PROVIDER REIMBURSEMENT REVIEW BOARD
DECISION

2025-D12

PROVIDER –
Mid Valley Home Health Care, Inc.

HEARING HELD –
August 23, 2024

PROVIDER NO. – 05-9488

FISCAL YEAR END–
06/30/2022

vs.

MEDICARE CONTRACTOR –
National Government Services, Inc. (J-6)

CASE NO. – 23-1250

INDEX

ISSUE STATEMENT

Whether the Centers for Medicare and Medicaid Services ("CMS") properly imposed a two (2) percentage point reduction to the Provider's calendar year 2023 market basket percentage increase for failure to meet Home Health Quality Reporting Program requirements.[1]

DECISION

After considering Medicare law and regulations, the arguments presented, and the evidence admitted, the Provider Reimbursement Review Board ("Board") finds that CMS properly imposed the reduction in the home health market basket percentage increase, in accordance with 42 C.F.R. § 484.225(b).

INTRODUCTION

Mid Valley Home Health Care, Inc. ("Mid Valley" or the "Provider") is a Medicare participating home health agency ("HHA") located in Van Nuys, California.[2] Mid Valley's designated Medicare contractor[3] is National Government Services, Inc. ("Medicare Contractor").

In a letter dated October 13, 2022, the Medicare Contractor informed Mid Valley that its CY 2023 market basket percentage increase, also referred to as the annual payment update ("APU"), would be reduced for "not meeting the Deficit Reduction Act (DRA) of 2005 requirement for HHAs to submit quality data."[4] More specifically, the letter states, "CMS review of OASIS [Outcomes and Assessment Information Set] and HHCAHPS [Home Health Consumer Assessment of Health Providers and Systems] submissions for this period found that your agency is not excluded or exempt from the reporting requirements and the HHA was noncompliant with OASIS."[5] Mid Valley subsequently submitted a request for reconsideration to CMS.[6]

In a letter dated January 12, 2023, Mid Valley was informed that CMS had reviewed the documentation submitted with their request for reconsideration and determined that it did not support compliance with the OASIS reporting. Specifically, the letter stated, "'[e]vidence of delays in access to billing systems or evidence of errors on the part of the HHA, its prior owners or it agents do not support compliance with the reporting requirement.'"[7] On January 13, 2023, CMS issued its official Notice of Quality Reporting Program Noncompliance Decision Upheld

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[1] *See* Transcript of Proceedings ("Tr.") at 6-7 (Aug. 23, 2024).
[2] Tr. at 14; Provider's Position Paper (hereinafter, "Provider's PP") at 1 (Nov. 22, 2023).
[3] CMS's payment and audit functions under the Medicare program were historically contracted to organizations known as fiscal intermediaries ("FIs") and these functions are now contracted with organizations known as Medicare administrative contractors ("MACs"). The term "Medicare contractor" refers to both FIs and MACs as appropriate.
[4] Medicare Contractor's Final Position Paper (hereinafter, "Medicare Contractor's FPP") at 10. *See also* Exhibit (hereinafter "Ex.") C-11 at 1, *referring to* Pub. L. No. 109-171, 120 Stat. 4 (2006).
[5] Ex. C-11 at 1.
[6] Neither Mid Valley nor the Medicare Contractor made the request for reconsideration part of the record. *See* Tr. at 38.
[7] Ex. C-11 at 4.

Letter stating that the reduction of Mid Valley's CY 2023 market basket update was upheld because of Mid Valley's ***failure to submit OASIS that "[a]chieve[d] a score of at least 90% on Quality Assessments Only metric***."[8]

On March 28, 2023, Mid Valley timely submitted an appeal request to the Board and has met the jurisdictional requirements for a hearing. The Board held a video hearing on August 23, 2024. Mid Valley was represented by Scottie Strong of Strong Consulting Inc. The Medicare Contractor was represented by Charles Moreland, Esq., of Federal Specialized Services.

STATEMENT OF RELEVANT FACTS

The Secretary of the Department of Health & Human Services (the "Secretary") declared a public health emergency ("PHE") on January 31, 2020, in response to the COVID-19 Pandemic.[9] Mid Valley notes that "[o]n March 13, 2020, the President [of the United States] issued an emergency declaration under the Robert T. Stafford Disaster Relief and Emergency Assistance Act, 42 U.S.C. § 5121-5207 (the "Stafford Act") to declare a national health emergency."[10] As a result of the PHE and national health emergency, the Secretary waived certain requirements under Section 1135 of the Social Security Act (the "waivers").[11] The Secretary renewed the PHE multiple times, finally ending the PHE on May 11, 2023.[12] Among other things, the waivers provided relief to HHAs on the timeframes related to the Home Health Quality Reporting Program ("HH QRP") reporting requirements, including OASIS data submission requirements.[13]

Mid Valley operated with a reduced office staff during the PHE to minimize personal contact and the spread of COVID-19.[14] Mid Valley ceased submission of OASIS data (*i.e.*, in-person patient assessments) based on its understanding of the waivers.[15]

STATEMENT OF RELEVANT LAW

A. Form, Manner, and Time

The Secretary increases the prospective payments made to HHAs each calendar year by a percentage known as the "home health market basket index amount" or "home health market

[8] Note that this letter was not included in either of the parties' exhibits but was uploaded in the Board's docket management system with Mid Valley's appeal request as the final determination letter. **Accordingly, the Board takes administrative notice of the January 13, 2023 letter as the final determination letter under appeal before the Board.**
[9] Ex. P-1 at P0001.
[10] Provider's PP at 2.
[11] *See* Ex. P-1. *See discussion infra* at Statement of Relevant Law.
[12] *See* Medicare Contractor's FPP at 10; *see also* Provider's PP at 3; *see also* Ex. P-2 at P0011.
[13] *See* Ex. P-3 at P0026.
[14] *See* Tr. at 10.
[15] *See* Tr. at 11 – 13; *see also* Provider's PP at 5.

basket percentage increase" (also sometimes referred to as a Market Basket Update ("MBU")).[16] In order to qualify for the full MBU, an HHA must submit data that the Secretary determines are "appropriate for the measurement of health care quality" (i.e., quality reporting requirements).[17] Specifically, 42 C.F.R. § 484.245 (2020), which sets forth the general requirements under the home health quality reporting program, states in pertinent part:

> (b) Data submission.
>
> (1) Except as provided in paragraph (d) of this section, and for a program year, ***an HHA must submit all of the following to CMS***:
>
> * * *
>
> (iii) Quality data required under section 1895(b)(3)(B)(v)(II) of the Act, [18] including [OASIS data and] HHCAHPS survey data.
>
> * * *
>
> (2) The data submitted under paragraph (b) of this section ***must be submitted in the form and manner, and at a time***, specified by CMS.***[19]***

Additionally, 42 C.F.R. § 484.250 (2020) states: "An HHA **must submit to CMS the OASIS data** described at § 484.55(b) and (d) as is necessary for CMS to administer the payment rate methodologies described in [this chapter]."[20]

Further, an HHA that fails to submit quality data in the specified form, manner, and time will be subject to a two (2)-percentage point reduction in its MBU for a particular payment year. Specifically, 42 C.F.R. § 484.225(b) (2020) states in pertinent part:

> (b) For 2007 ***and subsequent calendar years***, in accordance with section 1895(b)(3)(B)(v) of the Act, ***in the case of a home health agency that does not submit home health quality data***, ***as specified by the Secretary***, the unadjusted national, standardized prospective rate is equal to the rate for the previous calendar year increased by the applicable home health market basket index amount ***minus 2 percentage points.*** Any reduction of the percentage change will apply only to the calendar year involved and will not

[16] *See* 42 C.F.R. § 484.225 (2020). The enabling statute, 42 U.S.C. § 1395fff uses the term "home health market basket percentage increase" while the Secretary's regulation, 42. C.F.R. § 484.225, uses the term "home health market basket index amount."
[17] Deficit Reduction Act of 2005, 42 U.S.C. § 1395fff(b)(v)(II).
[18] Note that, while not specifically identified in the regulation like HHCAHPS, Section 1895(b)(3)(B)(v)(II) of the Social Security Act encompasses the requirement for OASIS data submission. *See also* 42 C.F.R. § 484.250.
[19] (Emphasis added). Note that "CMS" and "Secretary" are used interchangeably throughout the applicable regulations.
[20] (Emphasis added).

> be taken into account in computing the prospective payment amount for a subsequent calendar year.

Accordingly, in order to meet the conditions of participation and receive payment, 42 C.F.R. § 484.45 mandates that:

> HHAs must electronically report all OASIS data collected in accordance with § 484.55.
>
> (a) Standard: Encoding and transmitting OASIS data. An HHA ***must*** encode and ***electronically transmit each completed OASIS assessment to the CMS system,*** regarding each beneficiary with respect to which information is required to be transmitted (as determined by the Secretary), ***within 30 days of completing the assessment of the beneficiary.***[21]

B. Exception Process

An HHA may be granted an exception or extension to the reporting requirements when certain extraordinary circumstances exist. Specifically, 42 C.F.R. § 484.245(c) (2020), which sets forth the exception and extension request process, states:

> (c) Exceptions and extension requirements.
>
> (1) An HHA may request and CMS may grant exceptions or extensions to the reporting requirements under paragraph (b) of this section for one or more quarters, ***when there are certain extraordinary circumstances beyond the control of the HHA***.
>
> (2) An HHA may request an exception or extension ***within 90 days of the date that the extraordinary circumstances*** occurred by sending an email to CMS HHAPU reconsiderations at HHAPUReconsiderations@cms.hhs.gov that contains all of the following information:
>
> (i) HHA CMS Certification Number (CCN).
>
> (ii) HHA Business Name.
>
> (iii) HHA Business Address.
>
> (iv) CEO or CEO–designated personnel contact information including name, title, telephone number, email

[21] (Emphasis added).

address, and mailing address (the address must be a physical address, not a post office box).

(v) HHA's reason for requesting the exception or extension.

(vi) Evidence of the impact of extraordinary circumstances, including, but not limited to, photographs, newspaper, and other media articles.

(vii) Date when the HHA believes it will be able to again submit data under paragraph (b) of this section and a justification for the proposed date.

(3) Except as provided in paragraph (c)(4) of this section, ***CMS does not consider an exception or extension request unless the HHA requesting such exception or extension has complied fully with the requirements in this paragraph (c).***

(4) ***CMS may grant exceptions or extensions to HHAs without a request if it determines that one or more of the following has occurred:***

(i) An extraordinary circumstance, such as an act of nature, affects an entire region or locale.[22]

(ii) A systemic problem with one of CMS's data collection systems directly affects the ability of an HHA to submit data under paragraph (b) of this section.[23]

C. Burden of Proof and Standard of Review

A Board decision must include findings of fact and conclusions of law that "the provider carried its burden of production of evidence and burden of proof by establishing, by a preponderance of the evidence, that the provider is entitled to relief on the merits of the matter at issue."[24] Additionally, "[a] decision by the Board shall be based upon the record made at such hearing, which shall include the evidence considered by the [Medicare contractor] and such other evidence as may be obtained or received by the Board, and shall be supported by substantial evidence when the record is viewed as a whole."[25] In *Consolidated Edison Co. v. NLRB*, 305

[22] *See also* Ex. P-5 (where the COVID-19 PHE Tip Sheet states that CMS' Exception and Extension for Extraordinary Circumstances policy describes the extraordinary circumstances relative to CMS-initiated exceptions or extensions as those "that are based on Federal Emergency Management Agency (FEMA)-designated natural disasters.") The Board notes that Ex. P-5 and Ex. C-10 are identical. Because it is the provider that carries the burden of proof, the Board will refer to Mid Valley's Ex. P-5.

[23] (Emphasis added).

[24] 42 C.F.R. § 405.1871(a)(3).

[25] 42 U.S.C. § 1395oo(d). This statutory provision also confirms: "[t]he Board shall have the power to affirm, modify,

U.S. 197, 230 (1938), the U.S. Supreme Court held, "[s]ubstantial evidence is more than a mere scintilla. It means such relevant evidence as a reasonable mind might accept as adequate to support a conclusion."[26] Accordingly, in an appeal before the Board, a provider must prove, by a preponderance of substantial, relevant evidence that it is entitled to the relief sought.

D. Temporary HH QRP Exception Due to COVID-19 PHE

In accordance with 42 C.F.R. § 484.245(c)(4)(i), in response to the COVID-19 Pandemic, CMS exempted HHAs from reporting OASIS data for the following quarters: Q4 2019, Q1 2020, and Q2 2020.[27] The temporary exception for HHA quality reporting requirements ***ended on June 30, 2020***.[28] Starting on July 1, 2020 (the beginning of Q3 2020), HHAs were expected to resume timely quality data collection and submission of OASIS data following the normal HHA QRP requirements.[29] However, HHAs were given certain flexibility waivers that remained in place for the duration of the PHE including: 1) an extension of the 5-days (after start of care) completion requirement for comprehensive assessments to 30 days, and 2) a waiver of the 30-day OASIS submission requirement, whereby delayed submissions were permitted prior to submission of final claims for Medicare reimbursement.[30]

E. HHA QRP Quality Assessments Only Metric ("QAO")

Notwithstanding temporary exceptions for quality reporting requirements through June 30, 2020, and the flexibility waivers for the duration of the PHE, as of July 1, 2020, HHAs were required to comply with the HHA QRP data collection and submission requirements including the Quality Assessments Only ("QAO") pay-for-performance metric.[31] The QAO metric measures an HHA's quality episodes of care based on a minimum set of two matching assessments for each HHA patient admission. CMS identified seven types of assessments related to the start, resumption, and end of care, each of which can be appropriately matched to contribute to a quality episode of care. Once created and reported by an HHA, the quality episodes of care are included in the computation of the QAO metric, which is illustrated as:

$$\text{QAO} = \frac{\text{\# Quality Assessments} \times 100}{\text{\# Quality Assessments} + \text{\# Non-Quality Assessments}}$$[32]

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or reverse a final determination of the fiscal intermediary with respect to a cost report and to make any other revisions on matters covered by such cost report (including revisions adverse to the provider of services) even though such matters were not considered by the intermediary in making such final determination." *But also see* 42 C.F.R. § 405.1869(a).

[26] *See also Pomona Valley Hosp. Med. Ctr. v. Becerra*, 82 F.4th 1252, 1258-59 (D.C. Cir. 2023).

[27] *See* Ex. P-5, P0082.

[28] *Id.*

[29] *Id*.

[30] *Id*. at 0083.

[31] *See* CY 2016 HH PPS Final Rule (80 Fed. Reg. 68624, 68703-68706 (Nov. 5, 2015)); *see also Home Health Quality Reporting Requirements,* available at: https://www.cms.gov/medicare/quality/home-health/home-health-quality-reporting-requirements [last visited February 20, 2025].

[32] *See* 80 Fed. Reg. at 68704.

Since July 2017, the HHA QRP has required that all HHAs achieve a quality reporting compliance rate of at least 90%.[33]

DISCUSSION, FINDINGS OF FACT, AND CONCLUSIONS OF LAW

Each calendar year, HHAs participating in the HHA QRP must meet all program requirements to avoid being subject to a 2-percentage point reduction in their market basket update. As explained above, this includes the submission of all patient quality of care assessment data (OASIS) through the CMS designated data submission systems ***and*** meeting or exceeding a ninety percent (90%) data submission threshold ***for the QAO metric*** for the respective reporting period.

This case involves the CY 2023 payment year and the reporting period of July 1, 2021, through June 30, 2022.

Generally, the OASIS data required to be submitted includes a comprehensive patient assessment (e.g., determination of the patient's immediate care and support needs), completed in a timely manner, but no later than five (5) days after the start of care.[34] As previously stated, under the Covid-19 PHE flexibility waivers, the completion time was extended to 30 days for the duration of the PHE. Generally, OASIS data is due to CMS within thirty (30) days of the assessment.[35] Stated above, under the COVID-19 PHE flexibility waivers, the 30-day submission requirement was waived, and HHAs were allowed to submit the data prior to filing a final claim for payment. As for the HHA QRP reporting requirements, any exemptions for reporting ended on June 30, 2020. Thus, even if availing themselves of the flexibility waivers through the end of the PHE on May 11, 2023, HHAs were required to resume full compliance with the HHA QRP requirements starting July 1, 2020.

Accordingly, to find in favor of Mid Valley (*i.e.*, to find that the two (2) percentage point reduction does *not* apply), the Board must find that Mid Valley met all of the HHA QRP requirements, ***particularly, the 90% quality reporting compliance rate calculated using the QAO metric***, for the reporting period of July 1, 2021, through June 30, 2022.

Parties' Arguments

According to the Medicare Contractor, the issue at hand is the "failure to meet all of the OASIS reporting requirements for July 1st, 2021, to June 30th, 2022."[36] Mid Valley claims that,

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[33] *See* 80 FR at 68706 ("Final Action: After consideration of the comments received, we are adopting as final our proposal to implement an 80 percent Pay-for-Reporting Performance Requirement for Submission of OASIS Quality Data for Year 2 reporting period July 1, 2016 to June 30, 2017, and a 90 percent Pay-for-Reporting Performance Requirement for Submission of OASIS Quality Data for the reporting period July 1, 2017 to June 30, 2018 and thereafter.") The 90% data completion threshold was codified at 42 CFR 484.245(2) as of November 13, 2023.

[34] *See* 42 C.F.R. § 484.55(b).

[35] *See* 42 C.F.R. § 484.45; *see also* Ex. C-13 at C-0635.

[36] Tr. at 55-56. *See also* the MAC's 2% Reduction Letters (Ex. C-11) and Notice of Quality Reporting Program Noncompliance Decision Upheld notice, which cite to the noncompliance with OASIS reporting requirements. The Board takes administrative notice of the Notice of Quality Reporting Program Noncompliance Decision Upheld notice (Jan. 13, 2023) which was not submitted as an exhibit but was filed in the Board's document management

"[d]uring the period in question, the requirements to meet the CMS conditions of participation (CoPs) had been suspended due to the PHE in relation to COVID-19."[37] At the hearing, Mid Valley argued that "[t]he waivers removed the [thirty] 30-day [submission] requirement and just established that the data must be transmitted as soon as reasonably possible."[38]

The Medicare Contractor argues that the waivers did not ***fully exempt*** quality health data submission for the time period in question, which was July 2021 to July 2022; instead, the exception lasted until June 30, 2020, and after that date, a ***flexibility*** extended the assessment period from five (5) days to thirty (30) days.[39] Additionally, the Medicare Contactor states that Mid Valley has provided no documentation or support in the record to indicate that OASIS submissions were done at all – even late – for the period in question.[40]

Mid Valley contends that the *October 2020 CMS Quarterly OASIS Q&As* included in the MAC's exhibits "is simply the ***temporary guidance*** of how things had to operate under the initial wave of COVID."[41] Mid Valley avers that submission of OASIS was ***waived for the duration*** of the PHE based on a table provided by the National Association for Home Care & Hospice, which summarized various waivers and flexibilities applicable to home health during the PHE.[42] Mid Valley specifically relied upon the following rows in the table:

system ("OH CDMS") as the determination being appealed. This letter states that CMS's Oct. 14, 2022 decision that Mid Valley was subject to a penalty was based on noncompliance with the HH QRP requirement to "Submit Outcome and Assessment Information Set (OASIS) – Achieve a score of at least 90% on Quality Assessments Only metric."

[37] Provider's PP at 5.

[38] Tr. at 11.

[39] *Id*. at 16 - 17. *See also* Ex. P-5 (Home Health Quality Reporting Program COVID-19 PHE Tip Sheet) stating, "The temporary exception for HH quality reporting requirements end on July 1, 2020. Starting on July 1, 2020, HHAs are expected to resume timely quality data collection and submission of OASIS and CAHPS Home Health Survey data"; Ex. C-12 (October 2020 CMS Quarterly OASIS Q&As) stating, "Starting with Quarter 3 that begins July 1, 2020, CMS expects providers to report their quality data"; Ex. C-15 (Exceptions and Extensions for Quality Reporting Requirements) at C-0651 establishing the quarter ending June 30, 2020 (Q2) as the last quarter of the Temporary HH QRP Exception Due to COVID-19 PHE.

[40] Tr. at 36-37.

[41] Tr. at 12.

[42] *See* Tr. at 35 – 36, referring to Ex. P-8.

Statute or Regulation	Waiver/Flexibility	Status	Compliance Date[43]
§484.55(b)	Extends the five-day completion requirement for the comprehensive assessment to 30 days	Ends with the PHE	5/11/2023
	Waives the 30-day OASIS submission requirement. Delayed submission is permitted during the PHE, but the OASIS must be submitted before the final claim is submitted.	Ends with the PHE	5/11/2023

This third-party guidance (Exhibit P-8) is central to Mid Valley's argument that the OASIS requirements in question were ***suspended*** until May 11, 2023, and therefore, the Medicare Contractor's reduction of Mid Valley's market basket percentage increase was in error.[44]

Mid Valley argues that its participation in the Medicare program and payment under the Medicare program is evidence of meeting the reporting requirement.[45] This argument is based on the requirement that "HHAs must submit OASIS data prior to submitting their final claim in order to receive Medicare payment."[46] The Board notes a failure to meet reporting requirements does not preclude participation and payment under the Medicare program.

* * * * *

Neither the Provider's nor the MAC's arguments (in their position papers or during the hearing) address the specific reason for the 2-percentage point reduction set forth in the January 13, 2023 Notice of Quality Reporting Program Noncompliance Decision Upheld Letter that cited the reason for the penalty as Mid Valley's ***failure to submit OASIS that "[a]chieve[d] a score of at least 90% on Quality Assessments Only metric***."[47]

Nonetheless, taking the parties' arguments into consideration, the Board finds that the flexibility waivers did not exempt Mid-Valley from being subject to the 2% reduction in absence of full

[43] *See* Ex. P-8. This excerpt represents one row of the table at P0116.
[44] Tr. at 27 – 32.
[45] *See* Tr. 49: 8-18.
[46] Ex. P-5 at P0083; *See also* Tr. at 40.
[47] Note that this letter was not included in either of the parties' exhibits but was uploaded in the Board's docket management system with Mid Valley's appeal request as the final determination letter. **Accordingly, the Board takes administrative notice of the January 13, 2023 letter as the final determination letter under appeal before the Board.**

compliance with HHA QRP requirements. Although flexibility in submitting the OASIS data beyond the 30-day requirement was permitted, Mid-Valley still had to submit the data at some point in order to get paid. And, to meet the QAO metric quality reporting compliance rate of at least 90%, the OASIS submissions had to qualify to be used in the formula—only those OASIS assessments that contributed to creating quality episodes of care. Thus, the issue was not singularly that Mid-Valley failed to timely submit the data or that they did not submit the data at all, but that whatever they submitted either: 1) failed to qualify as "matching assessments" for each patient admitted to their agency and were not used in the formula as quality episodes of care and/or 2) the number of qualifying quality assessments submitted were not enough to meet the 90% threshold.

The Board finds that, in this case, there was no evidence presented that Mid Valley submitted any extension or exception request.[48] As set forth above, CMS may grant an extension or exception without a request if CMS determines an extraordinary circumstance, such as an act of nature, or a systemic problem with a reporting program.[49] However, no evidence has been presented that CMS did so in this situation. While the Board is sympathetic to the difficult circumstances organizations experienced during the COVID-19 pandemic, the Board also considers that this was the reason for the temporary suspension of quality reporting requirements at the time they were instituted by CMS.[50] For the period in question, which was July 2021 to July 2022, the circumstances were such that all participating home health agencies were subject to OASIS submission requirements as of July 1, 2020, although with a flexible deadline for the completion of assessments and OASIS data submission.

For the reasons stated above, the Board concludes that Mid Valley failed to prove, by a preponderance of substantial, relevant evidence, that it fulfilled the requirement to report the quality data in accordance with 42 C.F.R. §§ 484.245 and 484.250. Specifically, Mid Valley failed to demonstrate that its submissions qualified under the QAO metric and that it met the 90% quality reporting compliance rate. Further, Mid Valley failed to request an exception or extension if indeed Mid Valley was experiencing extraordinary circumstances outside of its control which prevented it from reporting the quality data.

The Board appreciates the efforts of Mid Valley to continue excellent care under extremely adverse conditions during the COVID-19 pandemic. The Board's decision here is no reflection of the Board's view of Mid Valley's operation, it is strictly a review of whether Mid Valley reported the QRP data consistent with statutory guidelines for the period in question; the Board finds that Mid Valley did not.

DECISION

After considering Medicare law and regulations, the arguments presented, and the evidence admitted the Board finds that CMS properly imposed the reduction in the home health market basket percentage increase, in accordance with 42 C.F.R. § 484.225(b).

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[48] *See* 42 C.F.R. § 484.245(c)(1) – (3) (2020).
[49] 42 C.F.R. § 484.245(c)(4) (2020).
[50] *See* Ex. P-5.

BOARD MEMBERS PARTICIPATING:

Kevin D. Smith, CPA
Ratina Kelly, CPA
Nicole E. Musgrave, Esq.
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FOR THE BOARD:

3/17/2025

X Kevin D. Smith, CPA

Kevin D. Smith, CPA
Board Chair
Signed by: Kevin D. Smith -A