medicaid rates for residential care and home and community-based services. The methods vary significantly in both the administrative and financial impact to providers and the State. This section summarizes potential ways to manage Vermont Medicaid rates for these services. *Note that the Medicaid wages for all self-directed Independent Direct Support Workers must be determined through the Collective Bargaining Agreement.*

1. Formal Rate-Setting

Most formal “rate-setting” methods are complex and typically utilizes accounting methods to evaluate the actual cost of doing business in order to determine how much to charge for a service. One usually considers the expected costs and volume of service utilization of a particular service when setting a rate that is reasonable. Before a rate-setting method can be developed, it is also very important to understand the provider business model and consider all sources of cost and revenue to determine the significance of cost shifting that occurs to maintain operations of a particular provider type.

For example, providers that hire more employees at minimum wage will be more greatly affected by the increasing minimum wage requirements. Therefore, the need to increase wages for their employees would have an unavoidable and direct negative effect on their cost center. For the rate to be sustainable, the provider’s revenue would need to increase to sustain their

increased costs. A rate-setting method that is reasonable and sustainable would include a regular review of costs and revenues with a resulting rate adjustment.

It is also important to note that most long-term services and supports do not have a Medicare equivalent as a model for reimbursement like most other Medicaid State Plan benefits.

A formal rate setting process can be resource intense, both for the providers, and even more so for the State. Required resources include:

- staff expertise and significant time, ,
- the availability of reliable data from providers and
- the development of regulations to govern the process.

The data collection, the workforce and the regulations used to calculate Medicaid rates for nursing facilities and Private Non-Medical Institutions (PNMI) for Children are managed by the Division of Rate Setting (DRS) of the Agency of Human Services. Annually, detailed cost data, census data and revenue data are collected from all nursing home providers and all PNMI providers. Each provider also must have an annual financial audit and must provide these audited financial statements to DRS. Staff at the Division include skilled accountants, an audit supervisor, a Director and an attorney for a current total of 9 full-time equivalents (FTE's). This amount will be reduced to 8 FTE's in February 2016 as a result of the State retirement incentive.

Regulations have been developed by DRS to govern the process of determining nursing home and PNMI Medicaid rates. These regulations are Vermont law after passing through the Vermont State rulemaking process.

There is a great deal of structure and many controls on the accuracy of data in the rate setting process at DRS. The same process would not be well suited to smaller Enhanced Residential Care and Assistive Community Care Service providers who may not have the resources to maintain the same level of required data reporting.

Currently, DRS maintains rates for 36 nursing facilities (with annual Medicaid payments of approximately \$125 million) and 13 PNMI providers (with annual Medicaid payment of approximately \$20 million). The DRS does not currently have capacity to set additional rates without added resources. Having recently lost staff due to the retirement incentive, it will be a struggle to perform the current existing work of the Division.

2. Annual Cost of Living Increases

Providers with multiple services and unpredictable costs and revenue sources are more likely to experience cost shifting in order to balance their operating budgets. This would make a shift to a more formal "rate-setting" method a complicated task. One simple method of creating a predictable source of increased provider revenue would be to build in a regular cost of living rate increase. For example, if all CFC home-based and residential care services were increased by 1%, the total cost to Medicaid would be about \$750,000 for one year based on SFY15 Medicaid claims paid. This type of guaranteed rate increase would help address expected and unexpected pressures that businesses experience to include increased wages and benefits, increased insurance costs and decreased service utilization. However, a simple cost of living increase does not reflect actual costs and may or may not be "reasonable" or "sustainable", depending on the providers' budget and other cost shifting phenomena.

Refer to Attachment A for a table of estimated Medicaid cost increases for home and community-based and residential care services based on percentage increases.

3. Payment Reform

The nation is currently experiencing a shift in the way healthcare is delivered and paid for. This shift involves paying providers for achieving health outcomes, rather than paying set fees for individual services. Vermont has participated in payment reform activities. Examples include the Blueprint for Health, which provides funding for community health teams as well as per member per month rate enhancements to assist primary care providers, and the Medicaid Shared Savings Program through Accountable Care Organizations (ACOs), in which the State provides ‘shared savings’ incentive payments to the ACOs when specific types of costs are reduced and quality of care is maintained.

Payment reform in Vermont is achieving the Triple Aim: better experience of care for the individual, improved population health, and reductions in the cost of health care. The initial focus of payment reform has been on primary care and hospital care across Medicare, Medicaid, and commercial insurance in order to improve quality while containing costs and integrating care. Vermont continues to work on how reform might improve the integration of long-term services and supports with other types of care. The existing ACO shared savings contracts do not expect savings from LTSS, but focus on cost containment in primary care and hospital care and associated costs. In related national initiatives a large proportion of avoidable health care costs for LTSS participants have been in hospital and physician based services, often achieved by investments and enhancements in home and community based services. This pattern is most conspicuous for dually eligible populations, for whom primary care, hospital care, and pharmacy are largely paid by Medicare, where savings may be achieved by improved access and increased spending in Medicaid services. The separate Medicaid and Medicare ACO models do not account for total Medicaid costs, much less total costs across both Medicaid and Medicare. Medicare, in fact, requires that dually eligible Vermonters be attributed to the Medicare ACO to ensure there is no “double counting” of saving, which could occur with attribution to both programs.

Under Vermont’s SIM (State Innovation Model) grant, workgroups and contractors have discussed payment reform options for LTSS. Prior to instituting a payment reform, it is important to assess the readiness of providers and payers to implement the change and to ensure that the provider has the tools necessary to better manage care, such as the necessary health information technology. The federal financial incentives were not provided to LTSS providers, so the take up of electronic medical records in this sector is less pervasive than in hospital and physician settings. Through the State Innovation Model, the State is working on these issues with LTSS providers and also providing assistance through learning collaboratives and, in some cases, sub-grants to specific providers.

For example, providers and stakeholders in the St. Johnsbury region are working on three related initiatives:

1. Work with SIM contractors and state staff to explore ways of improving Choices for Care by creating a more flexible funding mechanism for Choices for Care Home Health Agency services, piloting interdisciplinary team Case Management services, and coordinating the use of flexible funding streams through the interdisciplinary team.

2. Reform in complex state reporting requirements for the Designated Agency, to decrease administrative time and increase direct client support time among staff.
3. Exploration of bundled payments through Integrated Family Services, to allow greater coordination and flexibility of services affecting children and families, including those with LTSS needs.

V. Ways to Encourage Providers to Accept People

There are two things that might “encourage” a provider to accept people regardless of their payment source.

1. Designation

Currently, the only LTSS provider types that are “designated” and required by Vermont regulation to serve people regardless of payment source, are Designated Home Health Agencies (with caveats) and Designated Agencies for developmental and mental health services. Services provided by a Level III Residential Care Home (RCH) or Assisted Living Residence (ALR) are not designated which means a) enrollment in Medicaid is optional and b) they are not required to accept every person who comes to them for services. There are important reasons why designation might not work for each provider type. However, this is one way to compel, if not encourage, a provider to accept a person regardless of payment source.

2. Increased Rates

Providers such as Assisted Living Residences (ALR) that have a larger private pay market, experience a larger gap between their private rate and the Medicaid rate. That means providers that have a higher cost basis would be compelled to accept more private pay people. Therefore, having a Medicaid rate that more closely matches the market rate or cost of doing business would encourage a provider to accept people, regardless of their funding source. A higher rate that is based on costs would also have the impact of integrating ways to retain workers through training opportunities, increased wages and benefits.

VI. Recommendations

There are several options to improve the methodology for Medicaid rates to residential care and home and community-based services. Most options require a formalized process, including increased data reporting by the provider, and staff and budget impacts.

Recommendation #1. By design, residential care home services are the closest to nursing facility services. They are both licensed residential models, they both provide 24/7 staffing, they both have a building that must be maintained and is not a private home. It is recommended that the State evaluate the licensed Level III and Assisted Living Residences with the goal of determining whether a rate-setting “light” method would be viable. The evaluation should consider moving away from fee-for-service to a value based payment methodology, including quality measures and incentives. In order for that to be possible, the following must occur:

- The State must allocate additional staff resources to develop and maintain a new rate process that is reasonable, sustainable and based on provider costs
- The providers must be committed to developing and maintaining a formal process

- The Legislature must commit to funding Medicaid rates through the new process

Recommendation #2. As stated above, like nursing facilities, residential care homes are bundled daily rates for 24/7 care in a residential setting. The state currently manages a complex rate-setting method for nursing facilities that is intended to be reasonable and sustainable. One alternative to creating a new rate-setting method for residential care homes would be to set rates using a percentage of the average nursing facility rate as a proxy. Another possibility would be to move away from fee-for-service to a value based payment methodology, including quality measures and incentives. In order for this to be possible:

- The State must allocate additional staff resources to evaluate whether using nursing facility rates to help set residential care home rates is reasonable and sustainable
- Stakeholders must agree to the method
- The State must allocate additional staff resources to develop and maintain rates
- The Legislature must commit to funding Medicaid rates through the new process

Recommendation #3. Consider an annual Medicaid rate increase for the following home and community-based services.

- Adult Day
- Adult Family Care
- Area Agency on Aging and Home Health Agency Case Management
- Flexible Choices Pre-Admission Consultant
- Home Health Personal Care/Respite/Companion
- Home Health Respite/Companion
- Home Health Homemaker Services
- Self-Directed Services (currently managed through a Collective Bargaining Agreement)

One way to fund an increase would be to evaluate whether the cost associated with the annual nursing facility rate increase could be reasonably shared with home and community-based services. The evaluation must consider any risk factors association with reducing the annual increase to nursing facilities and whether the amount of the shared increase would have a valuable impact. For example, the average nursing facilities daily rate went from \$203.53 in SFY13 to \$210.87 per day in SFY14 (3.6% increase which included a cost of living and rebasing). This increase resulted in approximately \$4.6 million gross in increased nursing facility expenditures for SFY14. Half of that total amount equals about a \$2.3 million or a 3% estimated increase for HCBS services.

Recommendation #4. Continue to integrate home and community-based services into current payment reform efforts. Nationally, long-term services and supports are becoming a focus in the prevention of costly hospital and nursing facility admissions. With the recent consolidation of Vermont's Global Commitment to Health waiver, it would benefit the State to continue to find innovative ways to manage all long-term services and supports that use Vermont Medicaid to pay for home and community-based supports. This strategy will result in reduced health care costs overall and provide an incentive to invest in services which promote health or reduce more costly services. This strategy does not guarantee annual rate increases, however, and should be based on value based payments with a quality component.

Attachment A: Estimated Cost of 1% Rate Increases

Source: Medicaid Paid Claims Report: November 2015

Services Grouped by Provider Type	Total SFY15 Paid Claims	average pp/pm	1% Increase		1% Difference	
			annual	pp/pm	annual	pp/pm
CFC Area Agency on Aging Case Management	\$1,986,973	\$126	\$2,006,843	\$127	\$19,870	\$1
AAA Subtotal:	\$1,986,973	\$126	\$2,006,843	\$127	\$19,870	\$1
CFC Home Health Case Management	\$2,298,262	\$156	\$2,321,245	\$157	\$22,983	\$2
CFC Home Health Personal Care	\$14,635,578	\$1,801	\$14,781,934	\$1,819	\$146,356	\$18
CFC Home Health Companion/Respite	\$3,114,189	\$841	\$3,145,331	\$849	\$31,142	\$8
CFC Home Health Homemaker (Mod Needs)	\$2,813,094	\$214	\$2,841,225	\$216	\$28,131	\$2
CFC Home Health GDAC (Anderson Parkway)	\$619,686	\$5,164	\$625,883	\$5,216	\$6,197	\$52
HHA Subtotal:	\$22,861,123	\$3,012	\$23,089,734	\$3,042	\$228,611	\$30
CFC Self-Directed Personal Care	\$12,207,871	\$2,632.75	\$12,329,950	\$2,659	\$122,079	\$26
CFC Self-Directed Respite/Companion	\$6,815,932	\$1,645.08	\$6,884,091	\$1,662	\$68,159	\$16
CFC Self-Directed Flexible Choices Budgets			\$4,247,584	\$2,983	\$42,055	\$30
Self-Directed Subtotal:	\$19,023,803	\$4,278	\$19,214,041	\$4,321	\$190,238	\$43
CFC Adult Day (Mod Needs)	\$1,732,347	\$1,003	\$1,749,670	\$1,013	\$17,323	\$10
CFC Adult Day (High/Highest)	\$2,881,622	\$1,159	\$2,910,438	\$1,170	\$28,816	\$12
Adult Day Health Rehab (State Plan)	\$2,152,768	\$1,168	\$2,174,296	\$1,179	\$21,528	\$12
Adult Day Subtotal:	\$6,766,737	\$3,329	\$6,834,404	\$3,362	\$67,667	\$33
CFC Enhanced Residential Care Tier 1	\$2,711,175	\$1,459	\$2,738,287	\$1,474	\$27,112	\$15
CFC Enhanced Residential Care Tier 2	\$3,037,748	\$1,650	\$3,068,125	\$1,667	\$30,377	\$17
CFC Enhanced Residential Care Tier 3	\$3,198,264	\$1,858	\$3,230,247	\$1,876	\$31,983	\$19
Assistive Community Care Services (State Plan)	\$14,110,881	\$1,094	\$14,251,990	\$1,105	\$141,109	\$11
Residential Care Subtotal:	\$23,058,068	\$6,061	\$23,288,649	\$6,122	\$230,581	\$61
CFC Assistive Devices/Home Modifications	\$159,633	\$266	\$161,229	\$268	\$1,596	\$3
CFC Personal Emergency Response	\$252,484	\$61.00	\$255,009	\$62	\$2,525	\$1
CFC Intermediary Services Organization (ARIS)	\$543,126	\$53	\$548,557	\$54	\$5,431	\$1
Other Subtotal:	\$955,243	\$380	\$964,795	\$384	\$9,552	\$4
Grand Total:	\$74,651,947	\$17,185	\$75,398,466	\$17,357	\$746,519	\$172
Estimated 1% increase cost/year:	\$746,519					
Estimated 2% increase cost/year:	\$1,493,039					

Attachment B: Current Rate Table

HP Revenue Code	CFC Home-Based Setting	Unit	Max Amount Per Unit/Other	Hourly or Daily Rate	Effective Date
070	Case Management by HHA or AAA (48 hrs/calendar year max)	1 Unit=15 Min.	\$17.35	\$69.40	7/1/2015
072	Personal Care by HHA	1 Unit=15 Min.	\$6.92	\$27.70	7/1/2015
077	Personal Care by Consumer-Directed Personnel	1 Unit=15 Min.	\$3.20	\$12.80	7/6/2014
081	Personal Care by Surrogate-Directed Personnel	1 Unit=15 Min.	\$3.20	\$12.80	7/6/2014
073	*Respite or Companion Care by HHA	1 Unit=15 Min.	\$5.53	\$22.12	7/1/2015
075	*Respite or Companion Care by Consumer-Directed Personnel	1 Unit=15 Min.	\$3.06	\$12.24	7/6/2014
080	*Respite or Companion Care by Surrogate-Directed Personnel	1 Unit=15 Min.	\$3.06	\$12.24	7/6/2014
074	*Respite in Residential Care Home	1 Unit=1 Day	\$94.00	\$94.00	7/1/2015
084	*Respite by Adult Day Service provider	1 Unit=15 Min.	\$3.86	\$15.43	7/1/2015
088	Companion by Senior Companion Agency	1 Unit=15 Min.	\$1.99	\$7.98	7/1/2015
078	Home-Based Waiver Adult Day Service	1 Unit=15 Min.	\$3.86	\$15.43	7/1/2015
076	Assistive Devices & Modifications	1 Unit=1 Service	\$777 per year	actual cost, up to \$777	7/1/2015
082	Personal Emergency Response Systems-Installation & 1st Month	1 Unit= 1 month	One-time fee \$56.61	\$56.61 installation & first month's service	7/1/2015
083	Personal Emergency Response Systems-Ongoing	1 Unit= 1 month	\$30.89	\$30.89	7/1/2015
089	Group Directed Attendant Care (<i>approved providers only</i>)	1 Unit=1 day	\$173.35	\$173.35	7/1/2015
097	ARIS F/EA Employer Support Services #047W070	1 Unit=1 month	\$54.00	Up to \$54.00/month	2/1/2015
220	ARIS F/EA CFC Flexible Choices Support Services #047W070	1 Unit=1 month	\$54.00	Up to \$54.00/month	2/1/2015
071	Flexible Choices Services	As billed	Pay as billed	pay as billed up to max allowance	7/1/2007
079	Flexible Choices Consultant Pre-admission Service	1 Unit=15 Min.	\$17.35	\$69.42	7/1/2015

HP Revenue Code	CFC Adult Family Care (AFC)	Unit	Max Amount Per Unit/Other	Hourly or Daily Rate	Effective Date	
086	Tier 1 - Adult Family Care	1 Unit=1 day	\$77	\$77	7/1/2015	
086	Tier 2 - Adult Family Care	1 Unit=1 day	\$88	\$88	7/1/2015	
086	Tier 3 - Adult Family Care	1 Unit=1 day	\$94	\$94	7/1/2015	
086	Tier 4 - Adult Family Care	1 Unit=1 day	\$99	\$99	7/1/2015	
086	Tier 5 - Adult Family Care	1 Unit=1 day	\$104	\$104	7/1/2015	
086	Tier 6 - Adult Family Care	1 Unit=1 day	\$110	\$110	7/1/2015	
086	Tier 7 - Adult Family Care	1 Unit=1 day	\$116	\$116	7/1/2015	
086	Tier 8 - Adult Family Care	1 Unit=1 day	\$123	\$123	7/1/2015	
086	Tier 9 - Adult Family Care	1 Unit=1 day	\$135	\$135	7/1/2015	
086	Tier 10 - Adult Family Care	1 Unit=1 day	\$156	\$156	7/1/2015	
HP Revenue Code	CFC Enhanced Residential Care Setting	Unit	Max Amount Per Unit	Hourly or Daily Rate	unit	Effective Date
092	ERC-tier 1	1 Unit=1 Day	\$50.20	\$50.20	day	7/1/2015
			\$55.54	\$55.54	day	7/1/2015
093	ERC-tier 2	1 Unit=1 Day	\$57.15	\$57.15	day	7/1/2015
			\$62.48	\$62.48	day	7/1/2015
094	ERC-tier 3	1 Unit=1 Day	\$64.09	\$64.09	day	7/1/2015
			\$69.44	\$69.44	day	7/1/2015
090	ERC Special Rate	1 Unit=1 Day	Varies by provider	Provider Rate by individual	day	7/1/2007
	(rate set for individual by prior approval)				day	
HP Revenue Code	CFC Home-Based Setting, Moderate Needs	Unit	Max Amount Per Unit	Hourly or Daily Rate	unit	Effective Date
070	Case Management (max of 12 hrs per calendar year)	1 Unit=15 Min.	\$17.35	\$69.42	hour	7/1/2015
095	Homemaker (Max of 6 hours per week)	1 Unit=15 Min	\$4.97	\$19.88	hour	7/1/2015
096	*Adult Day (Max of 50 hours per week)	Unit=15 Min.	\$3.86	\$15.43	hour	7/1/2015
071	Flexible Funding	As billed	Pay as billed	max allowance	n/a	4/1/2014

HP Revenue Code	Global Commitment Services: ACCS and DHRS	Unit	Max Amount Per Unit	Hourly or Daily Rate	unit	Effective Date
98	Assistive Community Care Services (ACCS)	1 Unit = 1 day	\$37.25	\$37.25	day	7/01/2012
99	*Day Health Rehabilitation Services (DHRS)	1 Unit = 15 min	\$3.85	\$15.40	hour	11/1/2013

Attachment C: Stakeholder Input

Vermont Association of Area Agencies on Aging

Helping Vermonters Age with Independence and Dignity



October 9, 2015

Dear Ms. Tierney-Ward:

On behalf of the Vermont Association of Area Agencies on Aging, thank you for the opportunity to provide comments for consideration as DAIL and the Division of Rate Setting prepare a report for the legislature about Medicaid reimbursement rates for the Choices for Care services offered by community providers.

Vermont's population is rapidly aging, with 23 Vermonters turning 65 every day, many living into their 80s and 90s, and Vermont ranked second oldest state in the nation. Vermont's seniors are at high risk of chronic disease, illness, and hospitalization. They are the most frequent users of the healthcare system, costing \$142 million Medicaid dollars each year. It is fiscally responsible for Vermont to invest in the necessary workforce and community supports that will allow seniors to age at home. For the cost of caring for one senior in a nursing home, three can be cared for with home and community based services.

The AAAs currently provide care management services to over 7,000 vulnerable seniors across the state to allow them to remain independent in their own home or in the care setting of their choice. Each year the AAAs serve more seniors than the year before - 35% more seniors were served in 2014 than in 2005. Yet federal and state funding for these services has not kept pace with the rapidly increasing need for the work that we do. Older Americans Act funding has decreased or remained stagnant for almost a decade. Vermont's Medicaid reimbursement rates for home and community based providers have not increased in any substantial way in a number of years. The rates, and subsequently, the methods used to calculate them, are certainly not reasonable, sustainable, nor adequately reflect economic conditions and the changing health care system.

Currently, nursing homes receive an annual cost of living increase to their reimbursement rates that other home and community based service providers do not. Both nursing homes as well as home and community based services can be appropriate options for seniors, but both must receive fair and adequate funding to provide quality, sustainable care.

When asked where they would like to age, 90% of seniors wish to remain at home. As mentioned above, home-based services are much less expensive than institutional care. For both of these reasons, the State of Vermont has declared that helping people age at home is a priority. Yet home-based care providers struggle to meet the need in communities without sufficient funding, asked to provide the same services with less funding. As the number of seniors needing long-term care and supports continues to expand, this trend cannot continue. Providers of home

and community based care must be more adequately reimbursed to meet the growing level of need and the true cost of providing these services.

Serving seniors in need and providing high quality care management are our top priorities at the AAAs. However, the simple truth is that we cannot continue to meet these goals at current reimbursement levels. We sincerely hope that DAIL and the Division of Rate Setting are willing to take a serious look at the inadequate funding and how reimbursement rates contribute to the problem. We thank you again for the opportunity to provide our input into this process of evaluating reimbursement rates. We look forward to more discussion on this issue, and we anticipate positive changes that will develop a more equitable and sustainable system of care for our elders across Vermont.

Please reach out to us with questions you may have or to schedule a meeting on this topic. Thank you for your consideration.

Sincerely,

Angela Smith-Dieng, Executive Director
Vermont Association of Area Agencies on Aging



CVAA
802-865-0360
www.cvaa.org



Northeast Kingdom
Council on Aging, Inc.
802-748-5182
www.nekcouncil.org



Central Vermont
Council on Aging, Inc.
802-479-0531
www.cvcoa.org



Southwestern Vermont
Council on Aging, Inc.
802-786-5990
www.svcoa.org



Senior Solutions
(Council on Aging
of Southeastern Vermont)
802-885-2655
www.seniorsolutionsvt.org



TO: Monica Hutt, Commissioner, DAIL
Megan Tierney-Ward, Director, Adult Services Division
CC: Steven Costantino, Commissioner, DVHA; Agency Directors
FROM: Peter Cobb, Director, VNAs of Vermont
DATE: October 5, 2015
RE: Act 54, Section 27

Please accept the comments from the VNAs of Vermont concerning Act 54, Sec 27. Our comments relate to the three questions of interest to home health as presented in a memo to VNAVt by Megan Tierney-Ward on September 29, 2015.

Act 54, Sec. 27. PROVIDER RATE SETTING; MEDICAID

(a) The Department of Disabilities, Aging, and Independent Living and the Division of Rate Setting in the Agency of Human Services shall review current reimbursement rates for providers of enhanced residential care, assistive community care, and other long-term home- and community-based care services and shall consider ways to:

(1) ensure that rates are reviewed regularly and are sustainable, reasonable, and adequately reflect economic conditions, new home- and community-based services rules, and health system reforms;

(2) encourage providers to accept residents without regard to their source of payment.

(b) On or before January 15, 2016, the Department and the Agency shall provide their findings and recommendations to the House Committee on Human Services and the Senate Committees on Health and Welfare and on Finance.

VNAVt Comments

1. Describe the current Medicaid rates and how they are set for Choices for Care Enhanced Residential Care (ERC), Assistive Community Care Services (ACCS), and other Choices for Care home and community-based services.

Current Rates: State payments for all home care services including CFC do not cover costs. Since 2008, home care rates have increased by only 5%, far below inflation, and for several years there was a 2% across-the-board reduction for all payments. Losses have increased steadily over the past decade. Several agencies are at a breaking point where they can no

longer sustain these losses. VNAVt agencies lose approximately \$7.4 million a year providing service to state programs. These losses are often made up by community donations, which is not sustainable.

Rate Setting: There is no rate setting for home care services, nor any formal, systematic rate review. Since 2004 the gap between rates paid and costs has steadily increased.

2. Describe potential methods the State can use to ensure that Medicaid rates for these services are:
 - a. Reviewed regularly,
 - b. Sustainable,
 - c. Reasonable, and
 - d. Adequately reflect economic conditions, new home and community-based services rules and health system reforms.

Regular Review: VNAVt supports all of the above. Home care costs and rates should be reviewed annually and adjustments made based on the costs reported. Home Health agencies need annual inflationary increases otherwise the gap between payments and costs will continue to widen.

3. Describe potential ways to encourage providers to accept people without regard to their source of payment.

Service to All: This is not a problem for Vermonters seeking home care services as all VNAVt members provide care to everyone who qualifies regardless of income or the location of their homes. This has always been the policy of the nonprofit home care agencies. In addition, home care rules mandate that all home care agencies, profit and nonprofit, provide services to all.

State Home Care Rules

5.4 A home health agency has the obligation and the responsibility to provide or arrange for the provision of all services required under its designation, including Home Health Care, Hospice, Choices for Care and Medicaid High Tech services, to all eligible patients within its designated geographic area who are referred or who request its services. If home health agency has determined that it is unable to provide services to a patient or applicant for services, the agency shall provide information regarding alternative providers that might be able to serve the individual and shall make a referral to the alternative provider(s) unless the patient or applicant objects to the referral.

Conclusion: Home care agencies cannot continue to subsidize state payments at the current levels. It is necessary to pay reasonable rates that are reviewed and adjusted regularly to assure the sustainability of the agencies. Unless the state funding gap is closed, home health agencies will be forced to make difficult decisions regarding access to services or go out of business altogether. Without viable home health agencies operating at high levels of performance, there will be higher census levels in more expensive hospitals and nursing homes.

What is needed?

- A thorough review of the rates paid across the total spectrum of home care - from traditional Medicaid to Choices for Care.
- Reasonable payments that cover costs.
- Annual inflationary adjustments to assure the financial viability of the agencies.
- More flexibility to providers in determining how services are provided.

Home care represents only 3-4% of the total health care spending in Vermont. It is a good investment since home health is critical to bending the curve in the overall health care system. Vermonters who cannot be served at home receive care in more expensive hospitals and nursing homes.

Adult Day Input

Email 11/17/15 from Sue Chase at CarePartners Adult Day

From: Sue Chase [<mailto:sue@carepartnersvt.org>]

Sent: Monday, November 02, 2015 4:52 PM

To: Tierney-Ward, Megan

Cc: 'Virginia Renfrew'

Subject: RE: Seeking your feedback on Medicaid rates

a. Reviewed regularly, - *from an adult day perspective I do not believe the Medicaid rates are reviewed regularly by DAIL. They seem to only be looked at by DAIL when we request a rate increase. I would strongly encourage that the rates were looked at every year or two.*

b. Sustainable, *It is increasingly challenging to provide adult day services with the current rate of reimbursement. I do not have current information, but in the past adult day providers have stated that the cost of providing the service was not covered by the reimbursement rate. I can say for CarePartners our unit cost in FY 2015 was \$17.47 an hour. Increasingly adult days have been asked to meet the growing critical care needs of our participants. They have complex needs that require extensive nursing care and oversight. In light of this, I would say it is not sustainable for adult days to provide the level of care they are with the current reimbursement rates.*

c. Reasonable, and *As stated above, our cost of providing the service exceeds the rate of reimbursement. CarePartners' unit cost for FY 2015 was \$17.47 an hour. My sense is that figure is higher for many other adult day providers.*

d. Adequately reflect economic conditions, new home and community-based services rules and health system reforms. *Since I don't know how the new rules will impact adult day services it is difficult to respond. From the little bit I've heard about the changes, I would say that current reimbursement rates cannot sustain the proposed changes. In terms of health care reform VAADS is trying to figure out what it all means and how we can position ourselves for any changes that may be coming along. Personally, I have concerns about moving from the fee for service model. Many of the adult day providers are small free standing organizations. It would be very difficult for us to assume the risk of a capitated system. I think our experience with MNG speaks to that.*

Residential Care Input

Email 10/10/15 from Maricia DeRosia, President, American Health Care Software Enterprises, Inc & American Financial Services, LLC.

From: Maricia DeRosia [mailto:MarciaDerosia@ahconline.com]

Sent: Saturday, October 10, 2015 8:54 PM

To: Tierney-Ward, Megan

Subject: Re: Seeking your feedback on Medicaid rates

Megan,

I was out and missed getting back to you. I would suggest that they review the 2007 special report that was done for the State in which it was recommended RCF and AL file cost reports and be paid a reasonable rate.

As we all know the rates on ACCS have not changed since 2007 - and ERC received a modest increase during that same period.

At that time representatives indicated that RCF may not be sophisticated enough financial systems to track and file costs.

I am sure with the correct reimbursement it is feasible for them to recap their costs in a simplified cost report.

Marcia

Very truly yours,

Marcia DeRosia, President
American Health Care Software Enterprises, Inc. &
American Financial Services, LLC.
Corporate Office
20 Joy Drive Suite 200
South Burlington, Vermont 05403

Residential Care Input

Email 10/2/15 from Susan Sweetser, Ethan Allen Residence

From: Susan [mailto:swsweetser@msn.com]
Sent: Friday, October 02, 2015 5:27 PM
To: Tierney-Ward, Megan
Subject: FW: Seeking your feedback on Medicaid rates

Hi, Megan. I am the Administrator for Ethan Allen Residence in Burlington, home to 39 elders. Here is my response:

1. The current Medicaid rates are woefully inadequate. They do not even begin to come close to covering the cost of care. As a result, we have to limit the number of Medicaid residents we can afford to take (and, it hardly seems fair that our private pay residents are so heavily subsidizing the Medicaid residents). I have no idea how these rates are set but it certainly isn't any method based on reason. When it gets really bad, the State gives us a minor increase but all that does is help slow down the terrible inadequacy of the rates. Because the rates are so inadequate, few places in Chittenden County will accept Medicaid residents.
2. Ask us what it costs. We are a non-profit. We are not providing care in order to get rich. But, we would like to be able to replace our boiler if it should go, or the commercial washer and dryer that are over 20 years old or our 15 year old van. If we stopped taking Medicaid residents and only accepted private pay we could afford to do that. But right now we can't. So, because we DO take so many Medicaid residents, we struggle. In addition, there are a number of facilities, including non-profits, that will only accept private pay for Memory Care and the amount they charge is high. Medicaid rates do not even begin to reflect the costs to a facility for someone who has significant memory care issues.
3. It truly is a travesty that a number of facilities that we compete with will take someone when they have money and, when

they run out, give them a 30 day letter and tell them to apply for residency at Ethan Allen or St. Joe's. There should be a rule - if you accept someone for residency and take all their money, then when they run out of funds because they spent everything they had on their care and residency with you, you should not be allowed to evict them and you should be required to keep them and accept Medicaid. What happens now is just inhumane.

Hope this helps, Megan.

From: Laura Pelosi [mailto:laura@mmrvt.com]
Sent: Monday, November 30, 2015 4:34 PM
To: Tierney-Ward, Megan
Cc: Andy Bachand
Subject: RE: Seeking your feedback on Medicaid rates

Hi Megan,

This note is in follow up to our meeting a few weeks ago. I've discussed the issue with VHCA's financial analyst, Andy Bachand- he handles their work with DRS. He also handles work for many of our ERC and level III homes and is very knowledgeable in this area. Here is globally what we think:

While we do not recommend an intensive cost reporting and rate setting process similar to the nursing home process, we believe the following elements should be included in a methodology:

1. The system should be cost based in the sense that it adequately reflects major components of providing care such as nursing and other salaries, payroll taxes, benefits, property costs, other....
2. The costs should be calculated to set a baseline in year one;
3. Census information should be used to generate the cost per day for direct care in the base year;
4. Providers would complete an easy to use fillable form;
5. An inflationary increase should be provided annually

I would also propose that we perhaps meet with Andy, and Kathleen, to discuss what options you might include in your upcoming report.

Laura

Laura Q. Pelosi
MMR, LLC
MMR Legal Services, LLC
45 Court Street
Montpelier, VT 05602
802-225-3100
802-793-9372 (cell)
802-225-3105 (fax)