

Key Legislative Provisions

Eligible Employers: Medicaid-funded providers who deliver in-home personal assistance and private duty nursing services to the elderly and people with disabilities.

Incentive Policy: Employers who provide their direct-care workers with health care coverage that meets a set of criteria to be established by the state will receive an enhanced Medicaid reimbursement rate, at a level determined by the state.

Standards for Coverage: The state will establish criteria for acceptable insurance coverage that includes a list of services that must be covered; limits on employee premiums, co-payments, and out-of-pocket contributions; and a minimum number or percentage of employees who must participate.

Funding: The enhanced Medicaid reimbursement will be funded jointly by the state (30 percent) and the federal government (70 percent).

Accountability: Eligible employers who choose to participate will be required to verify that the enhanced Medicaid reimbursement is spent on employee health benefits that meet established criteria.

Participation: Participation is voluntary. Providers who choose not to participate will receive the regular reimbursement rate.

Healthcare for Montanans Who Provide Healthcare

Introduction

Nationwide, one out of four nursing home workers and one out of three workers in home care settings lack health insurance coverage, leaving both workers and their clients at risk. Employers in this sector, who rely heavily on Medicaid payments, often cannot afford to pay competitive wages and provide health coverage. As a result, they have difficulty recruiting and retaining the staff they need to meet clients' needs. Without coverage, caregivers are one major illness or injury away from financial devastation. This risk drives many to seek alternative employment, where insurance is more readily available.

The state will pay enhanced Medicaid reimbursement rates to Medicaid-funded home care agencies that provide health insurance.

In Montana, legislators recently approved an innovative policy to address this problem. Beginning in 2009, the state will pay enhanced Medicaid reimbursement rates to Medicaid-funded home care agencies that provide health insurance to their employees. This policy initiative, known as "Healthcare for Montanans Who Provide Healthcare" (HCM), was proposed by a privately owned, for-profit home care company, Consumer Direct Personal Care (CDPC). CDPC brought other advocacy and business organizations into a legislative campaign and, through these efforts, made direct-care workers the face of

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the uninsured, while articulating a strong business case for covering this workforce.

This case study profiles Montana’s direct-care workforce, the failure of previous broader health reform efforts to cover this segment of the uninsured, and the development of HCM as a policy solution. It illustrates how a sound policy solution—based on timely research and analysis, a strong business case for reform, and bipartisan support—combined to facilitate a legislative victory. While not scheduled to be implemented until 2009, “Healthcare for Montanans Who Provide Healthcare” is a promising policy model. This issue brief ends with key lessons from the Montana experience that are applicable for other states.

This case study is based on in-depth interviews with HCM’s chief proponents, Bill Woody, the owner of Consumer Direct Personal Care (CDPC), and Mike Hanshew, CDPC’s director of policy. Previously, Hanshew was an administrator in the Montana Department of Public Health and Human Services’ Senior and Long-Term Care Division. The combination of Woody’s hands-on knowledge of running a home care business and Hanshew’s in-depth understanding of Montana’s Medicaid program and related stakeholder groups was critical to HCM’s success.

Many workers choose to leave jobs they love rather than live with this insecurity.

Caregivers without Coverage

Montana provides Medicaid-funded in-home personal assistance services to more than 3,000 residents with age-related and other disabilities. These services, which include both agency-based personal assistance and self-directed personal assistance, enable people to stay in their homes for as long as possible rather than receiving more expensive nursing home care.

Across the state, 30 agencies and organizations employ approximately 4,000 caregivers who provide personal assistance services. More than 90 percent of their revenue comes from the Medicaid program, with the federal government paying nearly 70 percent of those costs.

Caregivers Can’t Afford Coverage

In Montana, as in other states, direct-care workers are primarily low-income women and many are uninsured. In order to document the insurance status of these workers, in 2006, the Montana Department of Public Health and Human Services surveyed 3,400 home care workers.¹ Results showed that:

- 90 percent are women
- Their average age is 44
- The average wage is \$9.05
- Over half are uninsured

The reasons cited for why these workers lack insurance were consistent with that of the broader population of uninsured in Montana—it is too expensive or not offered by their employer. Between 2003 and 2006 health insurance premiums in Montana increased from an average of \$295 to \$365 per month for single coverage and \$597 to \$677 per month for family coverage.² During that same period, the average monthly employee share of premiums for individual coverage increased from \$35 to \$62.

Without coverage, workers with health problems either delay or go without necessary health care services. When care is essential they turn to high cost emergency rooms or public clinics but often have no way to pay their bills. Many workers choose to leave jobs they love rather than live with this insecurity, leading to high turnover rates in this sector.

Employer Options Limited

Studies show that retention improves when workers receive health insurance benefits.³ The high cost of coverage, however, is undermining the employer-based insurance system. Nationwide, the percentage of employers offering health coverage declined from 69 percent in 2000 to 60 percent in 2007.⁴ In Montana, according to previous data collected by Department of Public Health and Human Services in FY 2005, most personal assistant providers are unable to offer any kind of employer-sponsored health insurance benefits.

In Montana, as in other states, Medicaid reimbursement rates do not account for the cost of providing employee health benefits and they are not automatically updated to keep up with the rising cost of providing services.

As of October 2007, the Montana Medicaid program reimburses providers \$16.64 per hour for agency-based services and \$15.36 per hour for consumer-directed services. Most of this funding goes directly to worker wages. For example, the agencies who led the HCM effort report an hourly wage rate of \$10.50 for agency-based caregivers and \$11.00 for consumer-directed caregivers.

After administrative expenses, limited funds remain for other operating expenses. Providing employee health care benefits could put many of these providers out of business.

State Policy Context: 2005–2007

In 2005, Montana had three efforts to expand health care coverage underway but all had either stalled or failed to provide a solution for direct-care workers and other low-income, childless adults. These efforts included a purchasing pool for very small businesses (those with two to nine employees); a complex waiver request to the federal government to use Medicaid funds to subsidize employer-based insurance; and a state planning grant from the federal Health Resources Services Administration (HRSA) to identify strategies to insure all Montanans by 2012.

- **Insure Montana:** Insure Montana, a program initiative that began in 2005, established a small business health insurance pool for businesses with two to nine employees. Small employers join together to form larger purchasing pools and also receive tax credits

and a subsidy to cover a portion of monthly premiums. Employee premiums are also subsidized by the state based on family income. While helpful to some, this program has not addressed the needs of many low-wage workers because it is open only to very small businesses. Most home care agencies in the state employ 10 caregivers or more.

- **HIFA Waiver:** In July 2006, Montana submitted a waiver request to the federal government to use Medicaid funds to subsidize employer-sponsored health insurance for low-wage individuals and provide premium assistance for working parents. This complex Medicaid Health Insurance Flexibility and Accountability (HIFA) waiver has not yet been approved. As of publication of this document, the state is still in negotiation with the Centers for Medicare and Medicaid Services (CMS).

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- **HRSA State Planning Grants:** The Montana Department of Public Health and Human Services has received two grants (first in 2002 and subsequently in 2005) from the HRSA State Planning Grant for the Uninsured (SPG) program to identify new strategies that would lead to health care coverage for all Montanans by 2012. This grant helped to set the context for the HCM effort.

In this context, Woody and Hanshew developed a proposal that would later become Healthcare for Montanans Who Provide Health Care (HCM). The proposal detailed an enhanced Medicaid reimbursement rate for home care agencies that would agree to use these funds to provide health care coverage to their employees. Proponents hailed it as a creative and affordable way to expand health insurance coverage to up to 1,000 uninsured personal assistant workers and private duty nurses, with the federal government picking up nearly 70 percent of the total cost.

Launching the Proposal

Introducing the Concept

To inject HCM into the state policy discourse on health reform, CDPC approached the Montana Department of Public Health and Human Services (DPHHS) and the governor's office with the general idea for HCM. The proposal received a favorable response and, based on those discussions, a more detailed concept paper was developed. The State Long Term Care Division then convened a work group, which included CDPC, to develop the concept further and to put forward a specific proposal to be considered in the governor's 2007–2009 budget.

At the same time, CDPC introduced HCM to the leaders of the State Planning Grant (SPG) process. Given the barriers to existing and proposed expansions, the SPG leaders were open to looking at health coverage expansion to targeted populations. Since covering direct-care workers could be done while maximizing Medicaid reimbursement and without going through the complex and time-consuming CMS waiver approval process, it was a popular approach.

Estimating Costs

Early on, CDPC recognized that to support HCM, policymakers needed an accurate picture of what it would cost. In order to develop a cost analysis, meetings were held with a representative of Blue Cross and Blue Shield of Montana, the largest insurer in the state, and staff from the small business purchasing pool to determine an appropriate premium amount for home care agencies and their workforce. The proposed budget for HCM estimated premium costs of \$400 per month in State Fiscal Year (SFY) 2008 and \$480 per month in SFY 2009. Based on these premium amounts, and the data from the state's survey, they projected biennium budget costs of \$9 million for workers who work an average of 20 hours per week or \$5.3 million for those working 30 hours per week.⁵ The cost differential was an indication of the large numbers of part-time caregivers in Montana.

Establishing Accountability

Policymakers would also want clear accountability mechanisms for how these funds would be spent. To address this, the proposal included safeguards to ensure that the enhancement funds would be used to provide health insurance. In addition, employers would be

required to submit verification to the state to document that their insurance would meet the requirements of a quality plan set forth by the state. In turn, the state would have to set requirements on what a quality health insurance benefit is by designating the following:

- Covered services
- Limits on employee premiums, co-payments, and out-of-pocket costs
- The minimum number of employees who must participate in the plan offered through the employer

Formulating a Legislative Strategy

Though CDPC developed what they believed to be a solid proposal, based on the state's 2006 survey data, they encountered some opposition to including HCM in the governor's 2007–2009 biennium budget. While many policy staff, both within the DPHHS and the governor's office, were very supportive of the proposal, there were some concerns that it would set a precedent for offering a similar rate enhancement for other Medicaid-dependent long-term care providers.

This could have been seen as a setback, but instead it provided a new framework in which to move the proposal through the legislature. Supporters of the legislation knew that if they could successfully address this fear of setting an industry precedent, their proposal could gain traction in the legislature.

They decided to make their case by focusing on the availability of data on coverage rates for the home care workforce, numbers that were not available for other industry sectors (e.g., nursing homes, developmental disability facilities, and other community-based providers). This set into motion a two-pronged strategy of lobbying for (a) an appropriation for home care providers where the data did exist, and (b) a data collection effort for the other long-term care providers.

The Legislative Process

Finding a Legislative Champion

By the summer of 2006, CDPC had recruited other partners, including key consumer and business organizations, to support its proposal. They circulated the proposal among legislators and soon gained the interest and support of Senator John Cobb, a veteran lawmaker with over 20 years of human service and appropriations

committee experience. According to Hanshew, Cobb, a respected Republican leader, “has a clear understanding of complex Medicaid funding issues and a history of promoting legislative actions aimed at improving the wages and working conditions of the direct-care workers employed in Montana’s human service programs.” His enthusiastic support gave the proposal new momentum and made it easier for advocates to garner support from both sides of the aisle.

Developing Legislative Vehicles

Over the summer before the legislature convened, advocates identified key legislators with membership on committees that could hear their proposal. They began meeting with this target group of legislators to explain their proposal.

Out of these discussions, the proposal developed into both a line item in the Appropriation Subcommittee’s budget for the Department of Public Health and Human Services to provide insurance coverage for home care workers and a separate study bill, SB 206, to gather data on the other long-term care providers. These two legislative measures provided multiple opportunities to talk with legislators. By the time HCM was passed, almost all members of the legislature had heard about the proposal.

Overcoming Objections

HCM will “Open the Flood Gates”: SB 206 required DPHHS to study the feasibility, impact, and cost of providing health insurance to direct-care workers employed by *all types* of long-term care organizations that receive funds through Medicaid. Advocates used this as a strategic opportunity to neutralize the concerns expressed by some policymakers that other long-term care provider groups would immediately demand a similar rate enhancement policy.

While the home care advocates, as a result of the 2006 state survey, had solid research and detailed cost analysis regarding personal care attendants and private duty nurses to present to the legislature, other sectors of the long-term care community did not have similar data on the health care needs of their workforce or the potential cost or expanding coverage.

Nursing home representatives and the developmental disability service community agreed that they did not yet have sufficient data and indicated that they had other agendas they were pursuing during the legislative session.

According to Hanshew, “These groups were willing to sit on the sidelines and were willing to not pursue a similar rate enhancement during this legislative session because of SB 206.”

Pitting Health Care vs. Wages: Despite this agreement, some providers in the long-term care community opposed the proposal for other reasons. They were concerned that providing an enhanced rate for health insurance would take away from other funding needs that rate increases could address, such as wages. To mitigate this argument of wages over benefits, HCM supporters countered that the choice of raising wages vs. providing health coverage was, in fact, an unfair choice.

Advocates argued that health care benefits were a separate issue from wage increases because health care policy should reflect the value of having healthy citizens with access to affordable health insurance. Opponents were reminded that the intent of the proposal was not solely about supporting the long-term care system—but to cover the uninsured. Therefore, if providers worked to kill this effort, the funds for it would not necessarily

Emphasizing coverage as a necessary cost of doing business is an effective strategy for gaining bipartisan support.

end up in an increase in wages or their provider rate; these funds could go to expand coverage for another uninsured population. Continued opposition would put providers in the unpopular light of having fought expanding coverage to their workers.

In the end, the appropriations subcommittee also included money for a direct-care worker wage increase in the budget, demonstrating that it was not a zero-sum game—the legislature funded both wages and insurance.

Making the Case

HCM was initially billed as a strategy to reduce the ranks of the uninsured, rather than as a workforce development or business strategy. However, early on in the process, it became clear that making a broader case would help to win passage.

The Business Case for HCM: Testifying before legislative committees in support of the HCM legislation, CDPC and

other bill proponents explained that existing Medicaid reimbursement rates were not sufficient to fund both fair wages and health insurance coverage. They illustrated that as employers who receive a large percentage of their revenue for providing publicly funded services, they cannot transfer business costs onto their consumer base. “The marketplace doesn’t set our price, Medicaid does,” explained Mike Hanshew.

Providing health insurance coverage is a strategy to attract new workers to caregiving.

Bill Woody, owner of CDPC, emphasized this point in an interview with the media, “If this program doesn’t work, more providers will be forced into their option of last resort—which is to limit the number of Medicaid patients under their care. Already they are turning away potential clients in some locations because they can’t find enough workers to care for them. Six of the state’s in-home health care providers have closed in the last 18 months.”⁶ Many home care employers are feeling the competition from other businesses such as Costco, which pays employees a competitive wage and provides comprehensive, affordable health insurance.

Addressing the Care Gap of the Future: Advocates framed HCM in the context of a “care gap” looming in the future for Montana, contrasting the dramatic increases predicted in the number of elderly citizens with the slow growth predicted for the number of workers available to serve them. Providing health insurance coverage is a strategy to attract new workers to caregiving.

Advocates also emphasized that the work of direct-care workers had gone largely ignored and undervalued by the state. “Essentially, not funding services at an adequate level to provide both decent wages and reasonable benefits amounted to a 30-year free ride. Someone ought to thank these women, but the ride is over,” said Hanshew.

The Prison System as a Precedent: To further address the concern about setting a precedent or “opening the flood gates,” advocates illustrated that the precedent had already been set by the Department of Corrections (DOC). The prison system in Montana is operated by private businesses that receive the vast majority of their funding from the state through the DOC. In reviewing the benefit structure of these companies, advocates for HCM found that employ-

ees working for firms under contract with the DOC received health insurance and other benefits. They were able to do this because the contract between the businesses and the DOC was funded at a level sufficient to both serve the prison population and support their staff.

As emphasized by Mike Hanshew, “If we provide health insurance to the people who watch over criminals—which is certainly the right thing to do—shouldn’t we also give it to the people who care for our grandmothers and disabled neighbors?”

Grassroots Mobilization

By the summer of 2006, a broad range of stakeholder groups—including the AARP, Montana Senior Citizens Association, the Montana Chamber of Commerce and the Services Employees International Union—began contacting legislators to encourage their support for HCM. CDPC established a database of caregivers organized by legislative district and began mobilizing workers to call key representatives to ask for their support for SB 206 and for including funding for the enhanced Medicaid rate in the DPHHS budget.

AARP Montana weighed in with their support. According to Claudia Clifford, associate state director for advocacy for AARP, “AARP Montana supported this legislation as a creative way of addressing the shortage of health care workers and the high rate of turnover in this profession. Patients deserve an experienced and stable workforce of caregivers and providing health coverage for the workers will certainly make a big difference. National AARP encourages other states to look at this concept as one way to improve the quality and stability of the long-term care workforce. This is also part of AARP’s campaign to ensure that all Americans have access to affordable health care.”

The Montana Health Care Association, an organization that represents skilled nursing, assisted living, and personal assistance providers, also went on the record in support of HCM. Rose Hughes, a representative of the association, appealed to legislators to support HCM as a workforce development policy and as the right thing to do: “Providing health care benefits for people who care for others is essential to assuring the availability of direct-care workers now and in the future. We can’t continue to expect these hard-working people to take care of others while their own and their family’s health care needs go unmet. They deserve better.”

In the end, advocates were successful in addressing

legislators' concerns and making a strong case for Medicaid enhancement for health care coverage. SB 206 passed with bipartisan support and almost no opposition during Montana's regular legislative session that ended in April 2007.

Securing approval of the appropriation was a more difficult task. The legislature's inability to adopt a state budget for the coming biennium during the regular session led to a special legislative session in May 2007. In essence, the process of putting together the budget began again from scratch. CDPC and its advocate allies had to again make their case for funding in what was by now a very heated environment.

In the end, a compromise was reached and the legislature approved \$2.6 million in new funding (including the federal match) for HCM, the level estimated to be necessary for employers to insure caregivers who work approximately 30 or more hours per week. However, in order to reduce the cost of HCM during the current biennium the effective date of the coverage was delayed until January 2009. On June 1, 2007, Montana Governor Brian Schweitzer signed the appropriations bill that funded HCM into law.

Looking Ahead

While the Montana legislature has acted, much work remains. Implementation of HCM is progressing on two fronts:

Sector-Wide Study

As required by SB 206, the Department of Public Health and Human Services is currently preparing surveys to assess the feasibility, impact, and cost of expanding health coverage to direct-care workers across the long-term care sector who work for providers who receive the majority of their revenue from Medicaid. Employers as well as their employees will be surveyed.

Rate Enhancement

At the same time, the Department of Public Health and Human Services is in the early stages of developing the policies and procedures required to implement the HCM rate enhancement. To inform this process, the state must define what a benchmark plan is, establish acceptable limits on employee cost sharing, identify possible carriers, and develop the specifics of a plan for reimbursing providers.

Possible implementation challenges include:

Plan quality: Will plans approved by the state be both affordable and comprehensive?

Funding: Will the level of the enhanced reimbursement be sufficient to fund coverage?

Administrative simplicity and accountability: Will applying for the enhancement and tracking and reporting on how it is spent be both streamlined and transparent?

Enrollment: How many eligible workers will actually sign up?

In a world of limited budgets and rising costs, expanding health care coverage is never easy. HCM illustrates a new and innovative model for reaching this goal. While not complete, it holds the potential to improve the quality of life of thousands of caregivers in Montana and is a model that could potentially be replicated in other states.

National AARP encourages other states to look at this concept.

– Claudia Clifford, Montana AARP

Lessons for Other States

Montana's policy design and advocacy strategy for expanding coverage to direct-care workers is instructive for advocates in other states. While each state has a distinct long-term care system and a unique political calculus to consider, elements of HCM are ripe for replication. Key lessons for other states include:

Use State Health Reform as an Opportunity

Advocates in Montana raised the concept of HCM in the context of broader statewide efforts to reduce the number of uninsured. Their proposal, both specific and simple to understand, provided an attractive complement to broader, more complex efforts that were either stalled or not reaching expectations.

In the absence of federal action, many other states are also engaged in broad health care reform. Within this context, advocates can highlight direct-care workers as the

“face of the uninsured.” Specific proposals to reach this population of low-income working adults can be packaged as a component of or a complement to broader reform.

Make a Business Case Argument to Attract Bipartisan Support

In Montana—an historically conservative state with a libertarian streak—a program that could be billed as a fair business practice was a much easier sell than a program that some might interpret as “just another handout to the poor.”

Home care providers made the case that employers who receive a majority of their funding from Medicaid are essentially doing business for the state. In doing so, they established a premise for the state to share responsibility for the health insurance status of their workforce. They framed the rate enhancement as a way to level the playing field to help small home care businesses compete for workers with private retailers such as Costco that offer health care benefits.

The business case was very compelling to conservative

Since covering direct-care workers could be done while maximizing Medicaid reimbursement, it was a popular approach.

legislators. They were comfortable with the idea that employer participation was completely voluntary. Keeping the solution within the framework of private employer-sponsored coverage was far more attractive to them than a public health insurance solution. In the end, the leadership of a high-profile Republican and across-the-board bipartisan support was critical for passage.

Advocates in other states can use a similar approach. Emphasizing health care coverage as a necessary cost of doing business and putting small business leaders upfront as primary spokespeople are effective strategies for gaining broad bipartisan support. Making the business case can set the stage for broader reimbursement reform (adequate rates for wages and benefits) or a more targeted approach such as the Montana rate enhancement.

Split Costs between the Federal Government and the States

The Montana solution will not be a state “budget buster” because nearly 70 percent of the cost will be paid by the federal government. By building the incentive for coverage into the Medicaid reimbursement rate, advocates maximized the state’s ability to draw down federal dollars to help pay for the solution.

Medicaid is funded jointly by the federal government and the states. The federal government pays a minimum of 50 percent of all Medicaid expenses. Each state’s specific share of expenditures is determined by Federal Medical Assistance Percentages (FMAPs) established by the U.S. Department of Health and Human Services. Generally, states with lower per capita income receive a higher federal match. Montana’s FMAP is relatively high at 68.53 percent, compared to California, Colorado, and Connecticut (all at 50 percent), but lower than a few states such as Mississippi, which receives the highest federal Medicaid match at 76.29 percent (FY08).

Funding health coverage for direct-care workers through the Medicaid program enables states to share their costs with the federal government. This feature makes proposals more attractive to state legislators, particularly in states with high-level matches.

Keep it Simple

Advocates in Montana crafted a simple and straightforward proposal that legislators could understand. Many health reform measures—from purchasing pools to premium subsidies with complex income eligibility rules—are not quick or easy to explain. In Montana, legislators could easily grasp the concept of enhanced reimbursement for employers who provide health insurance.

Policy proposals that have multiple components or complex rules often sink from their own weight. By developing proposals that are centered around a simple concept—such as rate enhancements—advocates for direct-care workers will be less distracted by trying to explain the “how” and have more energy and time left to focus on the “why.” This opportunity can be used to create a strong case for health care solutions that legislators can embrace.

Endnotes

1. Survey conducted by the Senior and Long-Term Care Division (SLTCD); results based on a total of 900 responses.
2. Montana Department of Public Health and Human Services (2007). *Montana Continuation HRSA State Planning Grant: Final Report to the Secretary*. Available at: www.dphhs.mt.gov/uninsured/spgfinalreport032007.pdf
3. For a review of this research, see *Health Insurance Vital to Job Retention*, a HCHCW publication available at: www.hchcw.org/uploads/pdfs/RetentionFactSheet.pdf
4. Kaiser Family Foundation (2007). *Employer Health Benefits: Summary of Findings*. Available at: www.kff.org/insurance/7672/upload/Summary-of-Findings-EHBS-2007.pdf
5. This total is combined federal and state costs.
6. Excerpt from Tyler Christensen, "Caregivers Lack Raises, Insurance," *The Missoulian*, April 23, 2007.

About the Authors:

A consultant to PHI, Ingrid J. McDonald, has over 15 years experience in long-term care policy. Tameshia Bridges is the Senior Health Policy Analyst for Health Care for Health Care Workers.



Health Care for Health Care Workers, an initiative of PHI (www.PHInational.org), seeks to expand health coverage for workers who provide support and assistance to elders and people living with chronic conditions and/or disabilities. These consumers need a skilled, reliable, and stable direct-care workforce to provide quality long-term care services. We believe that one way to ensure a quality direct-care workforce is to provide quality direct-care jobs—jobs that offer health coverage and pay a living wage.

This case study is part of a series designed to offer interested stakeholders and policymakers models to draw from as they seek to expand health coverage for direct-care workers.

This, and related publications, are available online at the Health Care for Health Care Workers website (www.coverageiscritical.org), or by calling the national campaign office at 718-928-2066.

For more information specifically about *Healthcare for Montanans Who Provide Healthcare*, contact: Mike Hanshew, Consumer Direct Personal Care, mikeh@consumerdirectonline.net.



349 East 149th Street, 10th Floor
Bronx, NY 10451
Phone: 718-928-2066
Fax: 718-585-6852